MARYLAND HEALTH CARE COMMISSION

For internal staff use

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MATTER/DOCKET NO.

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Application for Certificate of Conformance to Perform Primary and Elective Percutaneous Coronary Interventions

Applicant Information

Applicant University of Maryland Shore Medical Center at Easton

Street Address 219 S Washington St.

City Easton County Talbot State MD Zip Code 21601

Mailing Address (if different) _____

City _____ County _____ State _____ Zip Code _____

Medicare Provider Number(s) _____ National Provider Identifier _____

Primary Person to be contacted on matters involving this application

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Review Criteria for a Certificate of Conformance (COMAR 10.24.17.06B)

(1) An applicant hospital shall demonstrate its compliance with the general standards in COMAR 10.24.10.04A.

Ql. Is the applicant a Medicare provider in good standing? Yes ✓ No ____

If no, attach an explanation.

Q2. In the previous five years, has the applicant been sanctioned, barred, or otherwise excluded from participating in the Medicare program or been placed on a 23- or 90-day termination track? Yes ____ No ✓

If yes, attach an explanation.

Q3. Is the applicant accredited by the Joint Commission? Yes ✓ No ____

If no, attach an explanation.

Q4. In the previous three years, has the applicant had its accreditation denied, limited, suspended, withdrawn, or revoked by the Joint Commission or other accreditation organization, or had any other adverse action taken against it by an accreditation organization , including Provisional or Conditional Accreditation, Preliminary Denial of Accreditation, or Denial of Accreditation? Yes ____ No ✓

If yes, attach an explanation and provide copies of correspondence from the accreditation organization notifying the hospital of each change in its accreditation status and any relevant resulting correspondence.

Q5. In the previous five years, has the applicant been placed on Accreditation Watch by the Joint Commission?

Yes _____ No ✓

If yes, attach an explanation and provide copies of correspondence from the accreditation organization notifying the hospital of each change in its accreditation status.

Q6. Please provide a copy of the written policy for the provision of information to the public concerning charges for its services. At a minimum this policy shall include:

University of Maryland Shore Medical Center at Easton ("UMSMC-E") has a written policy in place that meets the requirements of this standard. See **Exhibit 1**.

(a) Maintenance of a representative list of services and charges that is readily available to the public in written form at the hospital and on the hospital's internet website.

The current list of representative services and charges that is readily available to the public, both at UMSMC-E and on the Hospital's internet web site:

Estimated Charges for Common Inpatient Procedures: http://umshoreregional.org/~/media/systemhospitals/shore/office-docs/patients-and-visitors/srh-ip-prices-for-web-page-03-31-15.pdf?la=en

Estimated Charges for Common Ancillary Services: http://umshoreregional.org/~/media/systemhospitals/shore/office-docs/patients-and-visitors/srh-op-prices-for-web-page-03-31-15.pdf?la=en

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

Please see **Exhibit 1**.

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

Please see **Exhibit 1**.

Q7. Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. Please provide a copy of this policy and details regarding its posting in the hospital and notice to the public, including the methods used to insure that public notice will reach the relevant population.

Please see **Exhibit 2**.

Q8. A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Services Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

The most recent (as of 9/20/15) HSCRC report on hospitals' Community Benefits (http://www.hscrc.state.md.us/documents/HSCRC_Initiatives/CommunityBenefits/cbr-fy14/FY14CB-Financial-Report.xlsx) is for FY 2014. UMSMC-E is not in the bottom quartile, as shown in **Table 1** below:

Table 1
Charity Care and Total Operating Expenses
FY 2014

Hospital	Total Charity Care	Total Operating Expenses	Percent
Bon Secours	$12,073,632	$119,439,002	10.11%
Garrett County Hospital	$3,225,760	$38,194,377	8.45%
Doctors Community	$14,726,686	$176,796,204	8.33%
UM Midtown	$14,755,634	$178,869,000	8.25%
Holy Cross Hospital	$30,739,060	$390,575,586	7.87%
Dimensions Prince Georges Hospital Center	$15,861,400	$217,477,100	7.29%
Adventist Washington Adventist	$14,404,325	$217,791,712	6.61%
Calvert Hospital	$7,010,751	$119,481,772	5.87%
Mercy Medical Center	$24,885,600	$426,907,600	5.83%
UM Shore Medical Dorchester	$2,305,000	$39,674,000	5.81%
Western Maryland Health System	$14,413,981	$282,308,921	5.11%
Frederick Memorial	$14,227,000	$319,313,000	4.46%
UM Shore Medical Chestertown	$2,067,000	$47,354,000	4.36%
Dimensions Laurel Regional Hospital	$4,507,400	$104,245,600	4.32%
UM Harford Memorial	$3,428,179	$80,416,000	4.26%
UMMC	$55,444,257	$1,305,636,000	4.25%
Johns Hopkins Bayview Medical Center	$22,183,000	$530,603,000	4.18%
Ft. Washington	$1,614,129	$38,620,727	4.18%
UM Baltimore Washington	$13,307,038	$319,031,000	4.17%
McCready	$572,384	$14,682,491	3.90%
MedStar Harbor Hospital	$6,997,842	$189,700,114	3.69%
UM Shore Medical Easton	**$5,828,000**	**$160,829,000**	**3.62%**
Peninsula Regional	$13,261,500	$368,170,415	3.60%
Atlantic General	$3,594,293	$101,574,098	3.54%
Shady Grove	$10,015,261	$295,844,877	3.39%
MedStar Union Memorial	$13,169,128	$394,669,299	3.34%
MedStar Montgomery General	$4,722,141	$141,655,632	3.33%
St. Agnes	$11,750,468	$392,471,132	2.99%
Lifebridge Northwest Hospital	$6,203,971	$212,164,000	2.92%
MedStar Franklin Square	$13,581,700	$469,241,214	2.89%
Meritus Medical Center	$7,993,597	$292,347,127	2.73%
MedStar St. Mary's Hospital	$3,430,456	$131,503,457	2.61%
Howard County Hospital	$6,010,720	$231,080,000	2.60%
MedStar Good Samaritan	$7,581,945	$303,307,419	2.50%
UM St. Joseph	$7,375,769	$310,933,000	2.37%
UM Upper Chesapeake	$4,956,053	$236,718,000	2.09%
Union Hospital of Cecil County	$3,064,396	$146,635,757	2.09%

Hospital	Total Charity Care	Total Operating Expenses	Percent
Suburban Hospital	$4,501,300	$225,204,531	2.00%
LifeBridge Sinai	$12,880,700	$669,579,000	1.92%
UM Charles Regional Medical Center	$1,864,000	$108,755,000	1.71%
Johns Hopkins Hospital	$32,721,000	$1,928,280,000	1.70%
MedStar Southern Maryland	$3,582,453	$219,466,790	1.63%
Carroll Hospital Center	$3,355,681	$209,384,000	1.60%
GBMC	$4,337,420	$381,697,000	1.14%
Anne Arundel Medical Center	$5,688,100	$514,545,000	1.11%

Q9. A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it has taken or is taking to improve performance for that Quality Measure.

Since this standard was adopted, the Commission launched a new and significantly re-designed Maryland Hospital Performance Evaluation Guide (the "Guide"). Under the new Guide, quality measure performance within the bottom quartile of all hospitals, which the standard requires an applicant to assess, is not readily apparent. However, UMSMC-E calculated the bottom quartile scores for each of the measures.

The chart attached as **Exhibit 3** shows the quality measures. UMSMC-E has calculated bottom quartile measures based on the data on the Commission's website at https://www.marylandqmdc.org/Article/View/6596c21f-1eec-42e0-90ac-c0963ff3ae73 on 9/30/2015. UMSMC-E's performance for each quality measure is also shown. The exhibit also describes the actions UMSMC-E is taking to improve performance for indicators for which it falls in the bottom quartile.

Need

(2) An applicant shall demonstrate that the proposed program is needed for its service area population through an analysis of current utilization patterns of the population for primary PCI services

Q10. Please provide information on the number of primary PCI cases for the population originating in your hospital's service area and the estimated travel time for this population to reach the nearest existing primary PCI provider. Please identify the sources and assumptions used to estimate case volume, travel time, and door-to-balloon time.

By email transmission on September 15, 2015, Ms. Eileen Fleck, the Commission's Chief of Acute Care Policy and Planning, provided CY 2014 data on both Primary and Elective PCI cases by Zip Code of residence to Dana Farrakhan, Senior Vice President, Strategy, Community and Business Development, University of Maryland Medical Center.

UMSMC-E then used the conversion list in **Table 2** to convert the Zip Codes to Counties.

Table 2
Zip Code to County Conversion

21609	BETHLEHEM	CAROLINE
21629	DENTON	CAROLINE
21632	FEDERALSBURG	CAROLINE
21636	GOLDSBORO	CAROLINE
21639	GREENSBORO	CAROLINE
21640	HENDERSON	CAROLINE
21641	HILLSBORO	CAROLINE
21649	MARYDEL	CAROLINE
21655	PRESTON	CAROLINE
21660	RIDGELY	CAROLINE
21670	TEMPLEVILLE	CAROLINE
21681	RIDGELY	CAROLINE
21682	RIDGELY	CAROLINE
21683	RIDGELY	CAROLINE
21684	RIDGELY	CAROLINE
21685	RIDGELY	CAROLINE
21686	RIDGELY	CAROLINE
21687	RIDGELY	CAROLINE
21688	RIDGELY	CAROLINE
21613	CAMBRIDGE	DORCHESTER
21622	CHURCH CREEK	DORCHESTER
21626	CRAPO	DORCHESTER
21627	CROCHERON	DORCHESTER
21631	EAST NEW MARKET	DORCHESTER
21634	FISHING CREEK	DORCHESTER
21643	HURLOCK	DORCHESTER
21648	MADISON	DORCHESTER
21659	RHODESDALE	DORCHESTER
21664	SECRETARY	DORCHESTER
21669	TAYLORS ISLAND	DORCHESTER
21672	TODDVILLE	DORCHESTER
21675	WINGATE	DORCHESTER
21677	WOOLFORD	DORCHESTER
21835	LINKWOOD	DORCHESTER
21869	VIENNA	DORCHESTER
21610	BETTERTON	KENT
21620	CHESTERTOWN	KENT
21635	GALENA	KENT
21645	KENNEDYVILLE	KENT
21650	MASSEY	KENT
21651	MILLINGTON	KENT
21661	ROCK HALL	KENT
21667	STILL POND	KENT
21678	WORTON	KENT
21607	BARCLAY	QUEEN ANNE'S
21617	CENTREVILLE	QUEEN ANNE'S
21619	CHESTER	QUEEN ANNE'S
21623	CHURCH HILL	QUEEN ANNE'S
21628	CRUMPTON	QUEEN ANNE'S
21638	GRASONVILLE	QUEEN ANNE'S
21644	INGLESIDE	QUEEN ANNE'S
21656	PRICE	QUEEN ANNE'S
21657	QUEEN ANNE	QUEEN ANNE'S
21658	QUEENSTOWN	QUEEN ANNE'S
21666	STEVENSVILLE	QUEEN ANNE'S
21668	SUDLERSVILLE	QUEEN ANNE'S
21690	CHESTERTOWN	QUEEN ANNE'S
21601	EASTON	TALBOT
21606	EASTON	TALBOT
21612	BOZMAN	TALBOT
21624	CLAIBORNE	TALBOT
21625	CORDOVA	TALBOT
21647	MCDANIEL	TALBOT
21652	NEAVITT	TALBOT
21653	NEWCOMB	TALBOT
21654	OXFORD	TALBOT
21662	ROYAL OAK	TALBOT
21663	SAINT MICHAELS	TALBOT
21665	SHERWOOD	TALBOT
21671	TILGHMAN	TALBOT
21673	TRAPPE	TALBOT
21676	WITTMAN	TALBOT
21679	WYE MILLS	TALBOT

Deriving travel time required reviewing the cases at the Zip Code level. The Region IV five county EMS System provided UMSMC-E with a chart showing the distance and driving times from various communities in the five county area to area hospitals. This is shown in **Figure 1** below (a more legible version of Figure 1 is attached as **Exhibit 4**). The green shading represents the primary hospital to which emergency cases (not just PCI) are taken. Yellow shading denotes backup hospitals based on traffic, Alerts, and other factors.

Figure 1
Distance and Driving Time to Selected Hospitals

Distance (mi), Time (min) to Destination

	AAMC		Kent General		Nanticoke		PRMC		Easton		Chestertown	
	Miles	Mins	Miles	Mins	Miles	Mins	Miles	Mins	Miles	Mins	Miles	Mins
Easton	41.8	48					47	53	0	0		
Cambridge	57.1	65			28.5	37	32.4	36	16	20		
Centreville	31.6	36	35.7	47					20.7	27		
Chester	18.3	22							28.6	35		
Chestertown*	50.6	60	34.3	52					37.1	51		
Cordova	39.6	46							9.4	15		
Crumpton*	48.5	50	27.1	39					38.5	44	10.4	14
Denton	44.1	52	27.8	40	25.7	34	45.8	59	17.2	26		
East New Market					21	28	30.5	36	22.1	27		
Federalsburg					11.4	17	32.3	42	19.9	30		
Greensboro	46.5	56	23.1	32	31.9	41	52	65	24.2	38		
Henderson	47.1	54	20	34	42	58			30.1	47		
Hillsboro	36.6	41	32.6	45	33.4	44	53.5	68	13.8	21		
Hurlock					13.8	21	30	37	20.9	32		
Madison	54.8	63			39.6	50	43.4	49	29	36		
Marydel	34	35	15.2	23	45.4	59	65.5	83	39.1	45		
Oxford	50.3	58			39.8	54	45.8	53	7.7	11		
Preston	50.1	58	42.4	58	20.4	28	35.6	44	11.6	19		
Queen Anne	36.8	39	34	45	37.3	49			15.8	23		
Queenstown	28.9	34							19.2	26		
Ridgley	40.3	47	29.3	41	32.4	45	52.5	69	18	29		
St. Michael's	52	60			41.6	60	56.9	67	10.5	18		
Stevensville	19.3	25							33.1	41		
Trappe	54.7	62			33.3	43	37.1	41	13.5	20		
Woolford					35.8	48	39.7	47	24.4	32		

Source: Region IV EMS

UMSMC-E only used the drive times from Figure 1 in its need calculations, since not all of the hospitals shown are PCI providers.

Primary PCI

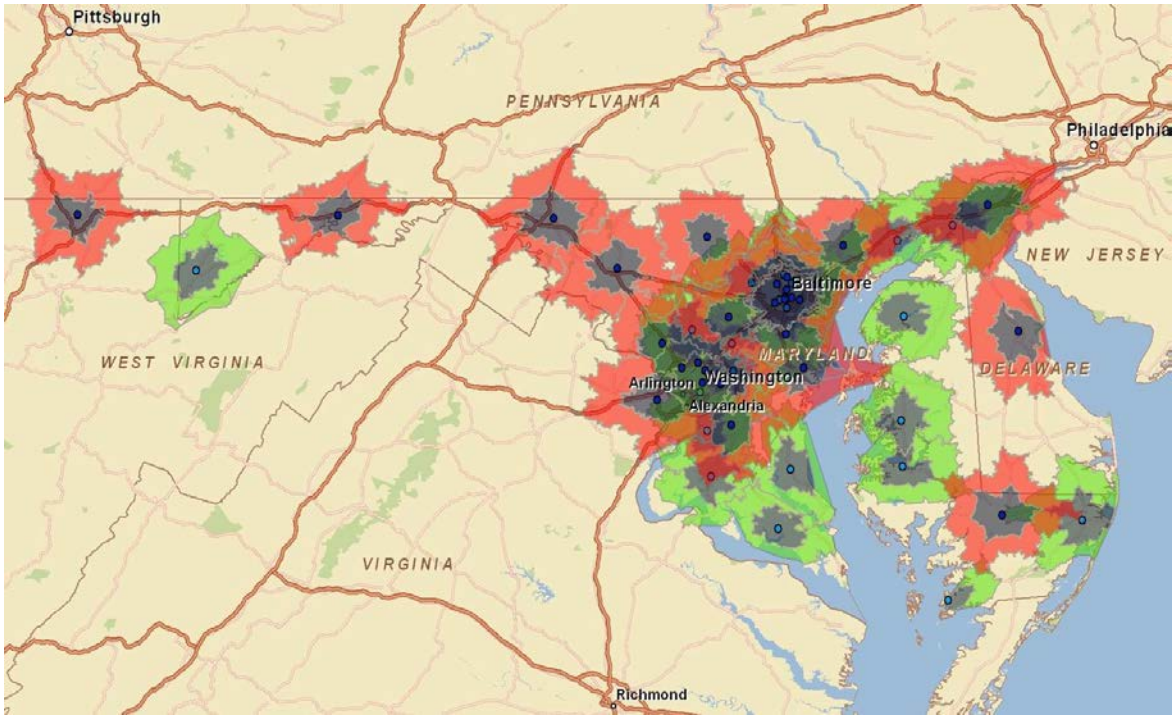
The relevant Maryland State Health Plan section ("State Health Plan for Facilities and Services: Specialized Health Care Services - Cardiac Surgery and Percutaneous Coronary Intervention Services," COMAR 10.24.17, Effective August 18, 2014) recognizes the need for a Primary PCI program in the mid-Eastern Shore region.

> The Maryland Institute for Emergency Medical Services Systems (MIEMSS) analyzed the drive time to acute care Maryland hospitals and some hospitals outside the State based on 2010 information. The map assembled by MIEMSS shows that the two largest geographic regions beyond a 30-minute drive time to a MIEMSS designated cardiac interventional hospital are: the three southernmost counties of Southern Maryland (Calvert, Charles, and St. Mary's); and the mid-Shore counties of the Eastern Shore (Caroline, Dorchester, Kent, Queen Anne's, and Talbot).

COMAR 10.24.17, at page 11.

The MIEMSS map that is cited in the State Health Plan, **Figure 2** below, clearly shows that the mid-Shore region is one of the few regions in the state that does not have 30 minute access to Primary PCI. (Regions in green do not have adequate access).

Figure 2
Maryland Institute for Emergency Medical Services Systems (MIEMSS)
Map of Regions with and without 30 Minute Drive Time to
Primary PCI at Acute Care Maryland Hospitals and Some Out of State Hospitals



Source:
http://mhcc.dhmh.maryland.gov/cardiacadvisory/Documents/Statewide_%20STEMI_%20map_MIEMSS_2010.jpg

Table 3 shows the total number of Primary PCI Cases in the five county service area in CY 2014.

Table 3
Primary PCI Cases
Five County Service Area
CY 2014

County	Total Primary PCI Cases
Caroline	5
Dorchester	20
Kent	1
Queen Anne's	10
Talbot	21
Total	57

Table 4 shows the number of Primary PCI cases by Zip Code in CY 2014 and the hospitals at which they were performed. Columns I, J, and K show the drive time minutes from the communities to the hospital where the procedure was performed. Where the EMS data from Figure 1 could be used, UMSMC-E used those driving time estimates. For communities not included in Figure 1, UMSMC-E used the Google estimated drive time from those communities to the relevant hospitals at approximately Noon on Thursday, 9/24/15. The drive times for which Google was used are shaded. Column L shows the number of cases at the relevant hospitals times the number of drive time minutes. (Where cases went to different hospitals, the number of cases at hospital A was multiplied by the drive time to hospital A. The same was done for hospital B, and then they were added together.) UMSMC-E did not include the drive times to "Howard" and UMMC because including these hospitals would skew the calculations in favor of UMSMC-E. Table 4 shows that if UMSMC-E provided primary PCI, the total average drive time would have been reduced by 44.9 percent.

Table 4

Primary PCI Cases by Zip Code of Residence and Hospital (CY 2014)
Drive Times from Community to Hospitals (Including UMSMC-E)
Drive Time Minutes Saved if UMSMC-E Provides Primary PCI

A	B	C	D	E	F	G	H	I	J	K	L	M
			Cases by Hospital					Drive Time Minutes			Cases X Minutes	
Zip Code	Name	County	AAMC	Howard	PRMC	UMMC	Total	AAMC	PRMC	UMSMC-E	Tot. Mins. to PCI Hosp (AAMC & PRMC Only)	Tot. Min. to UMSMC-E
21639	Greensboro	Caroline	1				1	56		38	56	38
21640	Henderson	Caroline			1		1	54	77	47	77	47
21655	Preston	Caroline	1			1	2	58		19	58	19
21660	Ridgely	Caroline	1				1	47		29	47	29
21613	Cambridge	Dorchester	1		12		13	65	36	20	497	260
21631	East New Market	Dorchester			2		2		36	27	72	54
21643	Hurlock	Dorchester			1	1	2		37	32	37	32
21835	Linkwood	Dorchester	1				1	72	28	27	72	27
21869	Vienna	Dorchester			2		2		24	36	48	72
21620	Chestertown	Kent				1	1				0	0
21619	Chester	Queen Anne's	5				5	22		35	110	175
21623	Church hill	Queen Anne's	1				1	43		40	43	40
21638	Grasonville	Queen Anne's	1				1	22		29	22	29

A	B	C	D	E	F	G	H	I	J	K	L	M
			Cases by Hospital					Drive Time Minutes			Cases X Minutes	
Zip Code	Name	County	AAMC	Howard	PRMC	UMMC	Total	AAMC	PRMC	UMSMC-E	Tot. Mins. to PCI Hosp (AAMC & PRMC Only)	Tot. Min. to UMSMC-E
21658	Queenstown	Queen Anne's	2	1			3	34		26	68	52
21601	Easton	Talbot	5		8		13	48	53	0	240	0
21625	Cordova	Talbot	1		1		2	46	65	15	99	30
21663	Saint Michael's	Talbot			1		1		67	18	67	18
21671	Tilghman	Talbot			2		2		85	34	170	68
21673	Trappe	Talbot			3		3		41	20	123	60
TOTAL			20	1	33	3	57				1,906	1,050
Average drive time (AAMC & PRMC only)											36.0	19.8
Total savings (in minutes)												856
Savings %												44.9%

Source of CY 2014 data: MHCC

Table 5 shows the number of cases by Zip Code and drive times to AAMC and PRMC (whichever hospitals served Primary PCI patients from each Zip Code) and to UMSMC-E. UMSMC-E then color coded the primary hospital to which STEMI patients would be transported and whether the patients would be shared among hospitals, based on drive times. Green denotes the primary hospital, and yellow denotes the secondary hospital. This was done to estimate market share of the patients by county. If UMSMC-E is the primary hospital, and there is no secondary hospital, UMSMC-E is shaded green and assumes that it would receive 100% of the patients. If the drive times are close, UMSMC-E assumes that traffic and other criteria may affect transport decisions. For example, in Zip Code 21631, the drive time to UMSMC-E is 27 minutes. The drive time to PRMC is 36 minutes. UMSMC-E assumes that it would be the primary hospital, and, under certain circumstances, PRMC will be the secondary hospital. UMSMC-E assumed that it would receive 75% of the cases. If the difference in drive time is five minutes or less, UMSMC-E assumes that each hospital would receive 50% of the cases (see Zip Code 21643). In this way, UMSMC-E projected market share by county. Based on this methodology, UMSMC-E estimates that, had it provided Primary PCI services in 2014, it would have treated 47.25 cases.

Table 5
Primary PCI Cases by Zip Code (CY 2014)
Drive Times to Primary PCI Providers
Identification of Nearest Provider and Projection of Market Share

			Cases	Driving Time				
Zip Code	Name	County	2014 Total	AAMC	PRMC	UMSMC-E	UMSMC-E Proj. Market Share	UMSMC-E Cases
21639	Greensboro	Caroline	1	56		38	100%	1
21640	Henderson	Caroline	1	54	77	47	100%	1
21655	Preston	Caroline	2	58		19	100%	2
21660	Ridgely	Caroline	1	47		29	100%	1
Caroline Total			5				100%	5
21613	Cambridge	Dorchester	13	65	36	20	100%	13
21631	East New Market	Dorchester	2		36	27	75%	1.5
21643	Hurlock	Dorchester	2		37	32	50%	1
21835	Linkwood	Dorchester	1	72	28	27	50%	0.5
21869	Vienna	Dorchester	2		24	36	25%	0.5
Dorchester Total			20				83%	16.5
21620	Chestertown	Kent	1	54	99	49	50%	0.5
Kent Total			1				50%	0.5
21619	Chester	Queen Anne's	5	22		35	25%	1.25
21623	Church Hill	Queen Anne's	1	43		40	50%	0.5
21638	Grasonville	Queen Anne's	1	22		29	25%	0.25
21658	Queenstown	Queen Anne's	3	34		26	75%	2.25
Queen Anne's Total			10				43%	4.25
21601	Easton	Talbot	13	48	53	0	100%	13
21625	Cordova	Talbot	2	46	65	15	100%	2
21663	Saint Michaels	Talbot	1		67	18	100%	1
21671	Tilghman	Talbot	2		85	34	100%	2
21673	Trappe	Talbot	3		41	20	100%	3
Talbot Total			21				100%	21
GRAND TOTAL			57				82.9%	47.25

Source of CY 2014 data: MHCC

UMSMC-E STEMI data for CY 2014 show that UM Shore Regional Health ("UM SRH") facilities already attract a large percentage of patients who need Primary PCI. **Table 6** shows that UMSMC-E had 28 "walk in" STEMI patients, while University of Maryland Shore Medical Center at Dorchester (formerly, Dorchester General Hospital) ("UMSMC-D") had 10, and the University of Maryland Shore Emergency Center at Queenstown ("UMSEC-Q") had 1.

Initiation of the Primary PCI program at UMSMC-E will reduce the transit time from the patient's location when the call was made to a site where the intervention could be performed. As MIEMSS investigates moving toward a format of measuring first medical contact to balloon time, loss of UMSMC-E as a PCI resource will put the patient at greater risk of not obtaining needed critical intervention in the optimal timeframe.

Table 6
Walk-In Transfers to Primary PCI Providers
From UMSMC-E, UMSMC-D, UMSEC-Q
CY 2014

	UM SRH			CARDIAC INTERVENTION CENTERS				
	UMSMC-E	UMSMC-D	UMSEC-Q	UMMC	AAMC	PRMC	WHC	EXP.
TOTAL	28	10	1	2	12	22	1	2

Source: UM SRH internal data

In the final step, UMSMC-E utilized Maryland Department of Planning population for the age cohorts 45-64 and 65+ to project the population for each county through 2018. UMSMC-E then divided the 2014 Primary PCI cases by the 2014 population to calculate a use rate, which it then applied through 2018. Finally, UMSMC-E applied the county-wide market shares it calculated in Table 5 to project the number of Primary PCI Cases. These projections are shown in **Table 7** below. UMSMC-E projects that it will receive 46.9 Primary PCI cases in 2017, 47.5 cases in 2018, 48.0 cases in 2019 and 48.6 cases in 2020. Please note that these projections are conservative, as the base year data are for cases performed only in Maryland hospitals and do not include cases that were performed in Delaware hospitals, such as Bayhealth Kent General Hospital in Dover, Christiana Hospital in Newark, or Nanticoke Memorial Hospital in Seaford. UMSMC-E does not have data on the number of cases from the five county Mid-Shore area that were performed in these hospitals.

Table 7
Projections of Primary PCI Cases at UMSMC-E
2016-2020

Caroline

MDP	2010	CAGR'10-'15	2011	2012	2013	2014	2015	CAGR'15-'20	2016	2017	2018	2019	2020
45-64	9,223	0.009	9,305	9,388	9,471	9,555	9,640	0.004	9,674	9,708	9,742	9,776	9,810
65+	4,413	0.027	4,532	4,654	4,779	4,908	5,040	0.032	5,203	5,371	5,545	5,725	5,910
	13,636		13,837	14,041	14,250	14,463	14,680		14,877	15,079	15,287	15,501	15,720
	Primary Cases					5	5		5	5	5	5	5
	Primary Use Rate					0.35							
	UMSMC-E Market Share									75.0%	75.0%	75.0%	75.0%
	UMSMC-E Cases									3.9	4.0	4.0	4.1

Dorchester

MDP	2010	CAGR'10-'15	2011	2012	2013	2014	2015	CAGR'15-'20	2016	2017	2018	2019	2020
45-64	9,806	0.002	9,829	9,851	9,874	9,897	9,920	(0.001)	9,914	9,908	9,902	9,896	9,890
65+	5,771	0.018	5,873	5,977	6,083	6,190	6,300	0.024	6,449	6,601	6,757	6,917	7,080
	15,577		15,702	15,828	15,957	16,088	16,220		16,363	16,509	16,659	16,813	16,970
	Primary Cases					20	20		20	21	21	21	21
	Primary Use Rate					1.24							
	UMSMC-E Market Share									72.5%	72.5%	72.5%	72.5%
	UMSMC-E Cases									14.9	15.0	15.2	15.3

Kent

MDP	2010	CAGR'10-'15	2011	2012	2013	2014	2015	CAGR'15-'20	2016	2017	2018	2019	2020
45-64	5,866	0.004	5,887	5,907	5,928	5,949	5,970	(0.001)	5,966	5,962	5,958	5,954	5,950
65+	4,397	0.029	4,526	4,658	4,795	4,935	5,080	0.030	5,231	5,386	5,546	5,711	5,880
	10,263		10,412	10,566	10,723	10,884	11,050		11,197	11,348	11,504	11,665	11,830
	Primary Cases					1	1		1	1	1	1	1

Kent

MDP	2010	CAGR'10-'15	2011	2012	2013	2014	2015	CAGR'15-'20	2016	2017	2018	2019	2020
	Primary Use Rate					0.09							
	UMSMC-E Market Share									50.0%	50.0%	50.0%	50.0%
	UMSMC-E Cases									0.5	0.5	0.5	0.5

QA

MDP	2010	CAGR'10-'15	2011	2012	2013	2014	2015	CAGR'15-'20	2016	2017	2018	2019	2020
45-64	14,868	0.014	15,076	15,288	15,502	15,720	15,940	0.003	15,994	16,047	16,101	16,156	16,210
65+	7,141	0.041	7,430	7,731	8,045	8,371	8,710	0.037	9,037	9,375	9,727	10,092	10,470
	22,009		22,507	23,019	23,547	24,090	24,650		25,030	25,423	25,828	26,247	26,680
	Primary Cases					10	10		10	11	11	11	11
	Primary Use Rate					0.42							
	UMSMC-E Market Share									55.0%	55.0%	55.0%	55.0%
	UMSMC-E Cases									5.8	5.9	6.0	6.1

Talbot

MDP	2010	CAGR'10-'15	2011	2012	2013	2014	2015	CAGR'15-'20	2016	2017	2018	2019	2020
45-64	11,273	(0.002)	11,246	11,220	11,193	11,166	11,140	(0.005)	11,079	11,019	10,959	10,899	10,840
65+	8,958	0.033	9,251	9,553	9,865	10,187	10,520	0.029	10,827	11,144	11,470	11,805	12,150
	20,231		20,497	20,772	21,058	21,354	21,660		21,907	22,163	22,429	22,704	22,990
	Primary Cases					21	21		22	22	22	22	23
	Primary Use Rate					0.98							
	UMSMC-E Market Share									100.0%	100.0%	100.0%	100.0%
	UMSMC-E Cases									22	22	22	23
	Total UMSMC-E Primary PCI Cases									**46.9**	**47.5**	**48.0**	**48.6**

Elective PCI

Table 8 shows the total number of Elective PCI Cases in the five county service area in CY 2014.

Table 8
Elective PCI Cases
Five County Service Area
CY 2014

County	Total Elective PCI Cases
Caroline	34
Dorchester	38
Kent	49
Queen Anne's	56
Talbot	70
Grand Total	247

Hence, there were a total of 57 Primary PCI cases and 247 Elective PCI Cases (for a total of 304 PCI Cases) deriving from the five county service area in 2014.

The number of hospitals to which patients go for Elective PCI is more diverse than for Primary PCI. **Table 9** shows the hospitals at which patients received Elective PCI in CY 2014, according to the Commission's data.

Table 9
Elective PCI Cases by Zip Code and Hospital
CY 2014

County	Anne Arundel	Johns Hopkins	Peninsula	Southern MD	St. Agnes	St. Joseph	Union Memorial	University of MD	Washington Adventist	Washington (DC)	Total
Caroline	7		5					19		3	34
Dorchester			23		1			12		2	38
Kent	10	3						12	3	21	49
Queen Anne's	22	3		1		1	1	8	3	17	56
Talbot	6	4	12			3	1	40		4	70
Grand Total	45	10	40	1	1	4	2	91	6	47	247

Source: MHCC

Because Elective PCI patients have more choice regarding the hospital where they will receive PCI services, UMSMC-E decided that it would use UM SRH's cardiology inpatient market share by county (including UMSMC-E, University of Maryland Shore Medical Center at Chestertown ("UMSMC-C"), and UMCMC-D) to project the number of Elective PCI cases it will attract. **Table 10** shows the UM SRH cardiology market share for FY 2015. **Table 11** shows UMSMC-E's projections of elective PCI procedures for the years 2016 – 2020.

Table 10
UM SRH
(UMSMC-E, UMSMC-C, UMSMC-D)
Cardiology Inpatient Admissions and Market Share by County
FY 2015

	UMSMC-E	UMSMC-C	UMSMC-D	All Other Hospitals	Total	UM SRH	
						#	%
Caroline	266	7	5	163	441	278	63.0%
Dorchester	83	0	329	225	637	412	64.7%
Kent	21	214	0	92	327	235	71.9%
Queen Anne's	102	47	4	377	530	153	28.9%
Talbot	515	0	18	230	763	533	69.9%
TOTAL	**987**	**268**	**356**	**1,087**	**2,698**	**1,611**	**59.7%**

Table 11
Projections of Elective PCI Cases at UMSMC-E
2016-2020

Caroline

MDP	2010	CAGR '10-'15	2011	2012	2013	2014	2015	CAGR'15-'20	2016	2017	2018	2019	2020
45-64	9,223	0.009	9,305	9,388	9,471	9,555	9,640	0.004	9,674	9,708	9,742	9,776	9,810
65+	4,413	0.027	4,532	4,654	4,779	4,908	5,040	0.032	5,203	5,371	5,545	5,725	5,910
	13,636		13,837	14,041	14,250	14,463	14,680		14,877	15,079	15,287	15,501	15,720
	Elective Cases					34	35		35	35	36	36	37
	Elective Use Rate					2.35							
	UMSMC-E Market Share									63.0%	63.0%	63.0%	63.0%
	UMSMC-E Cases									22.3	22.7	23.0	23.3

Dorchester

MDP	2010	CAGR '10-'15	2011	2012	2013	2014	2015	CAGR'15-'20	2016	2017	2018	2019	2020
45-64	9,806	0.002	9,829	9,851	9,874	9,897	9,920	(0.001)	9,914	9,908	9,902	9,896	9,890
65+	5,771	0.018	5,873	5,977	6,083	6,190	6,300	0.024	6,449	6,601	6,757	6,917	7,080
	15,577		15,702	15,828	15,957	16,088	16,220		16,363	16,509	16,659	16,813	16,970
	Elective Cases					38	38		39	39	39	40	40
	Elective Use Rate					2.36							
	UMSMC-E Market Share									64.7%	64.7%	64.7%	64.7%
	UMSMC-E Cases									25.2	25.5	25.7	25.9

Kent

MDP	2010	CAGR '10-'15	2011	2012	2013	2014	2015	CAGR'15-'20	2016	2017	2018	2019	2020
45-64	5,866	0.004	5,887	5,907	5,928	5,949	5,970	(0.001)	5,966	5,962	5,958	5,954	5,950
65+	4,397	0.029	4,526	4,658	4,795	4,935	5,080	0.030	5,231	5,386	5,546	5,711	5,880
	10,263		10,412	10,566	10,723	10,884	11,050		11,197	11,348	11,504	11,665	11,830
	Elective Cases					49	50		50	51	52	53	53
	Elective Use Rate					4.50							

Kent

MDP	2010	CAGR '10-'15	2011	2012	2013	2014	2015	CAGR'15-'20	2016	2017	2018	2019	2020
	UMSMC-E Market Share									71.9%	71.9%	71.9%	71.9%
	UMSMC-E Cases									36.7	37.2	37.7	38.3

QA

MDP	2010	CAGR '10-'15	2011	2012	2013	2014	2015	CAGR'15-'20	2016	2017	2018	2019	2020
45-64	14,868	0.014	15,076	15,288	15,502	15,720	15,940	0.003	15,994	16,047	16,101	16,156	16,210
65+	7,141	0.041	7,430	7,731	8,045	8,371	8,710	0.037	9,037	9,375	9,727	10,092	10,470
	22,009		22,507	23,019	23,547	24,090	24,650		25,030	25,423	25,828	26,247	26,680
	Elective Cases					56	57		58	59	60	61	62
	Elective Use Rate					2.32							
	UMSMC-E Market Share									28.9%	28.9%	28.9%	28.9%
	UMSMC-E Cases									17.1	17.3	17.6	17.9

Talbot

MDP	2010	CAGR '10-'15	2011	2012	2013	2014	2015	CAGR'15-'20	2016	2017	2018	2019	2020
45-64	11,273	(0.002)	11,246	11,220	11,193	11,166	11,140	(0.005)	11,079	11,019	10,959	10,899	10,840
65+	8,958	0.033	9,251	9,553	9,865	10,187	10,520	0.029	10,827	11,144	11,470	11,805	12,150
	20,231		20,497	20,772	21,058	21,354	21,660		21,907	22,163	22,429	22,704	22,990
	Elective Cases					70	71		72	73	74	74	75
	Elective Use Rate					3.28							
	UMSMC-E Market Share									69.9%	69.9%	69.9%	69.9%
	UMSMC-E Cases									51	51	52	53
	Total UMSMC-E Elective PCI Cases									**152.1**	**154.0**	**156.0**	**158.0**
	Total UMSMC-E Primary PCI Cases									46.9	47.5	48.0	48.6
	Total PCI Cases									**199.01**	**201.48**	**204.03**	**206.66**

Q11. Please provide information and analysis demonstrating that the simultaneous establishment of a primary PCI program and elective PCI program is required to assure the financial viability of the program. Please provide revenue and expense projections for the first four years of operation for both a primary PCI program only and for a program that includes both primary and elective PCI, using the attached Form B and adhering to the instructions provided for that form. Additionally, please provide an accompanying statement of all assumptions used in development of these revenue and expense projections.

As set forth in the response to Question 10, UMSMC-E projects that it will have 49 Primary PCI cases in 2020. This volume would not be enough cases to enable UMSMC-E to recruit two interventional cardiologists to establish a Primary PCI program. However, adding the projected 158 Elective PCI cases to the Primary PCI cases will produce a total of 207 PCI cases, which is adequate volume for recruiting the cardiologists.

Furthermore, the capital costs required for initiating a PCI program ($2,568,600), principally for the addition of a second Cardiac Catheterization Laboratory, would be spread over too few Primary PCI cases to be feasible. However, spreading the cost over the total PCI volume would enable the project to be cost-effective.

As a member of UM SRH, UMSMC-E's rates are set according to the Health Services Cost Review Commission's "Total Patient Revenue" ("TPR") program. With the exception of the downstream stress tests, which will be provided at Chesapeake Cardiology (a cardiology practice owned by UM SRH), all other PCI services will be provided in hospital space. Therefore, HSCRC Reimbursement guidelines apply. Under TPR, this service results in no increase to allowable hospital revenue for the service in the first year. Thus, the first year revenue shown on Form B reflects Outpatient Physician Fees only. UM SRH intends to submit a formal request to the HSCRC to increase the TPR CAP to help fund a new program/service. Consistent with past practice, UM SRH assumed that the HSCRC will approve an amount equal to the first year loss. Typically, the hospital is expected to shoulder the expense for one full year without financial assistance until volumes have been established. Then at that point the hospital's revenue base is adjusted on a prospective basis.

With the additional revenue that UMSMC-E is assuming the HSCRC will approve, this project would be a "break-even" program financially. There is a small loss of $127,250 projected in year 2020. With total revenues of approximately $170M, this loss represents only 0.07% of UMSMC-E's revenue. UMSMC-E had a positive net-revenue of approximately $8M in FY 2015.

Furthermore, if Project Depreciation is not considered, the PCI program has a positive net income of $169,704 in year 2020, as shown on **Form B**.

If UMSMC-E were to provide Primary PCI only, not only would the whole program not be feasible for the reasons stated above, but UMSMC-E would not generate additional Cardiac Catheterization Laboratory volumes or physician follow-up revenue and would generate even

less revenue. UMSMC-E needs to provide both Primary and Elective PCI for this program to be viable.

A Statement of Assumptions follows **Form B**.

Access

(3) An applicant shall present evidence, including emergency transport data and patient-level data that demonstrate that the proposed program's service area population has insufficient access to emergency PCI services and is receiving suboptimal therapy for STEMI.

Q12. Please provide information that demonstrates that the population to be served by the proposed program has insufficient access to primary PCI services and currently receives suboptimal therapy for STEMI.

There is a clear unmet need for a Primary PCI provider in the mid-Shore region, as demonstrated above. This fact is recognized by both MIEMSS and the Commission, as reflected in the State Health Plan. The mid-Shore region is one of two regions that does not have access to Primary PCI within a 30 minute transport time.

The 2013 STEMI Guideline: Data-driven Recommendations that Reduce Morbidity and Mortality states:

> "Primary percutaneous coronary intervention (PCI) remains the recommended method of reperfusion when it can be performed in a timely fashion by experienced operators. EMS transport directly to a PCI-capable hospital for primary PCI is the recommended triage strategy. The concept of "door-to-balloon time" or "door-to-needle time" is replaced with the concept of "first medical contact (FMC)-to-device time," representing both the recognition that the key issue is triaging and treating the patient as soon as possible, not only "counting" when the patient enters an emergency room. The systems goal of FMC-to-device time is 90 minutes or less."

If the proposed program is approved, UMSMC-E would improve the outcomes of STEMI patients in mid-Shore region through its close proximity. These patients are currently being transferred to farther regions for care. As demonstrated above, the proposed program would significantly reduce transport time for residents of the mid-Shore region. Providing PCI at UMSMC-E would reduce the average drive time from 36 minutes to current PCI providers to 19.8 minutes, a reduction of 44.9%. (see Table 4)

As noted above, the State Health Plan section on cardiac services states that MIEMSS has used a 30-minute drive time to a MIEMSS designated cardiac interventional hospital as the basis for evaluating adequate access. COMAR 10.24.17, at p. 11. It found that the mid-Shore region did not have adequate access. **Table 12** shows the same CY 2014 data that were included in Table 4 for cases that were performed at AAMC and PRMC. The highlighted cases identify

the STEMI cases that have longer drive times than 30 minutes to AAMC and PRMC but less than 30 minutes to UMSMC-E. It shows that 60% of the cases that were performed at AAMC with drive times greater than 30 minutes would have had drive times of less than 30 minutes if UMSMC-E had been a PCI provider. Likewise, 81.8% of the cases were performed at PRMC and had drive times greater than 30 minutes would have had drive times of less than 30 minutes to UMSMC-E.

Table 12
STEMI Cases at AAMC and PRMC
From the Mid-Shore Region, CY 2014
Driving Time to AAMC, PRMC, and UMSMC-E

A	B	C	D	E	F	G	H
			Cases by Hospital		Drive Time Minutes		
Zip Code	Name	County	AAMC	PRMC	AAMC	PRMC	UMSMC-E
21639	Greensboro	Caroline	1		56		38
21640	Henderson	Caroline		1	54	77	47
21655	Preston	Caroline	1		58		19
21660	Ridgely	Caroline	1		47		29
21613	Cambridge	Dorchester	1	12	65	36	20
21631	East new market	Dorchester		2		36	27
21643	Hurlock	Dorchester		1		37	32
21835	Linkwood	Dorchester	1		72	28	27
21869	Vienna	Dorchester		2		24	36
21620	Chestertown	Kent					
21619	Chester	Queen Anne's	5		22		35
21623	Church hill	Queen Anne's	1		43		40
21638	Grasonville	Queen Anne's	1		22		29
21658	Queenstown	Queen Anne's	2		34		26
21601	Easton	Talbot	5	8	48	53	0
21625	Cordova	Talbot	1	1	46	65	15
21663	Saint michaels	Talbot		1		67	18
21671	Tilghman	Talbot		2		85	34
21673	Trappe	Talbot		3		41	20
Grand Total			20	33			
Cases that would have been < 30 min.			12	27			
% Cases that would have been < 30 min.			60.0%	81.8%			

The drive times specified above do not tell the entire story. It is well known that traffic on the Eastern Shore varies by both time of day, day of week, and month. During the summer months, beach traffic and accidents can double the driving time from UMSMC-E to AAMC.

(Long transport times are the main reason that the freestanding medical facility known as UMSEC-Q was established.) Not only do the long transport times lead to unacceptable pick-up to balloon times for STEMI patients, but they also tie-up emergency transport vehicles and staff, reducing the resources for all other emergency calls.

Exhibit 5 shows the differences in normal and peak drive times during the week. They show that during peak times the drive time from UMSMC-E to AAMC increases substantially from 51 minutes to 80 minutes.

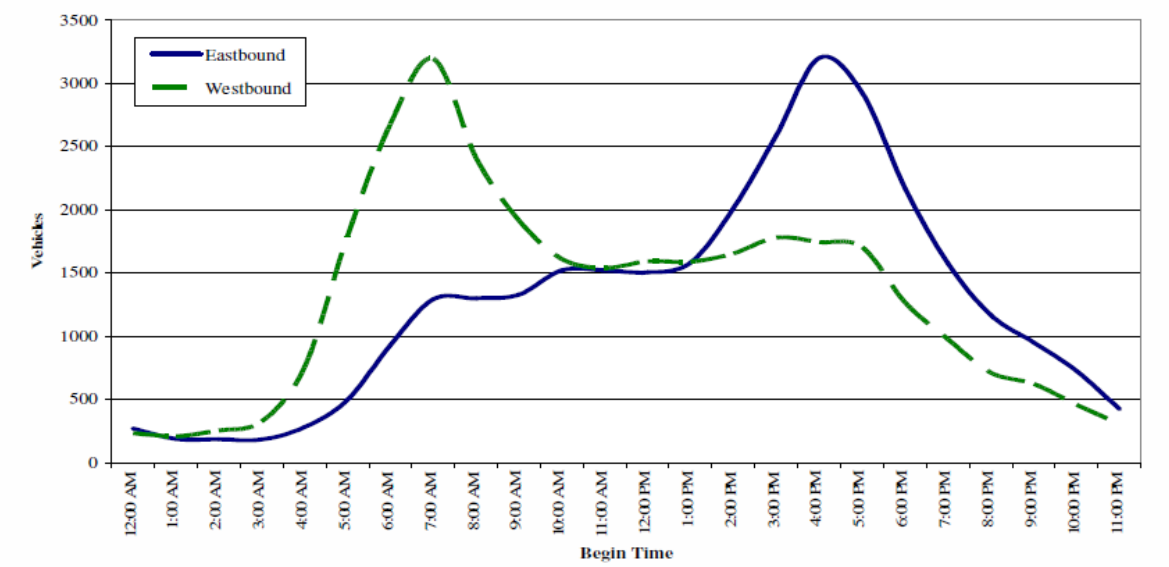
Even these drive time data do not represent the summer months when traffic becomes much more congested. A 2006 Talbot County Transportation Planning Study/Thoroughfare Plan stated:

> In addition to growth and changes in demographic trends, Talbot County is situated along two major "Reach the Beach" corridors: US 50 and MD 404. US 50, in particular, causes a significant transportation headache for county residents on summer weekends. Traffic volumes along US 50 cause such severe congestion that east-west movements across US 50 are nearly impossible. US 50 traffic in effect bisects Talbot County on summer weekends. The congestion along US 50 and the direct impact it has on east-west traffic is so severe that residents and County officials are expressing safety concerns. The congestion limits the ability for emergency vehicles to maneuver across the County in a timely fashion.

Source: Talbot County, Maryland, *Transportation Planning Study/Thoroughfare Plan 2006*, Introduction and Background, p. 2

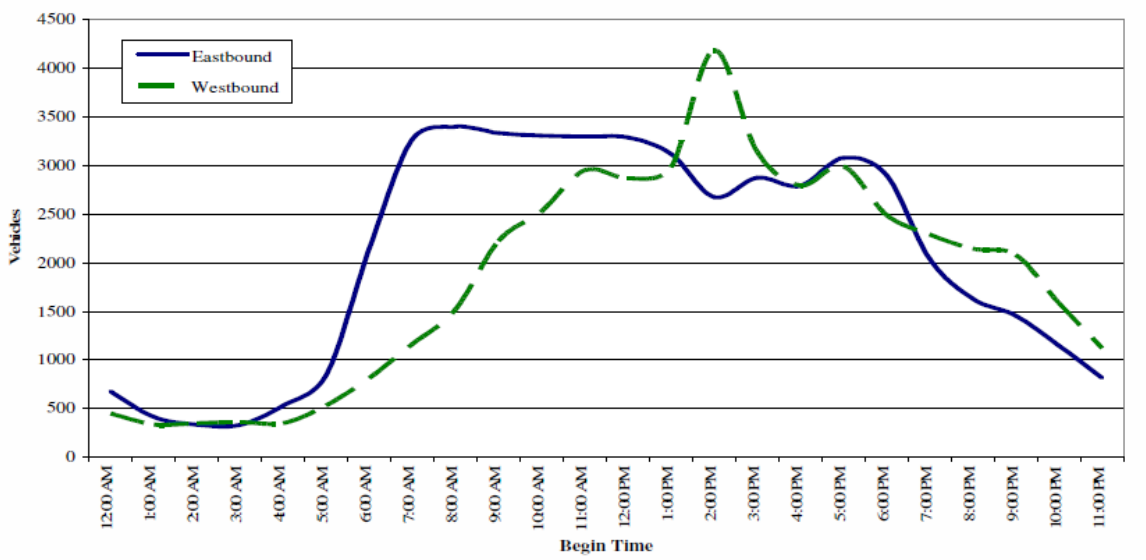
Furthermore, the Final Report on the 2007 *Analysis of Transit Only Concepts To Address Traffic Capacity Across the Chesapeake Bay* by the Maryland Transportation Authority included graphs showing that both eastbound and westbound traffic on the Bay Bridge is considerably higher on summer weekends than on non-summer weekdays. These graphs are shown in **Figures 3 and 4**.

Figure 3
Typical Trends for Traffic Volumes on the Bay Bridge on a Non-Summer Weekday (Existing Conditions)



Source: Maryland Transportation Authority, *Analysis of Transit Only Concepts To Address Traffic Capacity Across the Chesapeake Bay, Final Report*, 2007, P. 7

Figure 4
Typical Trends for Traffic Volumes on the Bay Bridge on a Summer Saturday (Existing Conditions)



Source: Maryland Transportation Authority, *Analysis of Transit Only Concepts To Address Traffic Capacity Across the Chesapeake Bay, Final Report*, 2007, P. 10

These factors have considerable impact on the ability to obtain Primary PCI for STEMI patients during the summer months. Providing PCI at UMSMC-E will help reduce the transport time.

The establishment of a PCI Program at UMSMC-E has generated significant community support, as the letters in **Exhibit 6** demonstrate. It is widely acknowledged that mid-Shore residents have insufficient access to emergency PCI services and are receiving suboptimal therapy for STEMI as a result of the current need to travel to Salisbury or to cross the Bay Bridge.

(4) The hospital shall demonstrate that its proposed elective PCI program is needed to preserve timely access to emergency PCI services for the population to be served.

Q13. Please provide information on the expected travel time for the population to be served, based on travel from their location of residence to the nearest available provider of primary PCI services and to your hospital. Please identify the sources and assumptions used for this analysis.

Please see the responses to questions 10 and 12.

Volume

(5) An applicant shall document that its proposed primary PCI program will achieve a volume of at least 36 PCI cases by the end of the second year of providing primary PCI services if the hospital is located in a rural area or an annual volume of at least 49 cases if the hospital is located in a non-rural area.

Q14. Please provide information that supports your projection of primary PCI case volume at your hospital by the end of the second full year of operation as a provider of primary PCI.

As demonstrated in the response to question 10, UMSMC-E projects that it will treat approximately 47 Primary PCI cases in its second year of operation.

(6) An applicant shall document that its proposed elective PCI program will achieve a volume of 200 or more total PCI cases by the end of the second year of providing elective PCI services. The Commission may waive the volume requirement of 200 or more total PCI cases by the end of the second year, if the applicant demonstrates that adding an elective PCI program at its projected annual case volume will permit the hospital's l PCI service (emergency and elective) to achieve financial viability.

Q15. Are you requesting that the volume requirement of 200 cases be waived?

Yes _____ No ✓

Q16. Please provide information that supports a projected PCI case volume of 200 or more cases by the end of the second full year of operation as a provider of elective PCI. Please provide projections for primary PCI cases and elective PCI cases separately, and include an explanation of the assumptions used to develop the projected primary and elective PCI case volumes.

Please see the response to Question 10.

Institutional Resources

(7) The hospital shall demonstrate that primary PCI services will be available for all appropriate patients with acute myocardial infarction 24 hours per day, seven days per week.

Q17. Please provide information plans for handling downtime that may occur due to required equipment maintenance or unforeseen circumstances.

Currently, UMSMC-E performs diagnostic catheterization, cardiac rhythm device implantation (PM, ICD, BiV) in a single, dedicated Cardiac Catheterization Laboratory.

Plans are under way to add a second Cardiac Catheterization Lab adjacent to the existing laboratory pending the Commission's approval of the program.

Regular maintenance for radiation emitting imaging equipment is of primary importance in providing safe operations for patients and staff. In that regard, regularly scheduled preventative maintenance will be carried out in a manner to ensure that one of two (proposed) laboratories will always remain in service.

In the unlikely event that the one laboratory remaining in service is interrupted with unforeseen failure, patients scheduled for elective procedures will be rescheduled. "Walk-in" STEMI patients who would possibly arrive during a period where both laboratories are out of service would be transferred to the nearest approved CIC Center in the same manner that UMSMC-E currently transfers those patients. For those STEMI patients transferred by EMS, County EMS 911 Centers will be notified of the temporary inability to perform primary angioplasty for STEMI patients arriving by EMS. They will be able to reroute the ambulances and transport STEMI patients to an approved alternative CIC Center by the protocols currently in place with our not being an approved MIEMSS CIC Center.

(8) The hospital shall commit to providing primary PCI services as soon as possible and not to exceed 90 minutes from patient arrival at the hospital, excluding transfer cases, for at least 75 percent of appropriate patients. The hospital shall also track the door-to-balloon times for transfer cases and evaluate areas for improvement.

Q18. Please provide a signed statement from the hospital's chief executive officer acknowledging agreement with the above statement.

Please see **Exhibit 7**.

(9) The hospital shall have adequate physician, nursing, and technical staff to provide cardiac catheterization laboratory and coronary care unit services to patients with acute myocardial infarction 24 hours per day, seven days per week.

Q19. Please provide information on the proposed staffing pattern, including on-call coverage, and backup coverage that demonstrates the hospital will be able to meet the requirement that cardiac catheterization laboratory and coronary care unit services are available to patients with acute myocardial infarction 24 hours per day, seven days per week.

UMSMC-E's Cardiac Catheterization Laboratory along with the Emergency Department, Telemetry unit, and Intensive Care/Coronary Care Unit are available to patients with acute myocardial infarction 24 hours/day, 7 days/week. The Emergency Department, Telemetry unit, and ICU/CCU are staffed 24 hours/day, 7 days/week. Staff to patient ratios determine the staffing level for any given shift. UMSMC-E currently has one Cardiac Catheterization Laboratory and will add a second laboratory if this application is approved. The Cardiac Catheterization Laboratory is staffed Monday-Friday, 7 a.m.-4:30 p.m. (See Staffing Pattern in response to Question 20.) Staffing consists of a minimum of one Interventional Cardiologist, two Registered Nurses, and one Cardiovascular Technologist assigned to each of two procedure rooms. After hours coverage (4:30 p.m.-7 a.m. Monday-Friday and 24 hours per day Saturday and Sunday) are covered by on-call staff to include one Interventional Cardiologist, two Registered Nurses, and one Cardiovascular Technologist.

UMSMC-E
PCI Services
Cardiac Catheterization Laboratory

CCL Room	Days and Hours of Operation							
	Hours	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**
Room 1	Regular:	7:00am - 3:30pm	7:00am - 3:30pm	7:00am - 3:30pm	7:00am - 3:30pm	7:00am - 3:30pm	N/A	N/A
Room 2 Proposed	Regular:	8:00am - 4:30pm	8:00am - 4:30pm	8:00am - 4:30pm	8:00am - 4:30pm	8:00am - 4:30pm	N/A	N/A
	On-Call:	4:30pm - 7:00am	4:30pm - 7:00am	4:30pm - 7:00am	4:30pm - 7:00am	4:30pm - 7:00am	24 hours	24 hours

Type of Clinical Staff on Team	Number of Staff	Call Rotation	Response Time
MD	1	1630-0700 M-F; 24 hours Sat-Sun	30 minutes
Nurses	2	1630-0700 M-F; 24 hours Sat-Sun	30 minutes
Technologists	1	1630-0700 M-F; 24 hours Sat-Sun	30 minutes

During regular hours of operation as depicted above, each Cardiac Catheterization Laboratory will consist of a minimum staff available in each of the two laboratories (Room 2 is proposed at this time awaiting approval of this application).

Q20. Complete the following table to show the number of physicians, nurses, and technicians who are available and able to provide cardiac catheterization services to acute myocardial infarction patients (as of one week before the due date of the application). Also indicate whether the nursing and technical staff are cross-trained to scrub (S), circulate (C), and monitor (M).

Total Number of CCL Physician, Nursing, and Technical Staff

	Number/FTEs	Cross-Training (S/C/M)
Physician	2.0 FTE	Interventional Cardiologist
Nurse	5.0 FTE	S/C/M
Technician	2.0 FTE	S/C/M

Assignments:
S = Scrub
C = Circulate
M = Monitor

(10) The hospital president or Chief Executive Officer, as applicable, shall provide a written commitment stating the hospital administration will support the program.

Q21. Submit a letter of commitment, signed by the hospital chief executive officer, acknowledging that the hospital will provide primary PCI services in accord with the requirements for primary PCI programs established by the Maryland Health Care Commission.

Please see **Exhibit 8**.

(11) The hospital shall maintain the dedicated staff necessary for data collection, management, reporting, and coordination with institutional quality improvement efforts.

Q22. Please list each position responsible for these activities for primary PCI services and the number of staff FTEs dedicated to these activities.

The Interventional Cardiology PCI Program at UMSMC-E will participate in the American College of Cardiology's National Cardiovascular Registry (ACC-NCDR), ACTION Registry, and Cardiac Cath/PCI Registry.

This will be accomplished by assigning data entry responsibility to two existing (1.5 FTE) data administration positions in the Department of Cardiovascular & Pulmonary Services. These positions are cross-trained to perform similar registry data entry tasks in other specialty areas of the Department as required by specialty accrediting agencies.

The Regional Director for Cardiovascular Services along with the Medical Director for Cardiac Services and the Director for Interventional Cardiology will oversee the quality data collection process.

Also included along with this effort associated with data collection will be the Clinical Specialist, Cardiac Catheterization Laboratory, along with the Registered Nurses who work in the Cardiac Catheterization Laboratory.

(12) A hospital shall develop and complete a PCI development plan that includes an on-call coverage back-up plan for primary PCI cases, when an on-call interventionalist covers more than one hospital on a given shift, as well as when two simultaneous STEMI patients present at the hospital.

Q23. Please submit a copy of the applicable policies and procedures. If simultaneous on-call coverage is not permitted, please state this.

Not Applicable. UMSMC-E's interventionalists will not be covering more than one hospital.

(13) The hospital shall identify a physician director of interventional cardiology services responsible for defining and implementing credentialing criteria for the cardiac catheterization laboratory and for overall primary PCI program management, including responsibility for equipment, personnel, physician call schedules, quality and error management, review conferences, and termination of primary PCI privileges.

Q24. Please name the anticipated director of interventional cardiology services, or if unknown, please commit to providing this information to Commission staff 90 days prior to first use approval.

UMSMC-E has been in discussions with two interventional cardiologists, one of whom is expected to be the Director of Interventional Cardiology Services. UMSMC-E expects to sign contracts with these cardiologists soon after the approval of this application by the Commission. The cardiologists have not informed their current employer of their potential relocation to Maryland, and they want to provide notice after approval, not have their employer learn about it through a public document. Also, UMSMC-E regards the names of these cardiologists to be sensitive competitive information, and it does not want another PCI provider to attempt to recruit them. UMSMC-E commits to providing this information to Commission staff 90 days prior to first use approval.

(14) The hospital shall design and implement a formal continuing medical education program for staff, particularly the cardiac catheterization laboratory and coronary care unit.

Q25. Please provide a list of the continuing educational programs and activities in which staff in the CCL and the Coronary Care Unit will participate in the first year of operation of the PCI program.

Exhibit 9 includes the continuing education program for Cardiac Catheterization Laboratory Staff, Emergency Department RN's, Telemetry Unit, and ICU/CCU RN's.

(15) The hospital shall maintain a formal and properly executed written agreement with a tertiary care center that provides for the unconditional transfer of each primary PCI patient who requires additional care, including emergent or Elective cardiac surgery or PCI, from the applicant hospital to the tertiary institution.

Q26. Does the hospital have a current signed and dated agreement with a tertiary care center that provides for the unconditional transfer of primary PCI patients from the applicant hospital to the tertiary institution and that covers the transfer of each non-primary PCI patient who requires additional care, including emergent or non-primary cardiac surgery or PCI?

Yes ✓ No _____

If yes, please provide a copy. If no, provide either a new agreement or a signed and dated amendment to an existing agreement.

Please see **Exhibit 10**.

(16) A hospital shall maintain its agreement with a licensed specialty care ambulance service that, when clinically necessary, guarantees arrival of the air or ground ambulance at the applicant hospital within 30 minutes of a request for primary PCI patient transport by the applicant.

Q27. Does the hospital's signed and dated formal written agreement with a currently licensed advanced cardiac support emergency medical services provider guarantee the

arrival of an air or ground ambulance at the applicant hospital within 30 minutes of a request from that hospital for the transport of a primary PCI patient to a tertiary care center? Yes ✓ No ____

If yes, please provide a copy. If no, provide either a new agreement or a signed and dated amendment to an existing agreement with a currently licensed advanced cardiac support emergency medical services provider that provides such a guarantee.

Please see **Exhibit 11**.

Quality

(17) A hospital shall develop a formal, regularly scheduled (meetings at least every other month) interventional case review that requires attendance by interventionalists and other physicians, nurses, and technicians who care for primary PCI patients.

Q28. Please submit a signed letter of commitment from the hospital chief executive officer, acknowledging that the hospital will meet this standard, if the applicant hospital obtains Commission approval to establish a primary PCI program.

Please **see Exhibit 12**.

(18) A hospital shall create a multiple care area group (emergency department, coronary care unit, and cardiac catheterization laboratory) that includes, at a minimum, the physician and nursing leadership of each care area and meets monthly to review any and all issues related to the primary PCI system, identify problem areas, and develop solutions.

Q29. Please submit a signed letter of commitment from the hospital chief executive officer, acknowledging that the hospital will meet this standard, if the applicant hospital obtains Commission approval to establish a primary PCI program.

Please see **Exhibit 13**.

(19) At least semi-annually, as determined by the Commission, the hospital shall conduct an external review of at least five percent of randomly selected PCI cases performed in the applicable time period and an internal review of at least 10 percent of randomly selected PCI cases performed in the applicable time period.**

Q30. Please submit a signed letter of commitment from the hospital chief executive officer, acknowledging that, if the applicant hospital obtains Commission approval to establish a primary PCI program, the hospital will meet this standard.[**]

[**] Although this is the current standard, a new standard was adopted in proposed regulations, COMAR 10.24.17, on July 16, 2015 that does not require hospitals with only primary PCI programs to conduct an external review. If COMAR 10.24.17 is adopted by the Commission as final regulations then the new standard would be applicable.

Please see **Exhibit 14**.

Physician Resources

(20) Each physician who performs primary PCI services at a hospital that provides primary PCI without on-site cardiac surgery shall achieve an average annual case volume of 50 or more PCI cases over a two-year period.

Q31. Please submit a signed letter from the hospital chief executive officer, acknowledging that, if the applicant hospital obtains Commission approval to establish a primary PCI program, it will submit documentation that demonstrates compliance with this standard 90 days prior to first use. The applicant shall submit to Commission staff a roster of all physicians who will be performing primary PCI with documentation showing that each currently meets the case volume requirement, using Form C.

Please see **Exhibit 15**. UMSMC-E has submitted **Form C** in a redacted form to protect the identity of the physicians who will staff the PCI program. The physicians are employed in New York State, and have not yet given notice that they will be resigning their positions. UMSMC-E has submitted a request for the Commission to accept each **Form C** under seal.

Patient Selection

(21) An applicant shall commit to providing primary PCI services only for suitable patients. Suitable patients are patients described as appropriate for primary PCI in the Guidelines of the American College of Cardiology Foundation/American Heart Association (ACCF/AHS) for Management of Patients with Acute Myocardial Infarction or in the Guidelines of the American College of Cardiology Foundation/American Heart Association/Society for Cardiovascular Angiography and Interventions (ACCF/AHA/SCAI) for Percutaneous Coronary Intervention.

Q32. Please provide a signed statement from the hospital's chief executive officer and medical director of cardiac interventional services attesting to the hospital's commitment to meeting the standards for patient selection.

Please see **Exhibit 16**.

Financial Viability

(22) An applicant shall document that its proposed primary PCI program will achieve financial viability.

Q33. Will the introduction of primary PCI services require a capital expenditure by the hospital? Yes ✓ No ____

If yes, please provide a project budget detailing the anticipated expenditures using Form A.

Please see **Form A**.

Q34. Please complete and submit a schedule of projected revenues and expenses for PCI services, using Form B. Please note that this schedule requires the reporting of projected revenues and expenses for future years through the third year of operation.

Please see **Form B**.

Section E – Applicant Affidavit

I solemnly affirm under penalties of perjury that the contents of this application, including all attachments, are true and correct to the best of my knowledge, information, and belief. I understand that if any of the facts, statements, or representations made in this application change, the hospital is required to notify the Commission in writing.

If the Commission issues a Certificate of Conformance to permit the hospital to perform PCI procedures, the hospital agrees to timely collect and report complete and accurate data as specified by the Commission. I further affirm that this application for a Certificate of Conformance to perform primary and elective percutaneous coronary interventions has been duly authorized by the governing body of the applicant hospital, and that the hospital will comply with the terms and conditions of the Certificate of Conformance and with other applicable State requirements.

If the Commission issues a Certificate of Conformance to permit the hospital to perform PCI procedures, the hospital agrees that it will voluntarily relinquish its authority to provide PCI services upon receipt of notice from the Executive Director of the Commission if the hospital fails to meet the applicable standards for a Certificate of Conformance, Certificate of Ongoing Performance, or performance standards included in a plan of correction when the hospital has been given an opportunity to correct deficiencies through a plan of correction.

I have been designated by the Board of Directors of the applicant hospital to complete this affidavit on its behalf.

Signature of Hospital-Designated Official: JoAnne Hahey

Printed Name of Hospital-Designated Official: JoAnne Hahey

Title: Senior VP & CFO

Date: 10/15/15

Form A: PROJECT BUDGET

INSTRUCTION: This form is to be completed if capital expenditures will be necessary for the applicant hospital to provide pPCI services. All estimates for 1.a.-d., 2.a.-h., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEETS.

A. Use of Funds

1. Capital Costs:

a.	New Construction	$
(1)	Building	
(2)	Fixed Equipment (not included in construction)	1,650,000
(3)	Land Purchase	
(4)	Site Preparation	
(5)	Architect/Engineering Fees	
(6)	Permits, (Building, Utilities, Etc.)	
SUBTOTAL		$ 1,650,000
b.	Renovations	$
(1)	Building	780,000
(2)	Fixed Equipment (not included in construction)	40,000
(3)	Architect/Engineering Fees	94,000
(4)	Permits, (Building, Utilities, Etc.)	4,600
SUBTOTAL		$ 918,600
c.	Other Capital Costs	
(1)	Major Movable Equipment	
(2)	Minor Movable Equipment	
(3)	Contingencies	
(4)	Other (Specify)	
TOTAL CURRENT CAPITAL COSTS (a - c)		$ 2,568,600
d.	Non Current Capital Cost	
(1)	Interest (Gross)	
(2)	Inflation (state all assumptions, including time period and rate)	
TOTAL PROPOSED CAPITAL COSTS (a - d)		$ 2,568,600

2.	Financing Cost and Other Cash Requirements:		
	a.	Loan Placement Fees	
	b.	Bond Discount	
	c.	Legal Fees (CON Related)	
	d.	Legal Fees (Other)	
	e.	Printing	
	f.	Consultant Fees	
		CON Application Assistance	
		Other (Specify)	
	g.	Liquidation of Existing Debt	
	h.	Debt Service Reserve Fund	
	i.	Principal Amortization	
		Reserve Fund	
	j.	Other (Specify)	
	TOTAL (a - j)		**$** 2,568,600
3.	Working Capital Startup Costs		$
TOTAL USES OF FUNDS (1 - 3)			**$** 2,568,600

B. Sources of Funds for Project:

1.	Cash	$ 2,568,600
2.	Pledges: Gross:	
	less allowance for uncollectables	
	= Net	
3.	Gifts, bequests	
4.	Interest income (gross)	
5.	Authorized Bonds	
6.	Mortgage	
7.	Working capital loans	
8.	Grants or Appropriation	
	(a) Federal	
	(b) State	
	(c) Local	
9.	Other (Specify)	
TOTAL SOURCES OF FUNDS (1-9)		**$** 2,568,600

Lease Costs:	$		x		= $	
a. Land	$		x		= $	
b. Building	$		x		= $	
c. Major Movable Equipment	$		x		= $	
d. Minor Movable Equipment	$		x		= $	
e. Other (Specify)	$		x		= $	

Form B: REVENUES AND EXPENSES – Percutaneous Coronary Intervention Services

INSTRUCTIONS: Specify whether data are for calendar year or fiscal year. All projected revenue and expense figures should be presented in current dollars. Specify sources of non-operating income. This table must be accompanied by a statement of all assumptions used in projecting all revenues and expenses. Please assure that the revenue and expenses figures in this table are consistent with the historic and project utilization of PCI services at the applicant hospital and the information on staffing of this service provided elsewhere in this application.

Revenues and Expenses – PCI Services	**Projected Years**			
	(ending with third full year in which the applicant projects provision of primary PCI services)			
CY or FY (Circle)FY	2017	2018	2019	2020
1. Revenue				
a. Inpatient Services		$1,140,560	$1,140,560	$1,140,560
b. Outpatient Services	$1,163,406	$2,330,489	$2,359,817	$2,392,914
c. Gross Patient Services				
Revenues				
2. Adjustments to Revenue				
d. Allowance for Bad Debt	$69,804	$71,396	$73,155	$75,141
e. Contractual Allowance	$423,681	$433,371	$444,041	$456,130
f. Charity Care				
g. Net Patient Services				
Revenue	$669,921	$2,966,281	$2,983,180	$3,002,202
h. Other Operating				
Revenues (Specify)				
i. Net Operating Revenue	$669,921	$2,966,281	$2,983,180	$3,002,202
3. Expenses				
a. Salaries, Wages, and	$1,543,086	$1,543,086	$1,543,086	$1,543,086
Professional Fees,				
(including fringe benefits)				
b. Contractual Services				
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation				
f. Project Depreciation	$148,477	$296,954	$296,954	$296,954
g. Current Amortization				
h. Project Amortization				
i. Supplies	$1,259,477	$1,260,475	$1,273,191	$1,289,412

Revenues and Expenses – PCI Services	**Projected Years**			
	(ending with third full year in which the applicant projects provision of primary PCI services)			
CY or FY (Circle)FY	2017	2018	2019	2020
j. Other Expenses (Specify)				
k. Total Operating Expenses	$2,951,040	$3,100,515	$3,113,231	$3,129,452
4. Income				
a. Income from Operation	-$2,281,119	-$134,234	-$130,051	-$127,250
b. Non-Operating Income				
c. Subtotal				
d. Income Taxes				
e. Net Income (Loss)	-$2,281,119	-$134,234	-$130,051	-$127,250
e2. Net Income (Loss) (Not including Project Depreciation)	-$2,132,642	$162,720	$166,903	$169,704
5. Patient Mix:				
A. Percent of Total Revenue				
1) Medicare	72%	72%	72%	72%
2) Medicaid	6%	6%	6%	6%
3) Blue Cross	12%	12%	12%	12%
4) Commercial Insurance	9%	9%	9%	9%
5) Self-Pay	1%	1%	1%	1%
6) Other (Specify)				
7) TOTAL	100%	100%	100%	100%
B. Percent of PCI Cases (as applicable)				
1) Medicare	72%	72%	72%	72%
2) Medicaid	6%	6%	6%	6%
3) Blue Cross	12%	12%	12%	12%
4) Commercial Insurance	9%	9%	9%	9%
5) Self-Pay	1%	1%	1%	1%
6) Other				
7) TOTAL	100%	100%	100%	100%

ASSUMPTIONS:

Project Description:

Analysis looks at the incremental impact to the bottom-line of starting a Percutaneous Coronary Intervention (PCI) program at University of Maryland Shore Regional Health ("UM SRH"). The only hospital that provides this service on the Eastern Shore currently is Peninsula Regional Medical Center in Salisbury, leaving a large "hole" on the mid-Shore where this service is not available. Patients may come to UM SRH for diagnostic cardiac catheterization procedures, however, if interventions are required, patients must go to either PRMC or across the Bay Bridge for care. By expanding the cardiac program to accommodate PCI procedures, the expectation is this will attract more patients to UM SRH's Catheterization Lab for diagnostic procedures as well.

Total Equipment and Construction Cost :

Service provided in existing catheterization lab and newly constructed second catheterization lab.

Volume

Volumes were assumed to be as projected in the PCI Application and are explained therein. Inpatient/Outpatient mix is consistent with the mix projected in the recent PCI application of University of Maryland Upper Chesapeake Health.

Assumed that a more comprehensive cardiology program will attract more diagnostic procedures to the Catheterization Lab as well.

Additional cardiac catheterization procedures and UMMS OP elective PCIs derived from UMMC Catheterization Lab Volume Statistics FY2014 (Oct. 2014) for Eastern Shore County Group. Diagnostic = cardiac catheterization procedures that could be gained, Interventional = PCIs that could be gained.

Additional PCIs means additional follow-up visits with the cardiologists (2vsts./patient). Assumed UM SRH's cardiology group already receiving 100% of f/u referrals from UMMS.

Payor Mix

Based on Catheterization Lab patients seen in FY2014 (42.4362299):

Medicare	12342	71.78%
Medicaid	1043	6.07%
Blue Cross	2059	11.97%
HMO	85	0.49%
Commercial	1560	9.07%
Self Pay	106	0.62%
	17,195	100.00%

Reimbursement %

Facility Fees
With the exception of the downstream stress tests, which will be provided at Chesapeake Cardiology, all other services under this program will be provided in hospital space, therefore, HSCRC Reimbursement guidelines apply. Under TPR, this service results in no increase to allowable revenue for the service in the first year. First year revenue reflects Physician Fees only. UM SRH intends to submit a formal request to the HSCRC to have the TPR revenue increased to help fund a new program/service. UM SRH has assumed that the HSCRC will approve an amount equal to the first year loss. Typically the hospital is expected to shoulder the expense for one full year without financial assistance until volumes have been established. Then at that point the hospital's revenue base is adjusted on a prospective basis.

Professional Fees
Rates set at UM SRH's Medical Group's customary charges and collection rate.

Salary Expense & Fringe Benefits
Salaries increase at a rate of 1% per year.

Minimum of two Physicians are required, because regulations require this service to be available 24/7. Physician Compensation figure includes on-call, call-back pay, and malpractice expense.

Rate = 2013 MGMA Survey/Sullivan Cotter Blended Rate, Median Compensation for Cardiology: Invasive-Interventional providers in the Northeast.

Analysis also includes expenses related to on-call and call-back pay of non-physician staff.

On-call pay is a flat $2.50/hr. Call-back pay is = time and half of base hourly rate.

Fringe Benefit % for Non-Physician Staff= 28%

Fringe Benefit % for Physicians = 16%

Contribution Margin

Analysis is incremental only. This is not a reflection of the program's profitability but rather the net financial impact to the system if implemented.

Pro forma contribution margin includes only direct departmental expenses and direct allocated overhead (of fringe benefits and marketing). Indirect overhead expense associated with Administration / Corporate functions are not allocated / reflected. The contribution margin is a reflection of the $ amount needed in the TPR CAP to provide this service at a break-even.

Form C

Form C. Please use this form to identify for each physician and quarter the volume of primary and non-primary PCI cases performed by the physician.

Interventionalist [redacted]

Quarter Ending	PCI Cases at Applicant Hospital			PCI Cases at Other Hospitals			Total PCI Cases- All Hospitals
	pPCI	npPCI	Total	pPCI	npPCI	Total	
9/30/2013				7	23	30	30
12/31/2013				7	20	27	27
3/31/2014				8	32	40	40
6/30/2014				9	41	50	50
9/30/2014				5	33	38	38
12/31/2014				3	29	32	32
3/31/2015				4	25	29	29
6/30/2015				7	17	24	24

Source of Data: [redacted] cardiac catheterization laboratory database which is submitted to NCDR (National Cardiovascular Data Registry) and New York State PCI registry

Affidavit

I solemnly affirm under penalties of perjury that the information contained in the above table is true and correct to the best of my knowledge, information, and belief.

Date: 10/4/15

Signature of Physician: [redacted]

Interventionalist [redacted]

Quarter Ending	PCI Cases at Applicant Hospital			PCI Cases at Other Hospitals			Total PCI Cases- All Hospitals
	pPCI	npPCI	Total	pPCI	npPCI	Total	
9/30/2013							
12/31/2013							
3/31/2014							
6/30/2014							
9/30/2014				12	23	35	35
12/31/2014				3	21	24	24
3/31/2015				3	25	28	28
6/30/2015				5	22	27	27

Source of Data: [redacted] **cardiac catheterization laboratory database which is submitted to NCDR (National Cardiovascular Data Registry) and New York State PCI registry**

Affidavit

I solemnly affirm under penalties of perjury that the information contained in the above table is true and correct to the best of my knowledge, information, and belief.

Date: 10/14/15

Signature of Physician: [redacted]

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

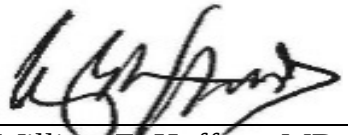
October 14, 2015
Date

Gary Jones
Regional Director, Cardiovascular & Pulmonary Services
UM Shore Regional Health

#541262
012516-0005

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

October 14, 2015
Date



William E. Huffner, MD, MBA,
FACEP, FACHE
Chief Medical Officer
UM Shore Regional Health

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

October 14, 2015
Date

Joanne Hahey
Chief Financial Officer
UM Shore Regional Health

#541264
012516-0005

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

October 14, 2015
Date

Kathleen McGrath
Regional Director
Outreach & Business Development
UM Shore Regional Health

#541266
012516-0005

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

October 14, 2015
Date

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

#541267
012516-0005

Table of Exhibits

Exhibit	Description
1.	Policy for provision of information concerning charges for services
2.	Policy for provision of charity care for indigent patients
3.	Quality measures
4.	Full-size copy of Figure 1—Distance and Driving Time to Selected Hospitals
5.	Drive time variables (off-peak / peak)
6.	Letters of support
7.	CEO acknowledgment re Q.18
8.	CEO acknowledgment re Q.21
9.	Continuing education programs/activities
10.	Agreement with tertiary care center
11.	Agreement with advanced cardiac support emergency medical services provider
12.	CEO acknowledgment re Q.28
13.	CEO acknowledgment re Q.29
14.	CEO acknowledgment re Q.30
15.	CEO acknowledgment re Q.31
16.	CEO acknowledgment re Q.32

Table of Tables

Table	Description
1.	Charity Care and Total Operating Expenses—FY 2014
2.	Zip Code to County Conversion
3.	Primary PCI Cases—Five County Service Area—CY 2014
4.	Primary PCI Cases by Zip Code of Residence and Hospital (CY 2014) / Drive Times from Community to Hospitals (Including UMSMC-E) / Drive Time Minutes Saved if UMSMC-E Provides Primary PCI
5.	Primary PCI Cases by Zip Code—CY 2014 / Drive Times to Primary PCI Providers / Identification of Nearest Provider and Projection of Market Share
6.	Walk-In Transfers to Primary PCI Providers From UMSMC-E, Dorchester General Hospital, Queen Anne's Emergency Center—CY 2014
7.	Projections of Primary PCI Cases at UMSMC-E—2016-2018
8.	Elective PCI Cases—Five County Service Area—CY 2014
9.	Elective PCI Cases by Zip Code and Hospital—CY 2014
10.	Shore Health (UMSMC-E, UMSMC C, UMSMC D) Cardiology Inpatient Admissions and Market Share by County—FY 2015
11.	Projections of Elective PCI Cases at UMSMC-E—2016-2018
12.	STEMI Cases at AAMC and PRMC From the Mid-Shore Region, CY 2014 / Driving Time to AAMC, PRMC, and UMSMC-E

Table of Figures

Figure	Description
1	Distance and Driving Time to Selected Hospitals
2	Maryland Institute for Emergency Medical Services Systems (MIEMSS) Map of Regions with and without 30 Minute Drive Time to Primary PCI at Acute Care Maryland Hospitals and Some Out of State Hospitals
3	Typical Trends for Traffic Volumes on the Bay Bridge on a Non-Summer Weekday (Existing Conditions)
4	Typical Trends for Traffic Volumes on the Bay Bridge on a Summer Saturday (Existing Conditions)

EXHIBIT 1

SHORE HEALTH UNIVERSITY OF MARYLAND MEDICAL SYSTEM	ADMINISTRATIVE POLICY & PROCEDURE	POLICY NO:	LD-66
		REVISED:	11/12
	PUBLIC DISCLOSURE OF CHARGES	PAGE #:	1 of 2
		SUPERSEDES	09/12

CROSS REFERENCE

Administrative Policy LD-34: Financial Assistance

SCOPE

This policy applies to Shore Health System ("SHS") acute care hospitals located in the State of Maryland; Memorial Hospital at Easton and Dorchester General Hospital.

PURPOSE

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

BENEFITS

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

1.0 POLICY

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

2.0 PROCEDURE

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

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

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

Gerard M. Walsh, Chief Operating Officer

Effective	09/12
Revised	11/12 (Minor Editorial Revision)
Approved	Walter Zajac, Sr. Vice President / CFO

EXHIBIT 2

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	ADMINISTRATIVE POLICY & PROCEDURE	POLICY NO:	LD-34
		REVISED:	8/28/13
	FINANCIAL ASSISTANCE	PAGE #:	1 of 10
		SUPERSEDES	8/12

1.0 POLICY

1.1 This policy applies to Shore Regional Health (SRH). Shore Regional Health is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation. The hospitals covered by this policy include:

- University of Maryland Shore Medical Center at Easton
- University of Maryland Shore Medical Center at Dorchester
- ***University of Maryland Shore Medical Center at Chestertown***

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

1.3 SRH will publish the availability of Financial Assistance on a yearly basis in the local newspapers and will post notices of availability at appropriate intake locations as well as the Billing Office. Notice of availability will also be sent to patients on patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided to patients receiving inpatient services with their Summary Bill and made available to all patients upon request.

1.4 Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.

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

2.0 PROGRAM ELIGIBILITY

2.1 Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who are poor, SRH strives to ensure that the financial capacity

of people who need health care services does not prevent them from seeking or receiving care.

2.2 Specific exclusions to coverage under the Financial Assistance program include the following:

2.2.1 Services provided by healthcare providers not affiliated with SRH (e.g., home health services).

2.2.2 Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, Workers Compensation or Medicaid), are not eligible for the Financial Assistance Program. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made considering medical and programmatic implications.

2.2.3 Unpaid balances resulting from cosmetic or other non-medically necessary services.

2.2.4 Patient convenience items.

2.2.5 Patient meals and lodging.

2.2.6 Physician charges related to the date of service are excluded from the SRH Financial Assistance Policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.

2.3 Patients may become ineligible for Financial Assistance for the following reasons:

2.3.1 Refusal to provide requested documentation or providing incomplete information.

2.3.2 Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid or other insurance programs that deny access to SRH due to insurance plan restrictions/limits.

2.3.3 Failure to pay co-payments as required by the Financial Assistance Program.

2.3.4 Failure to keep current on existing payment arrangements with SRH.

2.3.5 Failure to make appropriate arrangements on past payment obligations owed to SRH (including those patients who were referred to an outside collection agency for a previous debt).

2.3.6 Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program.

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

2.5 Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance eligibility criteria (See Section 3 below). If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services and for their overall personal health.

2.6 Coverage amounts will be calculated based upon 200-300% of income as defined by federal poverty guidelines and follows the sliding scale included in Attachment A.

3.0 PRESUMPTIVE FINANCIAL ASSISTANCE

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

3.1.1 Active Medical Assistance pharmacy coverage.

3.1.2 Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums).

3.1.3 Primary Adult Care (PAC) coverage.

3.1.4 Homelessness.

3.1.5 Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs.

3.1.6 Maryland Public Health System Emergency Petition patients.

3.1.7 Participation in Women, Infants and Children Programs ("WIC").

3.1.8 Food Stamp eligibility.

3.1.9 Eligibility for other state or local assistance programs.

3.1.10 Patient is deceased with no known estate.

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

3.2 Patients who present to the Outpatient Emergency Department but are not admitted as inpatients and who reside in the hospitals' primary service area may not need to complete a Financial Assistance Application but may be granted presumptive Financial Assistance based upon the following criteria:

3.2.1 Reside in primary service area (address has been verified).

3.2.2 Lack health insurance coverage.

3.2.3 Not enrolled in Medical Assistance for date of service.

3.2.4 Indicate an inability to pay for their care.

3.2.5 Financial Assistance granted for these Emergency Department visits shall be effective for the specific date of service and shall not extend for a six (6) month period.

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

3.3.1 Purely elective procedures (e.g., cosmetic procedures) are not covered under the program.

3.3.2 Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive Financial Assistance Program until the Maryland Medicaid Psych Program has been billed.

3.3.3 Qualifying Non-U.S. citizens are to be processed for reimbursement through the Federal Program for Undocumented Alien Funding for Emergency Care (a.k.a. Section 1011) prior to financial assistance consideration.

4.0 MEDICAL HARDSHIP

4.1 Patients falling outside of conventional income or Presumptive Financial Assistance criteria are potentially eligible for bill reduction through the Medical Hardship program. Uninsured Medical Hardship criteria is State defined as:

4.1.1 Combined household income less than 500% of federal poverty guidelines.

4.1.2 Having incurred collective family hospital medical debt at SRH exceeding 25% of the combined household income during a 12-month period. The 12-month period begins with the date the Medical Hardship application was submitted.

4.1.3 The medical debt excludes co-payments, co-insurance and deductibles.

4.2 Patient Balance after Insurance

SRH applies the State established income, medical debt and timeframe criteria to patient balance after insurance applications.

4.3 Coverage amounts will be calculated based upon 0- 500% of income as defined by federal poverty guidelines and follow the sliding scale included in Attachment A.

4.4 If determined eligible, patients and their immediate family are certified for a 12-month period effective with the date on which the reduced cost medically necessary care was initially received.

4.5 Individual Patient Situation Consideration

4.5.1 SRH reserves the right to consider individual patient and family financial situation to grant reduced cost care in excess of State established criteria.

4.5.2 The eligibility duration and discount amount is patient-situation specific.

4.5.3 Patient balance after insurance accounts may be eligible for consideration.

4.5.4 Cases falling into this category require management level review and approval.

4.6 In situations where a patient is eligible for both Medical Hardship and the standard Financial Assistance Programs, SRH is to apply the greater of the two discounts.

4.7 Patient is required to notify SRH of their potential eligibility for this component of the Financial Assistance Program.

5.0 ASSET CONSIDERATION

5.1 Assets are generally not considered as part of Financial Assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient responsibility without causing undue hardship. Individual patient financial situation such as the ability to replenish the asset and future income potential are taken into consideration whenever assets are reviewed.

5.2 Under current legislation, the following assets are exempt from consideration:

5.2.1 The first $10,000 of monetary assets for individuals and the first $25,000 of monetary assets for families.

5.2.2 Up to $150,000 in primary residence equity.

5.2.3 Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans. Generally this consists of plans that are tax exempt and/or have penalties for early withdrawal.

6.0 APPEALS

6.1 Patients whose financial assistance applications are denied have the option to appeal the decision.

6.2 Appeals can be initiated verbally or in writing.

6.3 Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.

6.4 Appeals are documented within the third party data and workflow tool. They are then reviewed by the next level of management above the representative who denied the original application.

6.5 If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.

6.6 The escalation can progress up to the Chief Financial Officer who will render a final decision.

6.7 A letter of final determination will be submitted to each patient who has formally submitted an appeal.

7.0 PATIENT REFUND

7.1 Patients applying for Financial Assistance up to 2 years after the service date who have made account payment(s) greater than $25 are eligible for refund consideration.

7.2 Collector notes and any other relevant information are deliberated as part of the final refund decision. In general, refunds are issued based on when the patient was determined unable to pay compared to when the payments were made.

7.3 Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for refund.

8.0 JUDGMENTS

If a patient is later found to be eligible for Financial Assistance after a judgment has been obtained or the debt submitted to a credit reporting agency, SRH shall seek to vacate the judgment and/or strike the adverse credit information.

9.0 PROCEDURES

9.1 Each Service Access area will designate a trained person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Customer Service, etc.

9.2 Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

9.2.1 Staff will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage.

9.2.2 Preliminary data will be entered into a third party data exchange system to determine probable eligibility. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations). To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.

9.2.3 SRH will not require documentation beyond that necessary to validate the information on the Maryland State Uniform Financial Assistance Application.

9.2.4 Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance.

9.2.5 Patients will have thirty (30) days to submit required documentation to be considered for eligibility. If no data is received within 20 days, a reminder letter will be sent notifying that the case will be closed for inactivity and the account referred to bad debt collection services if no further communication or data is received from the patient. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to.

9.3 In addition to a completed Maryland State Uniform Financial Assistance Application, patients may be required to submit:

9.3.1 A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations); proof of disability income (if applicable).

9.3.2 A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations or documentation of how they are paying for living expenses.

9.3.3 Proof of Social Security income (if applicable).

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

9.3.5 Proof of U.S. citizenship or lawful permanent residence status (green card).

9.3.6 Reasonable proof of other declared expenses.

9.3.7 If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.

9.4 ***Determination of Probable Eligibility will be made within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.***

9.5 A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on SRH guidelines. If the patient's application for Financial Assistance is determined to be complete and appropriate, appropriate personnel will recommend the patient's level of eligibility.

9.5.1 If the patient does qualify for financial clearance, appropriate personnel will notify the treating department who may then schedule the patient for the appropriate service.

9.5.2 If the patient does not qualify for financial clearance, appropriate personnel will notify the clinical staff of the determination and the non-emergent/urgent services will not be scheduled. A decision that the patient may not be scheduled for non-emergent/urgent services may be reconsidered upon request.

9.6 Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. With the exception of Presumptive Financial Assistance cases which are date of service specific eligible and Medical Hardship who have twelve (12) calendar months of eligibility. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance.

9.7 The following may result in the reconsideration of Financial Assistance approval:

9.7.1 Post-approval discovery of an ability to pay.

9.7.2 Changes to the patient's income, assets, expenses or family status which are expected to be communicated to SRH.

9.8 SRH will track patients with 6 or 12 month certification periods utilizing either eligibility coverage cards and/or a unique insurance plan code(s). However, it is ultimately the responsibility of the patient or guarantor to advise of their eligibility status for the program at the time of registration or upon receiving a statement.

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

Effective	10/05
Approved	SHS Board of Directors: 06/22/05
Revised	07/10 (Minor Changes)
Revised	02/11
Approved	SHS Board of Directors: 02/23/11
Revised	08/12 (Minor Changes)
SRH Administrative Policy	
Effective	08/13
Approved	SRH Board of Directors: 08/28/13
Policy Owner	Walter Zajac, Vice President, Finance & Budget

ATTACHMENT:

- Attachment A - Sliding Scale

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	ATTACHMENT A FINANCIAL ASSISTANCE POLICY	POLICY NO:	LD-34
		REVIEWED:	08/13
	SLIDING SCALE	PAGE #:	1 of 1
		SUPERSEDES	08/12

		% of Federal Poverty Level Income										
		200%	210%	220%	230%	240%	250%	260%	270%	280-290%	300% - 499%	
Size of Family Unit	FPL Income	Approved % of Financial Assistance										
		100%	90%	80%	70%	60%	50%	40%	30%	20%	25% of Income	
1	$10,830	$21,660	$22,743	$23,826	$24,909	$25,992	$27,075	$28,158	$29,241	$30,324	$32,490	$54,150
2	$14,570	$29,140	$30,597	$32,054	$33,511	$34,968	$36,425	$37,882	$39,339	$40,796	$43,710	$72,850
3	$18,310	$36,620	$38,451	$40,282	$42,113	$43,944	$45,775	$47,606	$49,437	$51,268	$54,930	$91,550
4	$22,050	$44,100	$46,305	$48,510	$50,715	$52,920	$55,125	$57,330	$59,535	$61,740	$66,150	$110,250
5	$25,790	$51,580	$54,159	$56,738	$59,317	$61,896	$64,475	$67,054	$69,633	$72,212	$77,370	$128,950
6	$29,530	$59,060	$62,013	$64,966	$67,919	$70,872	$73,825	$76,778	$79,731	$82,684	$88,590	$147,650
7	$33,270	$66,540	$69,867	$73,194	$76,521	$79,848	$83,175	$86,502	$89,829	$93,156	$99,810	$166,350
8	$37,010	$74,020	$77,721	$81,422	$85,123	$88,824	$92,525	$96,226	$99,927	$103,628	$111,030	$185,050

Patient Income and Eligibility Examples:

Example #1	Example #2	Example #3
- Patient earns $53,000 per year - There are 5 people in the patient's family - The % of potential Financial Assistance coverage would equal 90% (they earn more than $51,580 but less than $54,159)	- Patient earns $37,000 per year - There are 2 people in the patient's family - The % of potential Financial Assistance coverage would equal 40% (they earn more than $36,425 but less than $37,882)	- Patient earns $54,000 per year - There is 1 person in the family - The balance owed is $20,000 - This patient qualifies for Hardship coverage, owes$13,500 (25% of $54,000)

Notes: FPL = Federal Poverty Levels

Effective	02/11
Reviewed	08/12
Reviewed	08/13

Appendix I

Description of Shore Regional Health's Financial Assistance Policy (FAP):

It is the policy of Shore Regional Health to work with our patients to identify available resources to pay for their care. All patients presenting as self pay and requesting charity relief from their bill will be screened at all points of entry, for possible coverage through state programs and a probable determination for coverage for either Medical Assistance or Financial Assistance (charity care) from the hospital is **immediately** given to the patient. The process is resource intensive and time consuming for patients and the hospital; however, if patients qualify for one of these programs, then they will have health benefits that they will carry with them beyond their current hospital bills, and allow them to access preventive care services as well. Shore Regional Health System works with a business partner who will work with our patients to assist them with the state assistance programs, which is free to our patients.

If a patient does not qualify for Medicaid or another program, Shore Regional Health offers our financial assistance program. Shore Regional Health posts notices of our policy in conspicuous places throughout the hospitals- including the emergency department, has information within our hospital billing brochure, educates all new employees thoroughly on the process during orientation, and does a yearly re- education to all existing staff. All staff have copies of the financial assistance application, both in English and Spanish, to supply to patients who we deem, after screening, to have a need for assistance. Shore Regional Health has a dedicated Financial Assistance Liaison to work with our patients to assist them with this process and expedite the decision process.

Shore Regional Health notifies patients of availability of financial assistance funds prior to service during our calls to patients, through signage at all of our registration locations, through our patient billing brochure and through our discussions with patients during registration. In addition, the information sheet is mailed to patients with all statements and/or handed to them if needed. Notices are sent regarding our Hill Burton program (services at reduced cost) yearly as well.

- Shore Regional Health prepares its FAP in a culturally sensitive manner, at a reading comprehension level appropriate to the CBSA's population, and in Spanish.
- Shore Regional Health posts its FAP and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
- Shore Regional Health provides a copy of the FAP and financial assistance contact information to patients or their families as part of the intake process;
- Shore Regional Health provides a copy of the FAP and financial assistance contact information to patients with discharge materials.
- A copy of Shore Regional Health's FAP along with financial assistance contact information, is provided in patient bills; and/or
- Shore Regional Health discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.
- An abbreviated statement referencing Shore Regional Health's financial assistance policy, including a phone number to call for more information, is run annually in the local newspaper (*Star Democrat*)

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Appendix III

SHORE REGIONAL HEALTH SYSTEM PATIENT INFORMATION SHEET

Hospital Financial Assistance Policy

Shore Regional Health System is committed to ensuring that uninsured patients within its service area who lack financial resources have access to medically necessary hospital services. If you are unable to pay for medical care, you may qualify for Free or Reduced Cost Medically Necessary Care if you have no other insurance options or sources of payment including Medical Assistance, litigation or third-party liability.
Shore Regional Health System meets or exceeds the legal requirements by providing Financial assistance to those individuals in households below 200% of the federal poverty level
And reduced cost-care up to 300% of the federal poverty level.

Patients' Rights

Shore Regional Health System will work with their uninsured patients to gain an understanding of each patient's financial resources.

- They will provide assistance with enrollment in publicly-funded entitlement programs (e.g. Medicaid) or other considerations of funding that may be available from other charitable organizations.
- If you do not qualify for Medical Assistance, or financial assistance, you may be eligible for an extended payment plan for your hospital medical bills.
- if you believe you have been wrongly referred to a collection agency, you have the right to contact the hospital to request assistance. (See contact information below).

Patients' Obligations

Shore Regional Health System believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

- Cooperate at all times by providing complete and accurate insurance & financial information
- Provide requested data to complete Medicaid applications in a timely manner.
- Maintain compliance with established payment plan terms.
- Notify us immediately at the number listed below of any changes in circumstances.

Contacts:

Call 410-822-1000 x1020 or toll free 1-800-876-5534 with questions concerning:

- your hospital bill
- your rights and obligations with regards to your hospital bill
- How to apply for Maryland Medicaid
- How to apply for free or reduced care

For information about Maryland Medical Assistance
Contact your local department of Social Services
1-800-332-6347 TTY 1-800-925-4434
Or visit: www.dhr.state.md.us
Physician charges are not included in hospitals bills and are billed separately by the physician.

MHE/DGH/01/12

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

HOJA INFORMATIVA PARA LOS PACIENTES DE SHORE REGIONAL HEALTH SYSTEM

POLIZA DEL HOSPITAL PARA AYUDA FINANCIERA:

SHORE REGIONAL HEALTH SYSTEM está avocada para garantizar a los pacientes que residen dentro de su área y que no cuentan con seguro o recursos financieros, acceso a los servicios de atención médica necesarios.

Si Ud. no puede pagar la atención médica, puede aplicar por Atención Médica gratuita o con un costo reducido, en el caso de que no tenga ningún tipo de seguro o recursos para el pago que incluya atención médica, litigio o forma de pago por un tercero.

SHORE REGIONAL HEALTH SYSTEM reúne o excede los requisitos legales para proporcionar ayuda financiera a aquellos individuos con ingresos por debajo del 200% del nivel de pobreza determinado por el Gobierno, así como reducir el pago por atención médica hasta por encima del
300% del nivel de pobreza determinado por el Gobierno.

DERECHOS PARA LOS PACIENTES:

SHORE REGIONAL HEALTH SYSTEM encontrará la forma de llegar a un acuerdo con cada paciente que no cuente con un Seguro, de acuerdo a los ingresos económicos de cada paciente.

- Asimismo, proporcionará asistencia para afiliación a programas que cuentan con fondos solventados por el Gobierno, tales como Medicaid o afiliación a otras organizaciones que pueden ayudar económicamente.
- Si Ud. no califica para recibir ayuda Médica o financiera, puede optar por un plan de pagos a largo plazo, para pagar su cuenta del hospital.
- Si Ud. considera que erróneamente lo han referido a una agencia de recaudación de dinero, tiene el derecho de contactar al hospital para solicitar ayuda. (ver información para contactarse, en la parte inferior de la hoja)

OBLIGACIONES PARA LOS PACIENTES:

SHORE REGIONAL HEALTH SYSTEM considera que sus pacientes tienen responsabilidades con el pago por atención médica recibida. Se espera que los pacientes:

1. Colaboren proporcionando información sobre su compañía aseguradora así como información financiera.
2. Provean la información requerida para llenar las solicitudes de Medicaid en el menor tiempo possible.
3. Cumplan con los términos establecidos para el pago.
4. Nos notifiquen inmediatamente al teléfono indicado en la parte inferior de la hoja sobre algún cambio habido en la información que haya sido proporcionada.

INFORMACION PARA CONTACTARSE:

1. Llame al teléfono 410-822-1000, Anexo 1020 o al teléfono gratuito 1-800-876-5534, en caso de tener preguntas relativas a:
   - Su cuenta de hospital
   - Sus derechos y obligaciones con respecto a su cuenta
   - Cómo aplicar a Medicaid en Maryland
   - Cómo aplicar para la atención gratuita o con un costo reducido.
2. Para información acerca de la Ayuda Médica en Maryland:
   - Contacte al Departamento de Servicios Sociales de su Area, llamando al teléfono 1-800-332-6347 TTY 1-800-925-4434
   - O visite la Página Web: www.dhr.state.md.us

El pago por los servicios del médico no están incluídos en la cuenta del hospital. El médico cobra sus servicios por separad

EXHIBIT 3

Quality Indicators

Those in which UMSMC-E performed in the bottom quartile are shaded

	Category	Sub-Category	Indicator	Higher or Lower Is Better	Bottom Quartile Level	University of Maryland Shore Medical Center at Easton	The following processes and committees (for example, Mortality & Throughput committees) are all new in 2015. UMSMC-E has introduced many changes in practice to addresses opportunities for improvement.
1	Deaths or returns to the hospital	All Causes	Returning to the hospital for any unplanned reason within 30 days after being discharged	Lower	16.8	14.2	
2		Heart attack and chest pain	How often patients die in the hospital after heart attack	Lower	8.5352	8.9088	Mortality Review Committee - individual cases discussed for Operational and clinical opportunities for improvement. Peer Review receives clinical opportunities and Performance Management Committee receives operational opportunities for PI team creation.
3			Dying within 30-days after getting care in the hospital for a heart attack	Lower	15.225	15.1	
4		Heart failure	How often patients die in the hospital after heart failure	Lower	3.40555	4.0011	Mortality Review Committee - individual cases discussed for Operational and clinical opportunities for improvement. Peer Review receives clinical opportunities and Performance Management Committee receives operational opportunities for PI team creation.
5			Dying within 30-days after getting care in the hospital for heart failure	Lower	12	10.6	
6			Returning to the hospital after getting care for heart failure	Lower	18.825	18.6	
7			Returning to the hospital after getting care for heart failure	Lower	24.525	22.3	

	Category	Sub-Category	Indicator	Higher or Lower Is Better	Bottom Quartile Level	University of Maryland Shore Medical Center at Easton	The following processes and committees (for example, Mortality & Throughput committees) are all new in 2015. UMSMC-E has introduced many changes in practice to addresses opportunities for improvement.
8		Other surgeries	How often patients die in the hospital during or after surgery on the esophagus	Lower	N/A	N/A	
9			How often patients die in the hospital during or after pancreas surgery	Lower	2.807125	0	
10			How often patients die in the hospital during or after a surgery to fix the artery that carries blood to the lower body when it gets too large	Lower	44.3001	N/A	
11		Patient safety	How often patients die in the hospital after bleeding from stomach or intestines	Lower	3.0511	2.0828	
12			How often patients die in the hospital after fractured hip	Lower	3.7751	3.5122	
13			How often patients die in the hospital while getting care for a condition that rarely results in death	Lower	0.253275	0	
14		Pneumonia	How often patients die in the hospital while getting care for pneumonia	Lower	3.7049	5.1526	Mortality Review Committee - individual cases discussed for Operational and clinical opportunities for improvement. Peer Review receives clinical opportunities and Performance Management Committee receives operational opportunities for PI team creation.

	Category	Sub-Category	Indicator	Higher or Lower Is Better	Bottom Quartile Level	University of Maryland Shore Medical Center at Easton	The following processes and committees (for example, Mortality & Throughput committees) are all new in 2015. UMSMC-E has introduced many changes in practice to addresses opportunities for improvement.
15			Dying within 30-days after getting care in the hospital for pneumonia	Lower	11.8	10.5	
16			Returning to the hospital after getting care for pneumonia	Lower	18.95	17.6	
17		Stroke	How often patients who came in after having stroke subsequently died in the hospital.	Lower	9.8518	11.3114	Mortality Review Committee - individual cases discussed for Operational and clinical opportunities for improvement. Peer Review receives clinical opportunities and Performance Management Committee receives operational opportunities for PI team creation.
18		Surgical patient safety	How often patients die in the hospital because a serious condition was not identified and treated	Lower	150.7294	296.4187	Mortality Review Committee - individual cases discussed for Operational and clinical opportunities for improvement. Peer Review receives clinical opportunities and Performance Management Committee receives operational opportunities for PI team creation.
19	Emergency Room (ER)	Throughput	How long patients spent in the emergency department before leaving for their hospital room	Lower	402	398	
20			How long patients spent in the emergency department after the doctor decided the patient would stay in the hospital before leaving for their hospital room	Lower	169	125	
21	Heart attack and chest pain	Recommended care - Inpatient	Heart attack patients prescribed aspirin before leaving the hospital	Higher	99	96	above 90 % no plan necessary per application Q9

	Category	Sub-Category	Indicator	Higher or Lower Is Better	Bottom Quartile Level	University of Maryland Shore Medical Center at Easton	The following processes and committees (for example, Mortality & Throughput committees) are all new in 2015. UMSMC-E has introduced many changes in practice to addresses opportunities for improvement.
22			Heart attack patients given procedure to open blood vessels within 90 minutes of getting to the hospital	Higher	91.5	N/A	
23		Results of care	How often patients die in the hospital after heart attack	Lower	8.5352	8.9088	Mortality Review Committee - individual cases discussed for Operational and clinical opportunities for improvement. Peer Review receives clinical opportunities and Performance Management Committee receives operational opportunities for PI team creation.
24			Dying within 30-days after getting care in the hospital for a heart attack	Lower	15.225	15.1	
25	Heart failure	Recommended care	Heart failure patients given instructions for follow-up care before leaving the hospital	Higher	92.75	98	
26			Test of how well the heart is able to pump blood	Higher	99.75	100	
27			Heart failure patients given medicine to make the heart work better	Higher	96.75	96	above 90 % no plan necessary per application Q9
28		Results of care	How often patients die in the hospital after heart failure	Lower	3.40555	4.0011	Mortality Review Committee - individual cases discussed for Operational and clinical opportunities for improvement. Peer Review receives clinical opportunities and Performance Management Committee receives operational opportunities for PI team creation.
29			Dying within 30-days after getting care in the hospital for heart failure	Lower	12	10.6	

	Category	Sub-Category	Indicator	Higher or Lower Is Better	Bottom Quartile Level	University of Maryland Shore Medical Center at Easton	The following processes and committees (for example, Mortality & Throughput committees) are all new in 2015. UMSMC-E has introduced many changes in practice to addresses opportunities for improvement.
30			Returning to the hospital after getting care for a heart attack	Lower	18.825	18.6	
31			Returning to the hospital after getting care for heart failure	Lower	24.525	22.3	
32	Heart surgeries and procedures	Recommended care	How often the hospital uses a procedure to find blocked blood vessels in the heart on both sides of the heart instead of on only one side. Doing this procedure on both sides of the heart often leads to more complications.	Lower	2.0688	9.375	Peer review of both right and left heart catherization oocurs within the Cardiollgy section and in coordination with established Medical Staff Peer review processes to identify opportunities for improvement
33			Blood sugar level controlled after heart surgery	Higher	N/A	N/A	
34	Maternity & Newborn	Practice patterns	Percentage of births (deliveries) that are C-sections	Lower	33.8347	25.3579	
35			How often there are no complications for mothers who gave birth vaginally when the mother has had a C-section in the past	Higher	5.7471	2.4194	Medical Staff Peer review processes are followed. VBAC is avoided in all cases except precipitous deliveries.
36			Percent of women having their first time C-section	Lower	21.4159	14.8712	
37			How often babies are born vaginally when the mother has had a C-section in the past	Higher	5.3191	2.1898	as above in #35
38	Nursing care	Results of care - Complications	How often patients in the hospital get a blood clot in the lung or leg vein after surgery	Lower	4.8912	4.0281	

	Category	Sub-Category	Indicator	Higher or Lower Is Better	Bottom Quartile Level	University of Maryland Shore Medical Center at Easton	The following processes and committees (for example, Mortality & Throughput committees) are all new in 2015. UMSMC-E has introduced many changes in practice to addresses opportunities for improvement.
39		Results of care - Deaths	How often patients die in the hospital while getting care for a condition that rarely results in death	Lower	0.253275	0	
40			How often patients die in the hospital because a serious condition was not identified and treated	Lower	150.7294	296.4187	Mortality Review Committee - individual cases discussed for Operational and clinical opportunities for improvement. Peer Review receives clinical opportunities and Performance Management Committee receives operational opportunities for PI team creation.
41	Other surgeries	Results of care	Number of surgeries to remove part of the esophagus	N/A	N/A	N/A	
42			Number of surgeries to remove part of the pancreas	N/A	N/A	N/A	
43			Number of surgeries to fix the artery that carries blood to the lower body when it gets too large	N/A	N/A	N/A	
44			How often patients die in the hospital during or after surgery on the esophagus	Lower	N/A	N/A	
45			How often patients die in the hospital during or after pancreas surgery	Lower	2.807125	0	

	Category	Sub-Category	Indicator	Higher or Lower Is Better	Bottom Quartile Level	University of Maryland Shore Medical Center at Easton	The following processes and committees (for example, Mortality & Throughput committees) are all new in 2015. UMSMC-E has introduced many changes in practice to addresses opportunities for improvement.
46			How often patients die in the hospital during or after a surgery to fix the artery that carries blood to the lower body when it gets too large	Lower	44.3001	N/A	
47	Patient safety	Results of care -- Complications	Number of times a surgical tool was accidentally left in a patient's body during surgery	Lower	2	N/A	
48			How often the hospital accidentally makes a hole in a patient's lung	Lower	0.392875	0.4898	Medical Peer review processes evaluate Hospital complications and and potential harm to identify opportunities for improvement and/or Focused Professional Practice Evalaution opportunities.
49			How often patients accidentally get cut or have a hole poked in an organ that was not part of the surgery	Lower	1.643675	1.8663	Medical Peer review processes evaluate Hospital complications and and potential harm to identify opportunities for improvement and/or Focused Professional Practice Evalaution opportunities.
50			Number of patients who get a blood transfusion and have a problem or reaction to the blood they get	Lower	N/A	N/A	
51		Results of care -- Deaths	How often patients die in the hospital after bleeding from stomach or intestines	Lower	3.0511	2.0828	
52			How often patients die in the hospital after fractured hip	Lower	3.7751	3.5122	
53			How often patients die in the hospital while getting care for a condition that rarely results in death	Lower	0.253275	0	

	Category	Sub-Category	Indicator	Higher or Lower Is Better	Bottom Quartile Level	University of Maryland Shore Medical Center at Easton	The following processes and committees (for example, Mortality & Throughput committees) are all new in 2015. UMSMC-E has introduced many changes in practice to addresses opportunities for improvement.
54	Pneumonia	Recommended care	Right antibiotics given	Higher	95	95	
55		Results of care	How often patients die in the hospital while getting care for pneumonia	Lower	3.7049	5.1526	Mortality Review Committee - individual cases discussed for Operational and clinical opportunities for improvement. Peer Review receives clinical opportunities and Performance Management Committee receives operational opportunities for PI team creation.
56			Dying within 30-days after getting care in the hospital for pneumonia	Lower	11.8	10.5	
57			Returning to the hospital after getting care for pneumonia	Lower	18.95	17.6	
58	Prevention and Treatment	Blood Clot	Patients who developed a blood clot while in the hospital and did not get treatment that could have prevented it	Lower	8	0	
59	Preventive Care	Health care-associated	Patients in the hospital who got the flu vaccine if they were likely to get flu	Higher	95	97	
60	Stroke	Results of care	How often patients who came in after having stroke subsequently died in the hospital.	Lower	56.10008	6.9854	
61	Summary Scores	Deaths	How often patients die in the hospital from one of six problems: heart attack, heart failure, stroke, internal bleeding, hip fracture, or pneumonia	Lower	1.03915	1.1195	Mortality Review Committee - individual cases discussed for Operational and clinical opportunities for improvement. Peer Review receives clinical opportunities and Performance Management Committee receives operational

	Category	Sub-Category	Indicator	Higher or Lower Is Better	Bottom Quartile Level	University of Maryland Shore Medical Center at Easton	The following processes and committees (for example, Mortality & Throughput committees) are all new in 2015. UMSMC-E has introduced many changes in practice to addresses opportunities for improvement.
							opportunities for PI team creation.
62		Patient safety	How well this hospital keeps patients safe based on eight patient safety problems	Lower	0.85995	0.8671	Harm Committee Review of individual cases for clinical and operational opportinities for improvement.
63	Surgical patient safety	Recommended care after surgery	Antibiotics stopped within 24 hours after surgery	Higher	97.75	98	
64			Blood sugar level controlled after heart surgery	Higher	94	N/A	
65			Surgery patients who have a thin tube inserted to drain their bladder and it is removed on the first or second day after surgery	Higher	97	98	
66			Preventing low body temperature during and after surgery	Higher	100	100	
67		Recommended care before surgery	Medicine to lower blood pressure given (if needed)	Higher	97	97	
68			Antibiotics given one hour before surgery	Higher	98	99	
69			Right antibiotics given	Higher	98	100	
70			Surgery patients prescribed treatment to prevent blood clots at the right time	Higher	98	96	

	Category	Sub-Category	Indicator	Higher or Lower Is Better	Bottom Quartile Level	University of Maryland Shore Medical Center at Easton	The following processes and committees (for example, Mortality & Throughput committees) are all new in 2015. UMSMC-E has introduced many changes in practice to addresses opportunities for improvement.
71		Results of care	How often patients die in the hospital because a serious condition was not identified and treated	Lower	150.7294	296.4187	Mortality Review Committee - individual cases discussed for Operational and clinical opportunities for improvement. Peer Review receives clinical opportunities and Performance Management Committee receives operational opportunities for PI team creation.
72			How often patients in the hospital had to use a breathing machine after surgery because they could not breathe on their own	Lower	8.69425	4.9712	
73			How often patients in the hospital get a blood clot in the lung or leg vein after surgery	Lower	4.8912	4.0281	

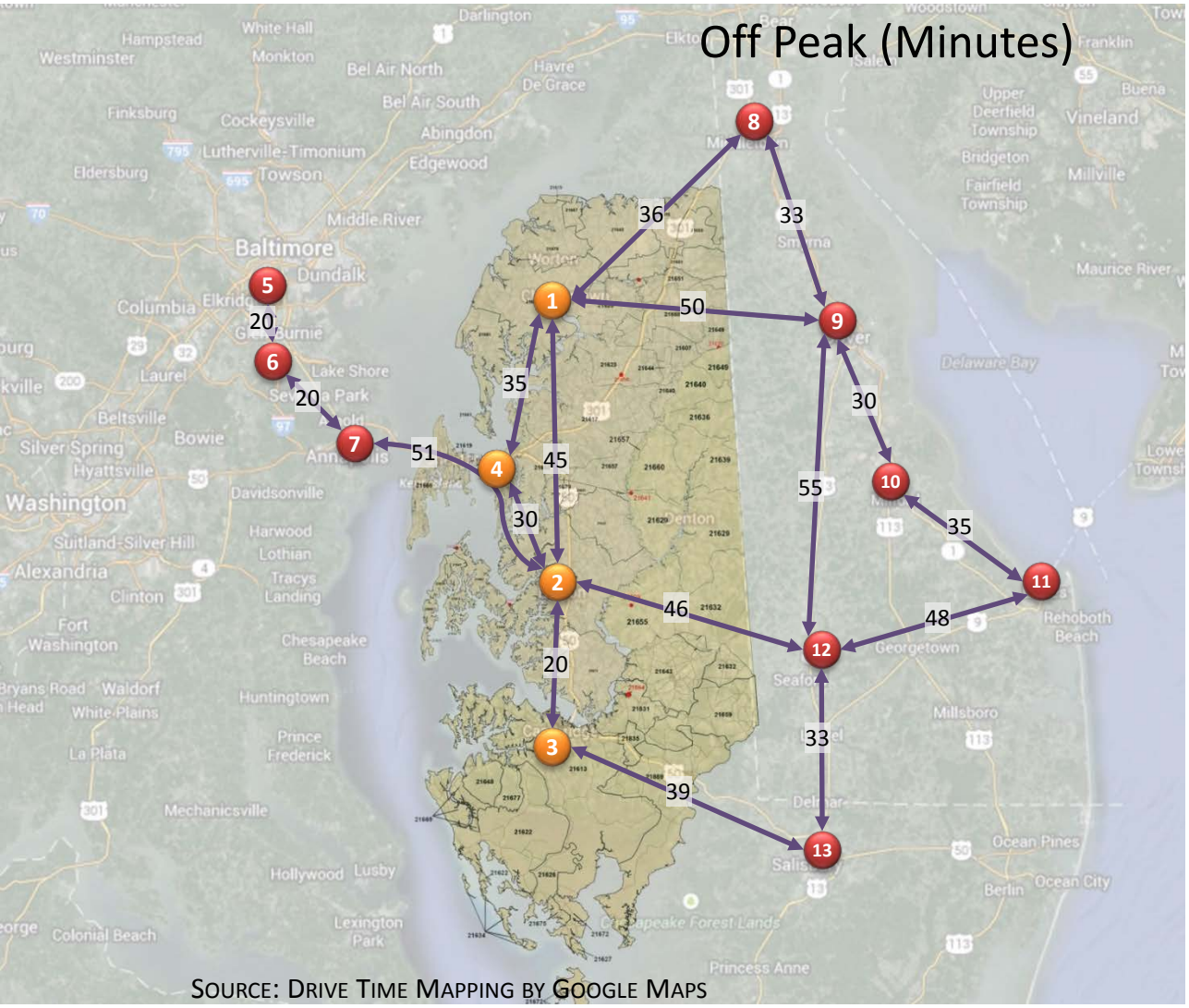
EXHIBIT 4

Distance (mi), Time (min) to Destination

	AAMC		Kent General		Nanticoke		PRMC		Easton		Chestertown	
	Miles	Mins	Miles	Mins	Miles	Mins	Miles	Mins	Miles	Mins	Miles	Mins
Easton	41.8	48					47	53	0	0		
Cambridge	57.1	65			28.5	37	32.4	36	16	20		
Centreville	31.6	36	35.7	47					20.7	27		
Chester	18.3	22							28.6	35		
Chestertown*	50.6	60	34.3	52					37.1	51		
Cordova	39.6	46							9.4	15		
Crumpton*	48.5	50	27.1	39					38.5	44	10.4	14
Denton	44.1	52	27.8	40	25.7	34	45.8	59	17.2	26		
East New Market					21	28	30.5	36	22.1	27		
Federalsburg					11.4	17	32.3	42	19.9	30		
Greensboro	46.5	56	23.1	32	31.9	41	52	65	24.2	38		
Henderson	47.1	54	20	34	42	58			30.1	47		
Hillsboro	36.6	41	32.6	45	33.4	44	53.5	68	13.8	21		
Hurlock					13.8	21	30	37	20.9	32		
Madison	54.8	63			39.6	50	43.4	49	29	36		
Marydel	34	35	15.2	23	45.4	59	65.5	83	39.1	45		
Oxford	50.3	58			39.8	54	45.8	53	7.7	11		
Preston	50.1	58	42.4	58	20.4	28	35.6	44	11.6	19		
Queen Anne	36.8	39	34	45	37.3	49			15.8	23		
Queenstown	28.9	34							19.2	26		
Ridgley	40.3	47	29.3	41	32.4	45	52.5	69	18	29		
St. Michael's	52	60			41.6	60	56.9	67	10.5	18		
Stevensville	19.3	25							33.1	41		
Trappe	54.7	62			33.3	43	37.1	41	13.5	20		
Woolford					35.8	48	39.7	47	24.4	32		

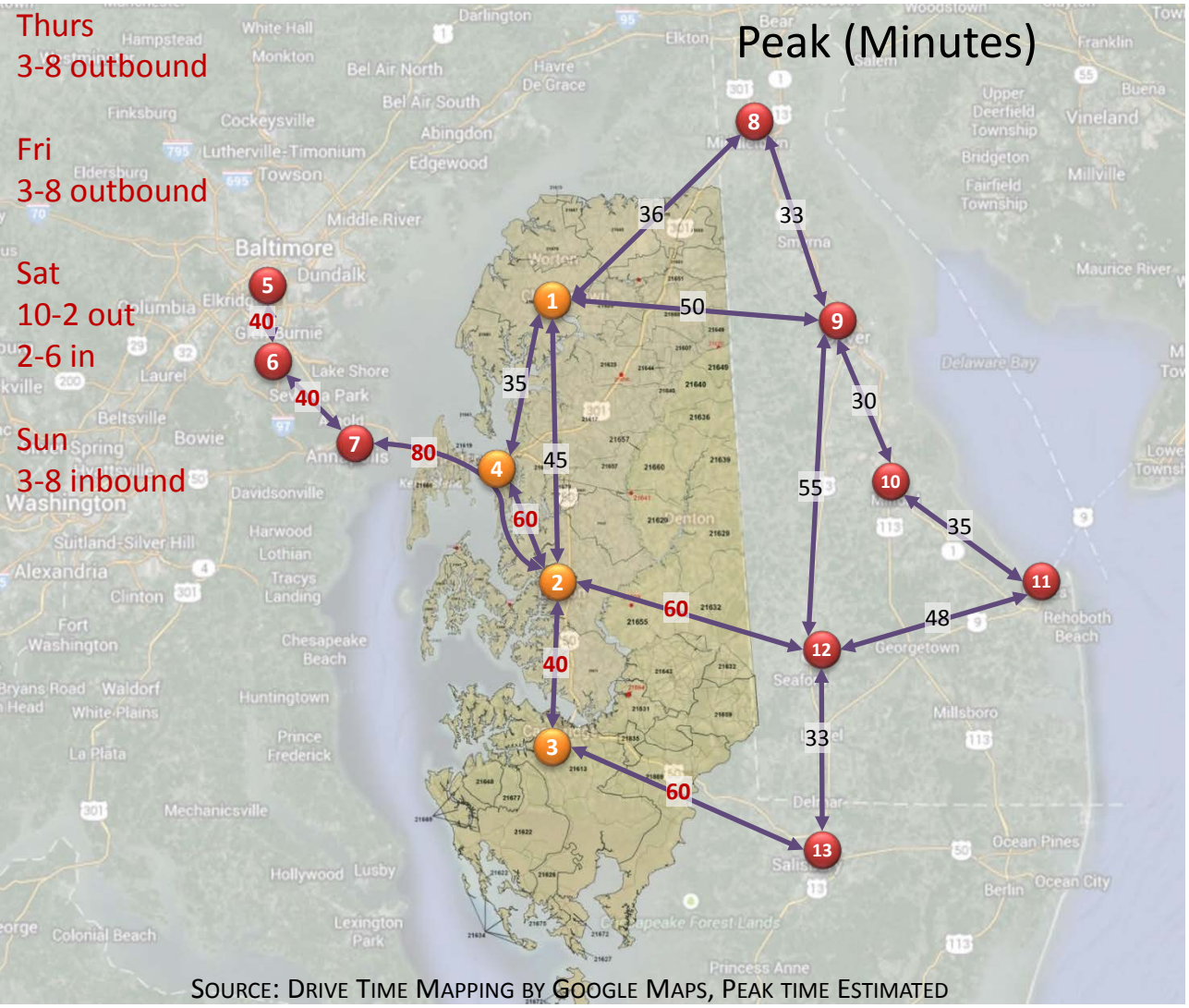
EXHIBIT 5

Drive Time Variables



Key	Hospital
1	UMSMC Chestertown
2	UMSMC Easton
3	UMSMC Dorchester
4	UMS EC Queenstown
5	UMMC
6	BWMC
7	AAMC
8	CCM
9	KGH
10	MGH
11	BMC
12	NMH
13	PRMC

Drive Time Variables



SOURCE: DRIVE TIME MAPPING BY GOOGLE MAPS, PEAK TIME ESTIMATED

Key	Hospital
1	UMSMC Chestertown
2	UMSMC Easton
3	UMSMC Dorchester
4	UMS EC Queenstown
5	UMMC
6	BWMC
7	AAMC
8	CCM
9	KGH
10	MGH
11	BMC
12	NMH
13	PRMC

EXHIBIT 6

LETTERS OF SUPPORT

Name	Title	Affiliation
Wayne L. Gardner, Sr.	President	Best Care Ambulance, Inc.
Ann Jacobs	Executive Director	Caroline County Chamber of Commerce
Dr. Andy Harris	Member	U.S. Congress
Dr. Jon R. Krohmer	Medical Director	Caroline County EMS
Leland D. Spencer, MD	Health Officer	Caroline County/Kent County Health Department
Dr. Jonathan Moss	Sr. Vice President/ Chief Medical Officer	Choptank Community Health System, Inc.
Steven J. White, MD	Medical Director	Dorchester County EMS
Roger L. Harrell, MHA	Health Officer	Dorchester County Health Department
Jacob F. Frego	Executive Director	Eastern Shore Area Health Education Center
Dr. Joseph Ciotola, Jr.	Health Officer	Queen Anne's County Health Department
Michael D. Joyce, MD	Director	UM Shore Health Sytem EMS/DGH
Arthur B. Cecil	Member	UM Shore Regional Health Board
Kathleen Deoudes	Member	UM Shore Regional Health Board
Joy & Richard Loeffer	Members	UM Shore Regional Health Board
David Milligan	Member	UM Shore Regional Health Board
John W. Ashworth III	President/ Chief Executive Officer	University of Maryland Medical Center
Larry C. Porter	President	Caroline County Commissioners
Wilbur Levengood, Jr.	Vice President	Caroline County Commissioners
Daniel J. Franklin	Commissioner	Caroline County Commissioners
Victoria Jackson-Stanley	Mayor	City of Cambridge
Ricky C. Travers	President	Dorchester County Council
Shelley L. Herman	County Administrator	Kent County Commissioners
Corey W. Pack	President	Talbot County Council
Laura E. Price	Vice President	Talbot County Council
Dirck K. Bartlett	Member	Talbot County Council
Chuck F. Callahan	Member	Talbot County Council
Jennifer L. Williams	Member	Talbot County Council
Robert C. Willey	Mayor	Town of Easton

Best Care Ambulance Inc.

Maryland Commercial License #97
Federal ID #52-1866845
NPI #1578671228
29468 Laurwayn Drive, Unit 11
Trappe, MD 21673
410 476-3688; 410 758-1999; FAX 410 476-5907

October 7, 2015

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington Street
Easton, MD 21601

Dear Mr. Kozel:

I am writing to express my full support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformation application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities serviced by UM Shore Regional Health - including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties – is one of two regions beyond a 30 minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI a UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

As owners of a commercial ambulance company on the mid shore we fully understand how important it is for PCI services to be provided to the local patient population in a timely manner, and we are confident that this service will result in patient's lives being saved.

I understand UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore it is my feeling that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It's an important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

Sincerely,

Wayne L Gardner, Sr

Wayne L. Gardner, Sr.
President

October 6, 2015

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

We are writing to express our full support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

We understand UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore, it is my/our feeling that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It's an important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

Kind regards,

Ann Jacobs
Executive Director
410-479-4638 Office
443-496-1755 Mobile

ANDY HARRIS, M.D.
FIRST DISTRICT, MARYLAND

COMMITTEE ON APPROPRIATIONS

SUBCOMMITTEES
AGRICULTURE, RURAL DEVELOPMENT, FOOD AND DRUG ADMINISTRATION
HOMELAND SECURITY
LABOR, HEALTH AND HUMAN SERVICES, EDUCATION

Congress of the United States
House of Representatives
Washington, DC 20515

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100 OLDE POINT VILLAGE, SUITE 101
CHESTER, MARYLAND 21619
PHONE 410.643.5425

WWW.HARRIS.HOUSE.GOV

October 1, 2015

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

I write in support of University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

Providing PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health, including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties, which I am proud to represent, is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

I understand UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore, it is my belief that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It is an important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

I believe this application has significant merit, and would appreciate your full consideration, consistent with existing guidelines and policies, to it. If I can provide any additional information or be of further assistance on this or other matters of interest or concern, please let me know.

Sincerely,

Andy Harris, M.D.
Member of Congress
APH/hld

CAROLINE COUNTY DEPARTMENT OF EMERGENCY SERVICES

October 5, 2015

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

Along with other letters you have received from Caroline County, I am are writing to express my full support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

The ability to transport our STEMI patients to UM SMC at Easton will potentially significantly improve outcome of those patients we identify in Caroline County. Currently, emergent PCI services are only available outside the 30 minute transport time or out of state. Although out of state resources may still remain the most time-efficient service for a small area of our county, having those services available in the immediate region would afford patients needed, time- and cardiac-saving services. It would also allow many of our patients to remain within their medical home.

9391 DOUBLE HILLS ROAD DENTON, MARYLAND 21629
TELEPHONE 410-479-2622 FACSIMILE 410-479-0668
WWW.CAROLINEDES.ORG

As an EMS medical director for over 30 years, I am completely committed to all improvements in our EMS and critical care services which address time-sensitive medical conditions, such as a STEMI. The ability of UM SMC at Easton to build upon its already existing cardiovascular program is a natural progression and will significantly improve the cardiac health of our community and our region. I fully support this CoC application.

Sincerely,

Jon R. Krohmer, MD, FACEP
Caroline County EMS Medical Director

9391 Double Hills Road Denton, Maryland 21629
Telephone 410-479-2622 Facsimile 410-479-0668
www.carolinedes.org

Caroline County Health Department

Leland Spencer, M.D., MPH
Health Officer

Attillio J. Zarrella, Th.D
Deputy Health Officer

October 5, 2015

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

I am writing to express my full support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge.

Caroline County consistently ranks among the worst 25% of County's statewide for heart disease mortality. In fact, according to the Maryland Department of Health and Mental Hygiene's MATCH data sets, from 2000-2010, 65-74 year olds were 36% more likely to die from heart disease compared to the Statewide average. Providing primary PCI at UM SMC at Easton could significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

I understand UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore, it is my feeling that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It's an important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

Sincerely,

Leland D. Spencer, M.D., M.P.H.

403 South 7th Street, Denton, MD 21629
Ph: 410.479.8030 • Fax 410.479.0554 • TTY Users: 800.735.2258
www.carolinehd.org

CHOPTANK
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10/5/15

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

I am writing to express my full support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

The Choptank Community Health System serves over 25,000 patients in Caroline, Dorchester and Talbot Counties and we depend on the UM SMC at Easton for inpatient as well as out patient hospital services including in-patient and outpatient cardiology services. Many of our patients have transportation difficulties and having a PCI program that is convenient to our Eastern Shore location is critical.

I understand UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore, it is my feeling that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It's an

important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

Sincerely,

Dr Jonathan Moss MD

Senior Vice President & Chief Medical Officer
Choptank Community Health System, Inc.
P.O. Box 660, 301 Randolph Street
Denton, MD 21629

Office Phone: (410) 479-4306 x-5002
Fax: (410) 479-1714
jmoss@choptankhealth.org

October 12, 2015

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

I am writing to express my full support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMMS) de ted cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

As medical director for Dorchester County EMS and a practicing emergency medicine physician at UM SMC at Dorchester and Easton, I am well aware of the difficulty meeting time deadlines for PCI in the event of acute ST-elevation MI. In particular, because of the remoteness / geographic isolation of several areas of Dorchester County combined with current distances to primary PCI centers, the benefits of PCI may be significantly reduced for those remote patients. The 30-minutes time savings offered by having a PCI center in Easton can be critical for a number of our patients.

I understand UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore, it is my feeling that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It's an important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

Sincerely,

Steven J. White, MD, M.S., FACEP, FAAP
Medical Director, Dorchester County Emergency Medical Services

Dorchester County Department of Health

"Working for Healthier People"

3 Cedar Street
Cambridge, MD 21613

www.dorchesterhealth.org

Tel# (410) 228-3223
FAX# (410) 228-9319

Roger L. Harrell, MHA, Health Officer

October 6, 2015

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

The Dorchester County Health Department fully supports the University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

The health behaviors of the citizens of Dorchester County for smoking, obesity and physical activity exceed the state and national averages. These lifestyle behaviors contribute to a higher incidence of morbidity and mortality for heart disease. The addition of PCI services improves the clinical care that is available to our citizens and will impact our ability to assure improved population health at a reduced cost with improved patient satisfaction.

As Health Officer I am pleased to offer my full support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton.

Sincerely,

Roger L. Harrell

Roger L. Harrell, MHA
Health Officer

Eastern Shore Area Health Education Center

814 Chesapeake Drive
Cambridge, Maryland 21613
Tel: (410) 221-2600
Fax: (410) 221-2605
www.esahec.org

October 2, 2015

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

On behalf of the Eastern Shore Area Health Education Center (ESAHEC) I am pleased to support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

We at the ESAHEC firmly believe that the implementation of this service will represent a significant asset in the health care arsenal to be made available to citizens of the mid-shore region.

I understand UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore, it is our feeling that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It's an important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

Sincerely,

Jacob F. Frego
Executive Director

Department of Health
Queen Anne's County

206 N. Commerce Street, Centreville, MD 21617-1049
Tel: 410-758-0720 • 410-778-0993 • Fax: 410-758-2838

Joseph A. Ciotola, M.D.
Health Officer

October 6, 2015

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

I am/We are writing to express my/our full support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

I/We understand UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore, it is my/our feeling that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It's an important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

Sincerely,

Joseph Ciotola, Jr., M.D.
Health Officer

MARYLAND

An Equal Opportunity Employer

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

October 2nd, 2015

Dear Mr. Kozel:

I am/We are writing to express my/our full support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

I have provided emergency care in the above county regions for 30 years. There have been many patients needing acute cardiac interventional service necessitating transfer to distant facilities. This has delayed cardiac interventions." Time is myocardium" and even a short delay beyond the 90 minute door to balloon window we strive for can greatly impact patient outcome. The ability to perform PCI within our region would greatly enhance the quality of cardiac care available to our patients.

I understand UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore, it is my/our feeling that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It's an important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

Sincerely,

Michael D Joyce, MD
Director of Emergency Services/Shore health System/DGH

Wright, Catherine

From: Art Cecil [abcecil@atlanticbb.net]
Sent: Wednesday, September 30, 2015 3:51 PM
To: Wright, Catherine
Subject: Letter of Support

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington Street
Easton, Md. 21601

September 30, 2015

Dear Mr. Kozel:

I am writing to express my full support for University of Maryland Shore Regional Health's Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Regional Health Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center. I am not a physician but understand from those who are that the proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

The geographic region of the communities served by UM Shore Regional Health - including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

This proposal ensures that our residents and others will receive vital, high quality health care close to home when they need it. This would be an important step forward that will guarantee best medical outcomes to our local community and the surrounding region.

Sincerely,

Arthur B. Cecil III

KATHLEEN DEOUDES
2519 Bennett Point Road
Queenstown, MD 21658

October 5, 2015

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

I am writing to express my full support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region. Given that a majority of the geographical area served by UM SRH is still deemed medically underserved, expansion of and access to healthcare at all levels is crucial to these communities.

I understand UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore, it is my/our feeling that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It's an important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

Sincerely,

Kathleen Deoudes
UM SRH Board of Directors

Joy & Richard Loeffler
13 Sandy Acres Rd
Cambridge, MD 21613

October 1, 2015

Mr. Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel,

We are writing to express our full support for the University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCE in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Region Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties – is one of two regions beyond a 30 minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

We understand UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore, it is our feeling that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It's an important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

Sincerely,

Joy & Richard Loeffer

September 30, 2015

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

I am writing to express my full support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

I understand UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore, it is my feeling that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It's an important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

Sincerely,

David Milligan

UNIVERSITY of MARYLAND
MEDICAL CENTER

Executive Office

22 S. Greene Street
Baltimore, Maryland 21201-1595

September 29, 2015

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

I am writing to express our full support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMSS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

We understand UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore, it is my/our feeling that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It's an important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

Sincerely,

John W. Ashworth, III
President and Chief Executive Officer

COUNTY COMMISSIONERS *of* CAROLINE COUNTY, MARYLAND

October 6, 2015

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

The County Commissioners of Caroline County are pleased to express our full support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

As you will see reflected in the letters from our Health Officer and Emergency Medical Services Medical Director, Caroline County has a great need for the services your team is seeking to bring to UM SMC at Easton. We believe strongly that, if your application is successful, PCI services at UM SMC at Easton will save the lives of Caroline residents on a regular basis. The Commissioners are pleased and thankful to you and your team for being excellent partners and working to address areas where additional services would make a meaningful impact for the Mid-Shore.

We understand UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore, it is my/our feeling

that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It's an important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

Again, you have our most sincere and staunch support as you pursue your application to bring PCI services to UM SMC at Easton. Please do not hesitate to call on us if there is anything additional that we can do to further that goal.

Sincerely,

County Commissioners of Caroline County

Larry C. Porter, President

Wilbur Levengood, Jr., Vice President

Daniel J. Franklin, Commissioner

Victoria Jackson-Stanley
Mayor

City of Cambridge
City Hall
410 Academy Street – P O Box 255
Cambridge, Maryland 21613
Phone: 410-228-4020 Fax: 410-228-4554
MD Relay (V/TTY) 711 or 1-800-735-2258
E-Mail mayor@choosecambridge.com

October 5, 2015

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

I am writing to express the Commissioners of Cambridge's full support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

We understand UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore, it is our feeling that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It's an important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

Sincerely,

Victoria Jackson-Stanley, Mayor
On behalf of
The Commissioners of Cambridge

COUNTY COUNCIL OF DORCHESTER COUNTY

COUNTY OFFICE BUILDING
P.O. BOX 26
CAMBRIDGE, MARYLAND 21613
PHONE: (410) 228-1700
FAX: (410) 228-9641

RICKY C. TRAVERS, PRESIDENT
TOM C. BRADSHAW, VICE PRESIDENT
WILLIAM V. NICHOLS
RICK M. PRICE
DON B. SATTERFIELD

JEREMY D. GOLDMAN
COUNTY MANAGER

E. THOMAS MERRYWEATHER
COUNTY ATTORNEY

October 6, 2015

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

I am writing on behalf of the Dorchester County Council to express our full support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

The County Council understands UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore, it is our feeling that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It's an important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

Sincerely,

DORCHESTER COUNTY COUNCIL

Ricky C. Travers
President

http://www.docogonet.com
e-mail: info@council.docogonet.com

The County Commissioners of Kent County

R. Clayton Mitchell, Jr.
Kent County Government Center
400 High Street
Chestertown, Maryland 21620
TELEPHONE 410-778-4600
FACSIMILE 410-778-7482
E-MAIL kentcounty@kentgov.org
www.kentcounty.com

October 14, 2015

Kenneth D. Kozel, MBA, FACHE
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

On behalf of the County Commissioners of Kent County, Maryland, I am pleased to offer a letter of support for the University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

Providing PCI services in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

Given that UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation, the ability to offer PCI is a natural evolution of that program. The proposal ensures that our residents will receive vital, high quality health care close to home and is an important step forward that will guarantee the best possible medical outcomes to our local community and the surrounding region.

Very truly yours,

Shelley L. Herman
County Administrator

KCC:smb

COUNTY COUNCIL OF TALBOT COUNTY
COURT HOUSE
11 N. WASHINGTON STREET
EASTON, MARYLAND 21601-3178
PHONE: 410-770-8001
FAX: 410-770-8007
TTY: 410-822-8735
www.talbotcountymd.gov

COREY W. PACK, President
LAURA E. PRICE, Vice President

DIRCK K. BARTLETT
CHUCK F. CALLAHAN
JENNIFER L. WILLIAMS

October 7, 2015

Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

The Talbot County Council wishes to express its full support for the University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at the University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care by providing lifesaving treatment for patients with obstructed coronary arteries.

It is critical that patients experiencing symptoms of arterial obstruction receive PCI in a timely and efficient manner. However, the geographic region of the communities served by UM Shore Regional Health, including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties, is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMMS) designated cardiac interventional hospital. In addition to the lengthy distance and travel times, delays also occur due to traffic patterns, including congestion at the Bay Bridge. When every minute counts, the ability to provide primary PCI at UM SMC at Easton would significantly change this dynamic. Coupled with the ability to perform elective PCI, this technology would bring accepted treatment modalities to the residents and visitors of our region.

The County Council understands that UM SRH currently offers a robust cardiovascular program at its Easton facility, including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. As such, it is our belief that the ability to offer PCI services at Easton is a natural extension of the current program. The proposal to bring PCI services to the Easton facility ensures that the residents in our community and region will receive vital, high quality healthcare when they need it, close to home. The provision of PCI services at UM SMC at Easton will,

most importantly, be an important step forward toward helping to guarantee the best possible medical outcome for the patient.

Sincerely,
COUNTY COUNCIL OF TALBOT COUNTY

Corey W. Pack, President

Laura E. Price, Vice President

Dirck K. Bartlett

Chuck F. Callahan

Jennifer L. Williams

Town of Easton

14 S. Harrison Street, Easton, Maryland 21601
410-822-2525
bobwilley@town-eastonmd.com

Robert C. Willey
Mayor

September 30, 2015

Mr. Kenneth Kozel
President and Chief Executive Officer
University of Maryland Shore Regional Health
219 S. Washington St.
Easton, MD 21601

Dear Mr. Kozel:

I am writing to express my full support for University of Maryland Shore Regional Health's (UM SRH) Certificate of Conformance application to develop both primary and elective percutaneous coronary intervention (PCI) services at University of Maryland Shore Medical Center at Easton (UM SMC at Easton), in partnership with the University of Maryland Medical Center (UMMC). The proposed PCI program will improve the region's access to quality cardiac care, and will provide lifesaving treatment for patients with obstructed coronary arteries.

To provide PCI in a timely and efficient manner is critical for patients experiencing symptoms of arterial obstruction. The geographic region of the communities served by UM Shore Regional Health – including Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties - is one of two regions beyond a 30-minute drive time to a Maryland Institute for Emergency Medical Services Systems (MIEMMS) designated cardiac interventional hospital. Aside from lengthy distance and travel times, delays also occur as a result of traffic patterns including congestion at the Bay Bridge. Providing primary PCI at UM SMC at Easton would significantly change this dynamic and coupled with the ability to perform elective PCI, would bring accepted treatment modalities to the residents and visitors of our region.

The town of Easton as well as surrounding communities rely heavily on progressive medical services at University of Maryland Shore Medical Center at Easton. Having the most advanced technological services is an asset not only to our residents, but as an economic advantage pursuing businesses and employees considering relocation to our area.

I understand UM SRH currently offers a robust cardiovascular program including diagnostic cardiac catheterization, device implant and cardiac rehabilitation. Therefore, it is my feeling that the ability to offer PCI is a natural evolution of that program. This proposal ensures that our residents will receive vital, high quality health care close to home when they need it. It's an important step forward that will guarantee best possible medical outcomes to our local community and the surrounding region.

Sincerely,

Robert C. Willey

Robert C. Willey
Mayor

EXHIBIT 7

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

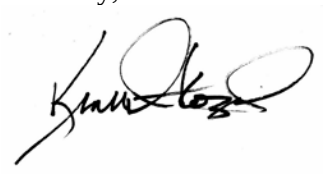
October 12, 2015

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21225

Dear Mr. Steffen,

As part of our application for a Certificate of Conformance, I am submitting this letter of commitment that if University of Maryland Shore Regional Health (UM SRH) obtains Commission approval to establish a primary PCI Program, University of Maryland Medical Center at Eason (UM SMC Easton) shall commit to providing primary PCI services as soon as possible and not to exceed 90 minutes from patient arrival at the hospital, excluding transfer cases, for at least 75 percent of appropriate patients. UM SMC Easton shall also track the door-to-balloon times for transfer cases and evaluate areas for improvement.

Sincerely,



Kenneth D. Kozel, MBA, FACHE
President and CEO
UM Shore Regional Health

EXHIBIT 8

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

October 12, 2015

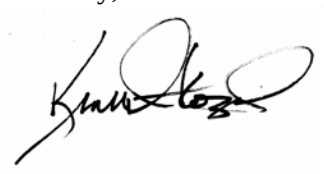
Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21225

Dear Mr. Steffen,

As part of our application for a Certificate of Conformance, I am submitting this letter of commitment to provide the staffing and facility support necessary to provide primary PCI services in accordance with the requirements for primary PCI programs established by the Maryland Health Care Commission.

The Primary PCI program is part of our System's vision and overall strategic plan. We are 100% committed to the program to provide critical care Cardiovascular services to our community.

Sincerely,



Kenneth D. Kozel, MBA, FACHE
President and CEO
UM Shore Regional Health

EXHIBIT 9

FORMAL CONTINUING MEDICAL EDUCATION PROGRAM AND SKILLS COMPETENCIES FOR CARDIAC CATH LAB STAFF, EMERGENCY DEPARTMENT RNs, TELEMETRY UNIT, AND ICU/CCU RN's

The following represent Continuing Medical Education and Skills Competencies for Cath Lab, Emergency Department RNs, Telemetry Unit and ICU/CCU RNs.

Once approval for performing Primary and Elective Angioplasty has been granted, continuing education and skills competencies related to PCI will be added to Annual Continuing Education and Skills Competencies for these same areas.

Skills Competencies, Cardiac Cath Lab

The following represents the annual continuing education and skills competencies for Cardiac Cath Lab staff.

Cardiovascular and Pulmonary Services

Cardiac Catheterization Laboratory

ANNUAL SKILLS COMPETENCIES

EMPLOYEE: _____ **DATE COMPLETED:** _____

SKILLS	MET	NOT MET	DATE/INITIALS
MONITORING (Demonstrate)			
Powering the Camtronics hemodynamic computer monitor			
Registering a new patient/ creating a new patient file			
How to initiate the NIBP cuff, timer			
How to input pertinent patient data (case #, staff, allergies, labs, equipment, IV fluids, pt identification, consent, meds, etc).			
Demonstrate how to zero and calibrate transducer			
Demonstrate how to record rhythm and pressure Waveforms (changing scale and sweep speed).			

SKILLS	MET	NOT MET	DATE/INITIALS
Initiating Thermodilution Cardiac Output on the Camtronics hemodynamic monitor			
Inputing blood sats for Fick cardiac output			
Calculating valve areas, resistances, and shunts			
Demonstrating how to initiate Training Mode			
Demonstrating how to initiate Full Disclosure Mode			
Demonstrating how to create a pseudo-pullback Using LV and AO waveforms			
Demonstrate how to print reports, write/copy patient cath angiography CD			
CIRCULATOR (Demonstrate)			
Proper positioning of patient on table to ensure Comfort, privacy and X-ray panning capability			
Proper placement of lead wires, NIBP cuff, manual and Doppler peripheral pulse checks, pulse oximetry probe placement			
Proper leveling and flushing of transducer			
Proper connection of manifold connecting lines to fluids, contrast and transducer hook-up			
Assessment of IV site and function to include proper function, location site, restarting IV if necessary			
Running a blood sample for labs, oxygen saturation analysis using OSHA precautions			
Proper Thermodilution Cardiac output injections			
Able to discuss dosage, route of delivery and side effects of meds used in the lab			
Able to locate appropriate supplies requested and proper sterile hand-off of supplies to scrub			

SKILLS	MET	NOT MET	DATE/INITIALS
Understanding of x-ray exposure reduction methods			
SCRUB (Demonstrate)			
Proper sterile setup of procedural table and supplies			
Proper hand scrub, sterile gowning and gloving			
Sterile prep and drape of patient			
Clearing of all manifold lines of air			
Handling of guide wires including pre-loading of catheters, catheter - wire exchanging			
Proper technique of withdrawing arterial and venous blood samples for oxygen saturation analysis			
Proper technique for leaving sheaths in-place for monitoring and/or transferring patient to another facility			
Assist physician with contrast power injector tubing/catheter hook-up			
Assist physician with air bubbles detection prior to power contrast injection			
HEMOSTATIS (Demonstrate)			
Proper positioning of patient on stretcher for sheath removal using C-clamp			
Proper monitoring of patient vial signs and continuation of patient documentation			
Peripheral pulse check prior to, during, and post Sheath removal			
Discuss sheath removal with patient prior to removal To ensure cooperation and understanding			
Proper hand position using manual pressure to Ensure hemostatic control of bleeding			

SKILLS	MET	NOT MET	DATE/INITIALS
Proper placement of pressure disk when using the C-clamp to ensure hemostatic control of bleeding			
Proper placement of Femstop clamp following hemostatic control of bleeding and application of Tegaderm dressing			
Discuss documentation of hematoma, and physician notification			
Discuss patient post cath instructions			
CONTRAST POWER INJECTOR (Demonstrate)			
How to insert syringe and fill with contrast			
How to attach the injector tubing and how to clear the air bubbles from the injector			
How to input the volume, flow rate, and linear rise for power injection			
IMAGING (Demonstrate)			
Powering up the Philips X-Ray Equipment			
Discuss the function of each switch/button on the table control panel and the control room panel			
Moving the C-Arm in all positions requested			
Disengaging the X-Ray pedals to prevent accidental exposure to staff			
Changing the image intensifier magnification from			
8” to 13” to 17” to 19” settings			
Discuss radiation safety as related to the distance of the image intensifier tube to exam table			
Discuss radiation safety of patient and staff in relation to distance of the x-ray tube and shielding			

SKILLS	MET	NOT MET	DATE/INITIALS
INTRA-AORTIC BALLOON PUMP (Demonstrate)			
Proper technique and procedure for balloon Preparation			
Describe technique for balloon insertion			
Describe proper position of balloon			
Describe proper timing of IABP inflation & deflation			
Describe proper documentation			
Demonstrate working knowledge of pump console including printout of waveforms, reading augmentation of pressures and alarms			
Identification of main trigger and activation			
Turning on the Datascope CS300 IABP			
Demonstrate setup of arterial pressure lines, transducer, flushing and zeroing of lines			
Describe connection of IABP catheter and setup of Datascope CS300 IABP console for balloon pump augmentation			
Filling of IABP catheter and starting augmentation			
Troubleshooting and resolving alarms/problems			
How to change the helium tank			
TEMPORARY PACEMAKER INSERTION (demonstrate)			
How to check and change battery in generator box			
How to connect catheter extension cable to generator box and temporary pacing catheter			
Identifying the different temporary pacing catheter for femoral insertion and subclavian/internal jugular vein insertion			

SKILLS	MET	NOT MET	DATE/INITIALS
How to perform threshold check using temporary pacemaker generator box			
DEFIBRILLATOR (LIFEPAK 20) (Demonstrate)			
Proper testing and documentation of AM defibrillator check			
Different methods of emergency defibrillation using both paddles and bi-phasic pads			
Identify steps required for defibrillation			
Identify steps required for synchronized cardioversion			
Explain proper positioning of bi-phasic pads for specific procedures			
PROCEDURAL KNOWLEDGE (Explain)			
Left Heart Catheterization			
Right Heart Catheterization			
Right and Left Heart Catheterization			
Pericardial Centesis			
Intra-Aortic Balloon Pump Insertion			
Temporary Pacemaker			
Reveal Loop Recorder Insertion			
Permanent Pacemaker Implantation			
Automatic Internal Cardiac Defibrillator (AICD) Implantation			
Bi-Ventricular Pacemaker			
Transesophageal Echocardiogram			
External Cardioversion			

SKILLS	MET	NOT MET	DATE/INITIALS
Dobutamine Stress Echocardiogram			
Tilt Table			
Radiation Safety			

INITIALS	SIGNATURE	INITIALS	SIGNATURE

Emergency Department/Telemetry Unit/ICU/CCU Orientation, Continuing Education, Annual Skills Competencies

ICU STAFF COMPETENCIES AND CONTINUING EDUCATION ACTIVITIES FY 15

Competencies

Dysrhythmias

Medication Reconciliation

Restraints

Lift Equipment

Performing ECGs

Glucometer

Communication

Work Place Bullying

Continuous Renal Replacement Therapy

NIHSS

Fall Prevention

Unit Inservices and Healthstream Education

Core Measures

Dangers of Lifting in Nursing

Conscious Sedation

Flexiseal

Dale Ace Connector

IV Fluids and Electrolyte Imbalance

Ebola

Donning and Doffing for Ebola

Vapotherm

Convex Vital Signs Machines

Policy Manager Implementation

Nurse Multistate Compact Agreement

Mandatory Training

Rapid Regulatory Compliance which includes:

Fire Safety

Electrical Safety

Back Safety

Radiation Safety

MRI Safety

Lifting and Ergonomics

Slips, Trips and Falls

Latex Allergy

Hazard Communication

Workplace Violence

Emergency Preparedness

Infection Prevention and Control

Hospital Acquired Infections

Hand Hygiene

Bloodborne Pathogens

Standard Precautions

Isolation – Airborne, Contact, Droplet and Use of PPE

Standards of Business Conduct

Corporate Compliance Training

In addition all RNs are certified in Basic and Advanced Life support according to the American Heart Association guidelines. Certifications such as CCRN and Pediatric Life Support are encouraged but not mandated.

ICU STAFF COMPETENCIES AND CONTINUING EDUCATION ACTIVITIES FY 16

Competencies

Restraint for inpatient Units/ED

Palliative Care Psychosocial Assessment & Appropriate Referral Completion

Pain Assessment and Intervention

Cleaning of Patient Equipment

Glucometer

Glucometer Controls

Pyxis Station

Communication

Conscious Sedation

Dysrhythmia

GE Monitors

Early Warning System

Stroke (4 hours)

Skills Day – Low Volume High Risk – Sepsis Station to include SCVo2, Flo trac, CVP, Arterial Line management, Aquaphoresis, Chest Tubes, Peritoneal Dialysis, Lift Equipment, Hypothermia Protocol, Central Line Insertion, Core Measures Station, Rapid Infuser, Code Cart, Mock Code Blue, Hyper/Hypothermia devices, CRRT.

Unit Inservices and Healthstream Education

Code Blue

MET (Medical Emergency Team)

Plan of Care

Joint Commission Task Force

Blood Transfusion and Adverse Reactions

ICD-10 Basic Awareness

Carefusion Pyxis ES Training

Comfort Care

Mandatory Training

Rapid Regulatory Compliance which includes:

Fire Safety

Electrical Safety

Back Safety

Radiation Safety

MRI Safety

Lifting and Ergonomics

Slips, Trips and Falls

Latex Allergy

Hazard Communication

Workplace Violence

Emergency Preparedness

Infection Prevention and Control

Hospital Acquired Infections

Hand Hygiene

Bloodborne Pathogens

Standard Precautions

Isolation – Airborne, Contact, Droplet and Use of PPE

Standards of Business Conduct

Corporate Compliance Training

In addition all RNs are certified in Basic and Advanced Life support according to the American Heart Association guidelines. Certifications such as CCRN and Pediatric Life Support are encouraged but not mandated.

TELEMETRY STAFF COMPETENCIES AND CONTINUING EDUCATION ACTIVITIES FY 15

Competencies

Dysrhythmias

Falls

Medication Reconciliation

Restraints

Lift Equipment

Performing ECGs

RALS

Glucometer

Communication

NIHSS

Stroke Education

Conscious Sedation

Unit Inservices and Healthstream Education

Donning and Doffing for Ebola

Cardiac Cath Pre and Post Procedure

Convex Vital Signs Machines

Policy Manager Implementation

Nurse Multistate Compact Agreement

How to become a PCCN

What is Magnet all about

Mandatory Training

Rapid Regulatory Compliance which includes:

Fire Safety

Electrical Safety

Back Safety

Radiation Safety

MRI Safety

Lifting and Ergonomics

Slips, Trips and Falls

Latex Allergy

Hazard Communication

Workplace Violence

Emergency Preparedness

Infection Prevention and Control

Hospital Acquired Infections

Hand Hygiene

Bloodborne Pathogens

Standard Precautions

Isolation – Airborne, Contact, Droplet and Use of PPE

Standards of Business Conduct

Corporate Compliance Training

In addition all RNs are certified in Basic and Advanced Life support according to the American Heart Association guidelines. Certifications such as PCCN are encouraged but not mandated.

TELEMETRY STAFF COMPETENCIES AND CONTINUING EDUCATION ACTIVITIES FY 16

Competencies

Restraint for Inpatient Units/ED

Palliative Care Psychosocial Assessment & Appropriate Referral Completion

Pain Assessment and Intervention

Cleaning of Patient Equipment

Glucometer

Glucometer Controls

Pyxis Station

Communication

Conscious Sedation

Dysthymia

GE Monitors

Early Warning System

Stroke (4 hours)

Skills Day- Low Volume High Risk – Aquaphoreis, Chest Tubes, Peritoneal Dialysis, Lift Equipment, Central Line Insertion, Core Measures, Code Cart, Mock Code Blue, Hypo/Hyperthermia devices

Unit Inservices and Healthstream Education

Code Blue

MET (Medical Emergency Team)

Plan of Care

Joint Commission Task Force

Blood Transfusion and Adverse Reactions

ICD-10 Basic Awareness

Carefusion Pyxis ES Training

Comfort Care

Mandatory Training

Rapid Regulatory Compliance which includes:

Fire Safety

Electrical Safety

Back Safety

Radiation Safety

MRI Safety

Lifting and Ergonomics

Slips, Trips and Falls

Latex Allergy

Hazard Communication

Workplace Violence

Emergency Preparedness

Infection Prevention and Control

Hospital Acquired Infections

Hand Hygiene

Bloodborne Pathogens

Standard Precautions

Isolation – Airborne, Contact, Droplet and Use of PPE

Standards of Business Conduct

Corporate Compliance Training

In addition all RNs are certified in Basic and Advanced Life support according to the American Heart Association guidelines. Certifications such as CCRN and Pediatric Life Support are encouraged but not mandated.

SHORE REGIONAL HEALTH

Critical Care Skills Checklist-RN

Orientee Name: _____

Instructions:

- Preceptor to place date and initials in boxes as appropriate.
- The Orientee is not to perform any skill independently that has not been validated by either preceptor or another qualified RN (staff RN from that unit, Clinical Specialist, Specialty Educator, Clinical Nurse Coordinator, Unit Manager, or Administrative Supervisor).
- If a skill is not applicable to the Unit to which the Orientee is being oriented, place "N/A" in the columns for that item.
- Each box must be dated and initialed separately. **It is not acceptable to draw arrows to indicate a date and initials for multiple boxes**.
- Any person who initials a box must complete the initial/signature section on the last page.
- At least 85% of the skills on the Competency Skills List must be completed, and documentation must be submitted to the Nurse
  Manager before the orientee is released from orientation.

COMPETENCY VALIDATION - Employee is able to demonstrate correctly the following components of care by: **1. Direct Observation** **2. Simulation** **3. Case Study/Case Scenario** **4. Written Exam** **5. Exemplar** **6. Class** **7.Self-Learning Module**			
Shore Regional Health Mission / Values ▪ Verbalizes understanding of the principles of Relationship-based Care ▪ Verbalizes understanding of the principles of "Creating Healthier Communities Together"			

	Completed in Dept of Nursing Orientation	Validation Code	Preceptor Date/Initials
Corporate Compliance			
Map of Area			
Tour of Hospital			
Location of Reference Materials			
Administrative Policies			

	Completed in Dept of Nursing Orientation	Validation Code	Preceptor Date/Initials
Dept Specific Policies			
Environment of Care Policies			
Infection Control Policies			
Lippincott Procedure Manual			
MSDS On-line			
Nursing Policies			
Pharmacy Protocols			
Computer Based Programs			
BMV (if applicable)			
Clinical Access (if applicable)			
Education Tools ▪ IV Compatibility ▪ MicroMedex ▪ Patient Education FYI ▪ Up-to-date			
Employee email (HR-53) (per diem/relief only)			
Healthstream			
Hendrich's II Fall Risk Assessment (TX-46)			
Meditech • EDM and CPOE (ED only) • PCS and POM (Inpatient units)			
On-line Incident Reporting			
SRH Intranet			
Nursing Education Calendar			
Nurse Credentialing Database			

	Completed in Dept of Nursing Orientation	Validation Code	Preceptor Date/Initials
Communication			
Cell Phone / Hands Free Technology Use – SHS Owned and Personal (HR 64)			
Customer Service Standards			
Intercom System			
Pager System			
Telephone System			
Department Specific Roles During Emergencies			
BAT Activation (TX-36)			
Code Blue (TX-15)			
Code Gold (EC-97)			
Code Gray (EC-07)			
Code Green (EC-01)			
Code H (EC-92)			
Code Light Blue (EC-98)			
Code Orange (EC-41)			
Code Pink (EC-14)			
Code Red (EC-95)			
Code Silver (EC-94)			
Code U (EC-18)			
Code White (TX-69)			
Code Yellow (EC-96)			
Code Zebra (EC-13)			
Code Purple (EC- 10)			
Flight One (CC-03)			
MET Activation (TX-36)			

	Completed in Dept of Nursing Orientation	Validation Code	Preceptor Date/Initials
STEMI			
Safety Plan			
Emergency Phone Numbers (x8888 x1111)			
Location of Crash Cart			
Location of Eye Wash Stations			
Location of Fire Alarms			
Location of Fire Exits			
Oxygen Shut-Off Valves			
Patient Evacuation Plan			
Unit Fire Plan			
Human Resources			
Annual Education (HR-09)			
Job Description			
Kronos system			
Work Breaks (HR-46)			
Peer Evaluation (Nursing Policy, HR 65)			
Unit Based Orientation Plan			
Scheduling Policy (Nursing Policy)			
Call-out Policy (Nursing Policy)			
Employee Injury Report			
Documentation			
Abbreviations and Symbols (IM-29)			
Meditech Charting PCS			
• Daily Assessments/Vital Signs			
• Admission Data Base			
• Interdisciplinary Notes			
• Patient Education Record			

	Completed in Dept of Nursing Orientation	Validation Code	Preceptor Date/Initials
• Plan of Care			
Medication Reconciliation (TX-35)			
Chart Checks (Nursing Policy)			
Diabetic Flow Sheet			
Controlled Substance Infusion Flowsheet			
Electronic Medication Administration Record			
Physician Order Sets			
MOLST Orders (RI-21)			
Delirium Screening			
Daily Rounding Form			
MRI Checklist			
Infection Control			
Hand Hygiene (IC-25)			
Isolation/Negative Pressure Rooms			
Location of Personal Protective Equipment			
MRSA Surveillance Cultures			
VAP Bundle			
Target Zero			
Equipment			
Infusion Pump			
Biomedical Engineering			
Cleaning and Maintenance			
Fall Prevention Equipment			
Glucometer			
Lift equipment			
PCA Pump (TX-28)			
Pneumatic Tube System			

	Completed in Dept of Nursing Orientation	Validation Code	Preceptor Date/Initials
Pyxis			
Restocking of Room			
Sequential Compression Devices			
Tube Feeding Pump			
Datascope			
Epidural Pump			
Temperature Regulating Device			
EV-1000			
CRRT Machine			
Specialty Beds			
Wound Vac			
Patient Care			
Accompanying Monitored Patient Off the Unit for a Procedure			
Admission Procedure			
Allergy/ Adverse Drug Reaction Identification (PE-03)			
Assisting a LIP with Procedure Including Verification of Bedside Procedure Form (TX-29-A)			
Blood Sampling from an Invasive Line			
Care and Preparation of a Pre-Op Patient			
Care and Assessment of a Post-Op Patient			
Management of patients at risk for suicide, including continuous visual observation form			
Demonstration of Medication Administration Process (TX-65)			
Demonstration of Performance and Documentation of Physical Assessment			

	Completed in Dept of Nursing Orientation	Validation Code	Preceptor Date/Initials
Discharge Procedure			
Interdepartmental Transfer of Patient			
Intravenous Insertion			
IV Fluid and Medication Administration, including administration set change			
Lab Specimen Collection and Labeling (IC-28)			
Patient Death			
Patient Identification Process (PE-04)			
Patient Undergoing TEE			
Restraints (TX-02) • Non-Violent Orders and Documentation • Violent • Invasive Device Restraint Protocol • Demonstration of quick release knot			
Substance Abuse/Detoxification Protocol			
Transfer of Patient to Another Hospital			
Transfusion of Blood Products (TX-68 - Consent, Administration, Procedure for Reaction)			
Venipuncture			
Care of a Patient Experiencing Chest Pain			
Care of the Patient Undergoing Cardiac Catheterization			
Care of the Patient Post-Permanent Pacemaker Insertion			
Care of the Patient Experience Cardiac Dysrhythmia			

	Completed in Dept of Nursing Orientation	Validation Code	Preceptor Date/Initials
Care of the Patient Undergoing Nuclear Stress Test			
Care of the Patient with Trancutaneous Pacing			
Care of the Patient with Transvenous Pacing			
Care of the Patient requiring Synchronized Cardioversion			
Care of the Patient With Sepsis			
Care of the Patient Experiencing a Stroke, including BAT and NIHSS			
Patient Requiring Aquaphoresis/CRRT			
Patient with a Chest Tube			
Multidisciplinary Rounds			
Care of the Patient on Hypothermia Protocol			
Contacting Living Legacy			
Care of the Patient Experiencing a Code White			
Administration of Conscious Sedation			
Patient Handoff			
Prioritization of Patients			
Pharmacy			
Notification of Pharm D for Protocols			
Look Alike/Sound Alike Drugs			
Profile vs Non-profile Medications in Pyxis			
Pharmacy Hours			
Lexi-comp in Pyxis			
Stericycle			
ICU Hyperglycemic Protocol			

	Completed in Dept of Nursing Orientation	Validation Code	Preceptor Date/Initials
ICU Sedation Protocol			
Pxyis Override			
Compatibility Charts			
Medication Variance Report			
Controlled Substance Counts			
Pyxis Discrepancies			
Respiratory Care			
Contacting RT			
Respiratory Protocols • Oxygen • Pulmonary Hygiene • Bronchodilator			
Oxygen Delivery Devices			
Tracheostomy Care			
Care of the Mechanically Ventilated Patient			
In-line Tracheal Suctioning			
Disposable Tracheal Suctioning Kit			
Use of Specimen Trap for Sputum Specimen			
Care of the Patient with Bi-Pap or C-Pap			
Assist with Intubation			
Emergency Airway Box			
Pulse Oximetry			
Scv02			
Cardiac Monitoring			
Lead Placement			
Verification of Telemetry Transmitter			

	Completed in Dept of Nursing Orientation	Validation Code	Preceptor Date/Initials
Rhythm Strip Verification and Documentation			
12 Lead EKG			
Hemodynamic Monitoring			
Assist Physician with Insertion of Central Line			
Central Venous Pressure Monitoring			
Assist with Insertion of Swan-Ganz Catheter			
Pulmonary Artery Pressure Monitoring			
Cardiac Output/Index Monitoring			
Calculation of Hemodynamics			
Assist with Insertion of Arterial Catheter			
Arterial Line BP Measurement			
Nursing Unit			
Pyxis			
Supply Room			
Soiled Utility Room			
Patient/Patient Nourishment			
Equipment Storage			
Patient Charts			
Downtime Forms			
Manuals/Resources			
Conference Room			
Break Room/Locker Room			
Communication Book			
Family Waiting Room			
Nurse Manager’s Office			

	Completed in Dept of Nursing Orientation	Validation Code	Preceptor Date/Initials
Clinical Coordinator's Office			
Clinical Educator/Specialist's Office			
Central Monitoring System/Slave Monitors			
Process Improvement Initiatives			
Shared Leadership Unit-based Council			
Refrigerator and Temperature Checks			
Location of PCA/Epidural Keys			
Emergency Cart Checks			
Patient Education Materials			
Patient Room			
Room Set-up			
Bed Operation			
Suction Wall/ Portable			
Oxygen/Compressed Air			
Storage of Patient Belongings			
Lock Box for Medication Storage			
Red Bag Trash			
Restocking of Patient Rooms			
Bedside Monitors			
Code Blue Button			
Emergency Outlets			
Resources			
Nurse Manager			
Clinical Nurse Coordinator			
Clinical Specialist			
Unit-based Educator			
Patient Education Specialist			

	Completed in Dept of Nursing Orientation	Validation Code	Preceptor Date/Initials
Enterostomal Therapist			
Vascular Access Specialist			
Care Coordinator			
Social Worker			
Clinical Dietician			
Patient/Family Advocate			
Patient Care Advisory Committee			
Chaplain Services			
Risk Manager			
Maryland Express Care			
Administrative Supervisor			

Initials	Signature	Initials	Signature

02/08/13

EXHIBIT 10

UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH

TRANSFER POLICY
FOR THE INTERFACILITY TRANSPORT OF
PRIMARY ANGIOPLASTY PATIENTS

Effective Date: 10/13/2015

Sponsoring Department: Cardiac Catheterization Laboratory

PURPOSE:

The waiver for primary angioplasty in hospitals without open heart surgery requires that University of Maryland Medical Center at Easton (UMSMC-E) have a process in place that will ensure that an ALS equipped ambulance will arrive within 30 minutes of a request for patient transfer to a tertiary facility prepared to perform open heart surgery.

This Transfer Policy exists to provide a clear notification, request and transfer process that will ensure timely and efficient response should a patient undergoing primary angioplasty require transfer to the University of Maryland Medical Center (UMMC). In addition, this will provide a mechanism that will improve access to and utilization of appropriate resources.

POLICY:

A. NOTIFICATION:

1. The purpose of notification is to provide preparation time for the mobilization of important resources should a request be made.

2. Notification is to be made at the point the patient has been identified for PTCA. A member of the UMSMC-E cardiac catheterization team will notify the Maryland Express Care Transfer Center at the University of Maryland Medical Center by dialing (410) 328-1234. This contact should be made as soon as possible after getting the patient on the cardiac cath table and it is known that the patient will be receiving primary angioplasty.

    a. Identify the facility as UMSMC-E and notify the Transfer Center that there is a patient about to undergo primary angioplasty.

    b. Provide the Transfer Center with logistical information, patient demographics and brief clinical information that they may request.

    c. If the decision is made to transport the patient, as soon as possible, fax a copy of the patient's "face sheet" with demographic data to the Transfer Center at (410)328-1235.

B. POINT OF CONTACT:

The Maryland Express Care Transfer Center (TC) at UMMC will be the sole source of contact throughout the process. All inquiries related to patient transport should go through the TC. This allows for the most timely and efficient utilization of resources and avoids conflicting communication.

Air transport is the preferred and most expeditious form of transportation in this time sensitive pPCI area. If a helicopter is not available or able to travel to respond to UMSMC-E, the Transfer Center will contact the UMSMC-E contractual vendor for appropriate ground transportation.

C. NO TRANSPORT NECESSARY:

Once transport is deemed not necessary, a member of the UMSMC-E cath lab team will notify the Transfer Center

D. REQUEST FOR TRANSPORT:

If patient transport becomes necessary, a member of the UMSMC-E cath lab team will place a request to the Transfer Center with the following information:

1. Will the patient require an intra-aortic balloon pump?
2. Patient status report

A copy of the patient's medical record will accompany the patient

3. The TC will dispatch the ExpressCare Team to include an RN and balloon pump if requested. Maryland ExpressCare guarantees arrival of the air ambulance within thirty (30) minutes of a request by UMSMC-E for patient transport. Such response time includes the period from receipt of a call by UMSMC-E to arrival of the air ambulance at UMSMC-E.

    a. If Maryland ExpressCare air ambulance is not available or able to fly, the Transfer Center will notify either another air ambulance vendor or the UMSMC-E contractual ground transportation vendor, as appropriate.
    b. If all vendor resources are exhausted with no Critical Care team availability, the TC will dispatch a UMMC cardiac fellow/attending and an ALS team to respond within 30 minutes.
    c. If all vendor resources are exhausted with no Critical Care team availability and no UMMC Cardiac fellow/attending availability, the TC will proceed with contacting the UMSMC-E contractual ground transportation vendor.
    d. If the UMSMC-E ground transportation vendor can not provide a Critical Care team, the TC will contact the UMSMC-E cath lab staff to inform them of the lack of Critical Care transport availability, and appropriate UMSMC-E staff will accompany the patient during transport with the dispatched ALS team.. The UMSMC-E staff member will be returned to UMSMC-E immediately following the transport.

4. If the balloon pump is not available in a timely manner, Maryland ExpressCare can utilize the UMSMC-E balloon pump and will return it to UMSMC-E expediently after delivering the patient to the University of Maryland Medical Center.

This Transfer Policy will be in effect for patients undergoing primary angioplasty following the granting of the waiver to perform primary angioplasty without open heart surgery back-up, and involves agreement between UMSMC-E and Maryland ExpressCare.

Approved:

Kenneth D. Kozel, MBA, FACHE
President and CEO
UM Shore Regional Health

Dana Farrakhan

Dana Farrakhan, Senior Vice President
University of Maryland Medical Center

EXHIBIT 11

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding ("MOU") made this 10th day of October, 1997, by and between the University of Maryland Medical System ("UMMS") and Shore Health System, Inc. ("SHS").

RECITALS

A. UMMS operates an established patient transfer system known as Maryland ExpressCare.

B. Maryland ExpressCare provides safe and convenient ambulance transportation.

C. Maryland ExpressCare emphasizes effective coordination and communication.

D. SHS operates an integrated health care system which includes two acute care hospitals.

E. SHS patients regularly need to be transported to and from other health care facilities.

F. In order to improve the responsiveness and quality of ambulance transportation for its patients, SHS desires to obtain the support and expertise of UMMS.

G. The parties desire to collaborate in the design and implementation of a program for ambulance transportation of SHS patients (the "Program").

H. The parties desire to describe the status and direction of their discussions.

NOW, THEREFORE, the parties hereby state their intentions and current understandings as follows:

1. SHS shall use UMMS and UMMS shall serve SHS for all patient transportation requiring an ambulance.

2. Obligations of UMMS

   A. Provide through Maryland ExpressCare twenty-four hour fully licensed and certified service to SHS for all patient transportation requiring an

ambulance.

B. Arrange for a fully equipped ambulance ("dedicated ambulance") staffed by a driver and paramedic to be dedicated to the Program from 8:30 a.m. to 8:30 p.m every day, or such other twelve hour period mutually agreed to by the parties, and to be stationed at MHI, or such other location as may be selected by SHS, when not in use;

C. Provide and maintain the communication and medical equipment described in Exhibit 1

D. Provide initial and periodic training, education, competency and certification for all Program personnel involved in the program. UMMS shall pay all tuition and fees;

E. UMMS services shall include a central telephone number and the full range of Maryland ExpressCare services;

F. Consult with and consider SHS input regarding quality, policy and procedures, standards and criteria of practice and performance and vendors providing services to UMMS under the Program;

G. The Primary Vendor RFP to be used by UMMS shall be substantially in the form of Exhibit 2;

H. Provide a qualified Medical Director for the Program; and

I. Provide or pay SHS for 2.4 Registered Nurse FTE's for the critical care transports.

J. Maintain an alternate vendor schedule, subject to reasonable approval by SHS of vendor selection and scheduling.

3. Obligations of SHS:

SHS shall:

A. Pay UMMS the sum of $79,000 for establishing the program;

B. Provide for a Registered Nurse trained in critical care transports to be immediately available as needed to accompany transports under the

Program;

C. Provide approximately 400 square feet of suitable office space to UMMS, parking space with electric service for the dedicated ambulance, housekeeping, medical supplies, telephone, biomedical engineering for maintenance of equipment; and

D. Provide management support to ensure the operational success of the Program.

E. Pay direct labor costs for personnel trained under Subsection 2.D.

4. Payment for Services. UMMS shall be paid for its services according to Exhibit 3.

5. Insurance:

a. Each party shall maintain general liability and medical malpractice insurance in the minimum amount of $1 million per occurrence ($3 million aggregate) and worker's compensation insurance in compliance with State of Maryland requirements.

* b. The Prime Vendor and any substitute vendor shall maintain automobile liability insurance in the minimum amount of $1 million per occurrence and $3 million in the aggregate or such other amount as the parties agree.

* 6. Indemnity. UMMS shall have sole responsibility for and shall indemnify SHS against any and all claims, actions or losses, related in any way to medical management, including attorney's fees, based upon or arising during transport.

7. Program Development. The parties intend to continue to develop these concepts described in this MOU generally in accordance with the timetable and task outline attached as Exhibit 4.

8. Program Oversight. The parties intend to create an oversight committee for the Program ("Oversight Committee."). The Oversight Committee will establish criteria for operational and financial performance, including reimbursement. The Oversight Committee will evaluate the Program on a quarterly basis.

9. Term The Term of this Agreement shall be three years commencing on March 1, 1998, or such other date upon which the parties mutually agree. This agreement shall automatically renew for successive one-year terms unless terminated by written notice of non-renewal at least sixty (60) days before the end of any term.

10. Termination This Agreement shall automatically terminate upon the sale, merger or consolidation of either party, unless the party is the surviving corporation. UMMS shall have the right to terminate the Agreement immediately upon the effective date of the termination of its agreement with the Primary Vendor. Either party may terminate this agreement without cause upon sixty (60) days written notice.

* 11. Payment by UMMS Upon Early Termination: In the event the Program is terminated pursuant to Section 10, UMMS shall pay SHS the lesser of the unamortized portion (based on a five year amortization period.) of the payment described in Sub-section 3A, calculated on a straight line basis, or the fair market value of the assets purchased and/or leased by UMMS pursuant to its obligations under Subsections 2C, which may be paid in kind, in whole or in part.

12. Payment by SHS Upon Early Termination. In the event the Program is terminated prior to the expiration of UMMS' contract with the Primary Vendor, SHS shall pay UMMS one-half of any early termination costs which UMMS is required to pay the Primary Vendor.

13. This Memorandum of Understanding is not a contract. The provisions hereof are merely the non-binding expressions of intent and current understanding of the parties.

* 14. Both the SHS and Maryland ExpressCare names and logos shall appear on the dedicated ambulance, as permitted under Maryland law.

15. UMMS shall not enter into an arrangement with any other hospital or health system with facilities on the Eastern Shore of Maryland or Delaware substantially similar to this agreement during the term of this agreement.

WITNESS:

UNIVERSITY OF MARYLAND MEDICAL SYSTEM

WITNESS:

SHORE HEALTH SYSTEM, INC.

UNIVERSITY OF MARYLAND
MEDICAL SYSTEM

AMBULANCE TRANSPORTATION SERVICES AGREEMENT

This Agreement ("Agreement"), is made this 7th day of September, 2010, by and between the **University of Maryland Medical System Corporation**, on its own behalf and on behalf of its Affiliates identified on Exhibit A hereto (collectively referred to herein as "Medical System") and **Best Care Ambulance, Inc** ("Best Care").

Whereas, Best Care is skilled and experienced in providing ambulance and medical transportation services; and

Whereas, Medical System owns and operates acute care hospitals throughout the State of Maryland; and

Whereas, Medical System wishes to purchase ambulance transportation services from Best Care and Best Care wishes to provide these services to Medical System; and

Now Therefore, in consideration of the mutual covenants hereinafter set forth, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. Non-Exclusive Engagement

1.1 Unless otherwise specified, in the Schedules, this Agreement is not an exclusive contract. Notwithstanding this provision, Best Care shall be the primary provider of the services contemplated by this Agreement.

2. Participation by Affiliates

2.1 Medical System is entering into this Agreement for itself and on behalf of its Affiliates, as listed in Exhibit A to this Agreement. The listed Affiliate is bound by the terms and conditions of this Agreement and the Affiliates may obtain services from Best Care in accordance with this Agreement.

3. Qualifications

3.1 Best Care hereby represents and certifies to Medical System that it is and at all times during the term hereof shall be duly licensed, fully qualified and authorized to provide critical care, advanced life support ("ALS") and basic life support ("BLS") ambulance transportation services in the State of Maryland. Specifically, Best Care shall:

3.1.1. obtain and maintain throughout the term of this Agreement all applicable State vehicle inspections and certifications, including an ALS ambulance certification from the Maryland Institute for Emergency Medical Services Systems ("MIEMSS");

3.1.2. configure and equip each ALS vehicle to complete critical care/advanced life support patient transfers;

3.1.3. repair and maintain the vehicles within the manufacturer's maintenance specifications, including all fixed medical equipment in the vehicle (e.g., on board suction, on board oxygen and air systems);

3.1.4. ensure that individuals assigned to each ambulance transport are fully qualified and hold all current licenses and certifications necessary to perform their respective responsibilities;

3.1.5 conduct continuous Quality Assurance – Quality Improvement (QA-QI) monitoring in order to assure compliance with local, State and Federal regulations, along with client and patient satisfaction. Areas monitored include On Time performance, health care delivery, documentation, crew safety, vehicle safety and inventory monitoring.

4. Insurance Coverage.

4.1 Best Care certifies that it has obtained and will maintain in full force and effect the following insurance coverages:

4.1.1. professional liability insurance covering the duties to be performed under this Agreement, in amounts not less than One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) annually in the aggregate, including an extended reporting option;

4.1.2. comprehensive general liability insurance in amounts equal to at least One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) annually in the aggregate;

4.1.3. such other employer's insurance as is necessary to protect Best Care from claims under the Worker's Compensation Act and all other applicable Employee Benefits Acts, in types and amounts which are similar to the coverages generally carried by other ambulance transportation providers in the area, and which are acceptable to Medical System.

4.2 Best Care further agrees to:

4.2.1 produce at Medical System's request a certificate of insurance from its insurance carriers demonstrating compliance with all provisions of this section of this Agreement;

4.2.2 name Medical System as an additional insured on all insurance policies required under this Agreement;

4.2.3 notify Medical System as soon as reasonably possible of any judgments awarded, claims filed, or settlement of claims against it as a result of an assertion of malpractice or other claim of unprofessional conduct;

4.2.4 notify Medical System as soon as reasonably possible of any threatened or actual cancellation or diminution of coverage under the insurance policies required by this Section.

4.3 The insurance requirements set forth above may not be modified without written prior approval by Medical System.

4.4 All required insurance policies shall be issued by companies that hold a current policyholder's alphabet and financial size category rating of not less than an A- (X) according to Best's insurance reports. Insurance shall be at the sole expense of Best Care. If Best Care does not adhere to the requirements of this Section, Medical System may arrange for such insurance and charge the cost thereof to Best Care, which amount shall be due and payable by Best Care upon demand.

4.5 The insurance requirements of this Section shall survive termination or expiration of this Agreement.

5. Indemnification

5.1 Best Care agrees to indemnify and hold Medical System harmless from all liability for injury or damage occasioned by any act or omission of Best Care or its agents or employees. Medical System agrees to indemnify and hold harmless Best Care from all liability for injury or damage occasioned by any act of Medical System, or its employees or agents.

5.2 The indemnification requirements of this Section shall survive termination or expiration of this Agreement.

6. Dedicated Critical Care/Specialty Care Transport Services

6.1 A description of the dedicated Critical Care/Specialty Care transport services performed by Best Care, in partnership with Maryland ExpressCare, is set forth in Schedule 2, which is attached hereto and incorporated by reference herein.

6.2 Compensation for these services is also described in Schedule 2.

7. Non Dedicated Transport Services

7.1 A description of the non dedicated transport services to be performed by Best Care is set forth in Schedule 3, which is attached hereto and incorporated by reference herein.

7.2 The compensation to be paid by Medical System for these services is set forth in the following documents, which are attached hereto and incorporated by reference herein:

7.2.1 Schedule 3(a) – compensation for non critical care transport services provided to Shore Health System, Inc. at Memorial Hospital at Easton and Dorchester General Hospital locations;

7.2.2 Schedule 3(b) – compensation for non critical care transport services provided to Shore Health System at its Queen Anne's County Emergency Center location;

7.2.3 Schedule 3(c) – compensation for non critical care transport services provided to Chester River Hospital Center, Inc.

8. Term, Termination and Suspension

8.1 **Term.** This Agreement shall commence as of August 1, 2010 ("Effective Date") and shall remain in effect for an initial term ending on July 31, 2013. Thereafter, this Agreement will automatically renew for subsequent one (1) year terms, subject to the other provisions contained in this Section unless either party delivers a written notice of termination at least thirty (30) days prior to the end of the then current term.

8.2 **Termination Without Cause.** Either party may terminate this Agreement, without cause, upon at least thirty (30) days' prior written notice of termination to the other party.

8.3 **Termination For Breach.** Either party may terminate this Agreement based on the other party's breach of a material term of the Agreement or of a material representation or warranty by providing the breaching party thirty (30) days' notice and the right to cure during such 30-day period.

8.3.1. If any event of breach occurs and is not cured by the breaching party within the applicable cure period specified above, the party not in breach, at its sole option, may employ any or all remedies then available to it, whether at law or in equity, including, but not limited to, the following:

8.3.1.1 Proceed by appropriate court action to enforce performance by the breaching party of the applicable covenants and obligations of this Agreement and to recover damages for the breach thereof, and/or to enforce the indemnification set forth in this Agreement;

8.3.1.2 Terminate this Agreement immediately upon notice to the breaching party; and/or

8.3.1.3 Pursue any other rights or remedies available to that party under the laws of the State of Maryland.

8.4 **Immediate Termination.** Medical System may immediately terminate this Agreement based upon one of the following occurrences, to the extent applicable:

8.4.1 Commencement of any disciplinary action against taken by any board, institution, organization, licensing or governmental body, or professional society having any privilege or right to pass upon Best Care's conduct;

8.4.2 Loss, limitation or suspension of Best Care's professional license(s) or other certification;

8.4.3 Best Care's exclusion, sanction or suspension from any federal health care program including without limitation the Medicare or Medicaid programs;

8.4.4 A material change or loss of Best Care's professional liability insurance coverage, including Best Care's failure to maintain insurance coverage in accordance with this Agreement;

8.4.5 Best Care's conviction or plea of guilty or no contest with respect to any felony charge or misdemeanor involving, professional competence or moral turpitude; or

8.4.6 Any occurrence of serious misconduct which brings the Medical System to the reasonable interpretation that Best Care may be delivering, or contributing to the delivery of, clinically inappropriate care if applicable.

9. Books and Records; Audit

9.1. **Generally Accepted Accounting Principles**. Best Care will maintain its billing and records in accordance with generally accepted accounting principles. Medical System shall have the right to examine all records relating to the Services provided to Medical System, and to examine all supporting documentation for invoices and payments upon reasonable notice during regular business hours, at no cost to Medical System.

9.2 **Record Retention**. Best Care agrees that for a period of four (4) years following the termination of this agreement, it shall maintain and make available, upon written request, to the Secretary of the United States Department of Health and Human Services (HHS) or the Comptroller General of the United States, or to any of their duly authorized representatives, this Agreement and any books, documents and records of Best Care which are necessary to verify the nature and extent of the cost of services provided hereunder.

10. Subcontractors; Recordkeeping.

10.1 Best Care shall obtain Medical System's written consent, which Medical System may withhold in its sole discretion, before entering into agreements with any subcontractors ("Subcontractors") who may supply any services that Best Care is required to provide to Medical System under this Agreement. At Medical System's request, Best Care shall provide information regarding Subcontractors' qualifications and a listing of Subcontractors' key personnel. Best Care's use of any Subcontractor shall in no way diminish, reduce, modify, or affect Best Care's duties or warranties to Medical System hereunder.

10.2 Best Care shall, and shall require all of its subcontractors to, keep all records, file all reports and otherwise comply with all federal, state and local laws and regulations applicable to the services including, without limitation, the Occupational Safety and Health Act of 1970, the Fair Labor Standards Act of 1939, Executive Order No. 11246 governing equal employment opportunity, and all other laws and Executive Orders and pertinent rules and regulations adopted thereunder applicable to vendors of the U.S. government.

10.3 If Best Care carries out any of the services provided hereunder through any subcontract with a value or cost of Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period with related organizations (as that term is defined under federal law), Best Care agrees that each such subcontract shall provide for such access to the subcontract, books, documents and records of the subcontractor. If the Medical System is requested to disclose books, documents or records pursuant to this Agreement for purposes of an audit, it shall notify Best Care of the nature and scope of such request. These requirements are effective as of the date of execution of this Agreement, and pertain to all records, which have or should have been maintained on or after that date.

11. Sanction Certification

11.1 Best Care hereby represents and warrants that neither it nor any of its Subcontractors or any of their respective employees has been listed by a federal agency as debarred, suspended, or excluded from, or otherwise ineligible for, participation in federal procurement and non-procurement programs or federally funded healthcare programs. Best Care agrees to immediately notify Medical System of any actual exclusion from any federally funded health care program, and that if an employee or contractor of Best Care becomes so excluded, such employee will be terminated from participating in any aspect of the delivery of services to Medical System. In the event that Best Care is debarred or excluded from participation in any federally funded health care program during the term of this Agreement, this Agreement shall, as of the date of such debarment or exclusion, automatically terminate.

12. General Provisions

12.1 Assignment. Neither Medical System nor Best Care may assign this Agreement or any of its rights or obligations hereunder without the prior written consent of the other. Notwithstanding the foregoing, Medical System may assign this Agreement to any subsidiary or parent corporations, now or hereinafter existing. For purposes of this Section, "assignment" shall include any assignment by operation of law and any change in control of Best Care.

12.2 Notices. Any notice required or permitted to be given pursuant to this Agreement shall be given in writing signed by or on behalf of the party giving such notice, and either delivered in person: deposited in the United States mail, postage pre-paid, registered or certified mail, properly addressed: or sent by nationally recognized overnight courier to:

Medical System:

University of Maryland Medical System Corporation
110 S. Paca Street, 7th Floor
Baltimore, MD 21201
Attn: Senior Director, Corporate Contracts

Best Care:

Best Care Ambulance, Inc.
29468 Laurwayn Drive, Unit # 11
Trappe, MD 21673
Attn: Dan Jewell, Executive Vice-President

Notices are considered delivered on the post-marked date or the date delivered to a courier for next business day delivery. Either party may change their respective notification addresses set forth herein.

12.3 Force Majeure. Neither party shall be responsible to the other or to any third party for any failure, in whole or in part, to perform any obligations under this Agreement, to the extent and for the length of time that performance is rendered impossible owing to acts of God, public insurrections, floods, fires, strikes, lockouts or other labor disputes, and other circumstances of substantially similar character beyond the reasonable control of, and not reasonably foreseeable by, the affected party (collectively, "Force Majeure"). Any party so affected shall (a) use all reasonable efforts to minimize

the effects thereof and (b) promptly notify the other party in writing of the Force Majeure and the effect of the Force Majeure on such party's ability to perform its obligations hereunder. The affected party shall promptly resume performance after it is no longer subject to Force Majeure.

12.4 Non-Discrimination in the Provision of Services. Best Care will not discriminate in the provision of services hereunder, whether on the basis of a person's age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, handicap, health status, or other unlawful basis including without limitation, the filing by a person of any complaint, grievance or legal action against Medical System, Best Care or any payer.

12.5 Non-Discrimination in Hiring. Best Care, in performing under this Agreement, agrees not to discriminate against any employee or applicant for employment because of race, ancestry, creed, color, sex, sexual orientation, religion, national origin, physical handicap, health status, marital status, age, veteran's status, disability or any other status protected by law and to insert the provisions of this paragraph into any subcontracts issued under this Agreement.

12.6 Support of Diversity. Medical System supports, encourages and facilitates the provision of opportunities to small diverse businesses as a means of strengthening the economic climate of the communities which it services. Vendors are asked to self-identify if they are a local business, a minority-owned business, woman-owned enterprise, or disadvantaged business. For each commodity or service acquired by Best Care through subcontractors or suppliers hereunder, Best Care is encouraged to make a concerted effort to select subcontractors that are local, minority-owned, woman-owned, or disadvantaged businesses. Evidence of commitment to purchasing from, subcontracting to, and the employment of minorities, women, physically disabled and/or disadvantaged individuals will be reviewed for future business arrangements with Best Care.

12.7 Compliance with HIPAA. To the extent applicable, Best Care will comply with the applicable privacy, security and confidentiality requirements of the Health Insurance Portability and Accountability Act, as amended, ("HIPAA") and Maryland law governing the confidentiality of patient information and medical records. Best Care will execute a Business Associate Addendum in the form attached hereto as Exhibit A, which is incorporated by reference herein.

12.8 Confidential Information.

12.8.1 Each party acknowledges that certain information of the other party that it may acquire or be exposed to will constitute information of a proprietary or confidential nature including, without limitation: (A) information concerning the other party's business affairs, property and methods of operation; and (B) in the case of Medical System: (i) any material, data or information disclosed by Medical System to Best Care that is not generally known by or disclosed to the public or to third parties including, without limitation, all materials, know how, processes, trade secrets, manuals, confidential reports, financial and operational information, Protected Health Information, as defined under HIPAA, and all other patient and medical record information, and other matters relating to the operation of Medical System's business (collectively, "Confidential Information").

12.8.2 It is understood that the term Confidential Information does not include information that:

12.8.2.1 is now or hereafter is in the public domain through no fault of either party;

12.8.2.2 prior to disclosure, is property within the rightful possession the other party;

12.8.2.3 subsequent to disclosure, is lawfully received by a party from a third party with no restriction on further disclosure; or

12.8.2.4 must be produced under order of a court or competent jurisdiction, unless made the subject of a confidentiality agreement, or order in connection with such proceeding

12.8.3 Each party will hold all of the Confidential Information in strict confidence and will not disclose any of the Confidential Information to any other entity or individual other than to its attorneys, accountants or other representatives who need to receive the Confidential Information as is necessary for the evaluation of the proposed business transaction. Prior to any such disclosure, a party will inform and direct any such recipients of Confidential Information that such Confidential Information must be treated in a confidential manner.

12.8.4 Return of Confidential Information. Upon termination of this Agreement, each party agrees to return the other party's Confidential Information or, if specifically requested, destroy all media and documentation containing such information. Each party further agrees to certify its compliance with such obligation if requested by the other party

12.9 Compliance with Other Laws and Requirements

12.9.1 Requirements under the Law. This Agreement is deemed to include all provisions specifically required by law to be incorporated herein. If Best Care performs any work contrary to such laws or regulations, Best Care shall promptly, without cost or expense to Medical System, modify its performance as necessary to so comply.

12.9.2 New Laws or Requirements. If, during the term of this Agreement, any federal, state or local government body or agency, or any court or administrative tribunal, passes, issues, or promulgates any law, rule, regulation, standard, interpretation, order, decision or judgment which, in the good faith judgment of either party: (a) causes one or both of the parties to be in violation of any applicable law, rule or regulation as a result of this Agreement, (b) restricts, limits, or in any way substantially changes the method or amount of reimbursement or payment for services, or (c) otherwise materially and adversely affects either party's rights or obligations under this Agreement, then the affected party may give the other party notice of the problem and of its intent to amend this Agreement so as to eliminate the problem. The parties shall then negotiate in good faith to resolve the problem while at the same time preserving, to the fullest extent possible, the substance of this Agreement. If this Agreement is not amended to the reasonable satisfaction of the affected party within thirty (30) days after notice is given (or sooner, if required by law), said affected party may terminate this Agreement immediately upon written notice to the party.

12.9.3 Modifications or Amendments for Compliance Purposes. The parties agree that this Agreement shall be modified or amended as may be reasonably deemed necessary by Medical System in order to bring this Agreement into compliance with all presently

applicable laws, regulations, procedures or rulings (and with any such laws, regulations, procedures or rulings or changes therein which may in the future become applicable), pertaining to or affecting Medical System's existing or future tax-exempt financing or tax-exempt status. Medical System shall give written notice of the need to so modify or amend this Agreement as soon as reasonably possible upon finally making its determination thereof. Should Best Care not have executed the amendment and modification of this Agreement within thirty (30) days after Medical System's written notice to Best Care, Medical System may recover from Best Care any payment that is determined by a court or government agency to be illegal or inconsistent with the Medical System's tax exempt status.

12.9.4 Fraud and Abuse Laws. The parties acknowledge and agree at all times during the term of this Agreement to comply with all applicable federal, state and local laws in performing its/his/her obligations hereunder, including but not limited to the Deficit Reduction Act of 2005, the Federal False Claims Act and other federal and state laws addressing anti-kickback, self-referral, fraud, waste, and whistleblower protections for those reporting violations of such laws. Medical System has adopted policies and procedures meant to detect and prevent fraud, abuse and waste; such policies and procedures are available upon request or on the Medical System's website.

12.9.5 The Joint Commission. In providing the services under this Agreement, to the extent applicable, Best Care agrees to cooperate with Medical System as necessary for Medical System to meet or exceed any standards and requirements of The Joint Commission, as they currently exist and as they may be amended in the future, and will assist Medical System in preparation for, during, and in responding to The Joint Commission reviews.

12.9.6 Permits, Licenses. Best Care possesses all permits and licenses necessary for performance of this Agreement.

12.9.7 Code of Conduct and Compliance Plans. Best Care agrees that it will cooperate at all times with Medical System's Code of Conduct and Medical System's Corporate Compliance Plan as applicable.

12.10 Dispute Resolution; Remedies

12.10.1 Dispute. If a dispute arises among the parties in connection with this Agreement, including an alleged breach of any representation, warranty or covenant (the "Dispute"), the parties agree to use the procedure set forth below in good faith prior to pursuing judicial remedies.

12.10.2 Notice; Resolution. Within ten (10) days after any party gives written notice of a Dispute to the other party, a meeting shall be held between representatives from each party who have decision-making authority to resolve the Dispute (subject to board of directors or equivalent approval, if required). The representatives will attempt in good faith to negotiate a resolution of the Dispute within thirty (30) days. After thirty (30) days, if the parties have been unable to resolve the Dispute, then both parties may pursue other remedies.

12.11 Use of Logos and/or Service Marks. Neither party shall use the name, service marks, trademarks, trade names or logos of the other party or any of its affiliates, subsidiaries or any variation or acronym thereof, for any purpose, without the prior written consent of the party whose name, service marks, trademarks, trade names or logos are proposed to be used, which consent may be provided or withheld in that party's sole and absolute discretion.

12.12 Choice of Law; Venue. This Agreement shall be governed by and construed in accordance with the laws of the State of Maryland.

12.13 Entire Agreement. This Agreement constitutes the entire agreement between the parties as relates to the services contemplated in this Agreement. This Agreement supersedes all prior and contemporaneous agreements, understandings, negotiations and discussions, written or oral, of the parties relating to the sale and performance of the services. In the event that a conflict occurs between a provision in this Agreement and any Schedules hereto, the terms and conditions as stated in this Agreement shall prevail.

12.14 Independent Contractor. The parties agree that, to the greatest extent permitted by law, in the performance of the duties and obligations of the parties to this Agreement, each party is a separate and independent entity. Neither is considered an employee of the other party, and neither has acted, acts or shall be deemed to have acted or to act, as an agent for the other. The employees of each party are not entitled to any of the benefits that the other party provides for its employees.

12.15. Severability. In the event any provision of this Agreement is held to be unenforceable for any reason, the unenforceable part thereof shall not affect the remainder of this Agreement, which shall remain in full force and effect and be enforceable in accordance with its terms.

12.16 Headings. Headings used to identify a paragraph have been included only for convenience and are not intended to contain or completely identify the contents of the paragraph.

12.17 Time of the Essence. Time is of the essence in this Agreement.

12.18 Amendments. This Agreement may not be amended except by a writing signed by Medical System and Best Care. Notwithstanding this provision, Medical System reserves the right to add other Affiliates to this Agreement, during the term of this Agreement, and the terms and conditions of this Agreement shall apply to the newly added Affiliates.

12.19 Waiver. Any waiver by either party of a breach of any provision of this Agreement shall not operate as or be construed to be a waiver of any other breach of such provision or of any breach of any other provision of this Agreement. The failure of a party to insist upon strict adherence to any term of this Agreement on one or more occasions shall neither be considered a waiver nor deprive that party of any right thereafter to insist upon strict adherence to that term or any other term of this Agreement. Any waiver must be in writing and signed by the party to be charged therewith.

12.20 Successors and Assigns. Except as otherwise provided, this Agreement shall be binding upon, and inure to the benefit of, Medical System, Best Care, and their respective successors and permitted assigns.

12.21 Counterparts. Provided that all parties hereto execute a copy of this Agreement, this Agreement may be executed in any number of counterparts, each of which shall be deemed an original and all of

which together shall constitute one and the same instrument. Executed copies of this Agreement may be delivered by facsimile transmission or other comparable means. This Agreement shall be deemed fully executed and entered into on the date of execution by the last signatory required hereby.

In Witness Whereof, the duly authorized representatives of the parties hereto have executed this Agreement as of the Effective Date.

Best Care Ambulance, Inc.

By: Dan A. Jewell
Dan A. Jewell
Executive Vice President
Date: 9-10-10

University of Maryland Medical System Corporation

By: Gary Kane
Gary Kane
Vice President, Supply Chain Management
Date: 9/7/2010

Attachments:

Schedule 1 List of Medical System Affiliates
Schedule 2 Description of Dedicated Critical Care Transportation Services and Schedule of Fees
Schedule 3 Description of Non-Critical Care Transportation Services

- Schedule 3A Schedule of Fees for services provided to Shore Health System, Inc. at Memorial Hospital at Easton and Dorchester General Hospital locations
- Schedule 3B - Schedule of Fees for services provided to Shore Health System, Inc. at its Queen Anne's County Emergency Center location
- Schedule 3C - Schedule of Fees for services provided to Chester River Health System, Inc.

Exhibit A – Business Associate Addendum

Schedule 1

List of Medical System Affiliates

Affiliate	Bill To:
University of Maryland Medical Center 22 South Greene Street Baltimore, Maryland 21201 Telephone: 410-328-3184	Senior Director, Maryland ExpressCare 110 South Paca Street Room 8N123 Baltimore, Maryland 21201
Shore Health System, Inc. 219 S. Washington Street Easton, MD 21601 Telephone: 410-822-1000	Accounts Payable Department Shore Health System, Inc. 219 S. Washington Street Easton, Maryland 21601
Chester River Health System, Inc. 100 Brown Street Chestertown, MD 21620 Telephone: 410 778 3300	Accounts Payable Department Chester River Health System, Inc 100 Brown Street Chestertown, MD 21620

Schedule 2

Description of Critical Care Transportation Services Performed in Partnership with Maryland Express Care

Responsibilities of Best Care

Best Care will provide a dedicated vehicle(s) and emergency medical technician staff to perform critical care/specialty care transports under the direction and management of Maryland ExpressCare, a division of Medical System. The service is operated under the trade name of Maryland ExpressCare. Best Care shall provide these services subject to this Agreement and the following terms and conditions:

1. Best Care will provide a dedicated vehicle(s) to provide services on behalf of ExpressCare. The assigned vehicle will be certified by MIEMSS as an ALS ambulance and appropriately configured and equipped to complete critical care/specialty care patient transfers.

2. For the purpose of communicating with Best Care vehicles and personnel, Best Care shall operate and maintain uninterrupted telephone and radio communication services on a twenty-four (24) hour a day, seven (7) day a week basis. In addition, a Best Care official shall be available by telephone within fifteen (15) minutes of a page by the ExpressCare staff. This official will have the ability to authorize the use of a replacement vehicle.

3. Between the hours of 8 a.m. and 8 p.m., seven (7) days per week, Best Care will supply the services of a licensed Emergency Medical Technician-Basic ("EMT-B") and one Emergency Medical Technician-Paramedic ("EMT-Paramedic") to staff critical care transports performed during these hours with the approval of the Medical System. These individuals will be dedicated to providing ExpressCare services under this Agreement.

4. In the event that Medical System requires additional EMT-Bs or EMT-Paramedics for any shift. Best Care will make every reasonable effort, but is not required, to provide such staff. In the event back up personnel fail to satisfy Medical System's requirements, Best Care will make every reasonable effort to provide Medical System with alternate staff within one (1) hour of receiving a request from Medical System.

5. Best Care will provide consumable medical supplies for the dedicated vehicle(s).

6. Best Care shall keep Medical System informed of its policies, procedures and activities relevant to Best Care's obligations under this Agreement, and shall meet with Medical System representatives on a regular basis to review procedures, policies and quality of services.

7. Best Care will inform its ExpressCare-assigned personnel of Medical System policies and guidelines relating to ambulance transportation services. Assigned personnel must conform to such policies and guidelines as well as applicable laws and regulations (e.g., MIEMSS regulations, vehicle traffic safety regulations).

8. Best Care personnel involved in the ExpressCare program will participate in Medical System continuing education for training, skills development and medical direction of ALS personnel

as may be necessary for such personnel to maintain ALS certification by MIEMSS. Such continuing education may include appropriate clinical rotations at Medical System.

Responsibilities of Medical System

1. The Maryland ExpressCare Transfer Center will receive, screen and as appropriate forward all requests for ambulance transportation to Best Care.

2. ExpressCare will provide the services of a Critical Care Transport Registered Nurse who will work with the Best Care EMT-B and EMT-Paramedic on transports involving the designated vehicle.

3. Medical System will provide parking, electricity and such other conveniences for the dedicated ambulance vehicle(s) based at Memorial Hospital at Easton. Best Care staff will also be based at Memorial Hospital at Easton and will be managed by ExpressCare staff.

4. Medical System will purchase directly or reimburse Best Care for any equipment purchased that does not appear on the MIEMSS list of ALS-required equipment.

5. Medical System will reimburse Best Care for the labor costs associated with staff participating in ExpressCare program orientation and any program specific training required by Medical System. Best Care agrees to pay any applicable tuition fee associated with such training.

6. Medical System will provide telemetry-capable ALS radio communications twenty-four (24) hours a day, seven (7) days a week. Medical System also agrees to provide access to a licensed and registered physician to support the ExpressCare program.

7. A Medical System official will be available by telephone within thirty (30) minutes of a page by the Best Care staff. This official will have the authority to act on behalf of the Medical System in the event of a critical situation.

8. Medical System's compensation to Best Care in return for its dedicated critical care transport services shall be as follows:

Service	*Transport Fee*
Emergency Medical Technician ("EMT-B")	$19.86 per hour
Emergency Medical Technician – Paramedic ("EMT-P")	$28.82 per hour
Dedicated Vehicle Fixed Expenses	$4,948.59 per month The rate includes the vehicle lease, insurance, certification and license fees
Mileage Fee	$0.55 per mile The rate includes all vehicle-related expenses not indicated in the dedicated vehicle fixed expenses, above
Management Fee	Ten percent (10%) of the cash receipts collected by Best Care for the transports performed as part of the dedicated ExpressCare service

These rates are effective as of August 1, 2010. On August 1 of each year thereafter during the term of the Agreement the rates shall increase by the percentage increase in the Consumer Price Index (CPI-U) for the twelve (12) month period immediately preceding that anniversary date of August 1. In no event, however, shall such increase result in a rate increase greater than three percent (3%) in any year or in a reduction in the rates charged in the preceding year.

Best Care will charge patients in accordance with its regular fee schedules and bill directly to Medicare, Medicaid or other third party payers. Medical System is not responsible for any amounts above the reimbursement amounts issued by any third party payer (including both contractual allowances negotiated by Best Care with a third party payer or any reasonable and customary reimbursement issued by such payers). After reasonable attempts to collect payment from a third party payer have been unsuccessful or patient is not insured, Best Care will bill the patient over the course of three (3) consecutive months. After that time, Best Care will turn over the account to a collections agency and submit the uncollectible claim to Medical System for payment. Uncollectible claims will not include any third party payer denials for any administrative reasons such as Best Care's failure to follow any policies and procedures developed by the payer.

On or before the 15th day of each month, Best Care will submit an invoice to Medical System that contains the following information:

- Monthly staffing costs for EMT-B and EMT-Paramedic services on the dedicated unit
- Monthly dedicated fixed vehicle cost
- Mileage fees
- Cash receipts from patient billings

- Amounts that have been deemed uncollectible following collection attempts from third party payers and patients
- Amounts received through collection efforts on those accounts previously deemed to be uncollectible

All accounts between Best Care and UMMS will be reconciled on a quarterly basis. Payment terms will be net forty-five (45) days from the reconciliation date.

In the event the ExpressCare Critical Care Transport Registered Nurse performs a MIEMSS-required critical care transport using a Best Care non-dedicated vehicle, Best Care will reimburse ExpressCare for the nurse's services based on collections for that specific transport.

Schedule 3

Description of Non-Dedicated Transportation Services

Best Care will provide non-dedicated ambulance transportation services, including BLS, ALS and critical care/specialty care transfers, to all patients for whom such services are requested by the Medical System. Best Care shall provide these services subject to this Agreement and the following terms and conditions:

1. Best Care will provide a non-dedicated vehicle to provide services under this Agreement. The vehicle will be certified by MIEMSS as an ALS/BLS ambulance and appropriately configured and equipped to complete critical care/ALS patient transfers. In the event a non-dedicated unit is not available, Best Care will make reasonable attempts to provide a vehicle as soon as possible.

2. Best Care will also provide the appropriate staff for the particular transport being performed (e.g., Cardiac Rescue Technician-Intermediate, EMT-B, EMT-Paramedic).

3. Best Care will provide consumable medical supplies for the non-dedicated vehicle(s).

4. For services provided to Memorial Hospital at Easton and Dorchester General Hospital, Best Care will respond within 30 minutes after a request for services Best Care will respond within 30 minutes after a request for services. Between the hours of 8 a.m. and 8 p.m., Between the hours of 8 p.m. and 8 a.m., Best Care will adhere to the following response times:

   - Forty-five (45) minutes for emergent cases
   - Three (3) hours for non emergent cases

   The response time for all transports from QAEC, twenty-four (24) hours per day, seven (7) days per week, shall be thirty (30) minutes after receipt of a request for services. With respect to transfers from QAEC, Best Care will use best efforts to maintain eighty percent (80%) on time performance (OTP) rating. Anticipated volumes for the services are not well established for QAEC and as such, the parties agree to cooperate in the event that adjustments need to be made for the performance standards set forth in this paragraph.

5. Medical System will provide Best Care with at least twenty-four (24) hours' advance notice for transports exceeding one hundred twenty-five (125) miles. For patient and crew safety, Best Care reserves the right to delay any transport that meets or exceeds this distance until 8:00 a.m. the following day.

6. Best Care agrees to have an official available by telephone, within fifteen (15) minutes of a page or phone call from Medical System, twenty-four (24) hours a day, seven (7) days a week. Such official must have the ability to make decisions or commitments on behalf of Best Care's organization.

7. Medical System agrees to provide, to extent reasonably possible, at the time of request for services, all billing, responsible party, and payer information that may be necessary to properly bill for the services rendered. This information includes authorization numbers, if applicable.

responsible party name(s), addresses, and telephone numbers, primary and secondary insurance provider information, and a valid Physician's Certification Statement of Medical Necessity, if applicable.

8. Medical System agrees to furnish to Best Care, at the time of pick-up, a valid Physician Certification Statement for all Medicare non-emergency ambulance transports.

Schedule 3(a)

Compensation for Non Dedicated Transport Services
Provided to Shore Health System, Inc.
at Memorial Hospital at Easton and Dorchester General Hospital locations

In certain transport cases, Best Care will be paid directly by Shore Health System and Shore Health in turn will bill the patient for the service. These cases include, but are not limited to, hospital-to-hospital round trip transports and transfers.

For all other patient transports, Best Care will charge patients in accordance with its regular fee schedules and bill directly to Medicare, Medicaid or other third party payers. Medical System is not responsible for any amounts above the reimbursement amounts issued by any third party payer (including both contractual allowances negotiated by Best Care with a third party payer or any reasonable and customary reimbursement issued by such payers). After reasonable attempts to collect payment from a third party payer have been unsuccessful or patient is uninsured, Best Care will bill the patient over the course of three (3) consecutive months. After that time, Best Care will turn the account over to a collections agency and will submit an invoice to Shore Health System detailing those medically necessary transfers where payment has not been received ("uncollectible claim"). Uncollectible claims will not include any third party payer denials for any administrative reasons such as Best Care's failure to follow any policies and procedures developed by the payer. Best Care agrees to provide Shore Health System with proof of denial from the third party payer and proof of the attempt to collect from the patient when submitting these claims. Shore Health will compensate Best Care for these uncollectible claims in accordance with the fee schedule set forth below.

Rebundled Transports

Basic Life Support Transport	$137.25 each way
Advanced Life Support/Specialty Care Transport	$274.50 each way
Mileage	$4.39 per mile

In the event Best Care's collection efforts are ultimately successful after Shore Health System has paid an uncollectible claim, Best Care will refund the collected amount to Shore Health.

Schedule 3(b)

Compensation for Non Designated Transport Services Provided to Shore Health System at its Queen Anne's County Emergency Center location

For all other patient transports, Best Care will charge patients in accordance with its regular fee schedules and bill directly to Medicare, Medicaid or other third party payers. Shore Health System is not responsible for any amounts above the reimbursement amounts issued by any third party payer (including both contractual allowances negotiated by Best Care with a third party payer or any reasonable and customary reimbursement issued by third party payers). After reasonable attempts to collect payment from a third party payer have been unsuccessful or patient is uninsured, Best Care will bill the patient over the course of three (3) consecutive months. After that time, Best Care will do the following:

1. turn the account over to a collections agency;

2. submit an invoice to Shore Health System, payable to Best Care, detailing those medically necessary transfers from the QAEC where payment has not been received ("uncollectible claims"). Uncollectible claims will not include any third party payer denials for any administrative reasons such as Best Care's failure to follow any policies and procedures developed by the payer. Best Care will document proof of denial from any third party payer and proof of the attempt to collect from the patient. Best Care's charges for these uncollectible claims will be in accordance with the fee schedule set forth below.

3. submit an invoice to The County Commissioners of Queen Anne's County, made payable to Shore Health System, detailing the uncollectible claims arising from medically necessary transfers from the QAEC. The invoice will be sent to the following address:

   The County Commissioners of Queen Anne's County
   107 North Liberty Street
   Centreville, MD 21617

Upon payment by the County to Shore Health for these uncollectible amounts, Shore Health will in turn make payment to Best Care for its services.

Rebundled Transports

Basic Life Support Transport	$137.25 each way
Advanced Life Support/Specialty Care Transport	$274.50 each way
Mileage	$4.39 per mile

In the event Best Care's collection efforts are ultimately successful after Shore Health System has compensated it for an uncollectible claim, Best Care will refund the collected amount to Shore Health System.

Schedule 3(c)

Compensation for Non Designated Care Transport Services Provided to Chester River Hospital Center, Inc.

In certain transport cases, Best Care will be paid directly by Chester River Hospital Center and Chester River Hospital Center in turn will bill the patient for the service. These cases include, but are not limited to, hospital-to-hospital round trip transports and transfers. Chester River Hospital Center will pay in accordance with Best Care's retail fee schedule, less thirty percent (30%). Best Care will provide Chester River Hospital Center at least thirty (30) days' prior written notice before increasing its retail fee schedules.

For all other patient transports, Best Care will charge patients in accordance with its regular fee schedules and bill directly to Medicare, Medicaid or other third party payers. Chester River Hospital Center is not responsible for any amounts above the reimbursement amounts issued by any third party payer (including both contractual allowances negotiated by Best Care with a third party payer or any reasonable and customary reimbursement issued by such payers). After reasonable attempts to collect payment from a third party payer have been unsuccessful, Best Care will bill the patient over the course of three (3) consecutive months. After that time, Best Care will turn the account over to a collections agency and will submit an invoice to Chester River, detailing those medically necessary transfers where payment has not been received ("uncollectible claim"). Uncollectible claims will not include any third party payer denials for any administrative reasons such as Best Care's failure to follow any policies and procedures developed by the payer. Best Care agrees to provide Chester River with proof of denial from the third party payer and proof of the attempt to collect from the patient when submitting uncollectible claims. For such transport services, Chester River Hospital Center will pay in accordance with Best Care's retail fee schedule, less thirty percent (30%).

In the event Best Care's collection efforts are ultimately successful after Chester River Hospital Center has compensated it for an uncollectible claim, Best Care will refund the collected amount to Chester River Hospital Center.

Exhibit A

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION
BUSINESS ASSOCIATE ADDENDUM
WITH
BEST CARE AMBULANCE, INC.

This Business Associate Addendum, effective as of the date of last signature hereto, supplements and is made a part of the Agreement ("Underlying Agreement") entered into as of the same date of that Underlying Agreement by and between University of Maryland Medical System Corporation ("the Medical System"), and Best Care Ambulance, Inc. ("Best Care").

WHEREAS, Medical System and Best Care have entered into the Underlying Agreement pursuant to which Best Care may be considered a "business associate" of Medical System as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") including all pertinent regulations, codified at 45 C.F.R. Parts 160 and 164, as amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), and as may be further amended in the future;

WHEREAS, the nature of the arrangements memorialized in the Underlying Agreement may involve the exchange of Protected Health Information ("PHI") as that term is defined under HIPAA and its implementing regulations; and

WHEREAS, in consideration of the covenants herein, Medical System and Best Care desire to enter into this Addendum for the purpose of ensuring compliance with the requirements of HIPAA, HIPAA's implementing regulations, the HITECH ACT and the Maryland Confidentiality of Medical Records Act (Md. Ann. Code, Health General §§ 4-301 *et seq.*);

NOW THEREORE, the parties agree as follows:

I. Definitions. The "Privacy and Security Rules" shall mean HIPAA and its implementing regulations rules codified at 45 C.F.R. Parts 160 and 164, as amended by the HITECH Act and as may otherwise be amended in the future. Unless otherwise provided in this Addendum, capitalized terms have the same meanings as set for the in the Privacy and Security Rules.

II. Scope of Use and Disclosure by BA of Protected Health Information.

A. Best Care may use and disclose PHI that Medical System discloses to Best Care as necessary to perform Best Care's obligations under the Underlying Agreement, provided:

1. Best Care makes such use or disclosure in accordance with Best Care's established policies, procedures and requirements.

2. Best Care's use or disclosure would not violate the Privacy and Security Rules; and

3. Best Care makes all reasonable efforts not to use or disclose more than the minimum amount of PHI necessary to accomplish the purpose of the use or disclosure, as such is defined under the Privacy and Security Rules.

B. Unless otherwise limited by this Addendum or the Underlying Agreement, Best Care may:

1. Use the PHI in its possession for its proper management and administration and to fulfill any legal responsibilities of Best Care; and

2. Disclose the PHI in its possession to a third party for the purpose of Best Care's proper management and administration or to fulfill any legal responsibilities of Best Care, provided, however, that the disclosures are required by law or Best Care has received from the third party written assurances that (i) the information will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the third party; (ii) the third party will notify Best Care of any instances of which it becomes aware in which the confidentiality of the information has been breached; and (iii) are overall compliant with the Privacy and Security Rules.

III. Obligations of Best Care. In connection with its use and disclosure of PHI, Best Care agrees that it will:

A. Use or further disclose PHI only as permitted or required by this Addendum or as required by law;

B. Use reasonable and appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Addendum;

C. Implement commercially reasonable, physical, and technical safeguards to protect the confidentiality, integrity, and availability of PHI in accordance with the Privacy and Security Rules;

D. To the extent practicable, mitigate any harmful effect that is known to Best Care of a use or disclosure of PHI by Best Care in violation of the Addendum;

E. Report any use, disclosure, or breach of security of PHI not provided for by this Addendum to Medical System , within five (5) business days of becoming aware of such use, disclosure or breach;

F. Require contractors or agents to whom Best Care provides PHI to agree to the same restrictions and conditions that apply to Best Care pursuant to this Addendum;

G. Make available to the Secretary of Health and Human Services or to Medical System Best Care's internal practices, books and records relating to the use and disclosure of PHI for purposes of determining compliance with the Privacy and Security Rules, subject to any applicable legal privileges;

H. Within fifteen (15) days of receiving a request from Medical System, Best Care will:

1. Make available the information necessary for Medical System to make an accounting of disclosures of PHI about an individual;

2. Make available PHI necessary for Medical System to respond to individuals' requests for access to PHI about them that is not in the possession of Medical System ; and

3. Incorporate any amendments or corrections to the PHI in accordance with the Privacy and Security Rules;

I. Not make any disclosure of PHI that is prohibited by the Privacy and Security Rules.

Termination.

A. Termination for Breach. Medical System may terminate the Underlying Agreement if Medical System determines that Best Care has breached a material term of this Addendum. Alternately, Medical System may choose to provide Best Care with notice of the existence of an alleged material breach and afford Best Care an opportunity to cure the alleged material breach. In the event Best Care fails to cure the breach to the satisfaction of Medical System , Medical System may immediately thereafter terminate the Underlying Agreement.

B. Automatic Termination. This Addendum will automatically terminate upon the termination or expiration of the Underlying Agreement.

C. Effect of Termination. Upon termination of the Underlying Agreement, Best Care will return or destroy all PHI received from Medical System or created or received by Best Care on behalf of Medical System that Best Care still maintains and retains no copies of such PHI; provided that if such return or destruction in not feasible, Best Care will extend the protections of this Addendum to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

V. Amendment. Best Care and Medical System agree to take such action as is necessary to amend this Addendum from time to time as necessary for Best Care and Medical System to comply with the requirements of the Privacy and Security Rules and as they may be amended.

VI. Inconsistent Provisions. To the extent that the Underlying Agreement has any provisions inconsistent with this Addendum, the provisions in this Addendum shall prevail.

VII. Survival. The obligations of Best Care under Section 4.c. of this Addendum shall survive any termination of the Underlying Agreement.

VIII. No Third Party Beneficiaries. Nothing express or implied in the Addendum is intended to confer, nor shall anything herein confer, upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

In Witness Whereof, the duly authorized representatives of the parties hereto have executed this Agreement as of the date specified below.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION

By: _____ Date: 9/7/2010
Gary Kane
Vice President, Supply Chain Management

BEST CARE AMBULANCE, INC.

By: Dan A Jewell Date: 9-10-10
Dan A. Jewell
Executive Vice President

EXHIBIT 12

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

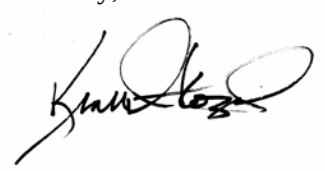
October 12, 2015

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21225

Dear Mr. Steffen,

As part of our application for a Certificate of Conformance, I am submitting this letter of commitment that if University of Maryland Shore Regional Health (UM SRH) obtains Commission approval to establish a primary PCI Program, formal, regularly scheduled meetings for the purpose of interventional case review will be established. The meetings will be mandatory for interventionists and other physicians, nurses, and technicians who care for primary PCI patients.

Sincerely,



Kenneth D. Kozel, MBA, FACHE
President and CEO
UM Shore Regional Health

EXHIBIT 13

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

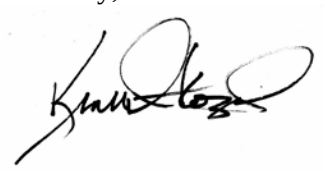
October 12, 2015

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21225

Dear Mr. Steffen,

As part of our application for a Certificate of Conformance, I am submitting this letter of commitment that if University of Maryland Shore Regional Health (UM SRH) obtains Commission approval to establish a primary PCI program, the hospital will create a multiple care area group (emergency department, coronary care unit, and cardiac catheterization laboratory) that includes, at a minimum, the physician and nursing leadership of each care area and will meet monthly to review any and all issues related to the primary PCI system, identify problem areas, and develop solutions.

Sincerely,



Kenneth D. Kozel, MBA, FACHE
President and CEO
UM Shore Regional Health

EXHIBIT 14

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

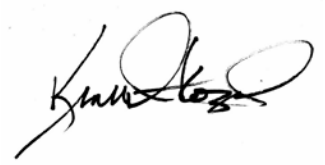
October 12, 2015

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21225

Dear Mr. Steffen,

As part of our application for a Certificate of Conformance, I am submitting this letter of commitment that the hospital shall conduct an external review at least semi-annually, as determined by the Commission, of at least five percent of randomly selected PCI cases performed in the applicable time period, and an internal review of at least 10 percent of randomly selected PCI cases performed in the applicable time period.

Sincerely,



Kenneth D. Kozel, MBA, FACHE
President and CEO
UM Shore Regional Health

EXHIBIT 15

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

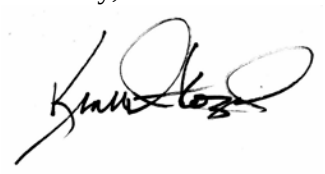
October 12, 2015

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21225

Dear Mr. Steffen,

As part of our application for a Certificate of Conformance, I am submitting this letter of commitment that, 90 days prior to first use, the hospital will submit documentation demonstrating that each physician who performs primary PCI services at a hospital that provides primary PCI without on-site cardiac surgery has achieved an average annual case volume of 50 or more PCI cases over a two-year period.

Sincerely,



Kenneth D. Kozel, MBA, FACHE
President and CEO
UM Shore Regional Health

EXHIBIT 16

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

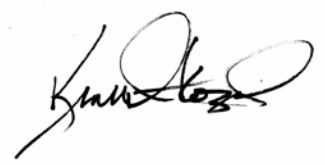
October 12, 2015

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21225

Dear Mr. Steffen,

As part of our application for a Certificate of Conformance, I am submitting this letter of commitment to provide PCI services only for suitable patients. Suitable patients are patients described as appropriate for primary PCI in the Guidelines of the American College of Cardiology Foundation/American Heart Association (ACCF/AHA) for Management of Patients with Acute Myocardial Infarction or in the Guidelines of the American College of Cardiology Foundation/American Heart Association/Society for Cardiovascular Angiography and Interventions (ACCF/AHA/SCAI) for Percutaneous Coronary Intervention.

Sincerely,



Kenneth D. Kozel, MBA, FACHE
President and CEO
UM Shore Regional Health