EXHIBIT 22

Maryland Health Care Commission Quality Data
State Mean and LHDCMC Data
[Insert Date]

CONSUMER RATINGS		
Metric	**State Mean** 70	**Performance Improvement Action Plan**
How often were the patients' rooms and bathrooms always kept clean?	**LHDCMC** 64%	Dedicated Director of Patient Experience, started at DCMC on Feb. 1st, 2021. - Initiation of Plan of Care Rounds: Nurse-Physician Dyad Bedside Rounding (November 2020) with 85% goal of completion daily (currently at 78%). - Opened back up to visitors in March 2021 which allows inclusion of family members in Plan of Care Rounds. - Daily 8 Communication Toolkit (began OCT 2020) integrated within Luminis RISE values (FEB 2021)– education is ongoing. - Daily inpatient hospital medicine patient satisfaction surveys (initiated in April 2019 and held for COVID since mid-2020) to be tentatively resumed in person for April 2021. - Increasing rounding (leader/patient/staff) across DCMC. - Patient Experience Steering Committee beginning April 2021. - Standardizing transparency of data and patient comments. - Standardizing DCMC Patient Experience Strategy. - Developing a Reward/Recognition banner program.
Metric	**State Mean** 61	**Performance Improvement Action Plan**
How often did patients always receive help quickly from hospital staff?	**LHDCMC** 61%	**Average**
Metric	**State Mean** 56	**Performance Improvement Action Plan**
How often was the area around patients' rooms always kept quiet at night?	**LHDCMC** 57%	Better than average
Metric	**State Mean** 76	**Performance Improvement Action Plan**

How often did nurses always communicate well with patients?	**LHDCMC** 73%	Dedicated Director of Patient Experience, started at DCMC on Feb. 1st, 2021. - Initiation of Plan of Care Rounds: Nurse-Physician Dyad Bedside Rounding (November 2020) with 85% goal of completion daily (currently at 78%). - Opened back up to visitors in March 2021 which allows inclusion of family members in Plan of Care Rounds. - Daily 8 Communication Toolkit (began OCT 2020) integrated within Luminis RISE values (FEB 2021)– education is ongoing. - Daily inpatient hospital medicine patient satisfaction surveys (initiated in April 2019 and held for COVID since mid-2020) to be tentatively resumed in person for April 2021. - Increasing rounding (leader/patient/staff) across DCMC. - Patient Experience Steering Committee beginning April 2021. - Standardizing transparency of data and patient comments. - Standardizing DCMC Patient Experience Strategy. - Developing a Reward/Recognition banner program.
Metric	**State Mean** 78	**Performance Improvement Action Plan**
How often did doctors always communicate well with patients?	**LHDCMC** 74%	Dedicated Director of Patient Experience, started at DCMC on Feb. 1st, 2021. - Initiation of Plan of Care Rounds: Nurse-Physician Dyad Bedside Rounding (November 2020) with 85% goal of completion daily (currently at 78%). - Opened back up to visitors in March 2021 which allows inclusion of family members in Plan of Care Rounds. - Daily 8 Communication Toolkit (began OCT 2020) integrated within Luminis RISE values (FEB 2021)– education is ongoing. - Daily inpatient hospital medicine patient satisfaction surveys (initiated in April 2019 and held for COVID since mid-2020) to be tentatively resumed in person for April 2021.

		- Increasing rounding (leader/patient/staff) across DCMC. - Patient Experience Steering Committee beginning April 2021. - Standardizing transparency of data and patient comments. - Standardizing DCMC Patient Experience Strategy. - Developing a Reward/Recognition banner program.
Metric	**State Mean** 61	**Performance Improvement Action Plan**
How often did staff always explain about medicines before giving them to patients?	**LHDCMC** 55%	Dedicated Director of Patient Experience, started at DCMC on Feb. 1st, 2021. - Initiation of Plan of Care Rounds: Nurse-Physician Dyad Bedside Rounding (November 2020) with 85% goal of completion daily (currently at 78%). - Opened back up to visitors in March 2021 which allows inclusion of family members in Plan of Care Rounds. - Daily 8 Communication Toolkit (began OCT 2020) integrated within Luminis RISE values (FEB 2021)– education is ongoing. - Daily inpatient hospital medicine patient satisfaction surveys (initiated in April 2019 and held for COVID since mid-2020) to be tentatively resumed in person for April 2021. - Increasing rounding (leader/patient/staff) across DCMC. - Patient Experience Steering Committee beginning April 2021. - Standardizing transparency of data and patient comments. - Standardizing DCMC Patient Experience Strategy. - Developing a Reward/Recognition banner program.
Metric	**State Mean** 87	**Performance Improvement Action Plan**
Were patients always given information about what to do during their recovery at home?	**LHDCMC** 85%	Dedicated Director of Patient Experience, started at DCMC on Feb. 1st, 2021. - Initiation of Plan of Care Rounds: Nurse-Physician Dyad Bedside Rounding (November

		2020) with 85% goal of completion daily (currently at 78%). - Opened back up to visitors in March 2021 which allows inclusion of family members in Plan of Care Rounds. - Daily 8 Communication Toolkit (began OCT 2020) integrated within Luminis RISE values (FEB 2021)– education is ongoing. - Daily inpatient hospital medicine patient satisfaction surveys (initiated in April 2019 and held for COVID since mid-2020) to be tentatively resumed in person for April 2021. - Increasing rounding (leader/patient/staff) across DCMC. - Patient Experience Steering Committee beginning April 2021. - Standardizing transparency of data and patient comments. - Standardizing DCMC Patient Experience Strategy. - Developing a Reward/Recognition banner program.
Metric	**State Mean** 49	**Performance Improvement Action Plan**
How well do patients understand their care when they leave the hospital?	**LHDCMC** 49%	**Average**
Metric	**State Mean** 66	**Performance Improvement Action Plan**
How do patients rate the hospital overall?	**LHDCMC** 60%	Dedicated Director of Patient Experience, started at DCMC on Feb. 1st, 2021. - Initiation of Plan of Care Rounds: Nurse-Physician Dyad Bedside Rounding (November 2020) with 85% goal of completion daily (currently at 78%). - Opened back up to visitors in March 2021 which allows inclusion of family members in Plan of Care Rounds. - Daily 8 Communication Toolkit (began OCT 2020) integrated within Luminis RISE values (FEB 2021)– education is ongoing. - Daily inpatient hospital medicine patient satisfaction surveys (initiated in April 2019 and held for COVID since mid-2020) to be tentatively resumed in person for April 2021.

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Metric	**State Mean** 66	**Performance Improvement Action Plan**
Would patients recommend the hospital to friends and family?	**LHDCMC** 64%	Dedicated Director of Patient Experience, started at DCMC on Feb. 1st, 2021. - Initiation of Plan of Care Rounds: Nurse-Physician Dyad Bedside Rounding (November 2020) with 85% goal of completion daily (currently at 78%). - Opened back up to visitors in March 2021 which allows inclusion of family members in Plan of Care Rounds. - Daily 8 Communication Toolkit (began OCT 2020) integrated within Luminis RISE values (FEB 2021)– education is ongoing. - Daily inpatient hospital medicine patient satisfaction surveys (initiated in April 2019 and held for COVID since mid-2020) to be tentatively resumed in person for April 2021. - Increasing rounding (leader/patient/staff) across DCMC. - Patient Experience Steering Committee beginning April 2021. - Standardizing transparency of data and patient comments. - Standardizing DCMC Patient Experience Strategy. - Developing a Reward/Recognition banner program.
STROKE		
Metric	**State Mean** 4.0616	**Performance Improvement Action Plan**
How often patients who came in after having stroke	**LHDCMC** 6.6554	**Average**

subsequently died in the hospital.		
Metric	**State Mean** 13.61	**Performance Improvement Action Plan**
Death rate for stroke patients	**LHDCMC** 12.3	**Average**
COPD (Chronic Obstructive Pulmonary Disease)		
Metric	**State Mean** 8.6	**Performance Improvement Action Plan**
Dying within 30-days after getting care in the hospital for COPD	**LHDCMC** 6.9	**Average**
Metric	**State Mean** 19.1	**Performance Improvement Action Plan**
Returning to the hospital after getting care for chronic obstructive pulmonary disease (COPD)	**LHDCMC** 20.3	**Average**
ED		
Metric	**State Mean** 404.5	**Performance Improvement Action Plan**
How long patients spent in the ED before leaving for their hospital room	**LHDCMC** 441	-Monitors will be placed in each area of the ED to communicate inpatient bed is ready and other throughput triggers -ANS will assign inpatient bed -Medical team will create a goal for ED bed request to orders written. -Monthly EM/IM meetings with review of the time it takes for orders to be placed with feedback -Initiation of holding/bridging orders during the end of hospitalist shifts to decrease delay during sign out - Monthly review of TAT for labs and radiology studies
Metric	**State Mean** 166.7	**Performance Improvement Action Plan**
How long patients spent in the ED after the doctor decided the patient would stay in the hospital before leaving for their hospital room	**LHDCMC** 225	-Review and discuss at monthly Throughput and quarterly Quality Management Committee factors contributing to an increased ED to inpatient bed length of stay (LOS). -Monitors will be placed in each area of the ED to communicate inpatient bed is ready and other throughput triggers -ANS will assign inpatient bed -Medical team will create a goal for ED bed request to orders written. -Team leaders and nursing staff will decrease room assigned to ED departure by 15%.

Metric	State Mean 200.6	Performance Improvement Action Plan
How long patients spent in the ED before being sent home.	LHDCMC 223	-ED Medical and Nursing Director are reviewing and discussing at monthly meetings. -Front end subcommittee will implement strategies to decrease door to room by 10% -RCE workgroup will trial a front end flow coordinator to decrease ED DC LOC for fast track patients by 10%
Metric	**State Mean 3.0**	**Performance Improvement Action Plan**
Patients who left the emergency department without being seen	LHDCMC 2%	Better than average
MATERNITY & NEWBORN		
Metric	**State Mean 1.3**	**Performance Improvement Action Plan**
Newborn deliveries scheduled 1-3 weeks earlier than medically necessary.	LHDCMC N/A	Not enough data to report
Metric	**State Mean 28.9864**	**Performance Improvement Action Plan**
Percentage of births (deliveries) that are C-sections	LHDCMC N/A	Not enough data to report
Metric	**State Mean 15.7091**	**Performance Improvement Action Plan**
How often babies in the hospital are delivered vaginally when the mother previously delivered by cesarean section (no complications)	LHDCMC N/A	Not enough data to report
Metric	**State Mean 17.0156**	**Performance Improvement Action Plan**
How often babies in the hospital are delivered using cesarean section when this is the mother's first birth.	LHDCMC N/A	Not enough data to report
Metric	**State Mean 15.1278**	**Performance Improvement Action Plan**
How often babies are born vaginally when the mother has had a C-section in the past (includes complications)	LHDCMC N/A	Not enough data to report
SURGERIES FOR SPECIFIC HEALTH CONDITIONS		
Metric	**State Mean 0.6705**	**Performance Improvement Action Plan**

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	**LHDCMC** N/A	Not enough data to report
Metric	**State Mean** 5.3224	**Performance Improvement Action Plan**
How often patients die in the hospital during or after surgery on the esophagus	**LHDCMC** N/A	Not enough data to report
Metric	**State Mean** 0.8193	**Performance Improvement Action Plan**
How often patients die in the hospital during or after pancreas surgery	**LHDCMC** 0.0	**Average**
ALL CAUSES DEATHS OR RETURNS TO THE HOSPITAL		
Metric	**State Mean** 14.9	**Performance Improvement Action Plan**
Returning to the hospital for any unplanned reason within 30 days after being discharged	**LHDCMC** 14.8	**Average**
HEART SURGERIES AND PROCEDURES		
Metric	**State Mean** 2.68	**Performance Improvement Action Plan**
Death rate for CABG	**LHDCMC** N/A	Not enough data to report
Metric	**State Mean** 12.3	**Performance Improvement Action Plan**
Rate of unplanned readmission for CABG	**LHDCMC** N/A	Not enough data to report
PREVENTIVE CARE		
Metric	**State Mean** 95.7	**Performance Improvement Action Plan**
Patients in the hospital who got the flu vaccine if they were likely to get flu	**LHDCMC** 100%	Better than average
HEART ATTACK AND CHEST PAIN (RECOMMENDED CARE INPATIENT)		
Metric	**State Mean** 70.8	**Performance Improvement Action Plan**
How long patients with chest pain or possible heart attack waited to be transferred to another hospital for a procedure	**LHDCMC** 91	• LHDCMC ED and MedStar leadership to meet monthly to decrease times with goal of improved documentation and coordination between accepting interventionalist and transferring ED provider agreeing upon whether the transfer was initiated for STEMI vs Unstable Angina

		· Monthly review of STEMI cases to determine timeline bottlenecks with monthly feedback to providers, in which we believe transfer times should improve via LHDCMC's recently built helipad adjacent to ED to decrease transport times from an off-site landing area to patient pick-up.
Metric	**State Mean** 11.2	**Performance Improvement Action Plan**
How long patients who come to the hospital with chest pain or possible heart attack waited to get a test that detects heart damage after a heart attack	**LHDCMC** 12	· Review indications for EKG on advanced triage orders to increase capture rate of STEMIs for patients without chest pain · Installation of up to date software for EKG machines and troubleshooting connectivity issues that have led to delays in getting EKGs in triage
Metric	**State Mean** 7.0598	**Performance Improvement Action Plan**
How often patients die in the hospital after heart attack	**LHDCMC** 3.7113	**Average**
Metric	**State Mean** 12.9	**Performance Improvement Action Plan**
Dying within 30-days after getting care in the hospital for a heart attack	**LHDCMC** 13.3	**Average**
Metric	**State Mean** 15.6	**Performance Improvement Action Plan**
Returning to the hospital after getting care for a heart attack	**LHDCMC** 15.7	**Average**
HEART FAILURE (RECOMMENDED CARE)		
Metric	**State Mean** 2.8964	**Performance Improvement Action Plan**
How often patients die in the hospital after heart failure	**LHDCMC** 2.1568	**Average**
Metric	**State Mean** 11.0	**Performance Improvement Action Plan**
Dying within 30-days after getting care in the hospital for heart failure	**LHDCMC** 7.8	Better than average
Metric	**State Mean** 21.2	**Performance Improvement Action Plan**
Returning to the hospital after getting care for heart failure	**LHDCMC** 20.4	**Average**
HIP AND KNEE REPLACEMENT SUGERY		
Metric	**State Mean**	**Performance Improvement Action Plan**

	2.5	
Complications after hip or knee replacement surgery	**LHDCMC** 2.7	**Average**
Metric	**State Mean** 4.0	**Performance Improvement Action Plan**
Returning to the hospital after getting hip or knee replacement surgery	**LHDCMC** 4.0	**Average**
NURSING CARE		
Metric	**State Mean** 3.3340	**Performance Improvement Action Plan**
How often patients in the hospital get a blood clot in the lung or leg vein after surgery	**LHDCMC** 5.4933	**Average**
PATIENT SAFETY (RESULTS OF CARE COMPLICATIONS)		
Metric	**State Mean** 0.1497	**Performance Improvement Action Plan**
How often the hospital accidentally makes a hole in a patient's lung	**LHDCMC** 0.0	**Average**
Metric	**State Mean** 14.9	**Performance Improvement Action Plan**
Returning to the hospital for any unplanned reason within 30 days after being discharged	**LHDCMC**	**Average**
Metric	**State Mean** 2.3	**Performance Improvement Action Plan**
Patients who developed a blood clot while in the hospital and did not get treatment that could have prevented it	**LHDCMC** 0	Better than average
Metric	**State Mean** 57	**Performance Improvement Action Plan**
Percentage of patients who received appropriate care for severe sepsis and septic shock	**LHDCMC** 82	Better than average
Metric	**State Mean** 1.0249	**Performance Improvement Action Plan**
How often patients accidentally get cut or have a hole poked in an organ that was not part of the surgery	**LHDCMC** 0.7747	**Average**
PATIENT SAFETY (RESULTS OF CARE DEATHS)		
Metric	**State Mean** 1.7208	**Performance Improvement Action Plan**

How often patients die in the hospital after bleeding from stomach or intestines	**LHDCMC** 1.5187	**Average**
Metric	**State Mean** 1.6742	**Performance Improvement Action Plan**
How often patients die in the hospital after fractured hip	**LHDCMC** 0.0	**Average**
Metric	**State Mean** 3.1269	**Performance Improvement Action Plan**
How often patients die in the hospital while getting care for a condition that rarely results in death	**LHDCMC** 0.0	Better than average
PNEUMONIA (RECOMMENDED CARE)		
Metric	**State Mean** 3.1166	**Performance Improvement Action Plan**
How often patients die in the hospital while getting care for pneumonia	**LHDCMC** 4.3001	**Average**
Metric	**State Mean** 16.1	**Performance Improvement Action Plan**
Dying within 30-days after getting care in the hospital for pneumonia	**LHDCMC** 12.3	Better than average
Metric	**State Mean** 16.6	**Performance Improvement Action Plan**
Returning to the hospital after getting care for pneumonia	**LHDCMC** 17.4	**Average**
PREVENTION AND TREATMENT		
Metric	**State Mean** 2.3	**Performance Improvement Action Plan**
Patients who developed a blood clot while in the hospital and did not get treatment that could have prevented it	**LHDCMC** 0.0	Better than average
SURGICAL PATIENT SAFETY (RESULTS OF CARE)		
Metric	**State Mean** 83.5769	**Performance Improvement Action Plan**
How often patients die in the hospital because a serious condition was not identified and treated	**LHDCMC** 111.3260	**Average**
Metric	**State Mean** 3.1854	**Performance Improvement Action Plan**
How often patients in the hospital had to use a breathing	**LHDCMC** 7.9108	**Average**

machine after surgery because they could not breathe on their own		
Metric	**State Mean** 3.3340	**Performance Improvement Action Plan**
How often patients in the hospital get a blood clot in the lung or leg vein after surgery	**LHDCMC** 5.4933	**Average**
Metric	**State Mean** N/A	**Performance Improvement Action Plan**
Number of times a medical tool was accidentally left in a patient's body during surgery or procedure	**LHDCMC** 1	N/A
COMBINED QUALITY AND SAFETY RATINGS		
Metric	**State Mean** 0.9140	**Performance Improvement Action Plan**
Patients who died in the hospital after having one of six common conditions.	**LHDCMC** 0.9871	**Average**
Metric	**State Mean** 1.5127	**Performance Improvement Action Plan**
How well this hospital keeps patients safe based on eleven patient safety problems	**LHDCMC** 1.7656	**Average**
IMAGING		
Metric	**State Mean** 39.9	**Performance Improvement Action Plan**
Patients who come to the hospital with low back pain who had an MRI without trying recommended treatments first, such as physical therapy (If a number is high, it may mean the facility is doing too many unnecessary MRIs for low back pain.)	**LHDCMC**	Not enough data to report
Metric	**State Mean** 2.7	**Performance Improvement Action Plan**
Contrast material (dye) used during abdominal CT scan	**LHDCMC** 30.3	Reduce repeat scanning by 15% with monthly interdisciplinary monthly meeting) between radiology (physician and technologist) leadership and ED (nursing and physician) leadership with first meeting scheduled for Monday 3/22/21.
Metric	**State Mean** 0.5	**Performance Improvement Action Plan**

Contrast material (dye) used during thorax CT scan	**LHDCMC** 0.3%	**Average**
Metric	**State Mean** 5.9	**Performance Improvement Action Plan**
Patients who had a low-risk surgery and received a heart-related test, such as an MRI, at least 30 days prior to their surgery though they do not have a heart condition	**LHDCMC** N/A	Not enough data to report
Metric	**State Mean** 1.9	**Performance Improvement Action Plan**
Patients who came to the hospital for a scan of their brain and also got a scan of their sinuses.	**LHDCMC** 0.9	Better than average