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EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

Part of Peninsula Regional Health System



Community Health Needs Assessment and Implementation Plan

FY 2013

Approved by the Community Needs Assessment Task Force: June 28, 2013
Board Approval: July 2013

Dear Friends and Neighbors,

For 116 years, Peninsula Regional Medical Center has had a proud heritage as a supportive and engaged innovator of healthcare services across the entire Delmarva Peninsula.

We find great pride in being the region's largest, busiest and oldest hospital, and embrace the responsibilities that come with caring, coaching and connecting with the 500,000 people who trust us for their healthcare needs each year.

As our change partners in healthcare, they bring to us passionate voices and fresh eyes as we, together, examine the needs of our communities.

In this most recent cycle, their message was clear: cancer, heart disease, stroke, diabetes and obesity are the concerns that they believe need to be our immediate focus. We agree, and will use the next few years to refine and expand those services with an emphasis on the Patient Centered Medical Home. We will transition from the hospital being the apex of the patient experience and further tilt that axis until our services revolve closer to the patient, near their homes and where it's most convenient to them.

One of our major roles is to create, fund and participate in a wide variety of community-based programs and services that benefit Delmarva families. Last year, PRMC provided over $24 million in financial, actual and in-kind contributions. Our Wagner Wellness van traveled thousands of miles providing free screenings. Our nurses administered hundreds of flu vaccinations to the less fortunate of our friends at local shelters and soup kitchens. Over 41,000 alone hours were spent on mission driven health services.

While outcomes matter and always will, the smiles and the hugs touch us equally as much. They inspire us to get up every day and bring our best game to the Medical Center, and not because we have to but because we want to.

Working with our partners throughout the area, we'll make this a stronger community, and teach our friends how to stay healthier.

We must. This is our home too.

Dr. Peggy Naleppa, MS, MBA, FACHE
President/CEO

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Section I. Introduction

a) Overview of Peninsula Regional Medical Center

Peninsula Regional Medical Center, a non-profit, 317 acute care bed, 30 transitional care beds and 28 newborn & specialty care nursery beds hospital at the hub of the Peninsula Regional Health System, is a 116-year-old, fully Joint Commission accredited tertiary care facility featuring Delmarva's widest array of specialty and sub-specialty services. Over 300 physicians and 3,000 health care professionals and volunteers provide the care and compassion that nearly 500,000 patients rely on each year for inpatient, outpatient, diagnostic, subacute and emergency/trauma services. It has been the recipient of over 125 national awards and recognitions over the past six years for the safety and quality of care it provides patients and for the outcomes they experience. Peninsula Regional and its staff believe in A Culture of Always, where we work to ensure that we are performing at our best for Every Patient, Every Person, Every Time.

Peninsula Regional is an affiliate of the elite Johns Hopkins Clinical Research Network (JHCRN), a group of academic and community-based clinical researchers designed to provide new opportunities for research collaborations and accelerate the transfer of new diagnostic, treatment, and disease prevention advances from the research arena to patient care.

Peninsula Regional, as the regional leader in healthcare, welcomes over 2,000 babies annually, treats more than 85,000 people seeking emergency care, performs nearly 14,500 surgical procedures using robotics and minimally invasive techniques and admits more than 21,000 patients for care each year. This year, Peninsula Regional will generate over $300 million in economic benefit back into the local community and economy, while re-investing millions into new healthcare equipment upgrades.

Peninsula Regional also supports numerous affiliations with clinical educational programs at area two-year and four-year universities that expand nursing, physician assistant, respiratory therapy, and surgical technology opportunities for area students.

We emphasize meeting local community needs with services for which location is important (e.g., senior care, obstetrics and emergency) and broader community needs with more complex services (e.g., cancer, high risk obstetrics and neonatology, minimally invasive surgery and neurosciences). We reached 52,872 encounters through our community benefit outreach programs last year.

b) Organizational Commitment

2012 Community Activities Summary	Hours Given	Dollars Given
Community Health Services	21,818	$1,375,755
Health Professions Education	15,811	761,835
Mission Driven Health Services	41,559	6,177,811
Research	32	3,973
Financial Contributions	4055	144,883
Community Building Activities	288	176,021
Community Benefit Operations	171	8,332
Charity Care		13,903,600
Medicaid Assessments		1,626,859
Total	83,734	24,179,071

Figure 1. Community Activities

Peninsula Regional Medical Center's overall approach to community benefit is to target the intersection of documented unmet community health needs and our organization's key strengths and mission commitments. We fully integrate our commitment to community service into our management and governance structures as well as our strategic and operational plans, and we are rigorous in monitoring and evaluating our progress. We seek and nurture relationships with a broad range of collaborative partners to build community and organizational capacity.

Our values are:

- *Respect for every individual*
- *Delivery of exceptional service*
- *Continuous improvement*
- *Safety, effectiveness*
- *Trust and compassion*
- *Transparency*

This Community Health Assessment is a systematic, data-driven approach to determining the health status, behaviors and needs of children, adolescents and adults in Somerset, Worcester and Wicomico counties in Eastern Maryland. Subsequently, this information may be used by local hospitals, health departments and other community organizations to formulate strategies to improve community health and wellness.

The Community Health Needs Assessment process provides timely information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- Improve the resident's health status and improve overall quality of life through healthcare.

- To reduce the health disparities among the population by identifying segments that are most at risk for various diseases and injuries. Plans for targeting these individuals may then be developed as evidenced in Peninsula Regional's participation in many of the local community health organizations.

- Increase accessibility to preventative services for all community residents.

c) The Community We Serve

Certain primary service area statistics are tabulated not on the basis of county boundaries, but on the basis of the 43 zip codes all or part of which are in those primary service area counties. In fiscal year 2012, approximately 77% of the patients discharged from the Medical Center were residents of the primary service area, which had an estimated population of approximately 177,422 in 2013 and is expected to increase to 179,814 in 2017. The primary service area population has grown by an estimated 10% since 2000.

The secondary service area, accounting for 18% of Peninsula Regional's FY 2012 discharges, consists of 14 zip codes in the southern portion of Sussex County, Delaware and the northern portion of Accomack County, Virginia. These two counties had a population of approximately 247,000 in 2012 and have experienced growth since 2000 of 19%. The primary and secondary service areas combined accounted for 94% of Peninsula Regional's total patient discharges in fiscal year 2011. Additional demographic information indicates the number of elderly (those aged 65+) represent a greater portion of the total population in both the primary and secondary areas as compared to the State of Maryland (17.1% and 21.3% respectively vs. 13.3%). The elderly have additional chronic conditions, consume healthcare resources at higher rates, and generally require more time and attention than other population segments.

All six counties can be classified as rural with a historic economic foundation in agriculture, poultry and tourism. Watermen and farmers have always comprised a large percentage of the peninsula population; however, their numbers have been declining with growth in the population and expansion of other small businesses. Ocean City, located in Worcester County is a major tourist destination, during the summer weekends, the city hosts between 320,000 and 345,000 vacationers, and up to 8 million visitors annually. The six counties have a diversified economic base; however, it is predominately made up of small employers (companies with less than 50 employees). Some of the major employers include the local hospitals, chicken industry, and local colleges and teaching institutions. The median income of our service area is considerably less ($37,985-$47,654) than Maryland's median income of $68,467. In addition, the August 2012 unemployment rates for each one of the counties is Wicomico 8.2%; Worcester 7.6%; and Somerset has a high of 9.6%. The August 2012 unemployment rate for Maryland was 7.1% and the National rate was 8.1%.

Additional socio-economic demographic information indicates the number of elderly (those aged 65+) represent a greater portion of the total population in both the primary and

secondary areas and will continue to grow over the next five years in each of the six counties between 11 and 18 percent. The elderly have additional chronic conditions, consume healthcare resources at higher rates, and generally require more time and attention than other population segments.

In March of 2012, The Office of Minority Health and Health Disparities (MHHD) at the Department of Health and Mental Hygiene assisted SHIP local planning groups in identifying issues of poor minority health disparities. For Worcester and Wicomico, diabetes emergency room visits are considerable higher for Blacks than the Statewide Black rates, and higher than the White rates in the same county. The White rates are also higher than the Statewide White rate. Overall, these statistics indicate there is a community wide need for diabetes education and management.

d) Demographics

Peninsula Regional Medical Center is located in Salisbury, Maryland, an approximately 116 mile drive from both Washington D.C. and Baltimore, Maryland. The Medical Center defines its primary service area in general terms as Wicomico County, Worcester County and Somerset County on Maryland's Eastern Shore.



Figure 1. Map of Counties PRMC services

Demographics		%	Source
Total Population	177,422		Thomson Reuters
Sex			Thomson Reuters
Male	86,665	49%	
Female	90,757	51%	
Age			Thomson Reuters
0 -14 years	29,537	16.7%	
15-18 years	6,119	3.4%	
18-24 years	22,258	10.1%	
25-34 years	23,849	13.4%	
35-54 years	43,915	24.8%	
55-64 years	23,849	13.4 %	
65+ years	30,415	17.1%	
Median Age: Wicomico	36.3		
Worcester	47.9		
Somerset	35.9		
Race/Ethnicity			Thomson Reuters
White	120,207	67.8%	
Black	41,363	23.3%	
Hispanic	7,9425	4.5%	
Asian & Pacific	3,5162	2.0%	
All Other	4,394	2.4%	

Figure 2. Demographics general (Thomson Reuters)

Demographics		%	Source
% of Uninsured people in CBSA			Thomson Reuters
Wicomico		19.7%	
Worcester		14.5%	
Somerset		30.7%	
Compared to MD		13.6%	
% of Medicaid people in CBSA			
Wicomico		19.1%	Thomson Reuters
Worcester		13.5%	
Somerset		17.2%	
Compared to MD		12.5%	
Life Expectancy in the CBSA			www.dhmh.maryland.gov/ship
Wicomico	76		
Worcester	79.4		
Somerset	74.7		
Compared to MD	78.6		
Compared to US	77.9		

Figure 3. Demographics CBSA (Thomson Reuters)

According to the Maryland Vital Statistics of 2011, all causes of death for leading causes age adjusted death rates in Wicomico are 829.3 deaths/100,000 and Somerset 946.6 deaths/100,000 13% and 29% respectively higher than that of the State of Maryland at 732.5 deaths/100,000. All three counties; Wicomico, Worcester and Somerset age adjusted related deaths are greater than the State of Maryland in disease of the heart, malignant neoplasm and chronic lower respiratory diseases. (www.dhmh.maryland.gov/vsa/documents/1 1annual.pdf)

Wicomico - Disease State	% Higher then the State of Maryland
Disease of the heart	31%
Malignant Neoplasm	21%
Chronic Respiratory	64%

Figure 4. Maryland Vital Statistics Annual Report 2011

Worcester - Disease State	% Higher then the State of Maryland
Disease of the heart	1%
Malignant Neoplasm	10%
Chronic Respiratory	20%

Figure 5. Maryland Vital Statistics Annual Report 2011

Somerset - Disease State	% Higher then the State of Maryland
Disease of the heart	57%
Malignant Neoplasm	58%
Chronic Respiratory	24%

Figure 6. Maryland Vital Statistics Annual Report 2011

Infant mortality rates for all races in the Tri-County area are 19 deaths per 1,000 live births. Caucasians are 9 deaths per 1,000 live births and African Americans are 10 deaths per 1,000 births. (www.dhmh.maryland.gov/vsa/documents/1 1annual.pdf)

Discharges by County	
County	Percentage
Wicomico	50.8%
Worcester	15.3%
Delaware	11.7%
Somerset	10.2%
Other	12.0%

Figure 7. Peninsula Regional Medical Center Discharge Data 2012

e) Income & Poverty

The combined average income for Wicomico, Worcester and Somerset is $45,205. This is 34% below the state and 14% below the US median household income levels. Somerset County has an even wider gap. There is a 45% difference between the State of Maryland and 28% below the US median household income levels. The research has shown that the lower income individuals health outcomes are worse than those who have a higher income.

Demographics		%	Source
Median Household Income			Thomson Reuters
Wicomico	$47,654		
Worcester	$49,977		
Somerset	$37,985		
Compared to MD	$68,467		
Compared to US	$52,434		
Households in Poverty (116% or below the federal poverty guidelines)			Healthy Communities (HCI) www.census.gov/acs
Wicomico		7.9%	
Worcester		6.2%	
Somerset		12.7%	

Figure 1 Income/Poverty levels

Key Snapshots

- The combined average income for Wicomico, Worcester and Somerset is $45,205. This is 34% below the state and 14% below the US median household income levels.

f) Access to Care/Health Insurance Coverage

National Snapshot

Achieving health equity focuses on access to comprehensive, quality health care services. Health care costs are high in the United States. Because of this, people without health insurance many times go without treatment or important medications. According to Healthy People 2020, nationally, in 2010, 4.6% of individuals were unable to obtain or delayed in getting necessary medical care. Rates decrease as family incomes increase. 7.0% of families whose incomes are below the Federal Poverty Level (FPL) were unable to get or were delayed in getting necessary medical care.
http://www.healthypeople.gov/2020/topicsobjectives2020/nationalsnapshot.aspx?topicId=1

Local Snapshot

According the United States Census Bureau, in Wicomico County in 2011, 84.9% of Adults have health insurance, with the highest age group being 18-24 at 90.5%. The lowest age group insured was the 25-34 at 73.3%. Black or African Americans were at 79.8 insurance rates compared to Whites, non-Hispanic 89.5%. This information was not available for Somerset and Worcester Counties. http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

Peninsula Regional Medical Center conducted a Community Needs Assessment Survey of 335 individuals. These individuals were Board Members, the Executive Team, Peninsula Partners (a community senior group), churches, the Lions and Rotary clubs and community wellness and

screening events. In addition the survey was posted on our website, Facebook and blog. Attachment 1

Within the survey, we assessed the level of participation each respondent has with a primary care provider. Access to primary care providers increases the likelihood that community members will have routine checkups and screenings. Communities that lack a sufficient number of primary care providers typically have members who delay necessary care when sick and conditions can be more complicated. Results of the PRMC survey showed that 93% of the group had a primary care physician. Another question asked about the reason you or others from getting healthcare they need. Twenty-nine percent of the respondents felt it was because of lack of health insurance.

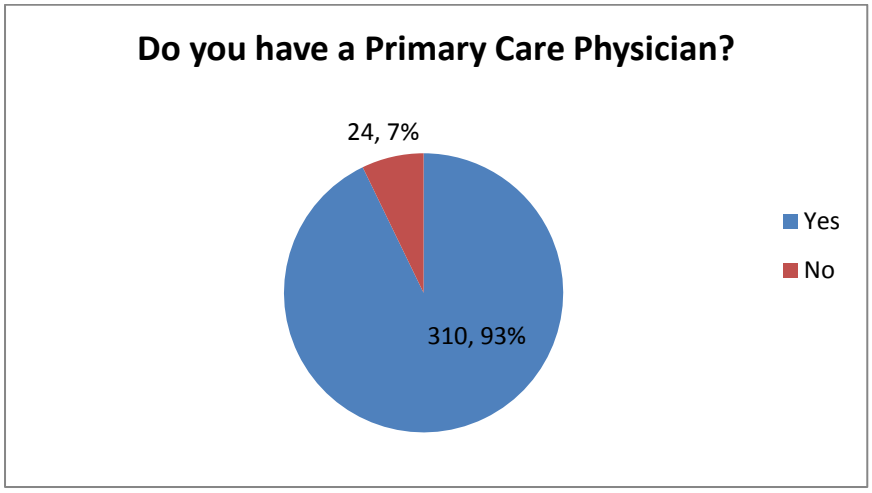


Figure 1. PRMC Community Needs Assessment Survey

According to the Community Dashboard, of the four counties tracked, Sussex DE, Somerset, MD, Wicomico, MD and Worcester, Somerset County has the lowest amount of providers at 34 for every 100,000 population.

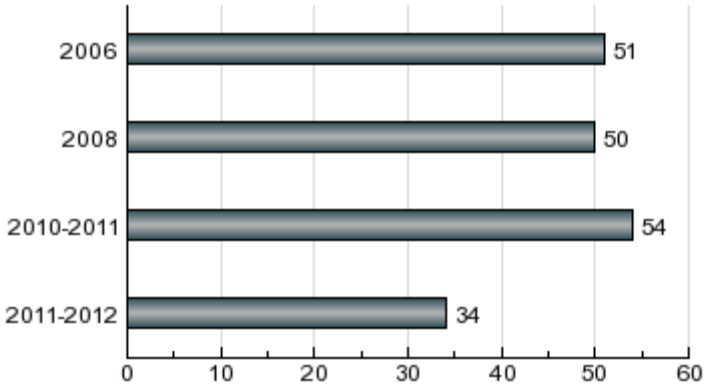


Figure 2. Community Dashborad Somerset; http://www.countyhealthrankings.org/rankings/data

In Wicomico County, 16.8% of adults are unable to afford to see a doctor and 81.6% have a routine checkup with a doctor. Both are in dangerously low levels. (MDBRFSS) Using the same data, 13.% of the Worcester County residents could not see a doctor due to costs.

Key Snapshots

- Another question asked on the Community Health Needs Assessment about the reason you or others from getting healthcare they need. Twenty-nine percent of the respondents felt it was because of lack of health insurance.
- In Wicomico County, 16.8% of adults are unable to afford to see a doctor and 81.6% have a routine checkup with a doctor.

Section II. Approach/Methodology

a) Community Health Needs Assessment Background

Peninsula Regional Medical Center formed a Community Benefit Team (CBT) to guide and lead its community benefit activities, including conducting the Community Health Needs Assessment. The members of the CBT include: Patti Serkes, Education Director; Alonzo Tull, Protection Services Director; Dan Rush, Maintenance Supervisor; Autumn Romanowski, Wellness Manager; Mollie Reymann, Exercise Specialist; Crystal Regels, Child Care Director; Scott Phillips, Director of Supply; Cathy Moore, Librarian; Alissa Carr, Marketing Manager; Roger Follebout, Community Relations Director; Gwen Garland, Community Relations and Chris Hall, Vice President Strategy and Business Development.

As part of the Peninsula Regional's ongoing commitment and mission statement "To Improve the Health of the Communities We Serve," we continue to assess the health needs of the community. We attend monthly Tri-County Community Health Improvement Process meetings. These meetings are made up of Wicomico, Worcester and Somerset's Health Department, local hospitals, local and national community health organizations and other local healthy lifestyle programs. We synergize as a group working toward our identified SHIP (State Health Improvement Process) initiatives in addition to sharing with each other our program successes and sometimes failures. The diversity of the participants and the dynamics of this particular group allow us to keep a better pulse on the needs of the community which contributes to planning and formulation of tactics to meet local health objectives. Peninsula Regional clinicians and Executives attend various public meetings as requested by either entity as we exchange community health ideas, data or bring resources to bare that both parties can benefit from.

Peninsula Regional's Diabetes Department works and meets regularly with the Tri-County Diabetes Alliance to continue to assess the needs and create programs to raise awareness and improve the health of Eastern Shore residents with diabetes. On a quarterly basis Peninsula Regional meets with a Community Health Council which is made up of residents from the Tri-County area. This Council is instrumental in dialoging with the Hospital on topics related to local health needs and improve access to health services.

b) Identification of Resources Used in Indentifying Community Health Needs

There are many resources used to help identify the health care needs of Peninsula Regional's community benefits service area. Peninsula Regional's inpatient, outpatient and emergency room data are analyzed annually; reviewing clinical diagnosis codes and other demographic data such as age, sex, race and zip codes to identify health needs. Peninsula Regional also has a Community Health Council that meets twice a year. This Council is made up of local individuals from the Tri-County area and is instrumental in discussing health services, technology, access to health series and physicians needed within their local communities. In addition, every three

years the Medical Center conducts a Medical Staff Development Survey, the overall purpose of this survey is to provide the community with adequate medical staffing for primary care physicians and specialists. Based upon the results of this survey Peninsula Regional will create a plan to recruit physicians for underserved areas and vulnerable specialties. An initiative in 2012 was the convening of a PFAC (Patient Family Advisory Council), which is a partnership between patients in the community and the Hospital. Our desire is for these patients to help shape our services, quality, processes and access to healthcare by providing pertinent feedback to what their needs are in relationship to the healthcare services we are delivering.

- Throughout the year Peninsula Regional utilized the following tools/resources to conduct community health needs assessments:

Thomson Rueters/Trueven: has a healthcare database that helps determine the prevalence and incidence rate of diseases by zip code. It is also useful in identifying chronic disease needs such as diabetes and asthma by zip code or census track in order to target that population for education and screening.

Creating Healthy Communities (www.peninsula.org): Peninsula Regional released in 2012 in collaboration with Atlantic General Hospital and McCready Foundation: "Creating Health Communities" a website based community health data dashboard made available to the public. This health metrics dashboard provides indicators on a variety of health and quality of life indicators in addition to health care disparities broke out by race, age, gender groups, etc.

These resources are used throughout the year as a benchmark tool to determine what health issues need to be addressed and to gauge any significant trends.

In the fiscal year 2013, Peninsula Regional Medical Center conducted a full-scale needs assessment. The following resources were utilized to complete the assessment.

- Community Needs Assessment Survey
- National HealthCare Disparities Report
- Maryland State Health Improvement Process Plan
- Maryland Vital Statistics
- Worcester County Community Health Improvement (CHIP) Plan
- Tri-County Community Health Improve (T-CHIP) Plan

Community Needs Assessment Survey
The survey was designed to obtain feedback from the community about health-related concerns. It was administered as follows:

- Via Paper Survey
  Paper surveys were administered during community events, including Rotary and Lion Club meetings; Peninsula Partners 55+ monthly meetings; and churches.

- Via the Internet
  An electronic form of the survey was administered through a link (Survey Monkey) was prominently displayed on the Peninsula Regional Medical Center website; and the link was published in multiple medical center publications; as well as emailed to various community groups.

National Healthcare Disparities Report
In 1999, Congress directed the Agency for Healthcare Research and Quality (AHRQ) to produce an annual report that tracks "prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations." Titled the *National Healthcare Disparities Report* (NHDR), this report examines disparities in health care among designated priority populations. The referenced priority populations consist of groups with unique health care needs or issues that require special focus, such as racial and ethnic minorities, low-income populations, and people with special health care needs.

Maryland State Health Improvement Process (SHIP) Plan
The goal of the State Health Improvement Process (SHIP) is to provide a framework for accountability, local action, and public engagement to improve the health status of Marylanders. The SHIP includes 39 measures in 6 vision areas (healthy babies, healthy social environments, safe physical environments, infectious disease, chronic disease, healthcare access) that represent what it means for Maryland to be healthy.

Worcester County Community Health Improvement (CHIP) Plan
The plan outlines goals, objectives, strategies and activities to improve community health. It focuses on four priority areas that were determined after review of the 2012 Community Health Assessment (CHA). The CHA presents the health status of Worcester County residents through a variety of health indicators. The four priority areas include: promote healthy lifestyles; improve access to care; improve prevention and control of communicable diseases; and promote behavioral health.

Tri-County Community Health Improve (T-CHIP) Plan
The Tri-county (Somerset, Wicomico, and Worcester Counties) community of the Eastern Shore of Maryland through the Tri-County Health Planning Board (Local Health Improvement Coalition) developed a Tri-County Health Improvement Plan (T-CHIP). T-CHIP established two priority areas- diabetes and childhood obesity.

In addition to the Community Needs Assessment, Peninsula Regional uses input from its Health Council (community based), local and national community health organizations such as the American Cancer Society, the March of Dimes, American Diabetes Association, Maryland's Office of Minority Health and Health Disparities local health department and state and national data sources such as the CDC Healthy People 2020 .

c) Limitations and Data Gaps Identified

Despite extensive efforts to prepare comprehensive sets of health access and health status indicators across races and ethnicities at the county level, the following limitations persist:

- No zip code level data were available for health findings.
- Often, databases do not differentiate races in persons of Hispanic origin.
- Many databases also group Asian Americans and Pacific Islanders in an “other” category.
- Much of the data were obtained from different sources with various data collection and publication protocols.
- Large amounts of county data collected, processed, and checked could not be used due to privacy concerns related to a small number of observations.
- Self-reporting in surveys can generate under-reporting or over-reporting, yielding unreliable estimates.
- No tests were performed to determine the statistical significance of data.

Section III. Findings

a) **Disease Incidence and Prevalence**

i. CANCER

Impact

Cancer is a term used for diseases in which abnormal cells divide without control and are able to invade other tissues. Cancerous cells are also called malignant cells. If the spread is not controlled, it can result in death. There are many different kinds of cancer. Cancer can develop in almost any organ or tissue, such as the lung and/or bronchus, colon, breast, skin, bones, or nerve tissue. There are many causes of cancer, including benzene and other chemicals, drinking excess alcohol, environmental toxins, excessive sunlight exposure, genetic problems, obesity, radiation, viruses, and other unknown causes (National Cancer Institute at the National Institutes of Health, http://www.cancer.gov/cancertopics/cancerlibrary/what-is-cancer;).

National Snapshot

In recent years, cancer has been the second highest cause of death in the United States, with only heart disease surpassing it. In 2012, about 577,190 Americans are expected to die of cancer, which is more than 1,500 people a day. The three most common cancers in men in the United States are prostate cancer, lung cancer, and colon cancer; in women in the United States, the three most common cancers are breast cancer, colon cancer, and lung cancer (National Cancer Institute at the National Institutes of Health, http://www.cancer.gov/cancertopics/cancerlibrary/what-is-cancer;).

State Snapshot

Though the overall cancer incidence rate in Maryland is steadily declining at a pace comparable to the national rate, a deeper look at specific populations and counties indicates that disparities exist, especially concerning the rate of mortality (Maryland DHMH, Cancer Report, 2010).

Local Data

Locally in Wicomico County as shown by the Community Dashboard shows death rates for breast, colorectal, lung and prostate cancer higher than most counties in the United States. For Somerset County the death rates are lower for the above mention cancers, except for prostate cancer, that is higher than most counties in the United States. For Worcester County, breast cancer is the only cancer higher than most counties. (http://statecancerprofiles.cancer.gov/deathrates/deathrates.html)

Malignant melanoma continues to be one of the cancers seen more frequently on the Eastern Shore than the rest of the state or country. Melanoma/skin cancer is one of the top 5 cancer sites for Peninsula Regional Medical Center. In fact, the percent of patients seen with melanoma/skin cancer is higher at Peninsula Regional Medical Center than the State of Maryland or even nationally. (PRMC 2012 Cancer Registry Data)

Key Snapshot

- Patients seen with melanoma/skin cancer is higher at Peninsula Regional Medical Center than the State of Maryland or even nationally.
- General cancer incidence rates are declining in Maryland.

ii. HEART DISEASE

Impact

Heart disease and stroke are among the most widespread and costly health problems facing out nation today, even though they are also among the most preventable. Heart disease and stroke are leading causes of death for both women and men. Coronary heart disease, often simply called heart disease, is the main form of heart disease. It is a disorder of the blood vessels of the heart that can lead to heart attack. A heart attack occurs when an artery becomes blocked, preventing oxygen and nutrients from getting to the heart. Heart disease is one of several cardiovascular diseases, which are diseases of the heart and blood vessel system. Other cardiovascular diseases include stroke, high blood pressure, angina (chest pain), and rheumatic heart disease (National Heart Lung and Blood Institute, 2012).

National Snapshot

Heart disease and stroke are major causes of illness and disability and are estimated to cost the nation hundreds of billions of dollars annually in health care expenditures and lost productivity. The total cost of cardiovascular disease is estimated at $448.5 billion annually (2008 estimate, AHRQ). Heart disease was ranked as the number one cause of death in the United States, causing 652,091 deaths in 2005 (Agency for Health Research and Quality. Accessed: http://www.ahrq.gov/qual/nhqr08/Chap2a.htm#heart).

State Snapshot

Heart disease and stroke affect portions of the population in Maryland disproportionately based on gender, race and ethnicity. Improvements in treatment have reduced the mortality rate for heart diseases by 25 percent between 2000 and 2009 (reduced by 22 percent among whites and 26 percent among blacks) (Maryland Vital Statistics Administration. Annual Report (2009). http://vsa.maryland.gov/doc/09annual.pdf). Although incidence rates have declined among all racial and ethnic groups in the state over the last several years, disparities among different racial/ethnic groups exist. White males have the highest prevalence rates of coronary heart disease, while blacks have the highest death rate, which suggests that minorities receive worse care, experience greater disease severity levels and, ultimately, worse health outcomes (MD DHMH, 2009).

In 2009, the death rate in Maryland for black males was 15 percent higher than white males and the death rate for black females was about 35 percent higher than white females. However, treatment in general is improving because over the last decade, diseases of the heart have resulted in about a quarter fewer deaths across Maryland.

Local Snapshot

When evaluating the information from the Community Dashboard, Worcester County death rates for heart disease is lower than most counties in the United States, however there is a high prevalence in high blood pressure and high cholesterol. For blood pressure, the prevalence is higher in the 65+ age group and cholesterol prevalence is higher in the 45-64 age group. (See figure 1 & 2)

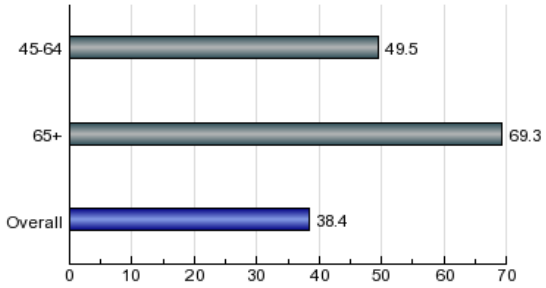


Figure 1. High Blood Pressure/age group
http://www.cdc.gov/brfss/

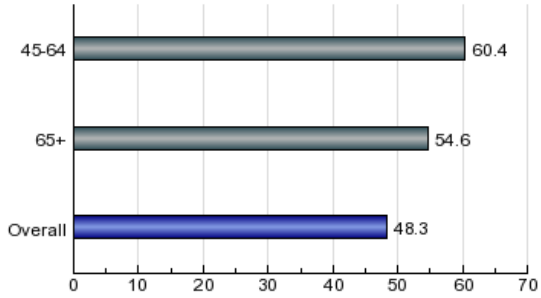


Figure 2. High Cholesterol/age group
http://www.cdc.gov/brfss/

For Wicomico County death rates for heart disease higher than most counties in the State of Maryland with blood pressure and cholesterol rates also higher than most counties Maryland. For both cholesterol and blood pressure, rates are higher in the 65+ age group.

The Community Dashboard for Somerset County reveals that like Wicomico, death rates are high due to heart disease, blood pressure prevalence is low compared to most counties in the United States, but high cholesterol are in the moderate category.

Wicomico County's Health Departments Report Card 2011, states that diabetes can lead to blindness, heart and blood vessel disease, stroke, kidney failure, amputations, nerve damage, pregnancy complications and birth defects. Emergency department visits for diabetes related complications may signify that the disease is uncontrolled. For Wicomico County the rate is 624.9/100,000 compared to the state rate of 347.2/100,000. (Healthcare Services Cost Review Commission; HSCRC) Wicomico is almost double the rate of the state.

The Report Card also states that as many as one third of all adults who have diabetes do not know they have it. In Wicomico County, 9.7% of adults have been diagnosed with diabetes. (Centers for Disease Control) There could be as much as 29.1%.

Key Snapshot

- Worcester County has a high prevalence in high blood pressure and high cholesterol.
- For Wicomico County death rates for heart disease higher than most counties in the State of Maryland with blood pressure and cholesterol rates also higher than most counties Maryland.
- Somerset County reveals that like Wicomico, death rates are high due to heart disease
- Similar to data in national statistics, heart disease and stroke affect Maryland's white population more than its black population.

iii. STROKE/CEREBROVASCULAR DISEASE

Impact

A stroke, or cerebrovascular disease, sometimes called a brain attack, occurs when a clot blocks the blood supply to the brain or when a blood vessel in the brain bursts. Lifestyle changes and, in some cases, medication, can greatly reduce one's risk for stroke. Stroke can cause death or significant disability, such as paralysis, speech difficulties, and emotional problems. Some new treatments can reduce stroke damage if patients get medical care soon after symptoms begin (CDC, 2012).

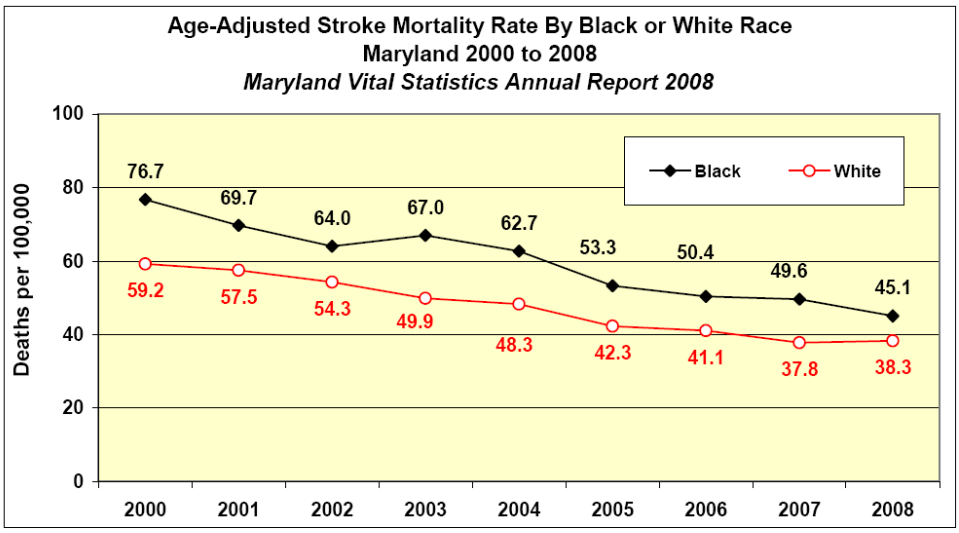
National Snapshot

Cerebrovascular disease, or stroke, is one of the top five leading causes of death in the United States. Heart disease is a risk factor for stroke. The risk of stroke can vary for different racial and ethnic groups. African Americans are at twice the risk of having a first stroke compared to whites; Hispanic Americans fall between the two. African Americans and Hispanics are more likely to die after suffering a stroke than whites (CDC, 2012).

State Snapshot

Cerebrovascular disease, or stroke, is the third leading cause of death in Maryland. Unlike coronary heart disease, the prevalence of stroke in Maryland differs nominally among racial and ethnic groups, as well as across years (MD DHMH, 2009).

Mortality rates for Maryland residents who suffered from stroke decreased from 2000 – 2008, during which time the rate decreased by 41.2 percent among blacks, by 35.3 percent among whites, and the mortality difference between the groups was reduced by 61.1 percent (see Figure 1) (MD Vital Statistics Administration, 2008).



Source: Maryland Vital Statistics Annual Report 2008 *[1]*

Figure 1. Age-Adjusted Stroke Mortality Rate by Race, Maryland, 2000-2008

Local Snapshot
In reviewing the data from the Community Dashboard, the death rate for all three counties, Wicomico, Worcester, and Somerset are low compared to the rest of the counties in the State of Maryland.

Key Snapshot
- The death rate for all three counties, Wicomico, Worcester, and Somerset are low compared to the rest of the counties in the State of Maryland
- Stroke, is the third leading cause of death in Maryland

iv. <u>DIABETES</u>

Impact
According to the American Diabetes Association, diabetes mellitus affects an estimated 25.8 million people in the United States, 8.3 percent of the total U.S. population, and of these, 7 million do not know they have the disease; it is the 7th leading cause of death. Diabetes is usually a lifelong (chronic) disease in which there are high levels of sugar in the blood. There are three types of diabetes. Type 1 can occur at any age, but it is most often diagnosed in children, teens, or young adults. In this disease, the body makes little or no insulin. Type 2 accounts for 95 percent of those diagnosed with diabetes among adults. The third type is gestational diabetes, which develops and is diagnosed as a result of pregnancy. (Centers for Disease Control and Prevention. *Diabetes Report Card 2012*. http://www.cdc.gov/diabetes/pubs/reportcard/diabetes-overview.htm)

Diabetes is a major cause of stroke, and is a leading cause of kidney failure, non-traumatic lower-limb amputations, and new cases of blindness among adults in the United States. Diabetes can lower life expectancy by up to 15 years and increases the risk of heart disease by 2 to 4 times. Overall, the risk for death among people with diabetes is about twice that of people of similar age without diabetes (CDC, National Diabetes Fact Sheet, 2011). Diabetes impacts diabetics and their families physically, financially, emotionally, in their home life, in their work, and in their day-to-day lives.

Diet, insulin, and oral medication to lower blood glucose levels are the foundation of diabetes treatment and management. It is also important for educational programs and self-care practices to maintain control of diabetes, allowing individuals to lead normal lives.

National Snapshot
Among U.S. seniors aged 65 and older, 10.9 million, or 26.9 percent, had diabetes in 2010; among people younger than 20, about 215,000 had either type I or type II diabetes (CDC, National Diabetes Fact Sheet, 2011). The number of people diagnosed with diabetes has risen from 1.5 million in 1958 to 18.8 million in 2010, an increase of epidemic proportions (see Figure 1)

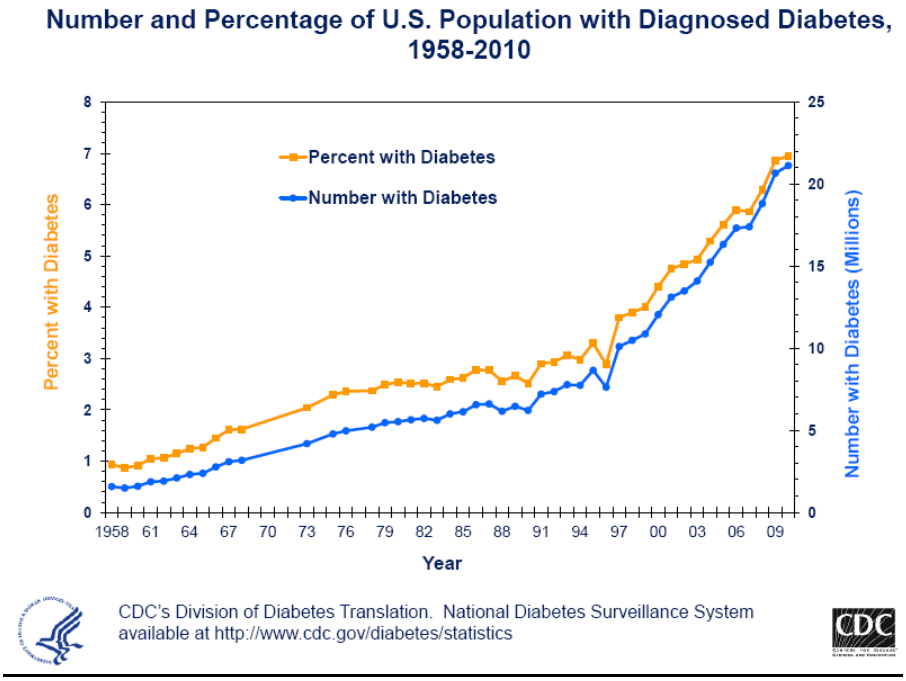


Figure 1. Number and Percentage of U.S. Population with Diagnosed Diabetes, 1958-2010

According to the National Diabetes Education Program, in 2010, 13.0 million men had diabetes (11.8 percent of all men ages 20 years and older) and 12.6 million women had diabetes (10.8 percent of all women ages 20 years and older). As obesity rates in American children continue to increase, Type II diabetes, a disease that used to be seen primarily in adults over 45, is becoming more common in young people. In the United States, compared to non-Hispanic whites, Asian Americans have an 18 percent higher risk of diagnosed diabetes, Hispanics/Latinos have a 66 percent higher risk, and non-Hispanic blacks have a 77 percent higher risk (NDEP, 2011).

The growth of diabetes has been exponential over the past decade, as is the cost of treatment and time lost. The National Diabetes Education Program estimates that the total health care and related costs for the treatment of diabetes run about $174 billion annually in the United States. Of this total, $116 billion is spent on hospitalizations, medical care, and treatment supplies, while $58 billion covers indirect costs like disability payments, time lost from work, and premature death (NDEP, accessed 2013).

State Snapshot

Maryland ranks 22nd in the country for diabetes based on data from 1990-2012 (America's Health Rankings, United Health Foundation, 2013). Across the state of Maryland, the number of people ever medically diagnosed with diabetes has grown from 6.8 percent in 1999 to 9.5 percent in 2012, which continues to be above the national level.4 In 2008, the average prevalence of diagnosed diabetes among white Marylanders was 7.5 percent and 12.3 percent among black Marylanders (MD DHMH). Black females had almost double the diabetes rates of white females at 12.5 percent and 6.8 percent, respectively (MD DHMH, 2008).

In 2011, 1,272 Maryland residents lost their lives to diabetes.5 From 2004 to 2008, black adults of all ages had significantly higher rates of diagnosed diabetes compared to non-Hispanic whites (MD DHMH, Maryland Chartbook of Minority Health, 2009).

Local Snapshot

Diabetes in Wicomico County for prevalence and death rates is better the most counties in the State of Maryland and specifically compared to Worcester and Somerset Counties.

In March of 2012, The Office of Minority Health and Health Disparities (MHHD) at the Department of Health and Mental Hygiene assisted SHIP local planning groups in identifying issues of poor minority health disparities. For Worcester and Wicomico, diabetes emergency room visits are considerable higher for Blacks than the Statewide Black rates, and higher than the White rates in the same county. The White rates are also higher than the Statewide White rate. Overall, these statistics indicate there is a community wide need for diabetes education and management.

As mentioned earlier health care access section, Peninsula Regional Medical Centers conducted a Community Needs Assessment Survey. One of the questions asked was, "What do you think are the biggest health concerns affecting Delmarva?" Diabetes was the 2nd highest concern to the participants, with 15.2% was diabetes.

The incidence of adults with diabetes is at a higher level for Somerset and Worcester Counties, with most of them in the 65+ age group.

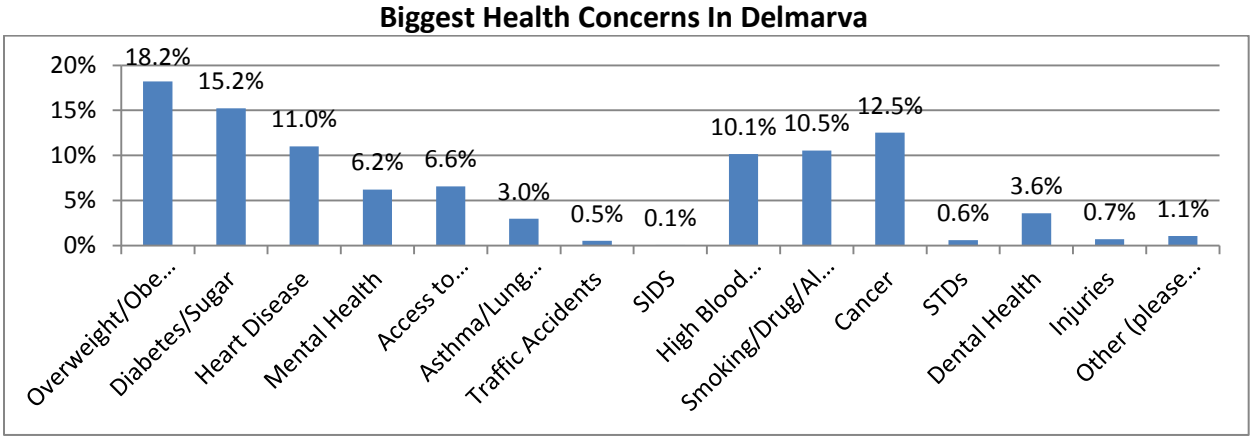


Figure 2. PRMC Community Needs Assessment Survey

Key Snapshot

- One of the questions in the PRMC survey was "What do you think are the biggest health concerns affecting Delmarva?" Diabetes was the 2nd highest concern to the participants, with 15.2%.

- For Worcester and Wicomico, diabetes emergency room visits are considerable higher for Blacks than the Statewide Black rates, and higher than the White rates in the same county.
- Maryland, the number of people diagnosed with diabetes has grown from 6.8 percent in 1999 to 9.5 percent in 2012, which continues to be above the national level.

v. OBESITY

Impact

Obesity is defined as having a Body Mass Index (BMI) that is greater than or equal to 30, while being overweight is defined as having a BMI of 25 – 29.9. Obesity has been linked to a number of diseases including diabetes, colorectal cancer, kidney cancer, breast cancer, and many types of cardiovascular disease (Cancer.gov, 2012). Childhood obesity is also on the rise due to the amount of sugary drinks and high energy foods that have become so easily available (CDC, 2013).

National Snapshot

The Centers for Disease Control and Prevention states that, sixty-eight percent of all Americans are overweight and approximately 147 billion dollars are spent on obesity-related diseases every year. The World Health Organization in 2009 stated that obese youth are at risk for factors associated with cardiovascular disease (e.g., high cholesterol or high blood pressure), bone and joint problems, sleep apnea, and poor self-esteem. Obese youth are at an increased risk of becoming obese adults and, therefore, are at risk for the associated adult health problems, such as heart disease, type 2 diabetes, stroke, cancer, and osteoarthritis.

State Snapshot

According to the Maryland Behavioral Risk Factor Surveillance System (BRFSS, 2010), nearly 2.7 million, or about 66.1 percent of Maryland adults, were classified as overweight or obese. Men were more likely to be classified as overweight or obese (73.4 percent) than women (59.1 percent), and black residents were more likely to be overweight or obese (74.0 percent) than white residents (62.9 percent); these differences are statistically significant. Adults with no college education and with a household income of less than $75,000 were significantly more likely to be overweight or obese.

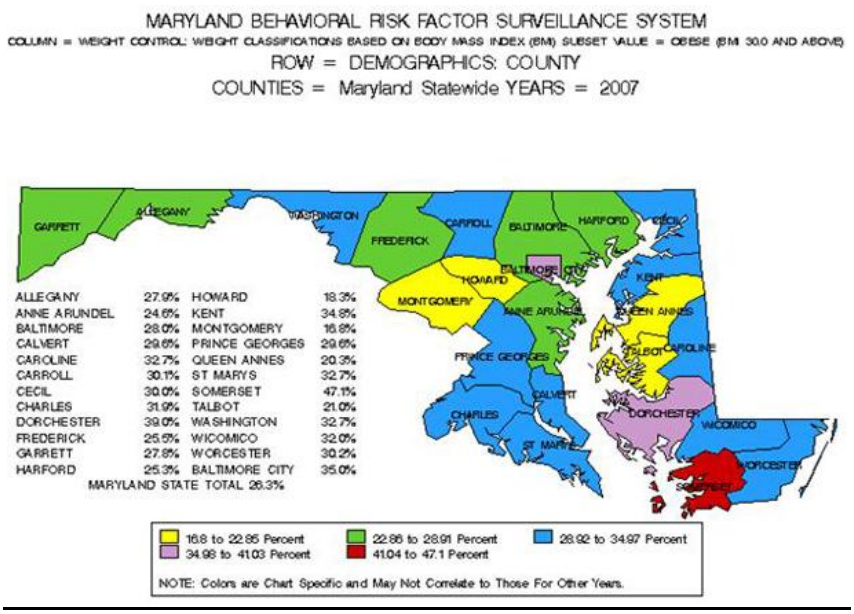


Figure 1. Distribution of Body Mass Index (Obese=30.0% and above) in Maryland (MD BRFSS, 2007)

State Snapshot

According to the Maryland State Department of Education's Maryland Youth Risk Behavior Survey (YRBS, 2009), the percentage of Maryland youth who are overweight or obese has not changed significantly between 2005 and 2009. One in 4 Maryland youth is overweight or obese. Although there are significantly more overweight or obese males than females, significantly more females describe themselves as overweight and are trying to lose weight.

Fruit, vegetable, and milk consumption among Maryland youth has remained steady between 2005 and 2009. There is little variation between males and females in fruit and vegetable consumption; however, significantly more males than females drink milk.

Local Snapshot

The Community Dashboard data showed that obesity or overweight for adults in Worcester County is better than most Maryland counties, for low-income preschool children it is higher than most counties in United States counties. Both Somerset and Wicomico counties have higher obesity or overweight adults than most counties in the State of Maryland. Low-income preschoolers in Wicomico County were moderately more obese than other counties in the United States, and Somerset County preschoolers were more obese than other counties across the United States. (http://ers.usda.gov/data-products/food-environment-atlas/data-access-and-documentation-downloads.aspx)

Key Snapshot

- Both Somerset and Wicomico counties have higher obesity or overweight adults than most counties in the State of Maryland.

- Low-income preschoolers in Wicomico County were moderately more obese than other counties in the United States, and Somerset County preschoolers were more obese than other counties across the United States
- Approximately 66 percent of Maryland adults are overweight or obese, with men more likely to be overweight or obese than women, and black residents more likely to be overweight or obese than white residents.

b) Population-Based Health

i. Minorities

Impact

The United States has become increasingly diverse in the last century. According to the 2010 US Census, approximately 36 percent of the population belongs to a racial or ethnic minority group. Though health indicators such as life expectancy and infant mortality have improved for most Americans, some minorities experience a disproportionate burden of preventable disease, death, and disability compared with non-minorities. http://www.cdc.gov/minorityhealth/

Local Snapshot

	Wicomico		Worcester		Somerset	
Indicator	Black, non-Hispanic	White, non-Hispanic	Black, non-Hispanic	White, non-Hispanic	Black, non-Hispanic	White, non-Hispanic
Adults Unable to Afford to See a Doctor by	35.3%	6.9%	*	*	*	*
Adults who have had a Routine Checkup by	77.8%	86.8%	*	*	*	*
Adults with Health Insurance	79.8%	89.5%	*	*	*	*
Children with Health Insurance	85.5%	97%	*	*	*	*
Age-Adjusted Death Rate due to Colorectal Cancer per 100,000 population	32.9	25.2	*	*	*	*
Age-Adjusted Death Rate due to Lung Cancer per 100,000 population	59.5	76.2	62	60.2	*	*
Age-Adjusted Death Rate due to Prostate Cancer per 100,000 population	58.1	25.4	*	*	*	*
Breast Cancer Incidence cases/100,000 female	112.2	128.4	118.5	132.4	115.2	97.8
Persons with a Disability	16.1%	14.3%	*	*	*	*
Adult Fruit and Vegetable Consumption	24.5%	24.1%	*	*	*	*
High Blood Pressure Prevalence	46.7%	38.1%	*	*	*	*
Mothers who Received Early Prenatal Care	62.6%	78.6%	58.4%	83.5%	79.5%	80%
Preterm Births	14.7%	9.4%	15.8%	9.1%	13.4%	7.1%
Adults who Smoke	41.9%	14.3%	*	*	*	*
Self-Reported General Health	84.1%	81.1%	*	*	*	*

Assessment: Good or Better						
Self-Reported Good Physical Health	84.3%	64.2%	*	*	*	*

Figure 1. PRMC Community Dashboard * Information not available

After reviewing the health indicators in figures 1 & 2, the data shows a difference in most areas between the Black, non-Hispanic and the White, non-Hispanic populations. These differences show not only health disparities, but income and education disparities too.

	Wicomico		Worcester		Somerset	
Indicator	Black, non-Hispanic	White, non-Hispanic	Black, non-Hispanic	White, non-Hispanic	Black, non-Hispanic	White, non-Hispanic
Median Household Income	$38,068	$57,708	$28,326	$63,129	$29,835	448,547
Children Living Below Poverty Level	31%	10.4%	39.%	9.7%	47.6%	15.2%
Families Living Below Poverty Level	18%	5.4%	21.6%	4.4%	25.5%	9.2%
People 65+ Living Below Poverty Level	18.4%	7.5%	28.5%	4.7%	10.6%	9.2%
People Living Below Poverty Level	23.2%	11.8%	24.5%	7.6%	35%	12%
High School Graduation	73%	86.9%	89.9%	77.8%	87.7%	8.75
People 25+ with a High School Degree or Higher	80.8%	88.2%	74.3%	91.1%	79%	83.6%
People 25+ with a Bachelor's Degree or Higher	15.3%	28.2%	10.1%	29.9%	11%	15.7%

Figure 2. PRMC Community Dashboard * Information not available

Key Snapshots

- For health indicators, income and education there are significant disparities between the Black, non-Hispanic and the White non-Hispanic.

ii. Seniors

Impact

During an individual's lifespan, many body functions naturally begin to decline. The changes are results of a combination of factors, including genes, lifestyle and disease. (Area Agency on Aging. *What is Normal Aging?* Accessed 2013. http://www.agingcarefl.org/aging/normalAging)

Normal aging brings about the following changes:

- **Eyesight** - loss of peripheral vision and decreased ability to judge depth. Decreased clarity of colors (for example, pastels and blues).
- **Hearing** - loss of hearing acuity, especially sounds at the higher end of the spectrum. Also, decreased ability to distinguish sounds when there is background noise.
- **Taste** - decreased taste buds and saliva.
- **Touch and Smell** - decreased sensitivity to touch and ability to smell.
- **Arteries** - stiffen with age. Additionally, fatty deposits build up in one's blood vessels over time, eventually causing arteriosclerosis (hardening of the arteries).

• **Bladder** - increased frequency in urination.
• **Body Fat** - increases until middle age, stabilizes until later in life, then decreases. Distribution of fat shifts - moving from just beneath the skin to surround deeper organs.
• **Bones** - somewhere around age 35, bones lose minerals faster than they are replaced.
• **Brain** - loses some of the structures that connect nerve cells, and the function of the cells themselves is diminished.
• **Heart** - is a muscle that thickens with age. Maximum pumping rate and the body's ability to extract oxygen from the blood both diminish with age.
• **Kidneys** - shrink and become less efficient.
• **Lungs** - somewhere around age 20, lung tissue begins to lose its elasticity, and rib cage muscles shrink progressively. Maximum breathing capacity diminishes with each decade of life.
• **Metabolism** - medicines and alcohol are not processed as quickly. Prescription medication requires adjustment. Reflexes are also slowed while driving, therefore an individual might want to lengthen the distance between oneself and the car in front and drive more cautiously.
• **Muscles** - muscle mass declines, especially with lack of exercise.
• **Skin** - nails grow more slowly. Skin is more dry and wrinkled. It also heals more slowly.
• **Sexual Health** - women go through menopause, vaginal lubrication decreases and sexual tissues atrophy. In men, sperm production decreases and the prostate enlarges. Hormone levels decrease.

National Snapshot

Demographics: The older U.S. population (age 65+) numbered 40.4 million in 2010, an increase of 5.4 million or 15.3 percent since 2000. They represented 13.1 percent of the U.S. population, which equates to over one in every eight Americans (see Figure 1).

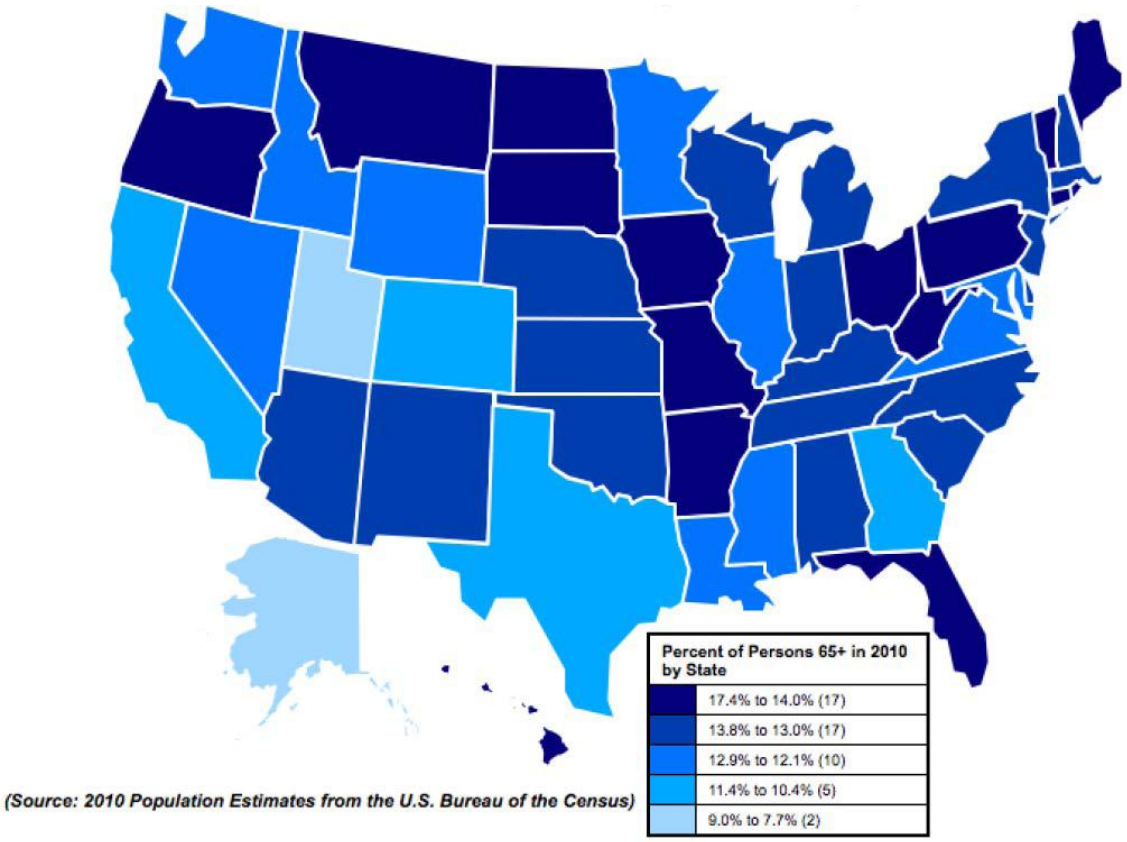


Figure 1. Persons Age 65+ as a Percentage of Total Population, United States, 2010

By 2030, it is estimated that there will be about 72.1 million seniors (19 percent of the total population), which is more than twice their number in 2000 (DHHS, administration on Aging, Profile 2011).

According to the U.S. DHHS Administration on Aging's report, *A Profile of Older Americans: 2011*, the number of Americans aged 45-64 who will reach 65 over the next two decades increased by 31 percent during this decade.

Minority populations have increased from 5.7 million in 2000 (16.3 percent of the elderly population) to 8.1 million in 2010 (20 percent of the elderly) and are projected to increase to 13.1 million in 2020 (24 percent of the elderly). In 2010, 20 percent of persons age 65+ in the United States were minorities: 8.4 percent were African American, 6.9 percent were persons of Hispanic origin (any race), about 3.5 percent were Asian or Pacific Islander, and less than 1 percent were American Indian or Native Alaskan. In addition, 0.8 percent of persons age 65+ identified themselves as being of two or more races (DHHS, Administration on Aging, Profile 2011).

Persons reaching age 65 have an average life expectancy of an additional 18.8 years (20.0 years for females and 17.3 years for males). Older women outnumber older men in the U.S. at 23.0 million older women to 17.5 million older men. Older men were much more likely to be married

(72 percent) than older women (42 percent), and 40 percent of older women were widows in 2010 (see Figure 2).

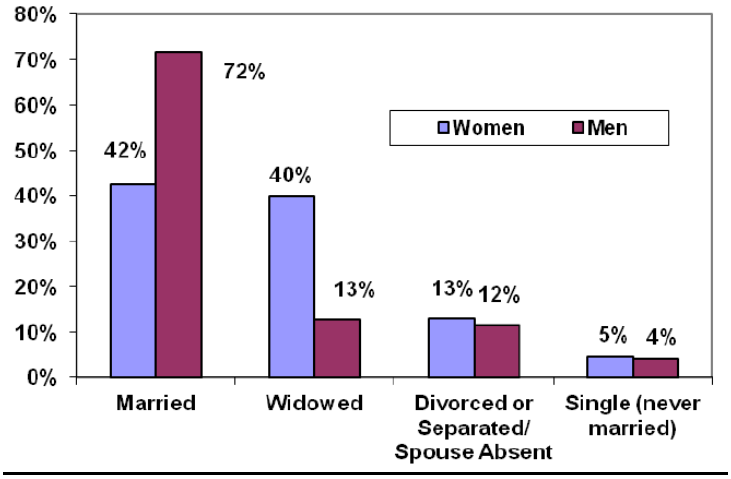


Figure 2. Marital Status of Persons Age 65+, United States, 2010 (Source: DHHS, Administration on Aging, 2011)

Over half (55.1 percent) of older non-institutionalized persons lived with their spouse in 2010, but the proportion living with their spouse decreased with age, especially for women. About 29 percent (11.3 million) of non-institutionalized older persons live alone (8.1 million women, 3.2 million men). Almost half of older women (47 percent) age 75+ live alone. Additionally, about 485,000 grandparents aged 65+ had the primary responsibility for their grandchildren who lived with them.

Living Arrangements of Persons 65+, 2010

Income & Poverty: The median income of older persons in 2010 was $18,819: $25,704 for males and $15,072 for females. Households containing families headed by persons 65+ reported a median income in 2010 of $45,763. The major sources of income as reported by seniors in 2009 were Social Security (reported by 87 percent of seniors), income from assets (reported by 53 percent), private pensions (reported by 28 percent), government employee pensions (reported by 14 percent), and earnings (reported by 26 percent). Social Security constituted 90 percent or more of the income received by 35 percent of beneficiaries in 2009 (22 percent of married couples and 43 percent of non-married beneficiaries).

Almost 3.5 million elderly persons (9.0 percent) were below the poverty level in 2010. During 2011, the U.S. Census Bureau also released a new Supplemental Poverty Measure (SPM) which takes into account regional variations in the livings costs, non-cash benefits received, and non-discretionary expenditures but does not replace the official poverty measure. The SPM shows a poverty level for older persons of 15.9 percent (DHHS, Administration on Aging, Profile 2011).

Health: Elderly people are healthier today than they were 30 years ago. From 2000-2009, 40 percent of non-institutionalized seniors assessed their health as excellent or very good (compared to 64.7 percent of persons aged 18-64 years). There were differences among racial/ethnic groups on this measure, with older African Americans (26.0 percent), older American Indians/Alaska Natives (24.3 percent) and older Hispanics (28.2 percent) less likely to rate their health as excellent or very good than were older whites (42.8 percent) or older Asians (35.3 percent). Most seniors have at least one chronic condition and many have multiple conditions. In 2007-2009, the most frequently occurring conditions among seniors were: uncontrolled hypertension (34 percent), diagnosed arthritis (50 percent), and all types of heart disease (32 percent), any cancer (23 percent), diabetes (19 percent), and sinusitis (14 percent) (DHHS, Administration on Aging, Profile 2011).

Almost 63 percent of U.S. seniors reported in 2010 that they received an influenza vaccination during the past 12 months and 59 percent reported that they had ever received a pneumococcal vaccination. About 27.7 percent (of persons 60+) reported height/weight combinations that categorize them as obese. Almost 35 percent of persons aged 65-74 and 24 percent of persons 75+ reported that they engage in regular leisure-time physical activity. Only 9.5 percent reported that they are current smokers and only 5 percent reported excessive alcohol consumption. Furthermore, only 2 percent reported that they had experienced psychological distress during the past 30 days (DHHS, Administration on Aging, Profile 2011).

Mental Health: It can be difficult for health care workers, families and seniors themselves to distinguish between problems related to aging and those linked to mental illness. Depression is considered the most common mental disorder of people aged 65 and older. The symptoms of depression often appear in people who have other conditions, or can mimic the symptoms of dementia; its victims withdraw, cannot concentrate, and appear confused. Some experts estimate that as many as 10 percent of those diagnosed with dementia actually suffer from depression that, if treated, is reversible. Dementia (characterized by confusion, memory loss, and disorientation) is not an inevitable part of growing old. In fact, only about 10 percent of Americans aged 65 and older suffer from this condition. Of that number, an estimated 60 percent suffer from Alzheimer's disease, a type of dementia for which no cause or cure has been found. Alzheimer's disease, which causes some of the brain's cells to die, involves a part of the brain that controls memory. As it spreads to other parts of the brain, the illness affects a greater number of intellectual, emotional, and behavioral abilities. An adult's chances of developing the illness are one in 100, but the incidence increases with age. One million people older than 65 are severely afflicted with Alzheimer's disease and another two million are in the moderate stages of the disease. Seniors take many more medications than other age groups. Coupled with a slower metabolism, these substances can stay in the body longer and quickly reach toxic levels. Moreover, because many older people take more than one medication and may drink alcoholic beverages, there is a high risk that drugs will interact, causing confusion, mood changes, and other symptoms of dementia.

Health Care: In 2007, the rate of discharge from short stay hospitals by seniors (3,395 per 10,000 persons aged 65+) was about three times the comparable rate for persons of all ages (1,149 per 10,000 persons). The average length of stay for persons aged 65+ was 5.6 days compared to 4.8 days for persons of all ages. Seniors also averaged more office visits with doctors in 2007 (7.1 visits for those 65+ versus 3.7 visits for persons 45-65). In 2010, older consumers averaged out-of-pocket health care expenditures of $4,843, an increase of 49 percent since 2000. In contrast, the total population spent considerably less, averaging $3,157 in out-of-pocket costs. Older Americans spent 13.2 percent of their total expenditures on health, which is more than twice the proportion spent by all consumers (6.6 percent) (NCHS and Bureau of Labor Statistics, accessed via DHHS, Administration on Aging, Profile 2011)

Health Insurance Coverage: In 2010, almost all (93.1 percent) of non-institutionalized persons age 65+ were covered by Medicare. Medicare covers mostly acute care services and requires beneficiaries to pay part of the cost, leaving about half of health spending to be covered by other sources. About 86 percent of non-institutionalized Medicare beneficiaries in 2009 had some type of supplementary coverage (see Figure 3).

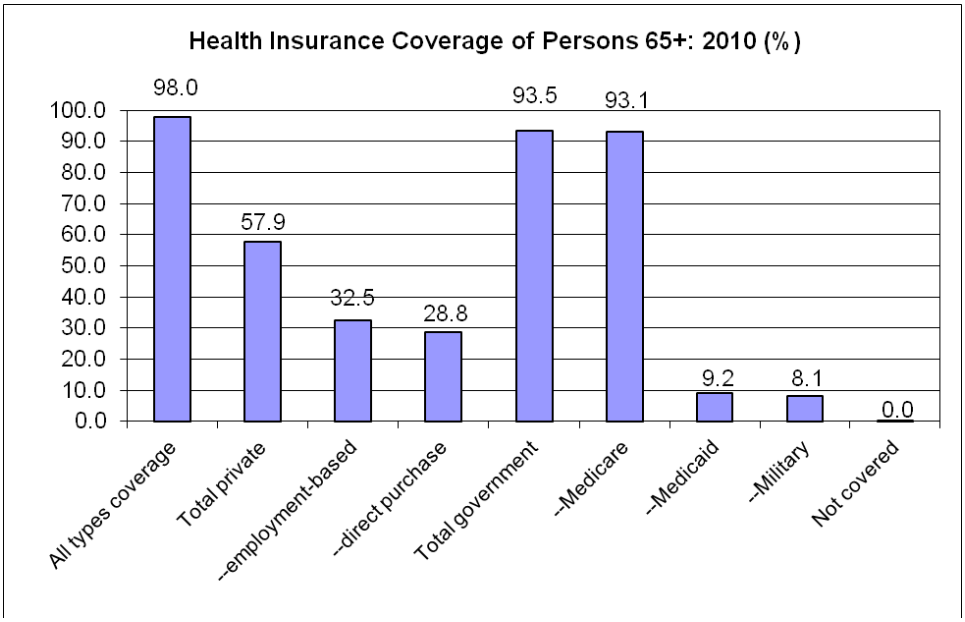


Figure 3. Health Insurance Coverage of Persons Age 65+, United States, 2010 (Source: DHHS, Administration on Aging, 2011. Note: Data is for the non-institutionalized elderly. A person can be represented in more than one category)

Disability/Activity Limitations: Some type of disability (i.e., difficulty in hearing, vision, cognition, ambulation, self-care, or independent living) was reported by 37 percent of seniors in 2010. Some of these disabilities may be relatively minor but others cause people to require assistance to meet important personal needs. Reported disability increases with age: 56 percent of persons over 80 reported a severe disability and 29 percent of the age 80+ population reported that they needed assistance. Presence of a severe disability is also associated with lower income levels and educational attainment (DHHS, Administration on Aging, Profile 2011).

In a study that focused on the ability to perform specific activities of daily living (ADLs), over 27 percent of community-resident Medicare beneficiaries over age 65 in 2009 had difficulty in performing one or more ADLs, and an additional 12.7 percent reported difficulties with instrumental activities of daily living (IADLs).

By contrast, 95 percent of institutionalized Medicare beneficiaries had difficulties with one or more ADLs and 74 percent of them had difficulty with three or more ADLs. Although nursing homes are being increasingly used for short-stay post-acute care, about 1.3 million elderly are in nursing homes (about half are age 85 and over). These individuals often have high needs for care with their ADLs and/or have severe cognitive impairment due to Alzheimer's disease or other dementias.

Almost all community resident seniors with chronic disabilities (over 90 percent) receive either informal care (from family or friends) or formal care (from service provider agencies) (National Long Term Care Survey, 1999).

State Snapshot

The number of older Marylanders is increasing, according to the Maryland Department of Aging. Of the 5.3 million people in Maryland in 2010, 15 percent (801,036) were over the age of 60. The percentage is expected to increase to 25 percent of Maryland's projected population of 6.7 million by the year 2030. Additionally, the number of older seniors over the age of 85 continues to grow rapidly. This cohort is projected to grow in number, statewide, from 98,126 in 2010 to 164,695 by the year 2030.3 Marylanders aged 60 and over, with functional disabilities related to mobility or personal care, which are living in the community, accounted for 237,004, over 19 percent of the total number of elderly Marylanders, in 2000. In 2000, 63,978 older Marylanders lived in poverty as defined by the federal poverty guidelines. Of Maryland's age 60+ minority populations in 2000, 15.7 percent lived in Montgomery County and 24.4 percent lived in Prince George's County (MD Department of Aging).

According to the American Association of Retired Persons (AARP), most seniors prefer to receive long-term care at home; however, Maryland spends almost 90 percent of the state's Medicaid funds on institutional care. In addition to the 11 percent that Maryland Medicaid spends on in-home care, 600,000 Marylanders are providing family care-giving to a loved one at home, which is valued at $6.6 billion. In 2007, Maryland's nursing homes had an occupancy rate of 87 percent. This care is expensive; the average nursing home private pay rate was $221 per day in 2008, which was the 13th highest rate in the nation. Maryland's average private pay rate for home health aides ($19 per hour) was right at the national average; its rate for Medicare-certified aides ($29 per hour) was lower than the national average; and its rates for adult day care ($69 per day) were higher than the national average in 2008 (AARP).
One in seven Maryland residents, and 86 percent of Maryland residents age 65 or older, received social security in 2010. Social Security makes up 50 percent or more of the income for half of Marylanders age 65+ and a quarter of Maryland seniors rely on Social Security as their only source of income.

Local Snapshot

PRMC socio-economic demographic information indicates the number of elderly (those aged 65+) represent a greater portion of the total population in both the primary and secondary areas and will continue to grow over the next five years in each of the six counties between 11 and 18 percent. The elderly have additional chronic conditions, consume healthcare resources at higher rates, and generally require more time and attention than other population segments. Self-reported general health and physical health is reported lower for adults over age 65 than those younger than 65.

Seniors 65+ Indicators vs. Other Age Groups						
	Worcester County		Wicomico County		Somerset County	
Indicator	Under 65 Rate %	65+ Rate %	Under 65 Rate %	65+ Rate %	Under 65 Rate %	65+ Rate %
Ability to afford to see a doctor	9.6	3.2	20.2	4.2	*	*
Having a routine check-up	89.4	96.9	80.5	95.2	*	*
Adults with Health Insurance	*	*	83.3	89.4	*	*
Adults with diabetes	9.8	30.2	6.3	26	*	*
Fruit & vegetable consumption	34.3	32.8	23.5	22.6	*	*
Engaging in moderate physical activity	19.8	23.9	39.8	27.6	*	*
Engaging in regular physical activity	48.3	52.4	52.6	36.6	*	*
Adults who are obese	36	36.1	46.6	31.3	*	*
Adults who are overweight or obese	68.1	71.9	72.1	73.6	*	*
High Blood Pres.	49.5	69.3	34.9	77.9	*	*
High Cholesterol	60.4	54.6	49.4	58.2	*	*
Mental Health Social & Emotional support	74.7	80.6	82.2	86.9	*	*
Self-reported good mental health	75.5	83.8	79.2	77.3	*	*
Adults with asthma	11.3	11.2	11.2	6.6	*	*
Adults who binge drink	15.9	4.6	17.4	3.9	*	*
Adults who smoke	22.2	10.1	13.9	3.8	*	*
Self-Reported General Health Assessments: Good or Better	79.6	75.7	82.4	69.4	*	*
Self-Reported Good Physical Health	80.8	68.7	70.2	67.2	*	*
Renters spending 30% or more of household income	42.9	57.6	57.4	64.2	61.6	41
Living below poverty level		6.8		9.1		9.3
High School Degree	92.3	80.7	87.9	72.8	84.2	72.6

Figure 4. *Data not available by age. Information provided by PRMC, Community Dashboard http://www.peninsula.org/body.cfm?id=627&oTopId=627

Key Snapshots

- seniors over the age 65 have better access to health care, having a routine check-up and having health insurance compared to those younger than individuals younger than 65
- blood pressure is higher, but high cholesterol prevalence is lower for the 65+ age group
- adults over age 65 have a higher incidence of diabetes than those younger than them
- 65+ individuals binge drink and smoke less than their younger counterparts
- The percent of Maryland residents over the age of 60 is expected to increase from 15 percent of the population in 2010 to 25 percent by 2030.

iii. Women and Children

Impact

The relationship between certain maternal behaviors and adverse pregnancy outcomes is well known; chief among these behaviors is the receipt of early and appropriate prenatal care. Ideally, prenatal care should begin in the first trimester of pregnancy, or, preferably, prior to conception.

This is especially important for minority women, as they experience higher rates of infant mortality and are also more likely to deliver low birth weight babies. Babies born prematurely are at a higher risk of death because they are likely to be underdeveloped and more susceptible to life-threatening infections, respiratory distress syndrome, cerebral palsy, and learning and developmental disabilities (NICHHD, 2012).

According to the Centers for Disease Control and Prevention, low birth weight is the single most important factor correlating with infant morbidity (CDC, Pediatric and Pregnancy Nutrition Surveillance System, 2009). Babies born weighing less than 2,500 grams (5.5 lbs.) who survive are at a higher risk for serious health problems than those infants who are born at healthy weights.

Infant mortality is defined as the rate at which babies die before 12 months of age, and is one of the most serious public health issues in the United States. It serves as an excellent indicator of the effectiveness of a country's health care system, as it is directly related to the quality and availability of health care and maternal health (Infant Mortality, CDC, 1997). One of the specific objectives of Healthy People 2020 is to decrease the number of infant deaths to fewer than 6.0 per 1,000 live births among all racial and ethnic groups (Healthy People, 2010).

National Data

Receipt of Prenatal Care: In the United States (2007), 70.8 percent of women who gave birth received prenatal care within the first three months of their pregnancies, while 7.1 percent either did not receive care until the last three months of their pregnancies or did not receive prenatal care at all (National Vital Statistics Reports, 2010).

Low Birth Weight: Nationally, 8.2 percent of all babies were born with a low birth weight and 12.2 percent were born preterm in 2009 (National Vital Statistics Reports, 2011). Infant Mortality: Despite advanced medical knowledge and technology, infant mortality continues to persist as a problem for minority populations in the United States. This is a particular concern for blacks across the country, as well as in Maryland, as the infant mortality rate in this group is significantly higher than for any other racial or ethnic group. Nationally, the infant mortality rate among black infants is 13.3 deaths per 1,000 live births, which is more than double the rate among whites at 5.6 deaths per 1,000 live births (U.S. Census Bureau, Current Population Survey, 2011).

State Data

Birth Rates: In 2009, there were 77,974 live births in Maryland, up from 74,880 in 2005 (MD Vital Statistics Administration, Annual Report, 2009).

Teenage mothers are at greater risk for having preterm and low birth weight babies, and are also therefore at greater risk of babies with infant mortality (Department of Health & Human Services, Preventing Infant Mortality, 2006). In 2009, the birth rate among girls of all races between the ages of 15 and 19 in Maryland was 31.2 per 1,000 females. The adolescent Hispanic birth rate, however, was just over double that figure, at 66.4 (MD VSA, Annual Report, 2009).

Receipt of Prenatal Care: In Maryland, 6.3 percent of pregnant women of all races received late or no prenatal care in 2010 (MD Vital Statistics, Annual Report, 2010). Over the last 10 years, the percent of pregnant women receiving late or no prenatal care has increased across the board in Maryland, indicating that rates of appropriate prenatal care are declining.

Low Birth Weight: Compared to the nation, Maryland had a higher percentage of low birth weight babies at 8.8 percent in 2010 (MD Vital Statistics, Annual Report, 2010). The percent of babies born with low birth weight increased very slightly among all racial groups in Maryland between 2000 and 2009, potentially due to the fact that rates of early prenatal care are decreasing (see Figure 2). Black mothers delivered low birth weight babies almost twice as often as white mothers in 2009.

Infant Mortality: In 2010, Maryland had an overall infant mortality rate of 6.7 deaths per 1000 live births for all races, and the infant mortality rate among blacks is significantly higher than for any other racial/ethnic group. The leading cause of infant mortality is low birth weight and preterm births, followed by congenital anomalies, Sudden Infant Death Syndrome and maternal complications (MD Department of Health & Mental Hygiene, 2011). Despite the fact that more women are going without prenatal care, the infant mortality rate in Maryland overall and for white mothers decreased slightly from 2000 – 2009.

Breastfeeding: Breastfeeding is advantageous to both the mother and baby, and is also addressed in Healthy People 2020. For babies, breastfeeding has many benefits including being extremely nutritious and boosting their immune systems. Breastfed babies may be at a lower risk for Sudden Infant Death Syndrome, Type 1 diabetes, childhood leukemia, and atopic dermatitis. Mothers can also benefit from breastfeeding by lowering the risk of developing Type 2 Diabetes, postpartum depression, ovarian cancer, and breast cancer (Breastfeeding, Office on Women's Health, 2011). In 2007, 73 percent of mothers in Maryland had ever breastfed, compared to 75 percent of mothers in the United States. The World Health Organization recommends that women exclusively breastfeed for the first six months after birth, but only 45.5 percent of mothers in Maryland were breastfeeding after six months (National Immunization Survey, 2007).

Local Snapshot

Prenatal Care

Babies born to mothers who do not receive prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who do get care. Increasing the number of women who receive prenatal care, and who do so early in their pregnancies, can improve birth outcomes and lower health care costs by reducing the likelihood of complications during pregnancy and childbirth. Figure 1 shows that 79.5% women in Somerset County received prenatal care in the first trimester, 72.7% in Wicomico County and 77.8% in Worcester County.

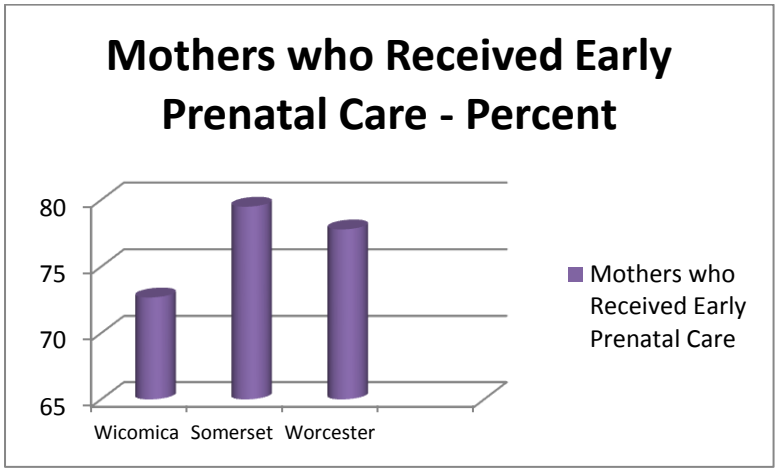


Figure 1. Mothers who Received Early Prenatal Care; PRMC Community Dashboard

Low Birth Weight Babies

Babies born with a low birth weight are more likely than babies of normal weight to require specialized medical care, and often must stay in the intensive care unit. Low birth weight is often associated with premature birth. While there have been many medical advances enabling premature infants to survive, there is still risk of infant death or long-term disability. The most important things an expectant mother can do to prevent prematurity and low birth weight are to take prenatal vitamins, stop smoking, stop drinking alcohol and using drugs, and most importantly, get prenatal care. The Healthy People 2020 national health target is to reduce the proportion of infants born with low birth weight to 7.8%.

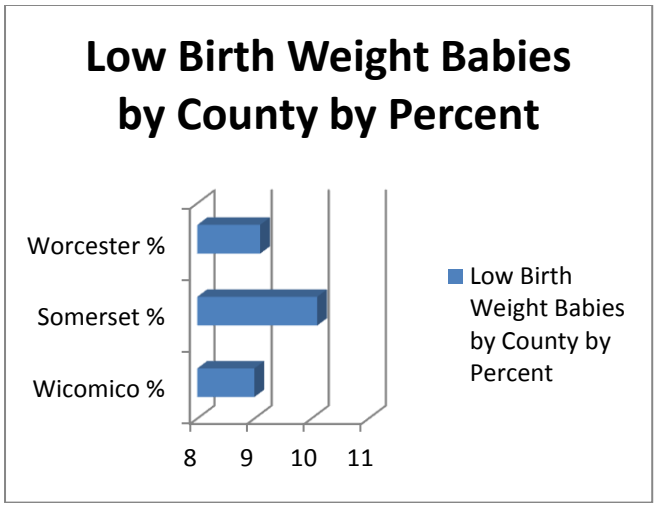


Figure 2. Low Birth Weight Babies; PRMC Community Dashboard

In figure 2 Somerset County has 10.1% of its babies that are born are considered low birth weight. Wicomico and Worcester are at 9 and 9.1%. All three of the counties are above the states percentage of 8.8%. The data from Maryland Department of Mental Hygiene also shows that there is a higher percentage of Black, non-Hispanic babies born with low birth weight in Worcester and Wicomico counties. Data was not available for Somerset County.

Infant Mortality Rate

Infant mortality rate continues to be one of the most widely used indicators of the overall health status of a community. The leading causes of death among infants are birth defects, pre-term delivery, low birth weight, Sudden Infant Death Syndrome (SIDS), and maternal complications during pregnancy. (See figure 3)

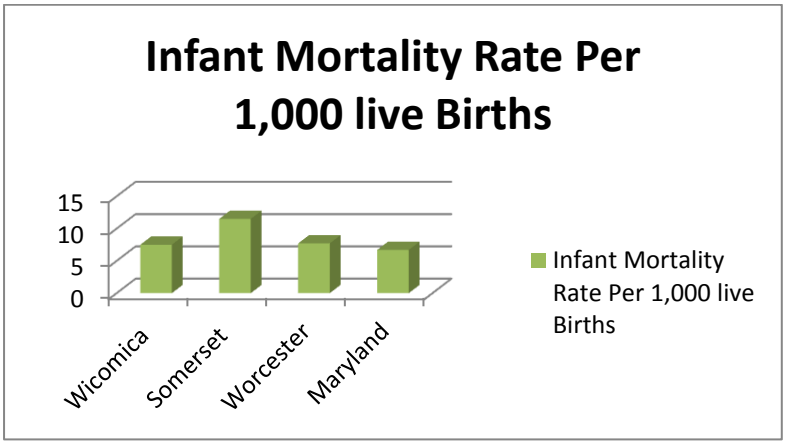


Figure 3. Infant Mortality Rate; PRMC Community Dashboard

Healthy People 2020 target is to reduce the infant mortality rate to 6 deaths per 1,000 live births and the State of Maryland average is 6.7 deaths per 1,000 lives. All three counties are above this target with Somerset at 11.5, Wicomico at 7.5 and Worcester is 7.7.

Preterm Births

Babies born premature are likely to require specialized medical care, and oftentimes must stay in intensive care nurseries. While there have been many medical advances enabling premature infants to survive, there is still risk of infant death or long-term disability. The Healthy People 2020 national health target is to reduce the proportion of infants who are born preterm to 11.4%. Figure 4 below shows that all three counties are below the target.

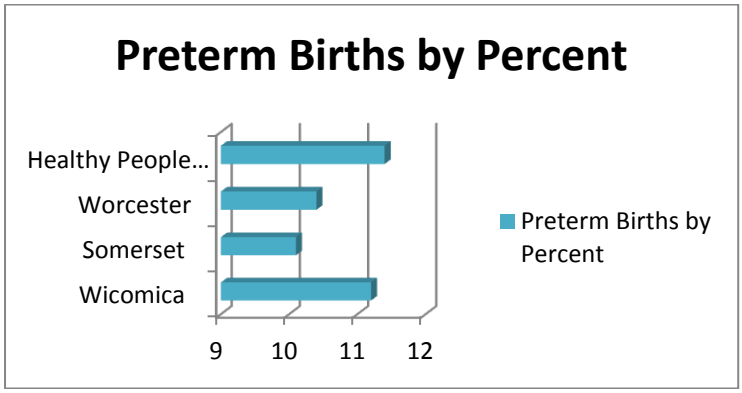


Figure 4. Preterm Births; PRMC Community Dashboard

Key Snapshot

- Prenatal care, 79.5% women in Somerset County received prenatal care in the first trimester, 72.7% in Wicomico County and 77.8% in Worcester County.
- Low birth weight babies - 10.1% of its babies that are born are considered low birth weight. Wicomico and Worcester are at 9 and 9.1%. All three of the counties are above the states percentage of 8.8%.
- Infant Mortality Rate- the State of Maryland average is 6.7 deaths per 1,000 lives. All three counties are above this target with Somerset at 11.5, Wicomico at 7.5 and Worcester is 7.7
- Across Maryland, rates of prenatal care are going down and rates of low birth weight are going up, but infant mortality continues to decrease as medical advances make it possible to save more at-risk babies.

iv. Mental Health

Impact

Mental health is essential to a person's well-being, healthy family and interpersonal relationships, and the ability to live a full and productive life. People, including children and adolescents, with untreated mental health disorders are at high risk for many unhealthy and unsafe behaviors, including alcohol or drug abuse, violent or self-destructive behavior, and suicide—the 11th leading cause of death in the United States for all age groups and the second leading cause of death among people age 25 to 34.

Mental health disorders also have a serious impact on physical health and are associated with the prevalence, progression, and outcome of some of today's most pressing chronic diseases, including diabetes, heart disease, and cancer. Mental health disorders can have harmful and

long-lasting effects—including high psychosocial and economic costs—not only for people living with the disorder, but also for their families, schools, workplaces, and communities. (Healthy People 2020)

Social and emotional support refers to the subjective sensation of feeling loved and cared for by those around us. Research has shown that individuals with social and emotional support experience better health outcomes compared to individuals who lack such support. For example, when individuals are exposed to stress, emotional support has been shown to decrease stress hormones and reduce blood pressure.

National Snapshot

One in four adults, or approximately 57.7 million Americans, experiences a mental health disorder in a given year. One in 17 adults lives with a serious mental illness, such as schizophrenia, major depression or bipolar disorder, and about 1 in 10 children live with a serious mental or emotional disorder. (The National Alliance of Mental Illness. *Mental Illness: Facts and Numbers*. 2006. www.nami.org)

State Snapshot

Overview: Approximately 175,000 adults and 62,000 children out of the 5.6 million residents of Maryland live with a mental health illness (National Alliance on Mental Illness, 2010). Seven percent of Maryland residents reported use of illicit drugs in the past month, compared to approximately eight percent nationally (Maryland Drug Control Update, 2010). The drug induced death rate in Maryland exceeds the national average, with heroin being the primary reason for treatment admissions. (Maryland Drug Control Update. 2010.)

Local Snapshot

Self-perceived health status is a subjective measure of personal health. In the three Maryland counties that Peninsula Regional Medical serves the Community Dashboard looked at the Self-Reported Good Mental Health. In 2011 all three counties reported 77.6% or higher in good mental health. Adequate social and emotional support is associated with reduced risk of mental illness, physical illness and mortality. According to the PRMC Community Dashboard, residents in Somerset, Wicomico and Worcester Counties are moderate to high risk for low emotional support.

Key Snapshot

- Adequate social and emotional support is associated with reduced risk of mental illness, physical illness and mortality. According to the PRMC Community Dashboard, residents in Somerset, Wicomico and Worcester Counties are moderate to high risk for low emotional support.

c) Social Determinants of Health

The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

i. Food Access

Impact

According to PolicyLink a national research and action institute advancing economic and social equity, many low-income communities across the country, the only places to buy food are fast-food restaurants and convenience stores that sell fatty, sugary, processed products. Some communities have no food vendors of any kind. The lack of access to healthy food makes it difficult for families to eat well, fueling the country's growing obesity epidemic and the severe health problems that are associated with it.
(http://www.policylink.org/site/c.lkIXLbMNJrE/b.7634003/k.519E/Access_to_Healthy_Food.htm)

Policy Link also point to studies that find that rural communities face significant healthy food-access challenges. In one example from the Mississippi Delta, nearly three-quarters of households that qualify for food stamp benefits must travel more than 30 miles to reach a large grocery store or supermarket. Residents of underserved communities typically lack the transportation to easily make trips to stores in other parts of town.

Local Snapshot

Based upon the density of grocery stores per 1,000 population residents of Wicomico and Somerset have limited access to grocery stores that sell healthy food. Since these are rural counties we have a higher number of convenience stores which have less healthy food choices. Residents of these rural counties living outside of local cities typically use convenience stores for food purchases. (Healthy Communities (HCI) www.ers.usda.gov/FoodAtlas/)

The summer months increase the availability of fresh fruits and vegetables since these counties have a strong agricultural heritage. The Tri-County Health Weight Coalition has sponsored a Local Farmers Market Guide; the guide shares helpful websites, preparation tips, food safety tips and Farmers' Market locations in Wicomico, Worcester, and Somerset Counties. This guide is produced annually. The guide also provides information on business that will deliver local produce to your home. (http://www.wicomicohealth.org/files/0/0/Tri-County%20Healthy%20Weight%20Coalition%20Brochure.pdf)

Worcester County is a more affluent county and has a very positive grocery store density to population ration.

Key Snapshot

- Since these are rural counties we have a higher number of convenience stores which have less healthy food choices.

ii. Housing Quality

Impact

HUD believes our communities should make homes available to families that are affordable and healthy. "Healthy Homes" is a century-old concept that promotes safe, decent, and sanitary housing as a means for preventing disease and injury. There is a lot of emerging scientific

evidence linking health outcomes such as asthma, lead poisoning, and unintentional injuries to substandard housing. And, there are more than 6 million substandard housing units nationwide.
(http://portal.hud.gov/hudportal/HUD?src=/program_offices/healthy_homes/healthyhomes)

Good-quality housing is a key element for ensuring a health community. Poor housing can lead to many health problems. Cramped and crowed conditions give rise to poor hygiene for via vermin and food and water contamination within the home. Poor indoor air quality leads to respiratory problems. Stress is also high for individuals living in poor housing and poverty. (http://www.who.int/water_sanitation_health/hygiene/settings/hvchap7.pdf) Areas with more households in public assistance programs have higher poverty rates. Public assistance income includes general assistance and Temporary Assistance to Needy Families.

Researchers looked at more than 17,500 5-year-old children in about 4,700 neighborhoods across the United States. Compared to children in wealthy areas, those in middle-class areas had a 17 percent greater risk of obesity, and those in poor neighborhoods had a 28 percent greater risk, the investigators found. (http://health.usnews.com/health-news/news/articles/2012/11/16/poor-neighborhoods-home-to-more-obese-kids-study) The same study stated that obesity risk was higher among children in neighborhoods with lower levels of education, while living in neighborhoods with a high percentage of foreign-born residents was associated with a 20 percent reduced risk of obesity, the study authors found

In the American Journal of Public Health a 2002 article on housing and health describes poor housing conditions being associated with a wide range of health conditions, including respiratory infections, asthma, lead poisoning, injuries and mental health.
(http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447157/)

Local Snapshot

Homeowners are more likely to improve their homes and to be involved in civic affairs, both of which benefit the individual and the community as a whole. In Somerset County the percent of households that need assistance has dropped from 2.4% to 1.9%. While both Wicomico and Worcester increased. (See figure 1)

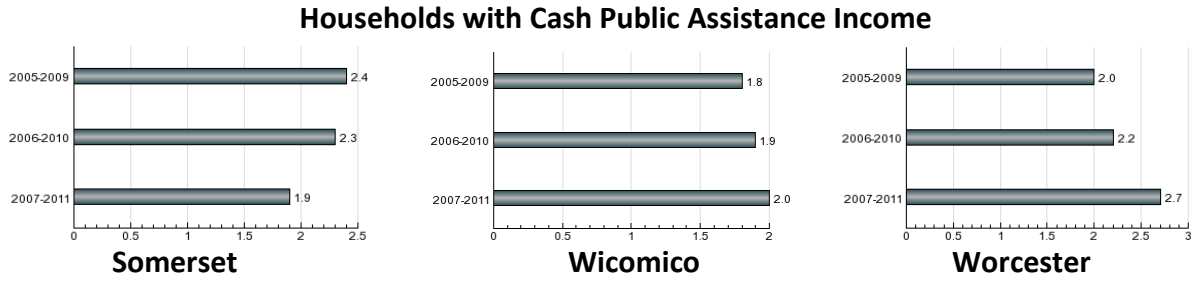


Figure 1: Community Dashboard; Source United States Census Bureau

Spending a high percentage of household income on rent can create a financial hardship, especially for lower-income renters. More renters in Somerset and Wicomico Counties are

spending more the 30% of their household income than those in Worcester County. (See figure 2)

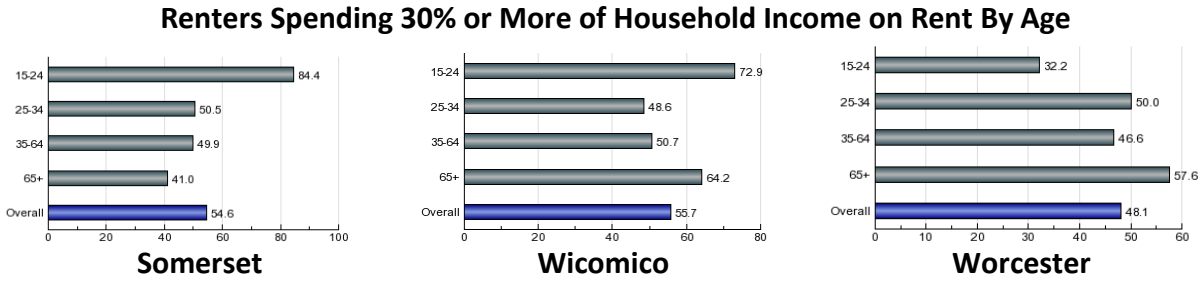


Figure 2: Community Dashboard; Source United States Census Bureau

Key Snapshot

- Somerset County the percent of households that need assistance has dropped from 2.4% to 1.9%.
- More renters in Somerset and Wicomico Counties are spending more the 30% of their household income than those in Worcester County.

iii. Education

Impact

One of the predictors of health and the quality of life is education. Focusing on both early childhood development and education is one of the best ways to improve the health of the community. (http://virtualmentor.ama-assn.org/2006/11/pfor1-0611.html) In a policy brief from the National Poverty Center it was noted by David M. Cutler and Adriana Lleras-Muney (2007), that better-educated people have lower death rates from common chronic and acute conditions.

Local Snapshot

Healthy People 2020 have a national health target to increase the proportion of students who graduate high school within four years of their first enrollment in 9th grade to 82.4%. In Somerset County in 2012, 83.6% students graduated high school within four years of their first enrollment in 9th. For Wicomico the rate was 81.1% and Worcester the rate was 93.1%. Worcester County's rate is significantly higher than the Healthy People 2020 goal. (See figure 1) Maryland's baseline rate is 80.7% with a target of 84.7% in 2014. For Worcester County, all age groups achieve this except the 65+. For Wicomico County the 25-35 is below the target and for Somerset the 35-44 is below the target.

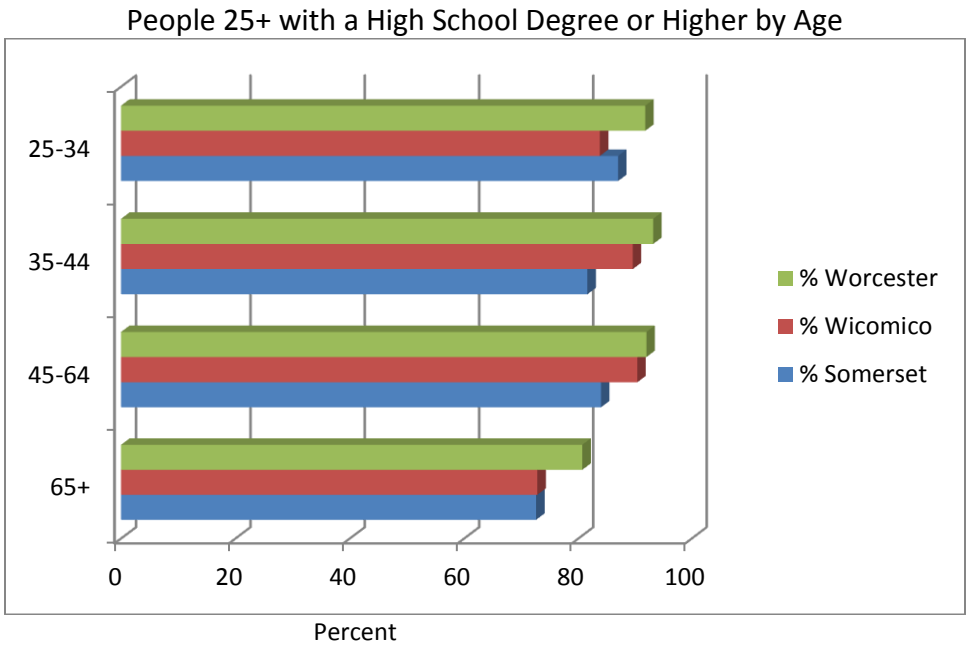


Figure 1. Community Dashboard; source United States Census Bureau 2011

Graduating high school is an important personal achievement and is essential for an individual's social and economic advancement. Graduation rates are also an important indicator of the performance of the educational system. In figure 2 we see that in Worcester and Wicomico the Hispanic/Latino group is below the state target percentage of 84.6% and the same for the Black/African American group in Wicomico.

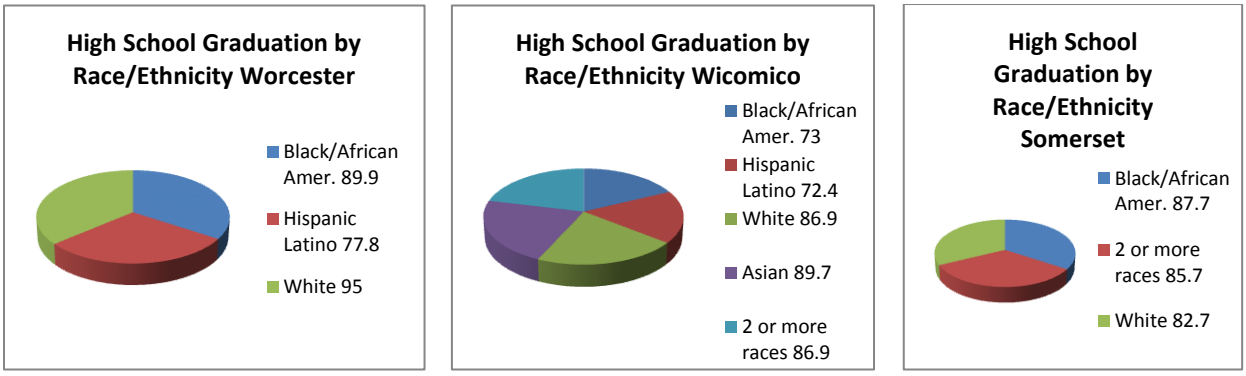


Figure 2. Community Dashboard; source United States Census Bureau 2011

Key Snapshot

- Graduation rates are an important indicator of the performance of the educational system. Worcester and Wicomico the Hispanic/Latino group is below the state target percentage of 84.6% and the same for the Black/African American group in Wicomico.

iv. Transportation

Impact

Access to appropriate transportation is a major health barrier for communities isolated by their remoteness. Efficient and affordable transportation systems ensure access to health care services, education and employment. The ability to use health care services declines as a person's distance from the health care location increases. Low-income, disability and increased age all play a role in decreased access to affordable health care.

Local Snapshot

Those individuals that do not own a car are limited to the ability to go to the supermarket, farmers markets, doctors' offices and hospitals. In Somerset County 8.9% of households do not own a vehicle, in Wicomico County 7.8% and in Worcester County 5.4%.

Peninsula Regional Medical Center and its Outpatient Services are accessible by Shore Transit, a division of the Tri-County Council for the Lower Eastern Shore of Maryland, is the public transit agency for the Maryland lower eastern shore counties of Somerset, Wicomico and Worcester. Shore Transit offers public transportation via fixed route and origin-to-destination services. (www.shoretransit.org).

Peninsula Regional does make available transportation service for those in extenuating circumstances.

Key Snapshot

- Access to appropriate transportation is a major health barrier for communities isolated by their remoteness.
- Those individuals that do not own a car are limited to the ability to go to the supermarket, farmers markets, doctors' offices and hospitals. In Somerset County 8.9% of households do not own a vehicle, in Wicomico County 7.8% and in Worcester County 5.4%.

Peninsula Regional Medical Center
Community Health Needs Assessment - Implementation Strategy
2013

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Overview

Peninsula Regional Medical Center, a non-profit, 317 acute care bed, 30 transitional care beds and 28 newborn & specialty care nursery beds hospital at the hub of the Peninsula Regional Health System, is a 116-year-old, fully Joint Commission accredited tertiary care facility featuring Delmarva's widest array of specialty and sub-specialty services. Over 300 physicians and 3,000 health care professionals and volunteers provide the care and compassion that nearly 500,000 patients rely on each year for inpatient, outpatient, diagnostic, subacute and emergency/trauma services.

Mission Statement

Improve the health of the communities we serve.

Values

• Respect for every individual • Delivery of exceptional service
• Continuous improvement • Safety and effectiveness
• Trust and compassion • Transparency

Peninsula Regional Medical Center (PRMC) provides community members with a wide range of services. The current community health plan has been developed in response to both the Maryland's Health Services Cost Review Commission (HSCRC) and IRS 990 guidelines. A formal community needs assessment was completed in June 2013. This implementation plan outlines the way PRMC will meet its Community Benefit requirement.

Using a Regional approach, significant resources including the local health departments, the Maryland SHIP county metrics, Maryland Vital Static Reports and feedback from Community Health Councils, many aspects of health in the Tri-County area are very similar to those recorded nationwide. Access is a key issue for communities across the county and individuals living at the lowest income level. African-American residents were far more likely to indicate cost or lack of insurance has prevented a physician visit for them in the past two years. African Americans and those living at or near the poverty level were two of four times more likely than residents overall to indicate they have had trouble getting dental care in the past two years. One-third of individuals living in the lowest income levels and one-fifth of African-Americans are without health insurance coverage, both segments being higher than the community overall. One positive finding is that local residents were more likely to have regular sources of care when compared to nation findings.

The Community We Serve

Certain primary service area statistics are tabulated not on the basis of county boundaries, but on the basis of the 43 zip codes all or part of which are in those primary service area counties. In fiscal year 2012, approximately 77% of the patients discharged from the Medical Center were residents of the primary service area, which had an estimated population of approximately 177,422 in 2013 and is expected to increase to 179,814 in 2017. The primary service area population has grown by an estimated 10% since 2000.

The secondary service area, accounting for 18% of Peninsula Regional's FY 2012 discharges, consists of 14 zip codes in the southern portion of Sussex County, Delaware and the northern portion of Accomack County, Virginia. These two counties had a population of approximately 247,000 in 2012 and have experienced growth since 2000 of 19%. The primary and secondary service areas combined accounted for 94% of Peninsula Regional's total patient discharges in fiscal year 2011. Additional demographic information indicates the number of elderly (those aged 65+) represent a greater portion of the total population in both the primary and secondary areas as compared to the State of Maryland (17.1% and 21.3% respectively vs. 13.3%). The elderly have additional chronic conditions, consume healthcare resources at higher rates, and generally require more time and attention than other population segments.

All six counties can be classified as rural with a historic economic foundation in agriculture, poultry and tourism. Watermen and farmers have always comprised a large percentage of the peninsula population; however, their numbers have been declining with growth in the population and expansion of other small businesses. Ocean City, located in Worcester County is a major tourist destination, during the summer weekends, the city hosts between 320,000 and 345,000 vacationers, and up to 8 million visitors annually. The six counties have a diversified economic base; however, it is predominately made up of small employers (companies with less than 50 employees). Some of the major employers include the local hospitals, chicken industry, and local colleges and teaching institutions. The median income of our service area is considerably less ($37,985-$47,654) than Maryland's median income of $68,467. In addition, the August 2012 unemployment rates for each one of the counties is

Wicomico 8.2%; Worcester 7.6%; and Somerset has a high of 9.6%. The August 2012 unemployment rate for Maryland was 7.1% and the National rate was 8.1%.

Additional socio-economic demographic information indicates the number of elderly (those aged 65+) represent a greater portion of the total population in both the primary and secondary areas and will continue to grow over the next five years in each of the six counties between 11 and 18 percent. The elderly have additional chronic conditions, consume healthcare resources at higher rates, and generally require more time and attention than other population segments.

In March of 2012, The Office of Minority Health and Health Disparities (MHHD) at the Department of Health and Mental Hygiene assisted SHIP local planning groups in identifying issues of poor minority health disparities. For Worcester and Wicomico, diabetes emergency room visits are considerable higher for Blacks than the Statewide Black rates, and higher than the White rates in the same county. The White rates are also higher than the Statewide White rate. Overall, these statistics indicate there is a community wide need for diabetes education and management.

Alignment of Peninsula Regional's Community Health Plan to the Tri-County Health Improvement Plan and Wicomico County Health Improvement Plan.

As part of Maryland's SHIP (State HealthPlan Improvement Process) initiative, the Tri-County Health Improvement Plan (T-CHIP) is adopting SHIP objective 27: reduce diabetes complications and reduce diabetes related emergency department visits; and SHIP objective 31: reduce the proportion of children and adolescents who are considered obese or overweight. Peninsula Regional will continue to partner with T-CHIP and Wicomico County Health Department to create strategies and tactics around SHIP objective 27 and 29. By adopting the same health improvement objectives we hope to create alignment, synergy and efficient resource allocation for establishing and promoting these community healthcare improvement objectives. Some of the milestones we are currently reviewing and may adopt including: reducing the number of diabetes related emergency room visits, tracking the number of tri-county diabetes risk assessment tests administered and increasing community participation in diabetes management and education programs. In response to SHIP objective 31, Peninsula Regional is reviewing the possibility of establishing a pediatric weight loss clinic in addition to reviewing other initiatives like creating an education module on obesity for our Child Care Center or working with Tri-County Diabetes Alliance on creating Restaurant Programs that promote low-calorie or diabetic meals. These types of initiatives are currently being discussed.

Below are the major initiatives and key community based programs

Priority #1: Diabetes- Awareness, Education & Management

Impact

According to the American Diabetes Association, diabetes mellitus affects an estimated 25.8 million people in the United States, 8.3 percent of the total U.S. population, and of these, 7 million do not know they have the disease; it is the 7th leading cause of death. Diabetes is usually a lifelong (chronic) disease in which there are high levels of sugar in the blood. There are three types of diabetes. Type 1 can occur at any age, but it is most often diagnosed in children, teens, or young adults. In this disease, the body makes little or no insulin. Type 2 accounts for 95 percent of those diagnosed with diabetes among adults. The third type is gestational diabetes, which develops and is diagnosed as a result of pregnancy. (Centers for Disease Control and Prevention. *Diabetes Report Card 2012*. http://www.cdc.gov/diabetes/pubs/reportcard/diabetes-overview.htm)

Diabetes is a major cause of stroke, and is a leading cause of kidney failure, non-traumatic lower-limb amputations, and new cases of blindness among adults in the United States. Diabetes can lower life expectancy by up to 15 years and increases the risk of heart disease by 2 to 4 times. Overall, the risk for death among people with diabetes is about twice that of people of similar age without diabetes (CDC, National Diabetes Fact Sheet, 2011). Diabetes impacts diabetics and their families physically, financially, emotionally, in their home life, in their work, and in their day-to-day lives.

Diet, insulin, and oral medication to lower blood glucose levels are the foundation of diabetes treatment and management. It is also important for educational programs and self-care practices to maintain control of diabetes, allowing individuals to lead normal lives.

National Snapshot

Among U.S. seniors aged 65 and older, 10.9 million, or 26.9 percent, had diabetes in 2010; among people younger than 20, about 215,000 had either type I or type II diabetes (CDC, National Diabetes Fact Sheet, 2011). The number of people diagnosed with diabetes has risen from 1.5 million in 1958 to 18.8 million in 2010, an increase of epidemic proportions (see Figure 1)

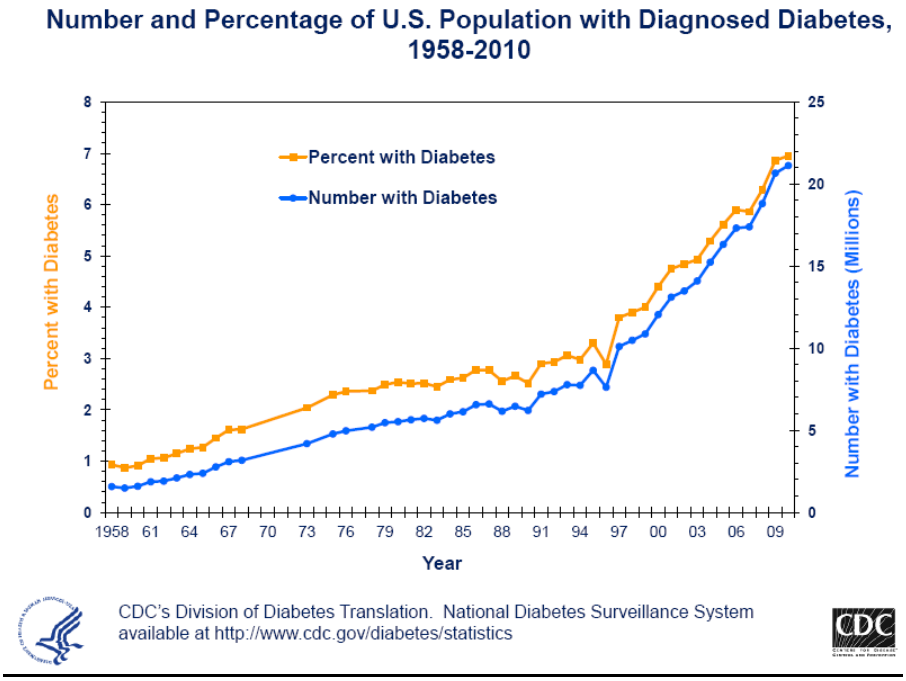


Figure 1. Number and Percentage of U.S. Population with Diagnosed Diabetes, 1958-2010

According to the National Diabetes Education Program, in 2010, 13.0 million men had diabetes (11.8 percent of all men ages 20 years and older) and 12.6 million women had diabetes (10.8 percent of all women ages 20 years and older). As obesity rates in American children continue to increase, Type II diabetes, a disease that used to be seen primarily in adults over 45, is becoming more common in young people. In the United States, compared to non-Hispanic whites, Asian Americans have an 18 percent higher risk of diagnosed diabetes, Hispanics/Latinos have a 66 percent higher risk, and non-Hispanic blacks have a 77 percent higher risk (NDEP, 2011).

The growth of diabetes has been exponential over the past decade, as is the cost of treatment and time lost. The National Diabetes Education Program estimates that the total health care and related costs for the treatment of diabetes run about $174 billion annually in the United States. Of this total, $116 billion is spent on hospitalizations, medical care, and treatment supplies, while $58 billion covers indirect costs like disability payments, time lost from work, and premature death (NDEP, accessed 2013).

State Snapshot

Maryland ranks 22nd in the country for diabetes based on data from 1990-2012 (America's Health Rankings, United Health Foundation, 2013). Across the state of Maryland, the number of people ever medically diagnosed with diabetes has grown from 6.8 percent in 1999 to 9.5 percent in 2012, which continues to be above the national level.4 In 2008, the average prevalence of diagnosed diabetes among white Marylanders was 7.5 percent and 12.3 percent among black Marylanders (MD DHMH). Black females had almost double the diabetes rates of white females at 12.5 percent and 6.8 percent, respectively (MD DHMH, 2008).

In 2011, 1,272 Maryland residents lost their lives to diabetes.5 From 2004 to 2008, black adults of all ages had significantly higher rates of diagnosed diabetes compared to non-Hispanic whites (MD DHMH, Maryland Chartbook of Minority Health, 2009).

Local Snapshot

Diabetes in Wicomico County for prevalence and death rates is better the most counties in the State of Maryland and specifically compared to Worcester and Somerset Counties.

In March of 2012, The Office of Minority Health and Health Disparities (MHHD) at the Department of Health and Mental Hygiene assisted SHIP local planning groups in identifying issues of poor minority health disparities. For Worcester and Wicomico, diabetes emergency room visits are considerable higher for Blacks than the Statewide Black rates, and higher than the White rates in the same county. The White rates are also higher than the Statewide White rate. Overall, these statistics indicate there is a community wide need for diabetes education and management.

Priority #1 – Diabetes – IMPLEMENTATION PLAN

SHIP Objectives	Hospital Initiative - Goal	Hospital Objective	Key Partners	Strategies	Action Steps	Milestones & Outcomes
Reduce Diabetes Complications as measured by SHIP 27. Reduce diabetes-related emergency department visits	Provide Diabetes – Awareness, Education & Management to the Community	Continue to create general public awareness around the high prevalence of diabetes in this region	PRMC Diabetes Education Program Tri-County Health Departments Tri-County Diabetes Alliance	Collaborate with partners Provide paper assessment for diabetes	Travel to community events where at-risk populations are present for screenings and education	Track # of public fairs/events where assessments were & # of lives touched Track number of self assessment questionnaires completed Track Diabetes Support Group meetings Track hits to Diabetes website

SHIP Objectives	Hospital Initiative - Goal	Hospital Objective	Key Partners	Strategies	Action Steps	Milestones & Outcomes
Reduce Diabetes Complications as measured by SHIP 27. Reduce diabetes-related emergency department visits	Provide Diabetes – Awareness, Education & Management to the Community	Diabetes Support Group for Teens and Kids	PRMC Diabetes Education Program	Collaborate with partners Provide paper assessment for diabetes	Group meetings once per month Advertise meetings in local publications	Track # of attendees to the support group Track # of physician referrals

SHIP Objectives	Hospital Initiative - Goal	Hospital Objective	Key Partners	Strategies	Action Steps	Milestones & Outcomes
Reduce Diabetes Complications as measured by SHIP 27. Reduce diabetes-related emergency department visits	Provide Diabetes – Awareness, Education & Management to the Community	"Educating the Educators"	PRMC Diabetes Education Program Wicomico County Board of Education Wicomico County School Nurses	Collaborate on a adolescent diabetes awareness campaign Provide paper assessment for diabetes	Teach educators to relay & recognize the signs & symptoms of diabetes for early diagnosis	Track # of educators trained educators Track # of groups presented to

SHIP Objectives	Hospital Initiative - Goal	Hospital Objective	Key Partners	Strategies	Action Steps	Milestones & Outcomes
Reduce Diabetes Complications as measured by SHIP 27. Reduce diabetes-related emergency department visits	Provide Diabetes – Awareness, Education & Management to the Community	Support and work with Tri-County Diabetes Alliance	Tri-County Health Departments UMES McCready Atlantic General TLC Salisbury Urban Ministries	Collaborate with community organizations addressing healthy lifestyle, exercise, obesity and diabetes management	Participate in all collaborative meetings and share information with the public online	Track # of Participate in all collaborative meetings

Priority #2 – Obesity – Reduce the # of residents in Wicomico, Worcester & Somerset who are considered overweight

Impact

Obesity is defined as having a Body Mass Index (BMI) that is greater than or equal to 30, while being overweight is defined as having a BMI of 25 – 29.9. Obesity has been linked to a number of diseases including diabetes, colorectal cancer, kidney cancer, breast cancer, and many types of cardiovascular disease (Cancer.gov, 2012). Childhood obesity is also on the rise due to the amount of sugary drinks and high energy foods that have become so easily available (CDC, 2013).

National Snapshot

The Centers for Disease Control and Prevention states that, sixty-eight percent of all Americans are overweight and approximately 147 billion dollars are spent on obesity-related diseases every year. The World Health Organization in 2009 stated that obese youth are at risk for factors associated with cardiovascular disease (e.g., high cholesterol or high blood pressure), bone and joint problems, sleep apnea, and poor self-esteem. Obese youth are at an increased risk of becoming obese adults and, therefore, are at risk for the associated adult health problems, such as heart disease, type 2 diabetes, stroke, cancer, and osteoarthritis.

State Snapshot

According to the Maryland Behavioral Risk Factor Surveillance System (BRFSS, 2010), nearly 2.7 million, or about 66.1 percent of Maryland adults, were classified as overweight or obese. Men were more likely to be classified as overweight or obese (73.4 percent) than women (59.1 percent), and black residents were more likely to be overweight or obese (74.0 percent) than white residents (62.9 percent); these differences are statistically significant. Adults with no college education and with a household income of less than $75,000 were significantly more likely to be overweight or obese.

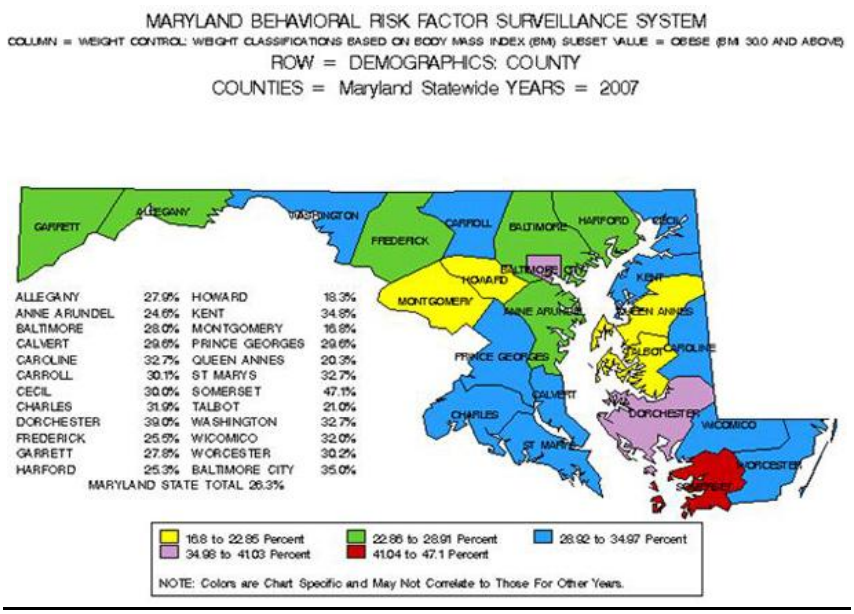


Figure 1. Distribution of Body Mass Index (Obese=30.0% and above) in Maryland (MD BRFSS, 2007)

The Maryland State Department of Education's Maryland Youth Risk Behavior Survey (YRBS, 2009), the percentage of Maryland youth who are overweight or obese has not changed significantly between 2005 and 2009. One in 4 Maryland youth is overweight or obese. Although there are significantly more overweight or obese males than females, significantly more females describe themselves as overweight and are trying to lose weight.

Fruit, vegetable, and milk consumption among Maryland youth has remained steady between 2005 and 2009. There is little variation between males and females in fruit and vegetable consumption; however, significantly more males than females drink milk.

Local Snapshot

The Community Dashboard data showed that obesity or overweight for adults in Worcester County is better than most Maryland counties, for low-income preschool children it is higher than most counties in United States counties. Both Somerset and Wicomico counties have higher obesity or overweight adults than most counties in the State of Maryland. Low-income preschoolers in Wicomico County were moderately more obese than other counties in the United States, and Somerset County preschoolers were more obese than other counties across the United States. (http://ers.usda.gov/data-products/food-environment-atlas/data-access-and-documentation-downloads.aspx)

Priority #2 – Obesity – IMPLEMENTATION PLAN

SHIP Objectives	Hospital Initiative - Goal	Hospital Objective	Key Partners	Strategies	Action Steps	Milestones & Outcomes
SHIP 31. Reduce the proportion of children and adolescents who are considered obese.	Reduce the # of residents in Wicomico, Worcester and Somerset who are considered overweight	PRMC will develop an educational module (including handouts) to be used whenever the Wagner Wellness Van participates in local community events	PRMC Health and Wellness Committee PRMC Education Department	Develop healthy plate and games for children Distribute material	Take Healthy Plate game to community events & encourage participation	Track # of venues information was distributed

SHIP Objectives	Hospital Initiative - Goal	Hospital Objective	Key Partners	Strategies	Action Steps	Milestones & Outcomes
SHIP 31. Reduce the proportion of children and adolescents who are considered obese.	Healthy Day Care Program	Implement Healthy Day Care Program for PRMC Day Care	PRMC Health and Wellness Committee PRMC Day Care	Develop healthy habits program for day care participants	Evaluate program materials appropriate for pre-schoolers Implement program	Track # of venues information was distributed Track consults/communication/education of parents

SHIP Objectives	Hospital Initiative - Goal	Hospital Objective	Key Partners	Strategies	Action Steps	Milestones & Outcomes
SHIP 31. Reduce the proportion of children and adolescents who are considered obese.	Restaurant Challenge	Create an appealing, nutritious, but tasty, restaurant dish.	PRMC Tri-County Diabetes Alliance	Develop an event with local restaurants that provides awards to winners	Implement program	Track # of restaurants participating Track # of community participants Track # of restaurants that use recipe after event

SHIP Objectives	Hospital Initiative - Goal	Hospital Objective	Key Partners	Strategies	Action Steps	Milestones & Outcomes
SHIP 31. Reduce the proportion of children and adolescents who are considered obese.	Health Fest Expo	Provide screening and educator for under and uninsured community members	PRMC James M. Bennett High School	Promote program and hold screenings	Impalement program annually	Track # of attendees, # of screening participants and # of critical values

SHIP Objectives	Hospital Initiative - Goal	Hospital Objective	Key Partners	Strategies	Action Steps	Milestones & Outcomes
SHIP 31. Reduce the proportion of children and adolescents who are considered obese.	Develop Healthy US Pediatric Weight Managemen t Program	Provide screening and education for under and uninsured community members Physical Activity	PRMC CNMC YMCA Delmarva We Can PRMC Foundation	Hold several 12-week programs to educated children & families on health lifestyle choices	Implement program and effect change with our partners	Track # of enrolled participants Track weight loss Track program attendance Continued outreach steps

Other Unmet Community Health Needs

In addition to the needs we and our partners have agreed to pursue together, there were a number of other health needs which (although important) were not a priority at this time. The health indicators we chose had outcomes measures much worse than the state, the nation and Healthy People 2020 targets. We also felt that working together we could ultimately effect a positive change in our communities as collectively we had the expertise, desire and means to effectuate such a change.

Our limited human and financial resources as well as those of our partners do not allow us to pursue additional interventions. When resources permit, we will aggressively plan for expanding the number of health needs indentified in our community health needs assessment.

Alternatively the health indicators we did not select will remain on our “watch list” and will continue to be monitored along with the other indicators. Some of those healthcare concerns on our “watch list” include:

- Heart Disease & Stroke
- Skin Cancer
- Access to Health Care Services
- Mental Health

Next Steps

Peninsula Regional Medical Center will monitor and evaluate the milestones and outcomes annually with its Community Benefit Team and it community partners.



PENINSULA REGIONAL MEDICAL CENTER

2016 Community Health Needs Assessment

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.
PENINSULA REGIONAL MEDICAL CENTER
Part of Peninsula Regional Health System

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SECTION 1

EXECUTIVE SUMMARY



1.1 INTRODUCTION

Peninsula Regional Medical Center (PRMC) is pleased to present the 2016 Community Health Needs Assessment (CHNA). This CHNA report was developed to provide an overview of the health needs in the PRMC tri-county service area, including Somerset, Wicomico, and Worcester counties in Maryland. PRMC partnered with Healthy Communities Institute (HCI), a Xerox Company, to conduct the CHNA. The goal of this report is to offer a meaningful understanding of the greatest health needs across the PRMC service area, as well as to guide planning efforts to address those needs. Special attention has been given to identify health disparities, needs of vulnerable populations, unmet health needs or gaps in services, and input from the community.

Members of the community are invited to provide feedback and comments on this report through multiple avenues. First, the report will be published on PRMC's website (www.Peninsula.org), when opening the report, a pop-up survey box will be there asking for feedback. In addition, community members are able to send emails to the community relations department via community.relations@peninsula.org.

1.2 SUMMARY OF FINDINGS

The CHNA findings are drawn from an analysis of an extensive set of secondary data (over 100 indicators from national and state data sources) and in-depth primary data from community health leaders and organizations that serve the community at large, as well as non-health professionals and community members. The main source for the secondary data, or data that has been previously collected, is the Peninsula Regional Medical Center Creating Healthy Communities platform, a publicly available data platform that is embedded on the main PRMC website. That platform can be found here: https://www.peninsula.org/community/creating-healthy-communities. You can read in more detail about the methods behind the secondary and primary data analysis in Section 5 of this report.

Significant Health Needs based on primary and secondary data:

- Access to Health Services
- Cancer
- Diabetes
- Exercise, Nutrition, and Weight
- Heart Disease and Stroke
- Mental Health and Mental Disorders
- Prevention and Safety
- Substance Abuse

1.3 PRIORITIZED AREAS

On June 8, 2016, PRMC's Community Benefit team and other members from various departments in the hospital came together to prioritize the significant health needs in a session led by consultants from HCI. While considering several prioritization criteria, the following three topics were identified as priorities to address:

- Diabetes
- Exercise, Nutrition, and Weight
- Behavioral Health (focusing on the topic areas of Mental Health and Mental Disorders as well as Substance Abuse)



SECTION 2

INTRODUCTION

2.1 ABOUT PRMC

Peninsula Regional Medical Center functions as the primary hospital for the rural southernmost three counties of the Eastern Shore of Maryland, which includes Somerset, Wicomico, and Worcester. In FY 2015, approximately 77% of patients discharged from the Medical Center were residents of the primary service area, which had an estimated population of approximately 179,605 in 2015. That number is expected to increase to 183,893, or by 2.4 %, in 2020.

Community Health Needs are woven throughout Peninsula Regional's Strategic Plan and are integral to each one of their Strategic Tenets, which encompass the following themes: patient-centered care, population health management, and expanding access through growth of an ambulatory presence. Peninsula Regional's mission statement is to "Improve the Health of the Communities We Serve."

2.1.1 PRMC COMMUNITY BENEFITS TEAM

The Community Benefits Team at PRMC encompasses many departments and facets of the organization.

Senior Leadership is responsible for defining the organization's population health objective and creating the infrastructure that delivers health services to targeted populations. Other roles include creating business cases for population health management initiatives, providing leadership for future health information systems connectivity, targeting high-risk populations for chronic disease management/ interventions, identifying service line gaps, building partnerships and collaborations with other health care providers, and setting overall direction and goals. The following individuals make up the senior leadership team:

- Dr. Peggy Naleppa, CEO
- Bruce Ritchie, CFO
- Cindy Lunsford, COO
- Dr. Charles B. Silvia, CMO
- Sheri Matter, CNO
- Steve Leonard, VP Operations
- Tim Feist, VP Safety and Compliance Officer
- Christopher Hall, VP Strategy/CBO
- Karen Poisker, VP Population Health
- Mitzi Scott, VP People

Clinical Leadership creates tactical action plans around population health initiatives that achieve the best health outcomes for residents. Their roles include designing

care management processes, engaging targeted population with care & wellness plans, health education, follow-up, intervention, transportation, coordination of care along the continuum, health analytics/ metrics, and collaborating with other providers and local health departments. The clinical leadership team consists of individuals from the following positions:

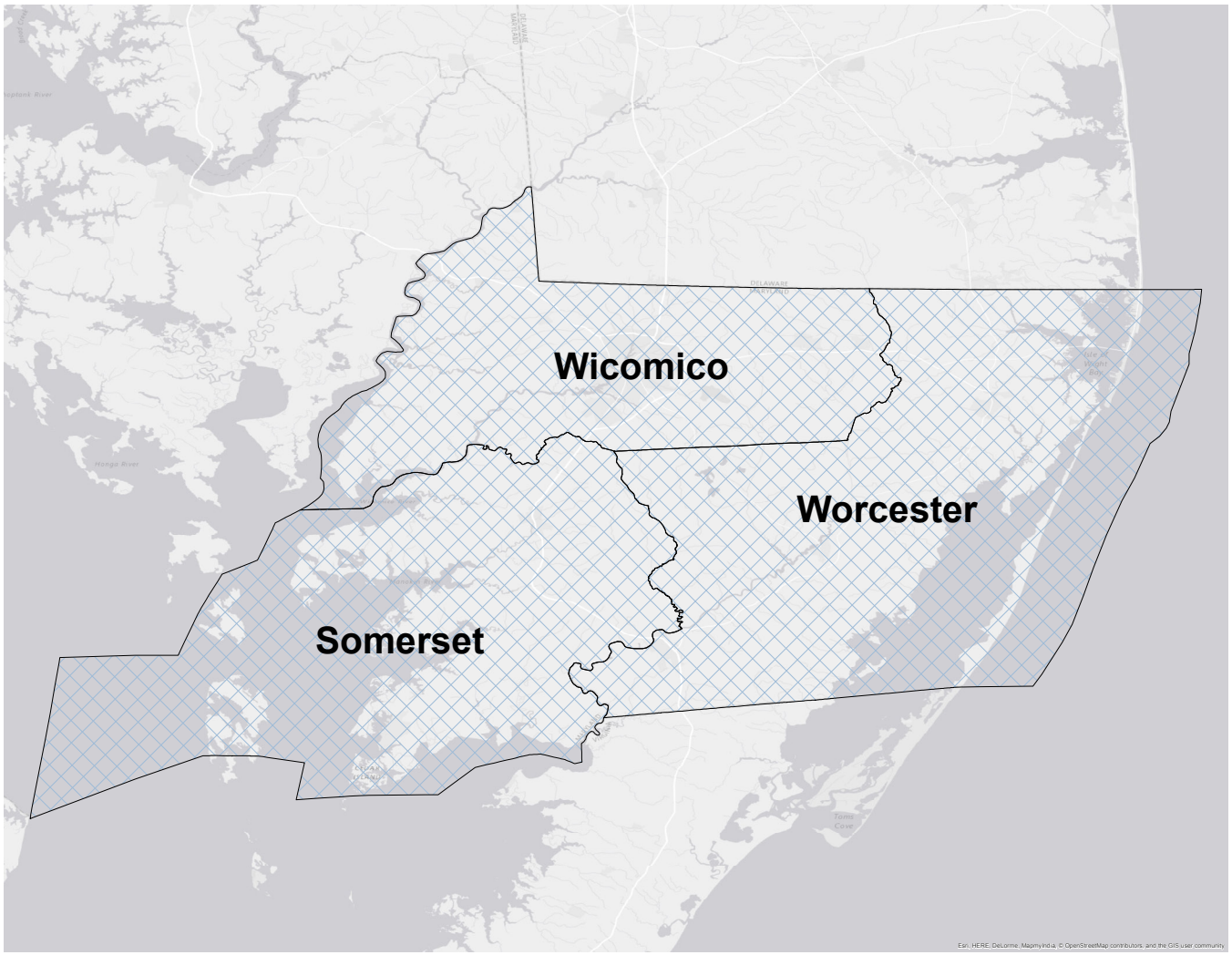
- Physician
- Nurse
- Social Worker
- Community Health Worker

Community Benefit Operations works to identify, target, develop and implement action plans for community health. This team collaborates with local county health departments, civic organizations, faith based groups, and other local providers. The operations team consists of the following individuals:

- Rhonda Lasher, Administration and Coordinator of Services
- Caroline Farrell, Exercise Physiologist and Nutrition Expert
- Gwen Garland, Communication and Messaging
- Laren Carmean, "Live Well" Campaign Administrator
- Pattie Serkes, Director Physician Relations and Coordinator of Community Benefits
- Christopher Hall, VP Strategy and Business Development
- Henry Nyce, Manager Strategic Planning
- Mitzi Scott, VP People
- Diane Hitchens, Director Women's and Children's Services
- Karen Poisker, VP Population Health
- Kathryn Fiddler, Executive Director Population Health
- Stephanie Elliot, Director Community Health Care Services
- Transitions of Care Managers: Jennifer Rayne, Lois Morgan, Anna Kirchner, Jeanne Mills, Murayah Nieves, Stephanie Mitchell, Betsy Niblett, Shelley Flaig, Susan Shoenfelder
- Tom Russ, Pulmonary Diagnostic Services Supervisor
- Susan Cottongim, Diabetes Education Coordinator
- Kim Butler, Behavioral Health Leadership
- Christine Carpenter, Director Weight Loss and Wellness Center

2.1.2 DEFINITION OF COMMUNITY AND MAP

FIGURE 1: THE PENINSULA REGIONAL MEDICAL CENTER SERVICE AREA IS DEFINED BY SOMERSET, WICOMICO, AND WORCESTER COUNTIES IN MARYLAND.



2.1.3 CONSULTANTS

Healthy Communities Institute, a Xerox Company, was retained by Peninsula Regional Medical Center to conduct the 2016 Community Health Needs Assessment. HCI, based in Berkeley, California, supports hospitals in meeting IRS 990 CHNA requirements. In addition, HCI provides customizable, web-based information systems that offer a full range of tools and content to improve community health. HCI and PRMC have collaborated since 2012 to develop the Peninsula Regional Medical Center Creating Healthy Communities platform (https://www.peninsula.org/community/creating-healthy-communities). HCI is composed of public health professionals and health IT experts committed to meeting clients' health improvement goals. To learn more, please visit www.HealthyCommunitiesInstitute.com.

Report authors from HCI include:

- Emily Hummel, MPH
- Norwin Espiritu, MPH
- Jenny Belforte, MPH

SECTION 3

SELECTED PRIORITY AREAS



On June 8, 2016, PRMC's Community Benefit team and other members from various departments in the hospital came together to prioritize the significant health needs in a session facilitated by HCI consultants. Needs were prioritized while considering the following criteria:

- Importance of problem to the community
- Alignment with Maryland SHIP 2017 objectives
- Opportunity for partnership
- Addresses disparities of subgroups
- Existing resources/programs to address the problem

The following three topics were selected as the top priorities:

1. **Diabetes**
2. **Exercise, Nutrition, and Weight**
3. **Behavioral Health (Mental Health and Mental Disorders as well as Substance Abuse)**

A plan for addressing these priority areas will be further described in Peninsula Regional Medical Center's 2016 Implementation Strategy report.

SECTION 4

EVALUATION OF PROGRESS SINCE PRIOR CHNA



As part of the 2013 Community Health Needs Assessment, Diabetes and Obesity were identified and recognized by Peninsula Regional Medical Center, the local Wicomico County Health Department and the State of Maryland as two very serious community health needs that need to be addressed.

As part of Maryland's SHIP (State Health Improvement Process) initiative, the Tri-County Health Improvement Plan (T-CHIP) is adopting SHIP objective 27: reduce diabetes complications and reduce diabetes-related emergency department visits; and SHIP objective 31: reduce the proportion of children and adolescents who are considered obese or overweight. Peninsula Regional will continue to partner with T-CHIP and Wicomico County Health Department to create strategies and tactics around SHIP objectives 27 and 31. By adopting the same health improvement objectives, we create alignment, synergy and efficient resource allocation for establishing and promoting these community healthcare improvement objectives.

Some of the goals and initiatives include: reducing the number of diabetes-related emergency room visits; tracking the number of tri-county diabetes risk assessment tests administered; and increasing community participation in diabetes management and education programs. In response to SHIP objective 31, Peninsula Regional established a pediatric weight-loss clinic in addition to creating an education module on obesity for our Child Care Center. Peninsula Regional is an active participant and member of the Tri-County Diabetes Alliance, which was created to identify and educate individuals at risk of developing diabetes and to develop programs that will help individual with diabetes reduce their risk of developing medical complications associated with the disease.

For more details on the impact since the prior CHNA, see Appendix 13.1.

4.1 COMMUNITY FEEDBACK ON PRIOR CHNA

The 2013 CHNA was posted for public consumption on the Peninsula Regional Medical Center website (https://www.peninsula.org) under "Community" then "Community Health Needs Assessment". The direct link to the file is: (http://online.fliphtml5.com/cxbl/rhxj/#p=1). The website allows for members of the community to email various individuals and departments. Community members were invited to read the report and provide comments. No community feedback was received.



SECTION 5

METHODS

5.1 SECONDARY DATA SOURCES AND ANALYSIS

Data on the Creating Healthy Communities platform is retrieved from a variety of state and national sources, including the American Community Survey and the Maryland Department of Health and Mental Hygiene. As of April 29, 2016, when the data was queried, there were 161 health and health-related indicators for the tri-county service area on the PRMC data platform for which the analysis outlined in the appendix of this report could be conducted. For each indicator, the online platform includes several ways (or comparisons) by which to assess the status of each county within the PRMC service area, including comparing to other Maryland counties, the Maryland state value, U.S. counties, the U.S. value, the trend over time, the Healthy People 2020 targets, and to the Maryland State Health Improvement Process (MD SHIP) measures. For more information about the methodology, please see Appendix 13.2.

5.2 PRIMARY DATA COLLECTION AND ANALYSIS

5.2.1 KEY INFORMANT INTERVIEWS

To expand upon the information gathered from the secondary data, HCI consultants conducted key informant interviews in order to collect community input. Interviewees who were asked to participate were recognized as having expertise in public health, special knowledge of community health needs and/or represented the broad interest of the community served by the hospital, and/or could speak to the needs of medically underserved or vulnerable populations. Fifteen individuals were contacted for the service area, and 12 agreed to participate and scheduled an interview. The following organizations are representative of the individuals who participated in the interviews:

- Chesapeake YMCA
- Community Foundation of the Eastern Shore
- Lower Shore Clinic
- Maryland State Police
- Salisbury University
- Somerset County Health Department
- St. Paul AME Zion Episcopal Church/Community Empowerment Center, Inc.
- Three Lower Counties Community Services, Inc.
- United Way
- Wicomico County Health Department

- Wicomico Public Schools (Board of Education)
- Worcester County Health Department

The 12 interviews were conducted from April 15, 2016 through May 11, 2016 by telephone. They ranged from 30 – 60 minutes in length. During the interviews, questions were asked to learn about the interviewee's background and organization, biggest health needs and barriers of concern in the community, as well as the impact of health issues on vulnerable populations. A list of the questions asked during the interviews can be found in Appendix 13.3.

Each interview included both an interviewer and a note taker from HCI, so much of the conversation was captured verbatim. The interview transcripts and notes were entered into the web application Dedoose, a qualitative data analysis software. The transcripts were coded according to a list of major health and quality of life topics. Input from key informants is included in each relevant health need topic area detailed in Sections 8 and 9 of this report.

Additionally, notes were uploaded to a summary qualitative data analysis tool, Wordle.net which creates a Word cloud. Word clouds help to identify the words or phrases mentioned most often in the interviews, and appear in the largest and darkest font as seen below.

FIGURE 2



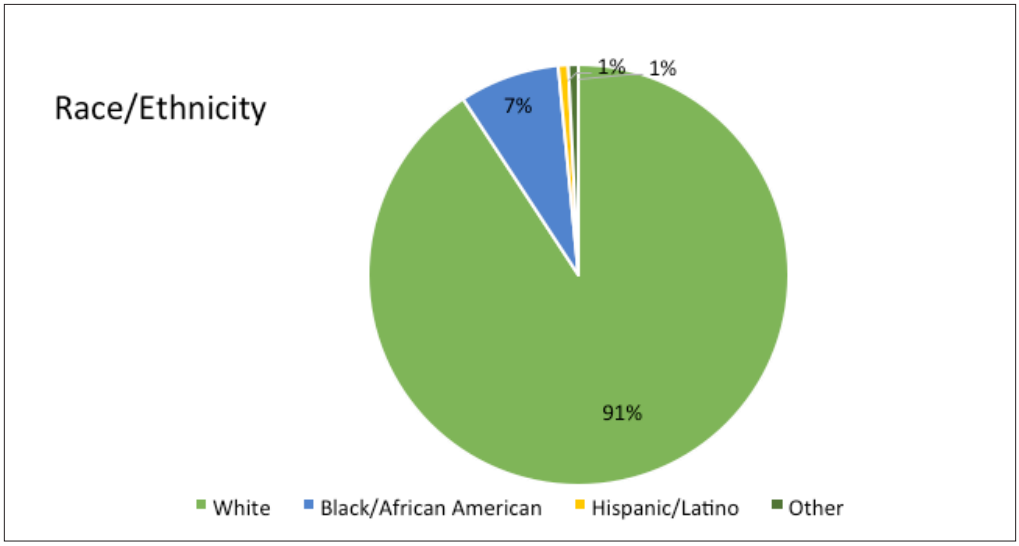
The word cloud was used to get a visual sense of the major themes that emerged from the coding and analysis of the key informant interviews.

5.2.2 COMMUNITY SURVEY

Another form of community input collected was via an online community survey. Survey Monkey was the tool used to distribute and collect responses for the community survey. It was distributed across PRMC's entire service area from April 14, 2016 – May 12, 2016. A total of 132 responses were collected. Results in this report are based on the three counties that comprise PRMC's service area — Somerset, Wicomico and Worcester. This was a convenience sample, which means results may be vulnerable to selection bias and make the findings less generalizable. Another limitation to the survey is that it was conducted only in English.

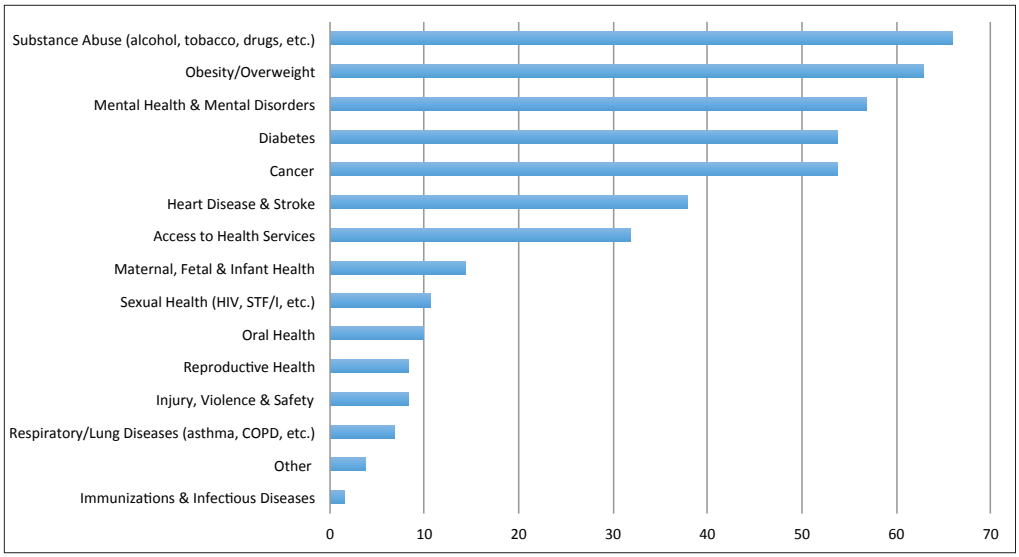
Out of the 132 respondents, about 70% were female and 30% were male. They were comprised of about 40% health professionals and 60% non-health professionals. Figure 3 below shows the breakout of race/ethnicities for the respondents.

FIGURE 3



Below, in Figure 4, are the full results of respondents' ranking of the most important health issues from the community survey.

FIGURE 4



5.3 PRIORITIZATION

In order to better target community issues with regards to the most pressing health needs, PRMC members participated in a group discussion facilitated by HCI to hone in on the eight significant health needs presented. Those health needs will be under consideration for the development of an implementation plan that will address some of the community's most pressing health issues.

5.3.1 PRIORITIZATION SESSION PARTICIPANTS

- Christopher Hall, VP Strategy & Business Development / Chief Business Officer
- Kathryn Fiddler, Executive Director Population Health
- Stephanie Elliott, Director of Community Health Initiatives
- Matthew Killam, Manager Ambulatory Analytics
- Henry Nyce, Manager Strategic Planning
- Susan Cottongim, Diabetes Education Coordinator
- Christine Carpenter, Program Director, Medically Supervised Weight Loss Center
- Logan Harris, Salisbury University Intern, Community Health Education

5.3.2 PRIORITIZATION PROCESS

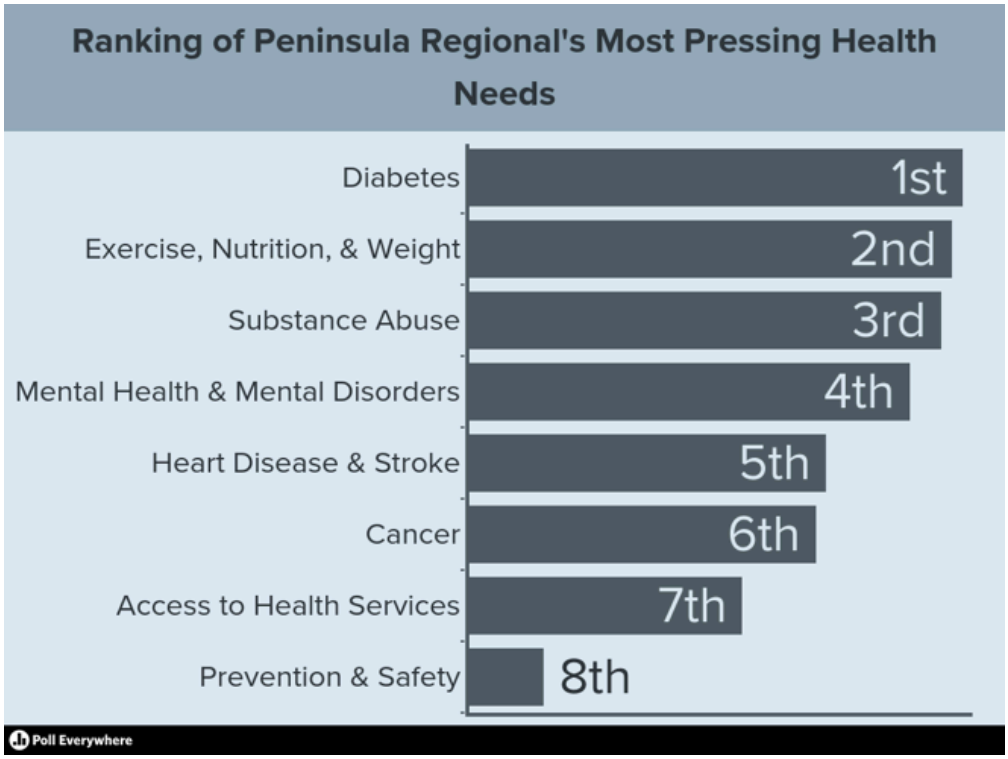
On June 8, 2016 the above participants convened at Peninsula Regional Medical Center to review and discuss the results of HCI's primary and secondary data analysis leading to the preliminary top eight significant health needs discussed in detail in Section 8. From there, participants utilized a prioritization toolkit (Appendix 13.4) to examine how well each of the eight significant health needs met the criteria set forth by PRMC project team. The criteria for prioritization can be seen below:

- **Importance of problem to the community**
- **Alignment with Maryland SHIP 2017 objectives**
- **Opportunity for partnership**
- **Addresses disparities of subgroups**
- **Existing resources/programs to address the problem**

Completion of the prioritization toolkit allowed participants to arrive at numerical scores for each health need that correlated to how well each health need met the criteria for prioritization. Participants then ranked the top eight health needs according to their topic scores, with the highest scoring health needs receiving the highest priority ranking. Participants were encouraged to use their own judgment and knowledge of their community in the event of a tie score. After completing their individual ranking of the eight health needs, participants' rankings were

submitted into an online polling platform that collates the responses, resulting in an aggregate ranking of the health topics. The aggregate ranking can be seen below.

FIGURE 5



5.3.3 PRIORITIZATION RESULTS

Upon seeing the group ranking above, prioritization participants engaged in a discussion about the topics that make most sense to prioritize for PRMC's tri-county service area. As mental health and substance abuse are often linked together, the group decided to combine them into the topic of Behavioral Health to address root causes. All participants agreed to prioritize three needs. Therefore, the top three health priorities for the Peninsula Regional Medical Center's tri-county service area to consider for subsequent implementation planning are:

- Diabetes
- Exercise, Nutrition, and Weight
- Behavioral Health

These three health needs will be broken down in further detail below in order to understand how findings in the secondary data and community input led to each issue becoming a high priority health need for the PRMC tri-county service area.

5.4 DATA CONSIDERATIONS

Several limitations of the data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas, within each topic there is a varying scope and depth of quantitative data indicators (secondary data) and qualitative findings (primary data). In some topics there is a robust set of quantitative data indicators, but in others there may be a limited number of indicators for which data is collected. The breadth of qualitative data findings is dependent on who was selected to be a key informant, as well as the availability of selected key informants for interviews during the time period of qualitative data collection. The Index of Disparity is also limited by data availability: there is no subpopulation data for some indicators, and for others there are only values for a select number of race/ethnic groups. For both quantitative and qualitative data, efforts were made to include as wide a range of secondary data indicators and key informant expertise areas as possible.

SECTION 6

DEMOGRAPHICS



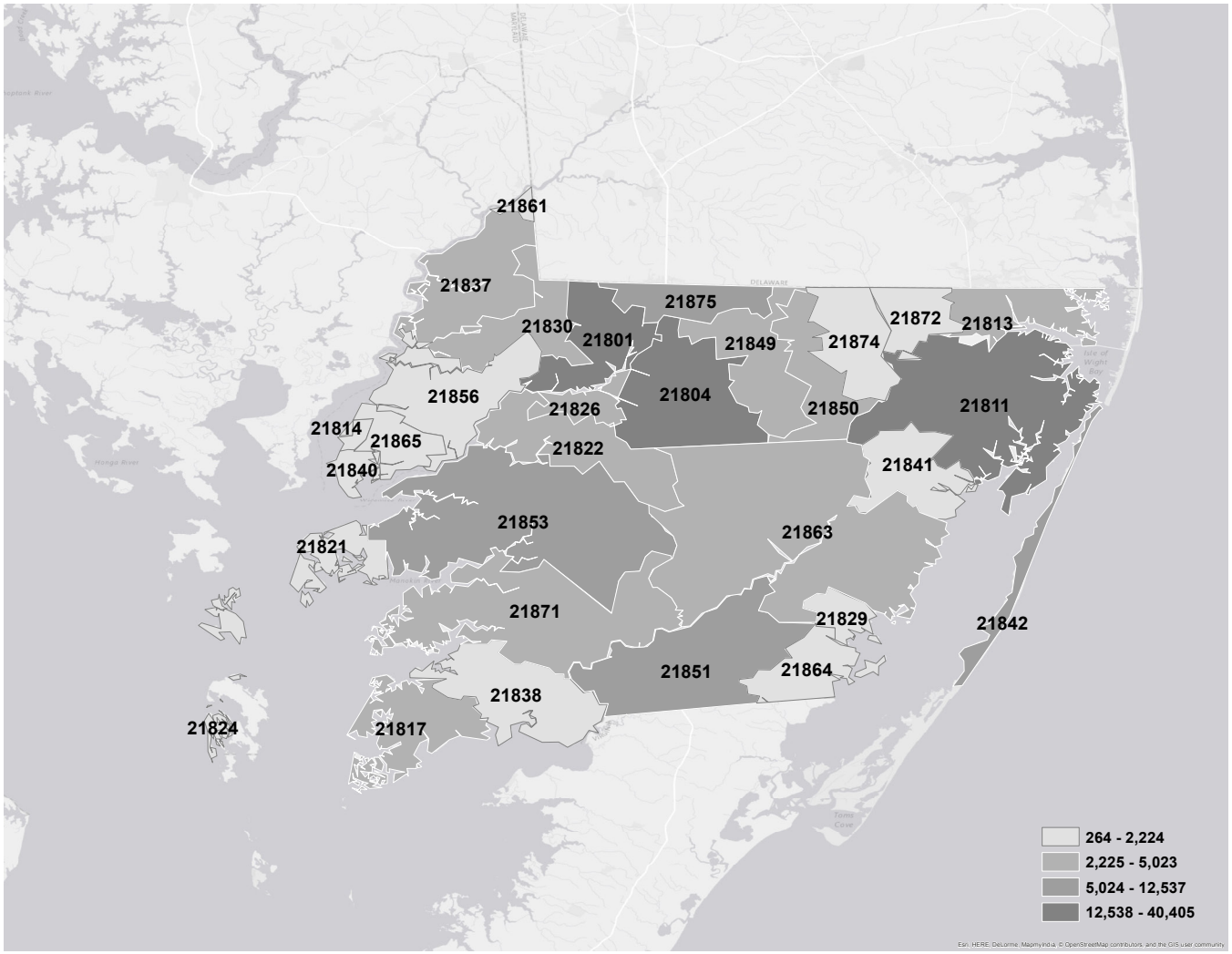
The demographics of a community significantly impact its health profile. Poverty, lack of a vehicle, and poor public transportation can limit the ability to access healthy foods and health services. Unsafe neighborhoods can make it difficult to get enough physical activity. Linguistic isolation can make it difficult for a patient to effectively communicate with their physician. Additionally, different race/ethnic, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts. All reported demographic figures are from Nielsen Claritas, 2016.

6.1 POPULATION

6.1.1 POPULATION COUNT

The total population estimate for the PRMC tri-county service area is 179,752. The majority of the population lives in Wicomico, which has an estimated 102,400 residents. The map below shows zip codes by population count. Zip codes 21811 and 21842 along the Atlantic coast, as well as two Salisbury zip codes, 21801 and 2180, have the highest population counts within the service area.

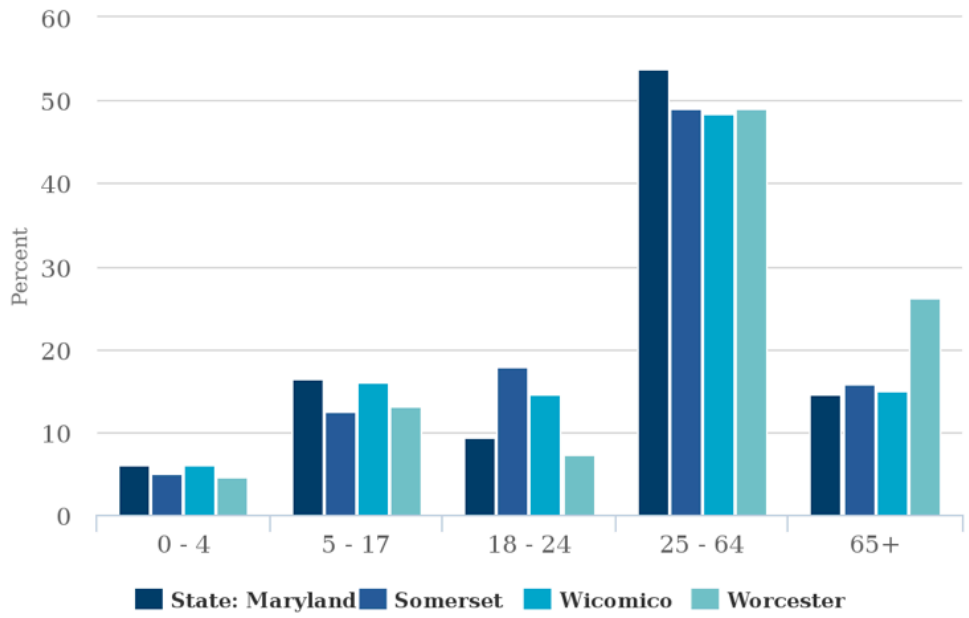
FIGURE 6



6.1.2 AGE

The counties in the PRMC service area have varying age distributions when compared to each other and to the state of Maryland. The proportion of young adults in Somerset and Wicomico are higher compared to Maryland or Worcester. Over half of Maryland is comprised of adults aged 25 to 64, whereas this age group accounts for slightly below 50% of the population of each of the three counties. Also, the proportion of older adults is much higher in Worcester when compared to Maryland and the other service area counties.

FIGURE 7

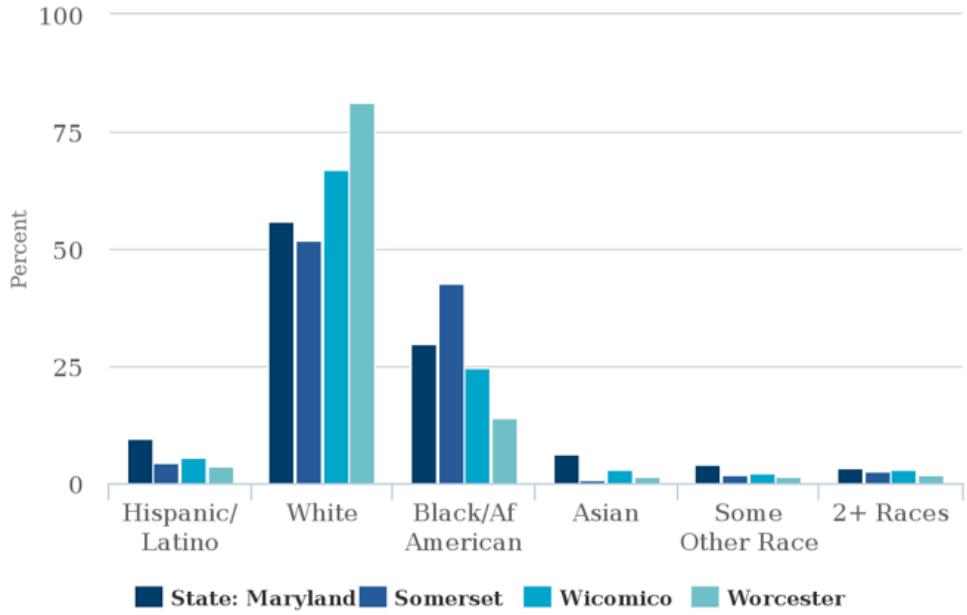


Nielsen Claritas, 2016

6.1.3 RACIAL/ETHNICITY DIVERSITY

Wicomico has the highest Hispanic/Latino population in the tri-county service area (6%); though all three counties have smaller percentages compared to Maryland. Worcester has the highest percentage of Whites (81%), whereas Somerset has the lowest percentage (52%). Somerset has the largest proportion of Black/African Americans (43%), whereas Worcester has the lowest (14%). The other race groups comprise a tiny sliver of the tri-county population in comparison.

FIGURE 8



Nielsen Claritas, 2016

6.2 SOCIAL AND ECONOMIC DETERMINANTS OF HEALTH

Healthy People 2020 defines social determinants of health as conditions in which people are born, grow, live, work, and age that affect a wide range of health outcomes and risks. The social determinants of health partly explain why some people are healthier than others, and generally why some people are not as healthy as they could be. Resources that address the social determinants of health and improve quality of life can have a significant impact on population health outcomes. Examples of these resources include access to education, public safety, affordable housing, availability of healthy foods, and local emergency and health services.[1]

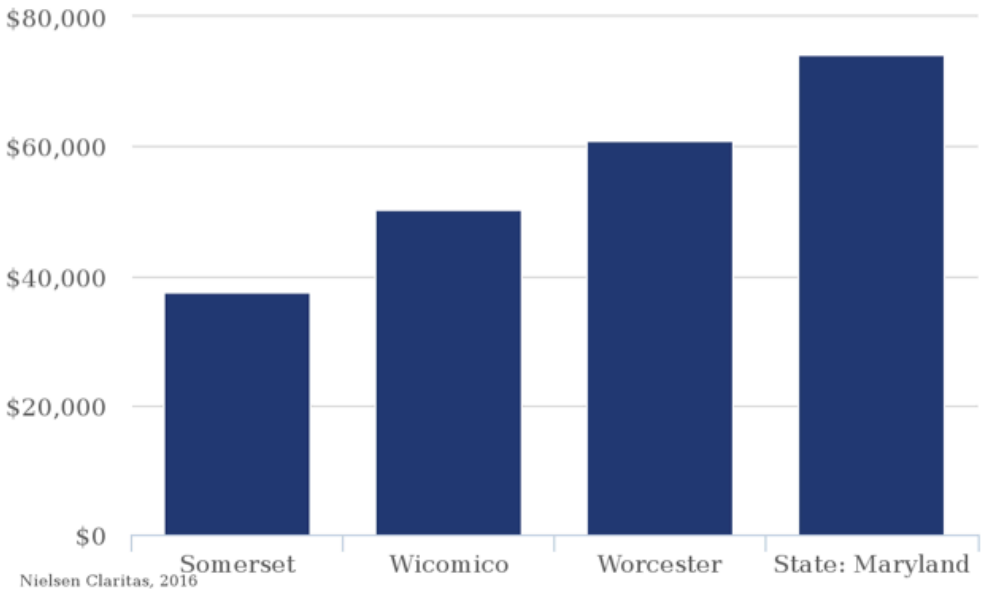
Understanding the different social determinants in the area can lead to potential programs and services that work to improve disparities in the community. Programs that address the social determinants such as: targeted outreach to people living alone, translation services for people with limited English proficiency, and financial counseling for people living in poverty, can help to improve the overall health of the community.

1. http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health

6.2.1 INCOME

The median household income values in all three counties are lower than that of Maryland. Somerset has the lowest median household income in the tri-county service area with a value of $37,385. Worcester has the highest median household income in the service area at $60,834.

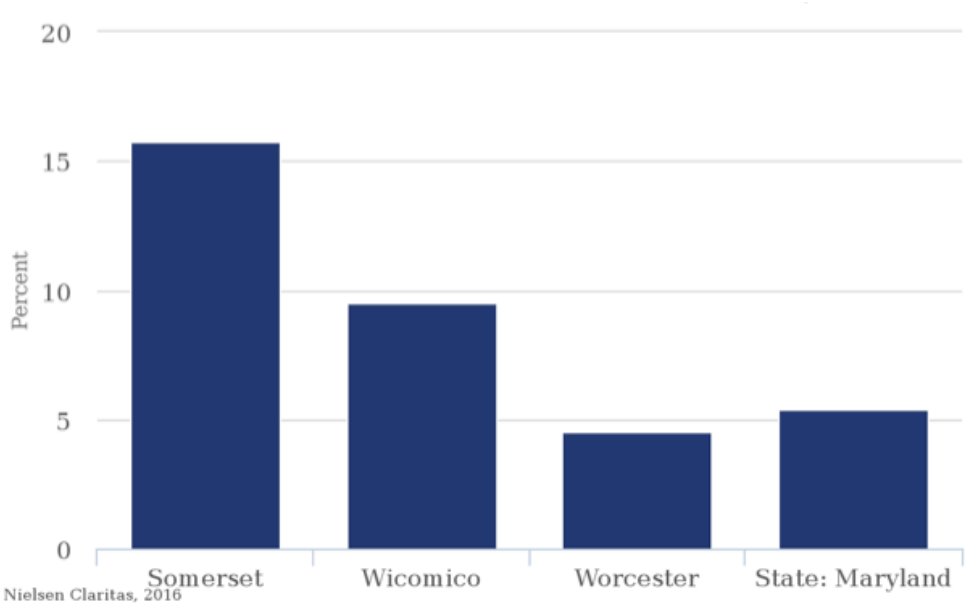
FIGURE 9



6.2.2 POVERTY

Somerset has the highest percentage of families with children living below the federal poverty level at 15%; Worcester has the lowest value at 4.5%. In comparison, families with children living below the poverty rate is slightly above 5%.

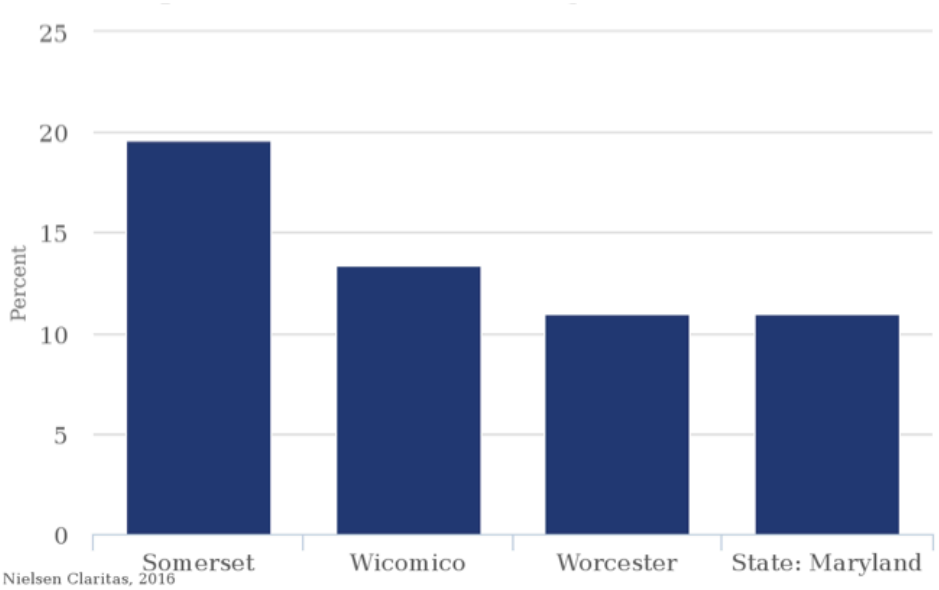
FIGURE 10



6.2.3 EDUCATION

As seen with poverty, Somerset also has the highest percentage of people aged 25 years and older without a high school education. Worcester also has the lowest value and equals the state's value of 11%.

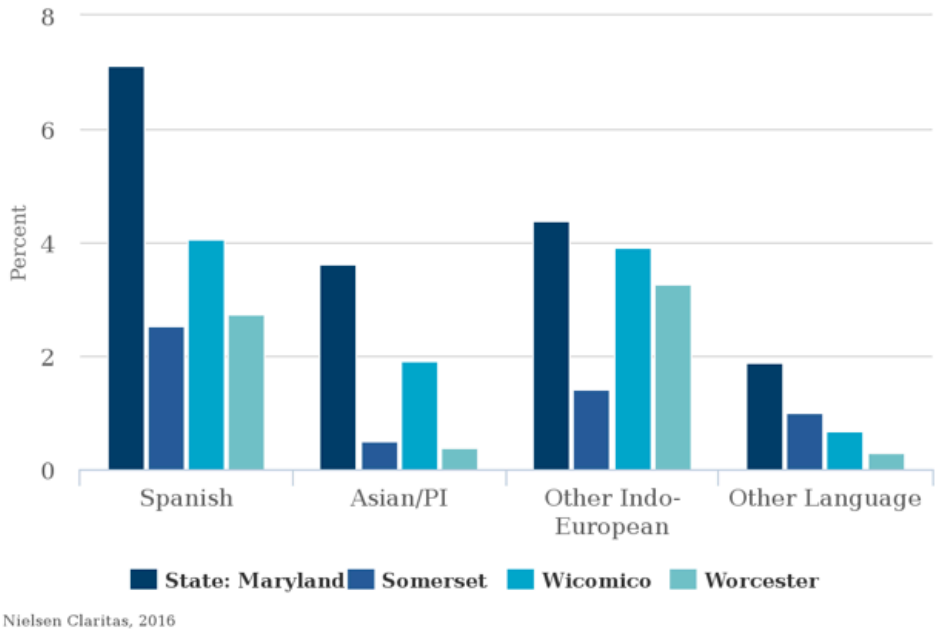
FIGURE 11



6.2.4 LANGUAGES SPOKEN

Of the three counties, Wicomico has the most Spanish-speaking households, households that speak another Indo-European language, or households that speak an Asian language. This makes sense since Wicomico has the largest and most diverse population of the tri-county area. Salisbury and the surrounding area, along with Ocean City, have the highest percentages of households that speak any non-English language in the PRMC service area.

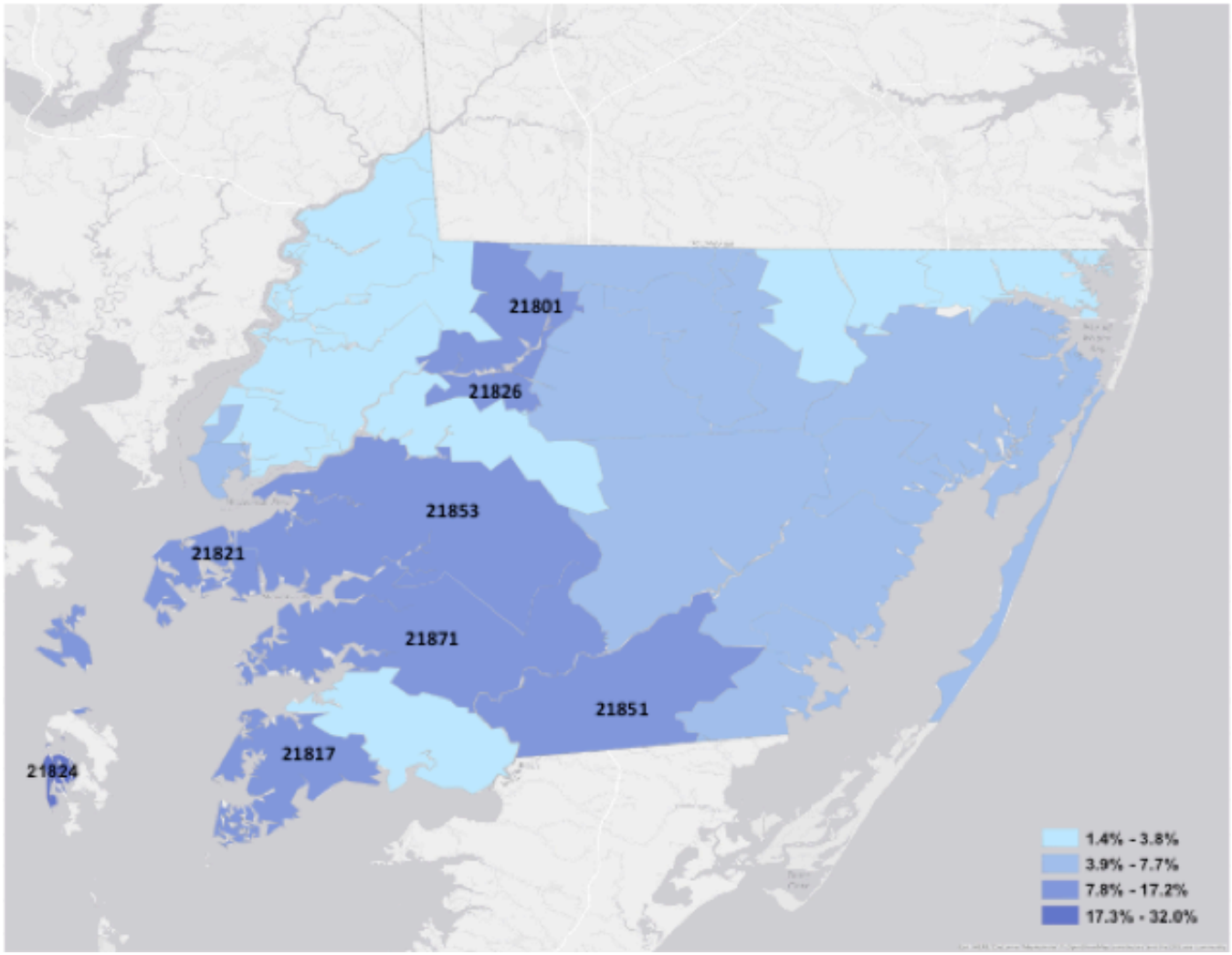
FIGURE 12



6.2.5 HOUSEHOLDS WITH NO VEHICLE

Smith Island (21824) has the highest percentage of households without a vehicle in the tri-county service area (32%); it can be considered an outlier since the next group of zip codes range between 8% and 17%. These zip codes lie in Somerset County and in the Salisbury area in Wicomico County.

FIGURE 13



6.2.6 SOCIONEEDS INDEX®

Healthy Communities Institute developed the SocioNeeds Index® to easily compare multiple socioeconomic factors across geographies. This index incorporates estimates for six different social and economic determinants of health — income, poverty, unemployment, occupation, educational attainment, and linguistic barriers — that are associated with poor health outcomes including preventable hospitalizations and premature death. Within the PRMC service area, zip codes are ranked based on their index value to identify the relative levels of need, as illustrated by the map (Figure 14). The zip codes with the highest levels of socioeconomic need can be found in all counties of the service area. Understanding where there are communities with high socioeconomic need is important when determining where to focus prevention and outreach activities.

FIGURE 14

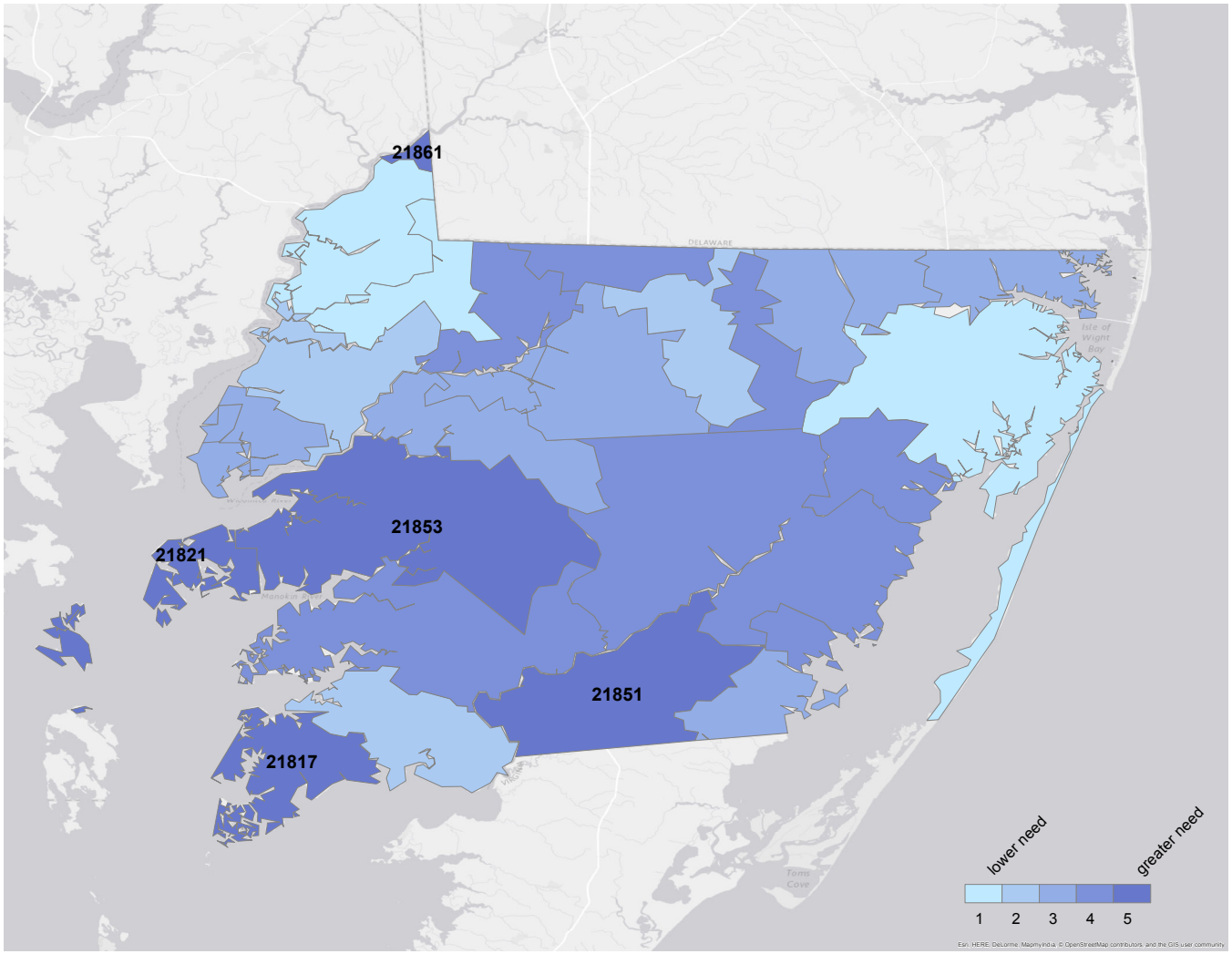


FIGURE 15: ZIP CODES WITH HIGHEST SOCIOECONOMIC NEED

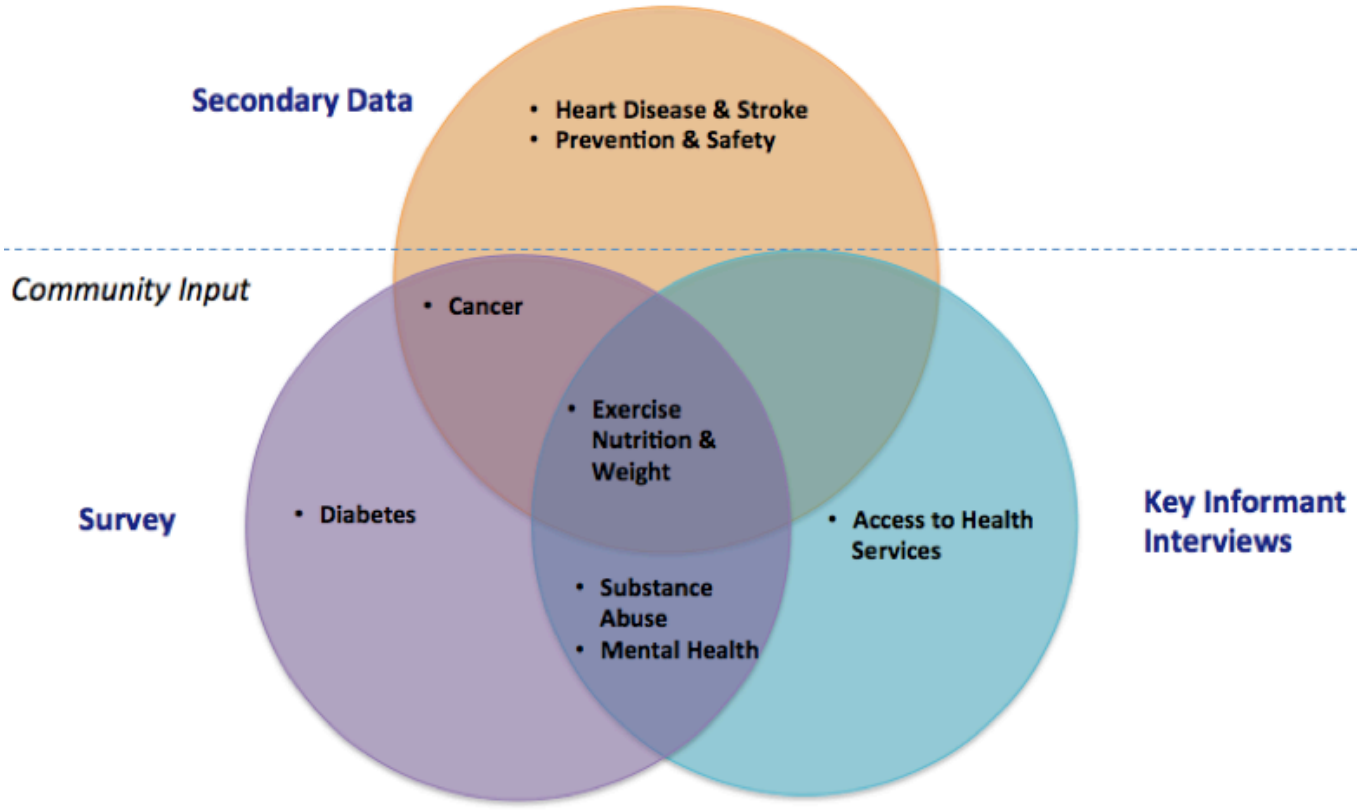
Somerset	21817	21821	21853
Wicomico	21861		
Worcester	21851		

SECTION 7

DATA SYNTHESIS

Primary and secondary data were collected, analyzed, and synthesized to identify the significant community health needs in the PRMC tri-county service area, and the results are shown in the figure below. Topic areas demonstrating strong evidence of need from secondary data and community input were determined to be significant health needs. In primary data, topic areas demonstrating strong evidence of need were the four most commonly discussed health needs during key informant interviews and the four highest ranked health needs per the community survey. In secondary data, topic areas demonstrating strong evidence of need were the five health needs with the highest data scoring result from across the tri-county service area. Data for all topic areas shown below are discussed in further detail in Sections 8 and 9.

FIGURE 16





SECTION 8

PRIORITIZED SIGNIFICANT HEALTH NEEDS

Peninsula Regional Medical Center has chosen to prioritize the following health needs after reviewing the primary and secondary data. These health topics will be the focus of their 2016 Implementation Strategy.

8.1 EXERCISE, NUTRITION, AND WEIGHT

The secondary data analysis for Exercise, Nutrition, and Weight resulted in a topic score in the top five of health concerns for the tri-county area. Warning indicators across all three counties included:

- Adults who are Obese
- Child Food Insecurity Rate

In Wicomico County, which has the largest population of the tri-county area, several indicators had multiple, extremely poor comparisons:

- Adults who are Obese — the Wicomico County value of 34.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%
- Adults with a Healthy Weight — the Wicomico County value of 31.3% in 2014 was lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%
- Other environmental indicators related to Nutrition and Exercise with poor comparisons included:
    - Child Food Insecurity Rate
    - Food Environment Index
    - Food Insecurity Rate
    - Grocery Store Density
    - Low-Income and Low Access to a Grocery Store
    - Fast Food Restaurant Density
    - Workers who Walk to Work

In Worcester County, several indicators had multiple extremely poor comparisons, mostly related to environment:

- Child Food Insecurity Rate
- 65+ with Low Access to a Grocery Store
- Fast Food Restaurant Density

Somerset County had the most indicators with very poor comparisons:

- Adults who are Obese — the Somerset County value of 49.5% in 2014 was higher than the U.S. and Maryland values of 29.6% and higher than the Healthy People 2020 target of 30.5%. Also, Somerset County fell in the bottom quartile of Maryland counties
- Adults with a Healthy Weight — the Somerset County value of 21.2% in 2014 was much lower than the Maryland value of 35.1% and the U.S. value of 35.2%, and lower than the Maryland SHIP 2017 objective of 36.6%. Also, Somerset County fell in the bottom quartile of Maryland counties
- Adults who are Overweight or Obese — the Somerset County value of 79.8% in 2014 was much higher than the U.S. value of 65% and Maryland value of 64.9%. Also, Somerset County fell in the bottom quartile of Maryland counties
- Adolescents who are Obese — the Somerset County value of 17.5% in 2013 was higher than three state comparisons: Maryland State value of 11%, Maryland SHIP 2017 target of 10.7%, and fell in the bottom quartile of Maryland counties
- Other environmental indicators related to Nutrition and Exercise with poor comparisons included:
    - Child Food Insecurity Rate
    - Food Insecurity Rate
    - Food Environment Index
    - Access to Exercise Opportunities
    - Low-Income and Access to a Grocery Store

When looking at sub-populations with disparities for Exercise, Nutrition, and Weight, we see racial and ethnic disparities as well as gender. In Worcester County adults, Blacks (47%) are more obese than Whites (27.1%). In Somerset County adults, Blacks (74%) and Latinos (60.3%) are more obese than Whites (40.8%); women (62.4%) are more obese than men (39.9%).

COMMUNITY INPUT

Nine out of twelve key informants cited Exercise, Nutrition, and Weight as a need in the PRMC tri-county service area.

KEY THEMES

- **Lack of access to affordable healthy foods**
- **Need for nutrition education**
- **Lack of exercise/physical activity**
- **Need for youth to learn healthy eating habits at young age**
- **Rural area with lack of exercise opportunities**

Key informants also provided more specific insight to their experiences and knowledge pertaining to Exercise, Nutrition, and Weight. The figure below includes some direct quotes from key informants regarding this topic area in their community and the populations most impacted.

"Obesity is a huge challenge for us. This is driven by inactivity and lack of access to or options for healthy and nutritious foods."

"Kids are having a tough time figuring out what healthy eating and adequate exercise for healthy living. When kids are overweight they are less likely to go out and be physical … we need to change habits from the beginning — start with the foundations of learning to get kids to make those changes."

"There is so much information out there, but processing and understanding it can be a huge barrier. For example, in [a] diabetes prevention program we had a goal for participants to reduce fat intake. People just started eating fat free pretzels and cottage cheese in huge amounts and included no exercise change in their behaviors."

In addition, Community Survey respondents cited Obesity/Overweight as a health concern, ranking it second out of fifteen for most important health issues in the community.

VOICES FROM THE COMMUNITY:

"Not enough recreational activities throughout Wicomico for children, teens and adults."

8.2 DIABETES

The secondary data analysis for Diabetes resulted in a score which ranked in the top ten in the list of health concerns for the tri-county area. Although the topic level secondary data score does not send an urgent signal about Diabetes, there are specific diabetes-related indicators of concern across the three counties:

- Adults with Diabetes (highest in Worcester County)
- ER Rate due to Diabetes (highest in Wicomico County)
- Diabetes Death Rate (highest in Somerset County)
- Diabetes in the Medicare Population (highest in Somerset County)

In Wicomico County, which has the largest population of the tri-county area, three indicators had multiple extremely poor comparisons:

- Diabetes in the Medicare Population — the Wicomico County value of 31.3% in 2014 was higher than the U.S. value of 26.7% and fell in the bottom quartile of U.S. counties
- Adults with Diabetes — the Wicomico County value of 12.9% in 2014 was much higher than the Maryland value of 10.2% and the U.S. value of 10%
- ER Rate Due to Diabetes — the Wicomico County value of 372.7 ER visits/100,000 population was much higher than the Maryland state value of 204, higher than the Maryland SHIP 2017 target of 186.3, and fell in the bottom quartile of Maryland counties

In Worcester County, one indicator had multiple extremely poor comparisons:

- Adults with Diabetes — the Worcester County value of 18.2% in 2014 was much higher than the Maryland value of 10.2%, the U.S. value of 10%, and fell in the bottom quartile of Maryland Counties

In Somerset County, four indicators had multiple extremely poor comparisons:

- Diabetes in the Medicare Population — the Somerset County value of 34% in 2014 was higher than the U.S. value of 26.7%, the Maryland value of 29%, and fell in the bottom quartile of both U.S. counties and Maryland counties
- Age-Adjusted Death Rate Due to Diabetes — the Somerset County value of 25.2 deaths/100,000 population in 2010-2012 was higher than the U.S. value of 21.2, the Maryland value of 19.9, and fell in the bottom quartile of Maryland counties
- Adults with Diabetes — the Somerset County value of 13.3% in 2014 was much higher than the Maryland value of 10.2%, the U.S. value of 10%, and fell in the bottom quartile of Maryland counties
- ER Rate Due to Diabetes — the Somerset County value of 253.8 ER visits/100,000 population was much higher than the Maryland state value of 204, higher than the Maryland SHIP 2017 target of 186.3, and fell in the bottom quartile of Maryland counties

Prevalence of Diabetes is high in this community, higher than average within Maryland and the country. Management of the disease among those with Diabetes is inadequate, as evidenced by the high ER and death rates.

When looking at sub-populations disproportionately impacted by diabetes, the Black community has a greater burden of the disease, almost double the prevalence of the White community. Of adults, in Wicomico County 16.9% of Black adults have diabetes, compared to 9.8% of White adults. In Somerset County, 28.8% of Black adults have diabetes, compared to 9.9% of White adults. There are also disparities for women in Somerset County with almost triple the diabetes prevalence of men — 20.6% of women have diabetes, compared to 7.5% of men. Asian and Other Race groups are also disproportionately affected in Wicomico County, with 17.9% of Asian adults and 33.1% of Other Race adults impacted by diabetes.

COMMUNITY INPUT

The strongest signal regarding the topic area of Diabetes came from the Community Survey. Respondents ranked Diabetes fourth of fifteen for the most important health issue in their community.

Although only five key informants mentioned Diabetes, they discussed concerns around the following themes:

- Lack of healthy foods/healthy eating habits
- Lack of exercise
- Overweight/obese youth
- Access to adequate treatment

The figure below includes some direct quotes from key informants regarding Diabetes and related health issues in their community and the populations most impacted.

"There is a pre-diabetes population on the Eastern Shore. Often times, our population isn't aware."

"Obesity and diabetes are main focuses in our community and our work."

8.3 BEHAVIORAL HEALTH

The topic areas of Substance Abuse and Mental Health and Mental Disorders ranked third and fourth respectively in the prioritization process. The team at PRMC elected to combine these two topic areas into one priority: Behavioral Health. A further discussion of the two topic areas follows.

8.3.1 SUBSTANCE ABUSE

The topic area of Substance Abuse was the only topic area out of the eight that was found significant in all three data sources, receiving a high secondary data score, ranking number one by respondents as the top health issue in the community survey, and discussed by eleven out of twelve key informants as the most pressing need in the tri-county service area. Substance Abuse scored in the top five of health needs, and indicators of concern for the three counties included:

- Adults who Smoke
- Adolescents who Use Tobacco
- ER Rate due to Alcohol/Substance Abuse

In Wicomico County, which has the largest population of the tri-county area, three indicators had multiple extremely poor comparisons:

- Adults who Smoke — the Wicomico County value of 22.7% in 2014 was higher than the U.S. value of 18.1%, Maryland value of 14.6%, the HP2020 target of 12%, the Maryland SHIP 2017 target of 15.1%, and fell in the bottom quartile of Maryland counties
- ER Rate Due to Alcohol/Substance Abuse — the Wicomico County value of 2870.5 ER visits/100,000 population in 2014 was much higher than the Maryland value of 1591.3, the Maryland SHIP 2017 target of 1400.9, fell in the lowest quartile of Maryland counties, and has been rising steadily every year over the last 4 measurement periods
- Death Rate due to Drug Use — the Wicomico County value of 16.2 deaths/100,000 population in 2012-2014 was higher than the U.S. value of 14.6, higher than the HP2020 target of 11.3, and is worsening over time

In Worcester County, many indicators had multiple very poor comparisons:

- Adults who Smoke — the Worcester County value of 19.6% for 2014 was higher than the Maryland value of 14.6, fell in the bottom quartile of U.S. counties, was higher than the HP 2020 target of 12%, and was higher than the Maryland SHIP 2017 target of 15.5%
- ER Rate Due to Alcohol/Substance Abuse — the Worcester County value of 2870.5 ER visits/100,000 population in 2014 was much higher than the Maryland value of 1591.3, the Maryland SHIP 2017 target of 1400.9, fell in the lowest quartile of Maryland counties, and has been rising steadily every year over the last 4 measurement periods
- Adolescents who Use Tobacco — the Worcester County value of 27.4% in 2013 was higher than the Maryland state value of 16.9%, the HP2020 value of 21%, the Maryland SHIP 2017 target of 15.2%, and fell into the worst quartile of Maryland counties

- Adults who Binge Drink — the Worcester County value of 22.1% in 2014 was higher than the Maryland (15.4%) and U.S. (16%) values, and fell in the bottom quartile of all Maryland counties
- Liquor Store Density — in addition, Worcester County has higher liquor store density than other Maryland and U.S. counties

In Somerset County, several indicators were cause for concern:

- Adults who Smoke — the Somerset County value of 19.8% for 2014 was higher than the Maryland value of 14.6, fell in the bottom quartile of Maryland counties, was higher than the HP 2020 target of 12%, and was higher than the Maryland SHIP 2017 target of 15.5%
- ER Rate Due to Alcohol/Substance Abuse — the Somerset County value of 1896.4 ER visits/100,000 population in 2014 was higher than the Maryland value of 1591.3, the Maryland SHIP 2017 target of 1400.9, and has been rising steadily every year over the last 4 measurement periods
- Teens who Smoke — the Somerset County value of 16.5% in 2014 was almost double the Maryland state value of 8.7%and fell into the worst quartile of Maryland counties

A closer look at disparately affected sub-populations regarding Substance Abuse reveals that men abuse substances more than women in each of the three counties.

FIGURE 17: GENDER DISPARITIES IN SUBSTANCE ABUSE FOR THE TRI-COUNTY AREA

		Overall	Male	Female
Adults who Smoke	Wicomico	22.7%	33.5%	13.1%
	Worcester	19.6%	21.4%	17.8%
	Somerset	19.8%	28.6%	8.4%
Adults who Binge Drink	Wicomico	9.2%	11.1%	7.5%
	Worcester	22.1%	29.0%	15.1%
	Somerset	10.8%	15.8%	4.8%

Maryland Behavioral Risk Factor Surveillance System, 2014

In Wicomico County, Whites had higher rates of Teen Smoking (13.2%) and Adult Binge Drinking (13.1%) than other races. Hispanics (16.7%) also had high rates of Teen Smoking. Blacks (32.1%) had higher rates of Adult Smoking than other races. In Worcester County, White adults (21.3%) smoked more than other races. In Somerset County, Black (22.1%) and Hispanic (37.9%) adults binge drank more than Whites (6.7%).

COMMUNITY INPUT

Substance Abuse was discussed by eleven key informants, more than any other topic, making this a very significant health issue in the community. Key themes that emerged included:

- Prescription drug abuse/opioid addiction
- Easily turn to heroin use from opioids
- Heroin overdose
- Teen/adolescent alcohol use
- Lack of support services for battling addiction

Below are some thoughts voiced by the key informants regarding the issues of Substance Abuse in their community:

"These are all rural communities and fall prey to the whole idle hand thing. We struggle with opportunity for mental health support and resources to support those battling drug additions."

"When prescription drugs are not accessible, they will move to something that is accessible."

"There is more heroin use and overdose than we should have for a rural area."

"Addiction is not looked at as a sickness — it is looked at as a weakness. People feel ashamed to get care."

"Heroin, opioids and prescription drug overdoses ... are off the charts right now. There are no economic barriers, even the low income population have access because it's so cheap."

Community members ranked Substance Abuse as the number one most pressing health need in the PRMC service area, validating the input from the key informants.

VOICES FROM THE COMMUNITY:

"The use of drugs on the Eastern shore, specifically heroin and pill usage is out of control ... there are not enough meetings or rehabilitation services available ... transportation to such meeting or rehabilitation is an issue."

8.3.2 MENTAL HEALTH AND MENTAL DISORDERS

Mental Health and Mental Disorders did not score particularly high in the secondary data analysis, but was in the top ten most pressing health needs. Indicators of concern for the tri-county area included:

- Suicide Death Rate
- Frequent Mental Distress
- ER Rate due to Mental Health

In Wicomico County, indicators of concern included:

- ER Rate due to Mental Health — the Wicomico County value of 6207.9 ER visits/100,000 population in 2014 was almost double the Maryland state value (3442.6) and the Maryland SHIP 2017 value (3152.6), fell into the worst quartile of Maryland counties, and has been worsening over time
- Suicide Death Rate — the Wicomico County value of 12.2 deaths/100,000 population in 2012-2014 is higher than the Maryland state value of 9.2, the Maryland SHIP 2017 target of 9.1, and the HP2020 target value of 10.2
- These indicators also had some poor comparisons:
  - Self-Reported Good Mental Health
  - Frequent Mental Distress
  - Poor Mental Health Days

In Worcester County, the following indicator had multiple poor comparisons:

- Suicide Death Rate — the Worcester County value of 12 deaths/100,000 population in 2011-2013 is higher than the Maryland state value of 9, the Maryland SHIP 2017 target of 9.1, and the HP2020 target value of 10.2

In Somerset County, the indicators of concern included:

- ER Rate due to Mental Health — the Somerset County value of 5665.2 ER visits/100,000 population in 2014 was much higher than the Maryland state value (3442.6) and the Maryland SHIP 2017 value (3152.6), and has been worsening over time
- Frequent Mental Distress — the Somerset County value of 12.6% in 2014 was higher than the Maryland state value of 10 and fell into the worst quartile of U.S. and Maryland counties
- Poor Mental Health Days — the Somerset County value of 12.4 days/previous 30 days in 2014 was higher than the Maryland state value of 3.3 days/previous 30 days and fell into the worst quartile of U.S. and Maryland counties

In looking at disparities in Mental Health, only Worcester County had disparate sub-population data for Self-Reported Good Mental Health. Women (62.6%) reported less good mental health than Men (93.9%).

COMMUNITY INPUT

Although Mental Health was not a significant high data scoring topic in secondary data, it is important to note the lack of data availability for Mental Health and

Mental Disorders in general. In primary data however, mental health was specifically brought up by key informants, being mentioned by nine out of twelve people. Informants repeatedly discussed the growing issue and concerns around lack of resources and services available to address Mental Health in their community. The following key themes arose out of the key informant interviews:

- Rising issue with mental health as it relates to drug abuse
- Lack of support for teens/adolescents with mental health issues
- Stigma and fear associated with mental health/ seeking care for mental illness
- Lack of resources and services in the community
- Lost opportunities for those ready to seek care with no place to go

Below are some direct quotes from the key informants in their discussion of the issues and concerns around the topic of Mental Health and Mental Disorders in their community:

"We struggle with opportunity for mental health support and resources to support those battling drug additions. There aren't many resources for that."

"The hospital alone can't do it all. We need prevention, awareness, and stigma removal when it comes to mental health issues."

"We are seeing kids with more significant mental health issues ... not sure what to contribute that to."

"Mental health services need to be in schools, but culturally there is stigma or 'black mark' associated with people who access mental health services."

"Usually there seems to be a window when people decide they want to access treatment. If the treatment is not available, you have missed the opportunity."

Furthermore, Mental Health ranked third highest out of fifteen most important health issues in the community by respondents from the community survey. One respondent mentioned that community members with mental illness are the most negatively affected by poor health outcomes.

SECTION 9

NON-PRIORITIZED SIGNIFICANT HEALTH NEEDS



These significant health needs emerged from a review of the primary and secondary data. However, PRMC will did not elect to focus on these topics in their 2016 Implementation Strategy.

9.1 ACCESS TO HEALTH SERVICES

Access to Health Services received the lowest topic score in the secondary data analysis, though there are several warning indicators to consider, including: Adults Unable to Afford a Doctor, Primary Care Provider Rate, and Adults who Visited a Dentist. Some of the themes from key informant interviews speak to these warning indicators. According to key informants, access to services is a major issue in the community.

COMMUNITY INPUT

Eleven out of twelve key informants Access to Health Services as a significant issue in the PRMC tri-county service area.

KEY THEMES

- **Rural community, geographical barriers**
- **Transportation difficulty**
- **Long travel times to access providers/clinics**
- **Lack of providers available**
- **Health literacy/need to educate about the health system**
- **Uninsured or underinsured populations**
- **High cost to utilize healthcare services**
- **Cultural and language barriers for ethnic populations**

In addition, Community Survey respondents cited Access to Health Services as a health concern, ranking it sixth out of fifteen for most important health issues in the community.

9.2 CANCER

Cancer was in the top five list of health topics resulting from the secondary data analysis. Top related indicators include: Breast Cancer Death Rate, Lung Cancer Death Rate, and Prostate Cancer Incidence Rate. Something to note would be that the topic of men's health ranked highest in the data scoring for secondary data, and that topic area is comprised mostly of prostate cancer related indicators.

COMMUNITY INPUT

Although Cancer was not as significant in the primary data, six of twelve key informants did speak to the issue of Cancer being widespread in the community and out of those discussions came the following themes:

- Lack of Cancer screenings
- Cancer prevalence high in the community
- Poor access to Cancer treatment
- Lack of treatment options and availability

Additionally, Cancer tied as the fourth highest ranked health need out of fifteen in the community survey.

9.3 HEART DISEASE AND STROKE

The strongest signal from all the data regarding Heart Disease and Stroke was the secondary data analysis, as it ranked in the top five health needs for the tri-county area. Indicators of concern included:

- Hyperlipidemia in the Medicare Population
- Hypertension in the Medicare Population
- Age-Adjusted Death Rate due to Heart Disease

COMMUNITY INPUT

Only one-third or four key informants mentioned Heart Disease and Stroke as a significant health issue in the community. However some key themes emerged from these conversations:

- High blood pressure
- Chronic conditions that feed into cardiac issues
- Lack of healthy eating habits
- Lack of exercise

In the online community survey, respondents ranked Heart Disease and Stroke as the fifth most important health issue in the community.

9.4 PREVENTION AND SAFETY

Like Heart Disease and Stroke, the topic area of Prevention and Safety was highlighted as a significant health need in the secondary data analysis, but was not stressed in the community input. The topic area of Prevention and Safety scored in the top five highest ranked health needs in secondary data for the tri-county area. Indicators of concern included:

- Pedestrian Death Rate
- Pedestrian Injuries
- Severe Housing Problems

COMMUNITY INPUT

Only two key informants mentioned Prevention and Safety during the interviews, mostly in relation to substance abuse and drug overdose. The topic was ranked tenth in the online community survey by respondents.

SECTION 10

OTHER FINDINGS



Both secondary and primary data alluded to issues surrounding barriers to health services and quality of life indicators related to the eight significant health needs discussed above. The findings were consistent in both secondary and primary for the following four topics:

- Transportation
- Social Environment
- Economy
- Education

10.1 TRANSPORTATION

These secondary data indicators: Households without a Vehicle, Workers Commuting by Public Transit, and Households with No Car and Low Access to a Grocery Store, pointed to Transportation as a concern in the tri-county service area.

Transportation was also the top barrier spoken about by key informants with regards to access to health services, primary care, specialty treatment, community resources, and more. Ten of the twelve informants repeatedly spoke about lack of Transportation and long distances being a barrier to people accessing the services needed in their community. Below are the key themes that came out of these conversations:

- Rural area, hard to access health services
- Geographic barriers
- Long bus routes to medical center(s)
- Expensive bus fares
- Lack of alternative means of transportation

In the community survey, Transportation was ranked sixth highest for conditions of daily life that most impact the community.

"The median education level for minority populations is a high school diploma or less. There is great disparity in socioeconomic status between races in our area."

10.2 SOCIAL ENVIRONMENT

Secondary data showed that there are indicators that issue warning about Social Environment being a concern. Most of these indicators were household family structure topics with regards to children. Seven of ten key informants, however, spoke more to the issues around Social Environment as it relates to the following:

- Stigma/fear associated with drug addiction or mental disorders
- Lack of support services in community

- Lack of teen/adolescent counseling or support
- Cultural barriers

Additionally, respondents in the community survey ranked Social Environment third highest for conditions of daily life that most impact the community.

> **"We have a very large population that live below the federal poverty level."**

10.3 ECONOMY

Economy was found significant in secondary data analysis with the following indicators: People Living Below Poverty Level, Homeownership, Households with Cash Public Assistance, and Unemployment Per Capita Income.

Key informants spoke about Economy as being a significant barrier with regards to accessing care, low income populations being highly affected, immigrant populations, and in general the high cost to utilize the healthcare system. The following are themes that emerged from those discussions:

- Poor, rural community
- Lots of low income families
- Immigrant families
- Seasonal farmers/watermen
- Healthcare costs high
- Need more money put towards building community resources and support services
- No health insurance

Respondents in the community survey also ranked Economy as the second highest condition of daily life that most impacts the community.

10.4 EDUCATION

Education was found to be a concern due to the following warning indicators: People 25+ with a HS Degree or Higher, People 25+ with a Bachelor's or Higher, and School Readiness at Kindergarten Entry. These signal issues around level of Education attained in the tri-county service area.

> **"The lack of unskilled jobs to replace the farming / manufacturing jobs has caused a huge strain on the local economy."**

On a slightly different level, eight of twelve key informants spoke mostly about Education as it related to being a barrier where there is lack of knowledge or awareness around health issues in the community. The following are themes base on these informants' discussions:

- Community awareness around health issues
- Healthcare navigation
- Teen/adolescent education for drug awareness
- Educate Hispanic populations on health resources
- Educate youth and parents on healthy eating

Education also ranked fourth by respondents on the community survey for top health issues that impact the community.

SECTION 11

A CLOSER LOOK AT HIGHLY IMPACTED POPULATIONS



There were several ways in which we examined disparities in the tri-county service area.

For secondary data health indicators, we utilized the index of disparity method (see Appendix 13.2 for detailed methodology) to see if there were large differences in indicator values between each subgroup and the overall county value.

FIGURE 18: INDICATORS WITH SIGNIFICANT RACE/ETHNIC OR GENDER DISPARITIES

TOPIC	INDICATOR	SUBGROUP
Substance Abuse	Adults who Smoke	Black, Other Race, Male
	Adults who Binge Drink	Black, Hispanic/Latino, Male
Exercise, Nutrition, & Weight	Adults who are Obese	Black, Other Race
Access to Health Services	Adults Unable to Afford to See a Doctor	White, Other Race
Diabetes	Adults with Diabetes	Black, Asian, Other Race, Female
Cancer	Oral Cancer Incidence Rate	Male

And in primary data, we asked key informants if there are any sub populations that are more negatively impacted by the health concerns they addressed. Immigrant communities, particularly the Hispanic population, were cited frequently as being largely affected by health and socioeconomic issues.

"Emerging immigrant communities often have language barriers. Their kids will enter preschool/kindergarten without knowing English ... they are at a massive disadvantage."

"The Hispanic population, both legal & illegal are challenged because when they get sick, sometimes they don't come in because they are afraid to be reported. Without interpreting services, they don't know what the healthcare professional is saying sometimes. There are language barriers and health literacy issues. We need more Spanish speaking providers."

SECTION 12

CONCLUSION



This community health needs assessment utilized a comprehensive set of secondary data and primary data to determine the greatest health needs in the Peninsula Regional Medical Center tri-county service area. The findings of this report will be used to identify the best strategies to improve the health of the area through the development of new programs, enhancing existing programs, and building new partnerships. While the priority areas of Diabetes, Exercise, Nutrition, and Weight, and Behavioral Health were identified as the top priority areas for PRMC, they are not the only topics that will be addressed in the coming years. PRMC remains committed to supporting existing program and strategies to improve the health for all the residents of Wicomico, Worcester, and Somerset counties. Please send your feedback and comments to The Community Relations Department via community.relations@peninsula.org.

SECTION 13

APPENDICES

13.1 IMPACT SINCE PRIOR CHNA

PRIORITY 1: Identify and provide diabetes awareness, education and management to the Lower Shore community. Create general public awareness around the high prevalence of diabetes in this region, including travel to community events where at-risk populations are present for screenings and education.

INITIATIVE 1: Increase the percentage of the general population that receives diabetes education and management

As part of this initiative, Peninsula Regional has partnered with the local Tri-County health departments (Wicomico, Worcester, Somerset) to create public awareness around the high prevalence of diabetes in this region. A collective team of clinicians and educators travel to local health fairs to conduct screenings and diabetes management educational sessions. This team also directs residents to support groups, primary care physicians and other healthy lifestyle resources such as nutritional cooking classes, weight loss classes, local gyms and more. In a typical year, at least five health fairs host interactive diabetes exhibits. As part of the educational process, we have enlisted the help of local radio stations. Several stations have supported diabetes education and awareness segments as a public forum for getting the message out.

As a follow-up to these local interactions we encourage residents to join one of many diabetes support groups, which lend emotional support in addition to providing clinical education and management. These groups typically meet once a month over the course of a year and have been very successful.

The four support groups include:

- Diabetes Support
- Insulin Pump Support
- Pre Diabetes/Weight Loss
- Children Support

Venue participation includes:

- Participation in health fairs throughout the region
- Travel to Community Events to promote healthy lifestyles
- Local health department health events
- Local school presentations (grade school, high school, colleges)
- Diabetes screenings at civic events
- Diabetes support group meetings

This initiative has placed diabetes on the local radar screen as we have communicated to thousands in the community that diabetes is a serious health issue, and that by working together, we can better educate and provide access and guidance to the diabetes resources needed to keep them healthy and out of the emergency room.



Peninsula Regional's Mobile Health Van is part of our overall initiative to bring health and wellness services to local residents. Many different screenings are offered throughout the year in multiple locations and include tests for vision/ hearing, blood pressure, balance, bone density, heart disease, nutrition counseling, diabetes education, mental health and more.

Following are sample locations and events that the Wagner Wellness Van attends annually:

Pocomoke Women's Screenings	Lower Shore Clinic	Farm Show- Education
Cardiac Check Worcester County	Day in the Park- Education	Community Day- Education
NASA Health Event	National Night Out	Riverside Pharmacy Screenings
Worcester County Government	Heart Screenings Sussex	Somerset Mental Health
Princess Anne Library	Sherwin Williams Health Screenings	Holly Center- Screenings
Seton Center- Screenings	Berlin Women's Heart	

Flu Shot Locations:

DTFC	Froggy 99 Radio Station	Delmarva Life
Delmarva Health Pavilion	WCTG Radio	Apple Scrapple Festival
Bayshore Services	Salvation Army – Salisbury	Lower Shore Enterprises
Local Church - Pocomoke	Local Church – Princess Anne	Local Church - Quantico

INITIATIVE 2: Target children for diabetes support

Children have been identified as a growing and future at-risk population for diabetes. This initiative's goal is to introduce healthy lifestyle concepts to children who are overweight, have pre-diabetes or diabetes. A diabetes support group for teens, children and their guardians was developed, marketed and opened to the general public and designed around the student, to engage and encourage them to be proactive participants in managing their own health and diabetes. The program addresses exercise, sports, eating, nutrition and self-awareness, and helps children manage diabetes as they support each other on their journey.

A core group of the children's and teen diabetes group has been established and meet regularly. This group supports, shares and encourages members in controlling their diabetes. As part of future development, we continue to broaden our efforts with local school nurses, parents and local county educators. Peninsula Regional will continue to promote this initiative through the dissemination of promotional flyers at local pediatric offices and pediatricians, as well as engaging the public through social media and local news outlets.

INITIATIVE 3: Raising diabetes awareness among educators

The primary objective of this initiative is to develop a relationship with educators within the community to promote diabetes awareness, in addition to providing information on available resources. Working with educators exponentially magnifies

the diabetes message as they educate and provide information to their students. Visits to both Wor-Wic Community College and Salisbury University trained educators how to relay and recognize the signs and symptoms of diabetes for early diagnosis and promotion in the schools.

This initiative is a good beginning; however, there is still room to grow and develop an overall healthy lifestyle campaign to reach students. A priority is now to engage educators within our local school system at all grade levels to provide education, review of appropriate menus for diabetic adolescents and provision of paper assessments for diabetes.

INITIATIVE 4: Partner with the Tri-County Diabetes Alliance to provide awareness, education and diabetes management to Wicomico, Worcester and Somerset counties

Peninsula Regional is a partner and member of TCDA (Tri-County Diabetes Alliance), along with eight other organization members and many community partners. These partners include several hospitals (Atlantic General and McCready), the three county health departments, University of Maryland Eastern Shore, Salisbury Urban Ministries and Three Lower Counties Community Services.

The mission of this organization is to:

- Educate citizens on why it is important to know if you have diabetes.
- Guide citizens to community resources to learn about the risk of developing diabetes.
- Guide citizens to community services to help them manage their diabetes if diagnosed.

The goals and objectives are:

- Increase the proportion of persons with diabetes who receive formal diabetes education.
- Increase the proportion of adults with diabetes whose condition has been diagnosed.
- Increase the proportion of people with pre-diabetes or multiple diabetes risk factors engaged in diabetes prevention efforts.

As part of Peninsula Regional's ongoing commitment, we participate in the Tri-County Diabetes Alliance monthly meetings, local healthy lifestyle events, diabetes clinics, educational seminars and general outreach efforts. Peninsula Regional refers high-risk patients (over 150 a year) for follow-up and support to TCDA. Here, these residents can be assessed and receive the help they need.

In an effort to reduce diabetic inpatient admissions and Emergency Department visits, identification of patients presenting to the Emergency Department due to non- or poor management of their disease is important. Peninsula Regional provides TCDA with "frequent flier" emergency room diabetes patients (5-10 per quarter) so they may be assisted by a case manager and referred for further diabetes education and support group participation.

INITIATIVE 5: Partner with MAC Area Agency on Aging to provide chronic disease self-management

MAC (Maintaining Active Citizens) is "shepherding the statewide expansion of programs to empower persons with chronic conditions to live a healthy life." The Maryland Department of Aging is a partner in the development of this program, along with other partners including the Maryland Department of Health and Mental Hygiene, Peninsula Regional, Johns Hopkins University School of Medicine and Meritus Medical Center.

MAC is working with healthcare systems, the aging network and state and community partners throughout Maryland to meet the goals of their Living Well project: to significantly increase the number of older adults and adults with disabilities who complete evidence-based self-management education and support programs to empower them to better manage their chronic conditions.

The primary objective for Peninsula Regional in this partnership is to deliver chronic disease self-management services to the community. The program promotes increased patient competence and coping through treatment plans that include education and referrals to necessary resources. It provides comprehensive assessments and assists patients in using the health system appropriately. The program, "Healthy Living with Diabetes," is a 6- to 8-week workshop developed at Stanford University that engages the patient and helps set attainable goals that help them take steps toward better self-care and knowledge.

FY 2015 referrals to MAC for Chronic Disease Self- Management Program (CDSMP):

Referrals
PRMC Health Fairs: 225
Referrals from PRMC Mobile Van: 35
Physicians & Community Health Care Workers: 131

MAC disease self-management sessions
Number of participants: 85
Number who completed 4 or more sessions: 76%

PRIORITY 2: Reduce the proportion of children/adolescents and residents who are considered obese.

Our Community Healthcare Dashboard indicates that both Somerset and Wicomico counties have more obese or overweight adults than most counties in the State of Maryland. Low-income preschoolers in Wicomico County were moderately more obese than other counties in the United States, and Somerset County preschoolers were more obese than other counties across the United States.

As obesity rates in American children continue to increase, Type II diabetes, a disease that used to be seen primarily in adults over 45, is becoming more common in young people. Peninsula Regional's Community Needs Assessment questionnaire/survey asked, "What do you think are the biggest health concerns affecting Delmarva?" Diabetes was listed the second-highest concern. The correlating link between rising obesity and increasing prevalence and incidence rates of diabetes was key to choosing both of these health care initiatives. Diabetes, a chronic disease, is a leading cause of stroke and kidney failure and the cost of not controlling the disease is monumental.

INITIATIVE 1: PRMC will develop educational modules and increase educational awareness around childhood and adolescent obesity to reduce the total number of children who are overweight.

The PRMC Health and Wellness Committee works with local employers, community groups, civic organizations and churches to introduce basic steps to healthy eating and mastering nutrition basics. PRMC's Health and Wellness Committee partners with the community and attends local events introducing and promoting a balanced diet and exercise. These venues provide an opportunity to talk to the children and their parents about nutrition, encouraging them with nutritional coloring books and beach balls to stay active and keep talking to each other about making good healthy choices.

FY2015 Community Impressions:

- Participated in a total of 11 local health festivals at which 2,052 encounters or "touch points" occurred.
- These encounters included 266 weight/healthy lifestyle screenings, and included subsequent suggested referrals.
- Over 750 "Healthy Eating Coloring Books" passed out.
- Over 200 "Fast Food Calorie Guides" distributed.
- 100 "Portion Control Plates" in both adult and child sizes.
- More than 100 pedometers distributed.
- More than 1,100 beach balls, jump ropes, frisbees and airplanes distributed to children to promote outdoor physical activity.

INITIATIVE 2: Create a Healthy Day Care Program.

Childhood obesity rates continue to be an issue, and the correlating link with childhood diabetes elevates this to a priority community wide health care initiative. As part of our "Healthy Day Care Program," our target population is the 100+ children within the program and their parents. The primary objective is to educate our children on how to make better healthy lifestyle choices at a young age, and to involve the parents in healthy lifestyle activities so that they will start to commit to a healthier lifestyle and reinforce this with their children. The healthy choices educational program features one class per month, with topics that include:

- Healthy Heart Curriculum
- Healthy Body Curriculum
- Cleanliness
- Importance of Exercise
- Plate Portions
- Pretend Food Activity

These interactive programs feature heart models, dance routines, films, coloring books and more. The children now have baseline health information to make wise lifestyle choices. A gym class is held every Friday for seven day care classes, and active group activities are included twice a day for 20 minutes; for example:

- Jump Frog
- Water Exercise
- Dance & Music
- Red Light, Green Light
- Jumping Jacks

In review, the initiative has shown a dramatic improvement in the nutritional value of the Child Care lunch and snack options, as most of the prepackaged and processed foods were replaced with fruits and wheat products. Children are learning basic nutritional concepts from age-appropriate material and there is robust feedback from a Q & A time. Teachers, students and parents participate and discuss healthy food choices and try healthy food options as part of their healthy snack and party celebrations.

INITIATIVE 3: Provide an annual HealthFest Expo with the Wicomico Board of Education to provide screenings and education for the underserved and uninsured members of the community.

Peninsula Regional, in partnership with the Wicomico County Board of Education, provides more than 35 free screenings and a showcase of healthy exhibits in its free, public Live Well HealthFest at James M. Bennett High School in Salisbury, Maryland. Peninsula Regional healthcare specialists and other area healthcare providers are available at the event to anyone looking to find out how healthy they are, and to learn what they can do to lead a healthier lifestyle. PRMC offers to the more than 1,200 attendees an opportunity to participate in a paper diabetes screening conducted by the Peninsula Regional Diabetes and Endocrinology Center team. If determined to be at high risk, individuals are provided education and offered a Hemoglobin A1C (HbA1c) blood draw. The HbA1c test is preferred over glucose because it can actually detect diabetes, and is a much more accurate measure of a person's health risk.

Live Well HealthFest visitors may enjoy a therapy dog demonstration, dance and cheer team performances, chair aerobics and Zumba, a rock climbing wall, a fire rescue obstacle course, fire engine and ambulance tours, a fly-in and helicopter tours by the Maryland State Police, "Ask the Provider" and "Ask the Pharmacist" booths for medical questions, a health corner for kids presented by PRMC Child Care, a cooking demonstration and more. Participants can also visit over 50 community health exhibitors with valuable information on their services. This health fair has become very popular with the community and typically draws over a thousand to several thousand residents.

INITIATIVE 4: Develop a Healthy Us pediatric weight loss clinic in collaboration with Children's National Health System

The Healthy Us program is a newly designed collaborative initiative with the YMCA's comprehensive program. The program is specifically designed and dedicated to improving the health of the pediatric community by interrupting and preventing the cycle of childhood obesity. The focus is on educating and creating a fun and safe environment for children, but the families will also plan an integral role. The eight-week class typically has approximately 12-15 students.

The team consists of a Peninsula Regional pediatric hospitalist, a registered dietitian, wellness coordinator from the YMCA and the Director of Pediatric Obesity at Children's National Medical Center as consultant.

We plan to continue our successful partnership with the YMCA promoting pediatric weight loss. In addition, PRMC has expanded our collaborative with the YMCA with the signing of an MOU stating our common desire to extend the continuum of health, wellness, preventive and educational programs to the Delmarva community.

INITIATIVE 5: Develop community-wide awareness and education regarding heart disease, hypertension, obesity and healthy lifestyles.

Peninsula Regional serves a rural population where the percentage of adults who are obese is very high. The three Lower Counties' obesity rate per population is: Somerset County 54.3%, Wicomico County 31.3% and Worcester County 30.7%. The high rate of obesity contributes to the higher prevalence of hypertension, heart disease and kidney disease.

Peninsula Regional's Wagner Wellness Van is an ideal tool to reach those in our community who have limited access to healthcare. This mobile health van provides heart screenings to the residents across the Delmarva Peninsula. A component of the heart screenings is an educational session that highlights reducing obesity, exercising, and healthy food choices, all of which contribute to a healthy heart.

The obesity component of the screening includes:

- Height
- Weight
- BMI
- Body Fat percentage
- Education session on nutrition
- List of resources available and help attaining resources
- Potential referral if needed

SAMPLE FY2015

Coastal Cardiac Checks/Obesity Screening Component
Locations Visited: 15
Patients Screened: 186
Referred: 6

Women's Heart/Nutrition Session Component
Patients Screened: 54
Referred: 1

OTHER POPULATION HEALTH INITIATIVES:

Population Health: Over the last few years, population health activities have been based on community and regional needs. PRMC's overarching goals have been to provide care within the community to improve the overall quality of life, reduce health disparities, work with community organization and county health departments that impact population health on a daily basis, and to increase access to care outside of the acute care setting. The Community Health Benefits Report details efforts around diabetes and obesity; however, PRMC has been working to further population health efforts.

Patient Centered Care — Sampling

- Developed a behavioral health "Partial Hospitalization Program" in partnership with Adventist secondary to a community assessment for gaps in service for the region.
- Provision of medication for indigent population to pay for medications, to help prevent readmissions and develop a healthier community.
- Palliative care with a focus on patients with complex chronic disease states;

specialized care revolves around symptom control, counseling, family support and education/assistance with end-of-life decision making.
- RN coordinators to improve access to primary care appointments within 72 hours of discharge.
- Additional social worker to connect Emergency Department high utilizers with community services, primary care physicians including helping to provide transportation.

Provider Care Teams — Sampling

- Health coaches at Peninsula Home Care focus on heart failure and chronic kidney disease patients, providing assistance with improving compliance with dietary and medication management.
- Endocrinology: Implementation of telemedicine/diabetes clinic for pediatric patients with a focus on accurate diagnosis/treatment engaging family support and school nurses.
- Continued recruitment of primary care physicians that develop care models targeting high-risk patients, assigning them to specific care plans and care plan coordinators.

Health Information Systems

Health information technology has been implemented to support predictive analytic modeling software to determine high-risk renal patients, and engaging physicians and caregivers in participating in the patient's self-care regimen compliance. Processes have been developed to identify high-risk patients for care, identification of quality care issues and improvements to prevent complications and readmissions.

Employee/Family "Live Well" Campaign

Building on the externally focused "Live Well" marketing efforts, Peninsula Regional turned that inward to the new "Live Well" campaign directed at employees and their families. This campaign encourages and promotes healthy lifestyles through education, financial benefits, health care assessments, chronic disease management and other collective health activities.

A specific module associated with the "Live Well" campaign focuses on employees with diabetes as a diagnosis, the primary objective is to improve diabetes control and reduce A1C for individuals over time. Employees participating in the program receive a reduction in cost for their health care benefit and receive free testing and medications for their diabetes care. Employees with heart disease may participate in a Cardiovascular Health Management Program, which provides free cardiovascular medications as well as other health-related services. In addition, PRMC is currently developing a playbook to build ways to engage its employees and their families in a comprehensive "Live Well" lifestyle.

Ambulatory Access

PRMC is committed to being an integrator of health services, and as an integrator we must provide appropriate access to service for the populations we seek to serve across the entire continuum. The range of services required by our populations is broad and includes:

- Facility-based services such as hospitals, free-standing urgent care centers, clinics and other essential ambulatory networks
- Non-facility-based services
- Partnerships, relationships, affiliations and pathways to drive integration and innovation
- Health professional services such as physicians, nurse practitioners and physician assistants.

In the last several years Peninsula Regional has opened several health pavilions within the community: one in Millsboro, Delaware and one in Ocean Pines, Maryland. As part of our plan to expand health services outside the hospital walls and into communities, the strategy provides ease of access and promotes continuity of primary and population health services. These health pavilions provide primary care physicians, a pharmacy, rehab, medical imaging, and specialty service partnerships such as cardiology and orthopedics. Each pavilion has an educational room that can be used by the public and other community health providers to hold health seminars and educational sessions. PRMC continues to develop its ambulatory care presence in addition to affiliations and partnerships.

Future Community Benefit Intent:

PRMC has determined that there is a great need to focus activities in the community, with dedicated care managers located in primary care offices to assist physicians in caring for patients with multiple admissions/emergency room visits and with multiple chronic conditions. Further, there is a need to provide access to care for patients who do not have a primary care physician by providing a bridge clinic. Action plans are being developed to assist patients by providing a mobile van to address rural disparities in accessing health. Chronic disease management will be enhanced with data collection and health coaches who use that information to assist patients in managing chronic disease. We are also developing a program for care managers to assist primary care practitioners, patients and their families in making palliative care and hospital referrals for outpatient symptom control and counseling, as well as in-home services. Finally, in collaboration with multiple partners such as Atlantic General, McCready Hospital, Crisfield Clinic and multiple SNFs/Rehab, PRMC seeks to prevent avoidable admissions by addressing behavioral/chronic health needs and chronic disease management.

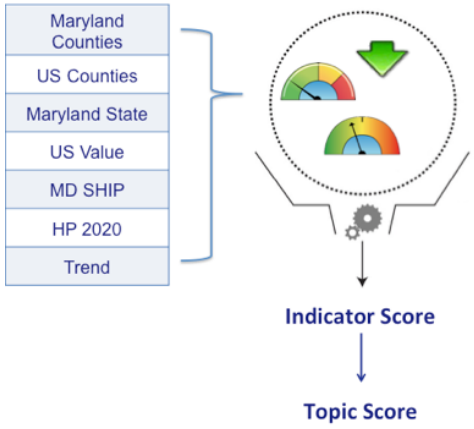
13.2 SECONDARY DATA

13.2.1 QUANTITATIVE ANALYSIS

For each indicator, the PRMC online platform includes several ways (or comparisons) by which to assess the status of each county within the tri-county service area, including comparing to other Maryland and U.S. counties, the Maryland state value, the U.S. value, the trend over time, and to Healthy People 2020 and Maryland State Health Improvement Process targets.

For this analysis, we summarized the aforementioned comparisons with a secondary data score for each indicator from the PRMC online platform. The score ranges from 0 to 3, with 0 meaning the best possible score and 3 the worst possible score. This score summarizes how each PRMC county compares to the other counties in Maryland, other counties in the U.S., the Maryland state value, the U.S. value, Healthy People 2020 targets, Maryland State Health Improvement Process targets, and the trend over the four most recent time periods of measure. A topic score for each county in the tri-county region equals the mean of the indicator scores of the topic area. Finally, a topic score for the entire tri-county service area is calculated by using a weighted average based on the population count of each county.

FIGURE A.1



13.2.2 COMPARISONS

Each indicator from PRMC health data platform was assessed for the counties the service area using up to seven possible comparisons. Each one is scored from 0-3 depending on how the county value compares to the relevant benchmarks as described below.

Comparison to Distribution of Maryland and US values

A distribution is created by taking all Maryland or U.S. counties, ordering them from low to high, and dividing them into four equally sized groups based on their order. The comparison score is determined by which of these four groups (quartiles) the county falls in.

FIGURE A.2



Comparison to Maryland value and U.S. value

For the comparisons to a single value, the scoring depends on whether the county within the tri-county service area has a better or worse value, and the percent difference between the two values. The same method is used to score the comparison to the value for both Maryland state and the U.S.

Comparison to Healthy People 2020 and Maryland State Health Improvement Process Targets

For a comparison to a Healthy People 2020 or Maryland State Health Improvement Process target, the scoring depends on whether the target is met or unmet, and the percent difference between the indicator value and the target value.

Comparison to Trend

The Mann-Kendall statistical test for trend is used to assess whether the indicator value is increasing over time or decreasing over time, and whether the trend is statistically significant.

The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by direction of the trend and statistical significance.

Missing Values

Indicator scores are calculated using the comparison scores, the availability of which depends on the data source. All missing comparisons are substituted with a neutral score for the purposes of calculating the indicator's weighted average.

Indicator and Topic Scores

For each county, indicator scores are calculated by using a weighted average of all comparison scores. Topic scores for each county are calculated as an average of all relevant indicator scores, and indicators may be included in multiple topics as appropriate. A weighted average is used to calculate topic scores for the entire tri-county service area.

DATA

The tables on the following pages present the data used in the quantitative data analysis by county. Each table shows the county value for each indicator followed by various comparison values, period of measurement, and indicator scores. Higher scores indicate a higher need. Additional data can be found on the South Shore Health Compass platform at http://www.peninsula.org/community/creating-healthy-communities.

GENDER AND RACE/ETHNICITY DISPARITIES

Indicator data were included for gender and race/ethnicity groups when available from the data source. The health needs disparity by gender or race/ethnicity was quantified by calculating the Index of Disparity[1] for all indicators with at least two gender-specific or race/ethnicity-specific values available. This index represents a standardized measure of how different each subpopulation value is compared to the overall population value. Indicators for which there is a higher Index of Disparity value are those where there is evidence of a large health disparity.

1 Pearcy JN, Keppel KG. A summary measure of health disparity. Public Health Reports. 2002;117(3):273-280.

13.2.3 INDICATOR DATA SOURCES

Key	Source
1	American Community Survey
2	Centers for Medicare & Medicaid Services
3	County Health Rankings
4	Fatality Analysis Reporting System
5	Feeding America
6	Institute for Health Metrics and Evaluation
7	Maryland Behavioral Risk Factor Surveillance System
8	Maryland Department of Health and Mental Hygiene
9	Maryland Department of the Environment
10	Maryland Governor's Office for Children
11	Maryland Governor's Office of Crime Control & Prevention
12	Maryland State Board of Elections
13	Maryland State Department of Education
14	Maryland YRBS
15	National Cancer Institute
16	National Center for Education Statistics
17	Small Area Health Insurance Estimates
18	U.S. Bureau of Labor Statistics
19	U.S. Census - County Business Patterns
20	U.S. Department of Agriculture - Food Environment Atlas

13.2.4 SECONDARY DATA SCORING RESULTS

Refer to key in Appendix 13.1.3 for source names *values in () are for race/ethnic group for indicator

SOMERSET
INDICATOR DATA SCORING BY TOPIC AREA

MEASUREMENT PERIOD	**ACCESS TO HEALTH SERVICES**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	Source
2013	Primary Care Provider Rate	*providers/100,000 population*	30			89		**2.28**		3
2014	Adults who Visited a Dentist	*percent*	59.3			70.2	65.3	**2.03**		7
2014	People with a Usual Primary Care Provider	*percent*	81.3			82.6		**1.95**		8
2013	Adults with Health Insurance	*percent*	81.7		100	85.7	79.7	**1.90**		17
2013	Persons with Health Insurance	*percent*	85.0		100	88.3	83.3	**1.85**		17
2015	Non-Physician Primary Care Provider Rate	*providers/100,000 population*	62			75		**1.58**		3
2013	Children with Health Insurance	*percent*	94.4		100	95.2		**1.53**		17
2015	Mental Health Provider Rate	*providers/100,000 population*	193			215		**1.43**		3
2013	Adolescents who have had a Routine Checkup: Medicaid Population	*percent*	60.5	57.4		54.7		**0.95**		8
2014	Adults who have had a Routine Checkup	*percent*	93.8			89.6	13.2	**0.88**		7
2013	Children who Visited a Dentist	*percent*	69.4	64.6		63.3		**0.80**		8
2014	Uninsured Emergency Department Visits	*percent*	7.2			11.0		**0.75**		8
2014	Adults Unable to Afford to See a Doctor	*percent*	6.7			10.1	13.1	**0.68**	Black (5) White (5.7) Other (85.1)	7
2014	Dentist Rate	*dentists/100,000 population*	132			74		**0.53**		3

MEASUREMENT PERIOD	**CANCER**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2008-2012	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/100,000 population*	28.6		14.5	15.4	14.7	**2.85**		15
2008-2012	Age-Adjusted Death Rate due to Cancer	*deaths/100,000 population*	219.5	147.4	161.4	171.7	166.4	**2.80**		15
2008-2012	Lung and Bronchus Cancer Incidence Rate	*cases/100,000 population*	99.8			60.7	63.7	**2.70**		15
2008-2012	Age-Adjusted Death Rate due to Lung Cancer	*deaths/100,000 population*	68.0		45.5	46.4	45.0	**2.65**		15
2008-2012	Colorectal Cancer Incidence Rate	*cases/100,000 population*	52.6		39.9	38.8	41.9	**2.65**		15
2005-2009	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/100,000 males*	38.1		21.8	26.7		**2.33**		15
2014	Pap Test History	*percent*	68.1		93	79.8	75.2	**2.18**		7
2008-2012	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/100,000 population*	11.8			10.5	11.3	**1.80**		15
2014	Cancer: Medicare Population	*percent*	8.5			8.5	7.8	**1.55**		2
2008-2012	Prostate Cancer Incidence Rate	*cases/100,000 males*	136.1			141.1	131.7	**1.40**		15
2014	Colon Cancer Screening	*percent*	76.9			73	69.3	**0.98**		7
2014	Mammogram History	*percent*	86.4			82	75.6	**0.98**		7
2008-2012	Breast Cancer Incidence Rate	*cases/100,000 females*	110.0			129.9	123.0	**0.75**		15
2006-2010	Age-Adjusted Death Rate due to Breast Cancer	*deaths/100,000 females*	19.3		20.7	24.5	22.6	**0.25**		15

MEASUREMENT PERIOD	CHILDREN'S HEALTH	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2013	Child Food Insecurity Rate	*percent*	28.3			19.1	21.4	**2.40**		5
2014	Child Abuse Rate	*cases/1,000 children*	30.5			9.9		**2.25**		10
2013	Children with Asthma	*percent*	25.1			16.1		**1.95**	Black (38.9) White (19.5) Other (100)	7
2009-2011	Low-Income Preschool Obesity	*percent*	16.9					**1.85**		20
2014	Blood Lead Levels in Children	*percent*	0.38	0.28		0.33	0.53	**1.83**		9
2013	Children with Health Insurance	*percent*	94.4		100	95.2		**1.53**		17
2010	Children with Low Access to a Grocery Store	*percent*	3.0					**1.35**		20
2013	Children who Visited a Dentist	*percent*	69.4	64.6		63.3		**0.80**		8

MEASUREMENT PERIOD	DIABETES	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Diabetes: Medicare Population	*percent*	34.0			29.0	26.7	**2.50**		2
2010-2012	Age-Adjusted Death Rate due to Diabetes	*deaths/100,000 population*	25.2			19.9	21.2	**2.18**		8
2014	Adults with Diabetes	*percent*	13.3			10.2	10.0	**2.08**		7
2014	ER Rate due to Diabetes	*ER Visits/100,000 population*	253.8	186.3		204.0		**2.05**		8
2013	Diabetic Screening: Medicare Population	*percent*	85.6			85.0		**1.13**		3

MEASUREMENT PERIOD	ECONOMY	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2010-2014	Children Living Below Poverty Level	*percent*	34.2			13.2	21.9	**2.70**		1
2010-2014	People Living Below Poverty Level	*percent*	23.7			10	15.6	**2.70**	Black (31.5) White (17.8) Asian (25.6) AIAN (0) Mult (54.2) Other (54.2) Hisp (45)	1
2010-2014	Per Capita Income	*dollars*	$16,471			$36,670	$28,555	**2.70**		1
2010-2014	Families Living Below Poverty Level	*percent*	17.9			6.9	11.5	**2.50**	Black (24.2) White (14.3) Asian (32.1) Mult (44.4) Other (100) Hisp (41.8)	1
2010-2014	Homeownership	*percent*	49.2			60.3	56.3	**2.50**		1
2010-2014	Median Household Income	*dollars*	$36,716			$74,149	$53,482	**2.50**		1
2010-2014	People Living 200% Above Poverty Level	*percent*	54.7			76.7	65.5	**2.50**		1
2010-2014	Renters Spending 30% or More of Household Income on Rent	*percent*	62.9			51.8	52.3	**2.50**		1
Jan 2016	Unemployed Workers in Civilian Labor Force	*percent*	8.7			4.9	5.3	**2.50**		18
2013	Child Food Insecurity Rate	*percent*	28.3			19.1	21.4	**2.40**		5
2013	Food Insecurity Rate	*percent*	19.1			12.8	15.8	**2.40**		5
2010-2014	Homeowner Vacancy Rate	*percent*	4.2			1.8	2.1	**2.30**		1
2013-2014	Students Eligible for the Free Lunch Program	*percent*	66.6			38.2		**2.28**		16
2008-2012	Severe Housing Problems	*percent*	21.3			17.3		**2.18**		3

2010	Low-Income and Low Access to a Grocery Store	*percent*	11.1				**2.10**		20
2010-2014	People 65+ Living Below Poverty Level	*percent*	9.3		7.6	9.4	**2.05**	Black (6) White (10) Asian (0) AIAN (0) Mult (50)	1
2009-2011	Low-Income Preschool Obesity	*percent*	16.9				**1.85**		20
2012	SNAP Certified Stores	*stores/1,000 population*	0.9				**1.25**		20
2010-2014	Households with Cash Public Assistance Income	*percent*	2.3		2.6	2.8	**1.15**		1
2014	Affordable Housing	*percent*	89.3		46.1		**0.80**		8

MEASUREMENT PERIOD	**EDUCATION**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2010-2014	People 25+ with a High School Degree or Higher	*percent*	79.0			89.0	86.3	**2.55**		1
2010-2014	People 25+ with a Bachelor's Degree or Higher	*percent*	15.1			37.3	29.3	**2.15**		1
2014	4th Grade Students Proficient in Reading	*percent*	85.5			86.3		**1.65**		13
2014	8th Grade Students Proficient in Reading	*percent*	73			76.9		**1.65**		13
2014-2015	School Readiness at Kindergarten Entry	*percent*	47.0	85.5		47.0		**1.65**		13
2015	High School Graduation	*percent*	88.0	95.0	82.4	87.0		**1.35**		13
2013-2014	Student-to-Teacher Ratio	*students/teacher*	13.6			15.0		**1.28**		16

MEASUREMENT PERIOD	**ENVIRONMENT**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2016	Access to Exercise Opportunities	*percent*	12.9			93.4		**2.18**		3
2016	Food Environment Index	*0 (worst) to 10 (best)*	5.8			8.1		**2.18**		3
2008-2012	Severe Housing Problems	*percent*	21.3			17.3		**2.18**		3
2010	Low-Income and Low Access to a Grocery Store	*percent*	11.1					**2.10**		20
2010	Households with No Car and Low Access to a Grocery Store	*percent*	5.6					**1.95**		20
2014	Blood Lead Levels in Children	*percent*	0.38	0.28		0.33	0.53	**1.83**		9
2012	Recreation and Fitness Facilities	*facilities/1,000 population*	0.04				0.06	**1.80**		20
2012	Grocery Store Density	*stores/1,000 population*	0.2					**1.40**		20
2010	Children with Low Access to a Grocery Store	*percent*	3.0					**1.35**		20
2010	People 65+ with Low Access to a Grocery Store	*percent*	2.0					**1.35**		20
2012	SNAP Certified Stores	*stores/1,000 population*	0.9					**1.25**		20
2012	Fast Food Restaurant Density	*restaurants/1,000 population*	0.5					**1.20**		20
FY 2013-14	Drinking Water Violations	*percent*	0.0			16.2		**1.13**		3
2013	Liquor Store Density	*stores/100,000 population*	11.4			20.1	10.4	**1.10**		19

2013	Farmers Market Density	*markets/1,000 population*	0.08			0.03	**0.73**		20

MEASUREMENT PERIOD	**ENVIRONMENTAL & OCCUPATIONAL HEALTH**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	ER Rate due to Asthma	*ER visits/10,000 population*	78.7	62.5		68.3		**2.00**		8
2013	Children with Asthma	*percent*	25.1			16.1		**1.95**	Black (38.9) White (19.5) Other (100)	7
2014	Adults with Asthma	*percent*	15.8			13.5	13.8	**1.93**	Black (25.7) White (11.6) Other (94.8)	7
2014	Blood Lead Levels in Children	*percent*	0.38	0.28		0.33	0.53	**1.83**		9
2014	Asthma: Medicare Population	*percent*	4.8			5.2	5.0	**1.05**		2

MEASUREMENT PERIOD	**EXERCISE, NUTRITION, & WEIGHT**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Adults who are Obese	*percent*	49.5		30.5	29.6	29.6	**2.43**		7
2014	Adults with a Healthy Weight	*percent*	20.2			35.1	35.2	**2.43**		8
2013	Child Food Insecurity Rate	*percent*	28.3			19.1	21.4	**2.40**		5
2013	Food Insecurity Rate	*percent*	19.1			12.8	15.8	**2.40**		5
2014	Adults who are Overweight or Obese	*percent*	79.8			64.9	65.0	**2.28**		7
2016	Access to Exercise Opportunities	*percent*	12.9			93.4		**2.18**		3
2016	Food Environment Index	*0 (worst) to 10 (best)*	5.8			8.1		**2.18**		3
2013	Adolescents who are Obese	*percent*	17.5	10.7	16.1	11		**2.15**		8
2010	Low-Income and Low Access to a Grocery Store	*percent*	11.1					**2.10**		20
2010	Adult Fruit and Vegetable Consumption	*percent*	17.2			27.1		**1.95**		7
2013	Adults Engaging in Regular Physical Activity	*percent*	42.1		47.9	48.0		**1.95**		7
2010	Households with No Car and Low Access to a Grocery Store	*percent*	5.6					**1.95**		20
2009-2011	Low-Income Preschool Obesity	*percent*	16.9					**1.85**		20
2012	Recreation and Fitness Facilities	*facilities/1,000 population*	0.0				0.06	**1.80**		20
2012	Grocery Store Density	*stores/1,000 population*	0.2					**1.40**		20
2010	Children with Low Access to a Grocery Store	*percent*	3.0					**1.35**		20
2010	People 65+ with Low Access to a Grocery Store	*percent*	2.0					**1.35**		20
2012	SNAP Certified Stores	*stores/1,000 population*	0.9					**1.25**		20
2012	Fast Food Restaurant Density	*restaurants/1,000 population*	0.5					**1.20**		20
2010-2014	Workers who Walk to Work	*percent*	3.4		3.1	2.3	2.8	**1.00**	Black (5.9) White (1.6) Asian (0) AIAN (0) Mult (22) Other (75) Hisp (0)	1
2013	Farmers Market Density	*markets/1,000 population*	0.08				0.0	**0.73**		20

MEASUREMENT PERIOD	**HEART DISEASE & STROKE**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2012-2014	Age-Adjusted Death Rate due to Heart Disease	*deaths/100,000 population*	294.4	152.7		169.9	169.1	**2.43**		8
2013	High Blood Pressure Prevalence	*percent*	46.6		26.9	33.6	31.4	**2.33**		7
2013	High Cholesterol Prevalence	*percent*	43.1		13.5	37	38.4	**2.33**		7
2014	Hypertension: Medicare Population	*percent*	66.2			59.2	55.1	**2.30**		2
2014	Hyperlipidemia: Medicare Population	*percent*	53.9			48.9	44.7	**2.25**		2
2014	Stroke: Medicare Population	*percent*	4.4			4.3	3.7	**2.10**		2
2014	Heart Failure: Medicare Population	*percent*	14.5			12.6	13.7	**1.80**		2
2014	Ischemic Heart Disease: Medicare Population	*percent*	28.8			26.4	27	**1.50**		2
2014	ER Rate due to Hypertension	*ER Visits/100,000 population*	239.3	234.9		252.2		**1.35**		8
2014	Atrial Fibrillation: Medicare Population	*percent*	7.7			7.9	8.0	**1.30**		2
2011-2013	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/100,000 population*	28.5		34.8	36.5	37.0	**0.78**		8

MEASUREMENT PERIOD	**IMMUNIZATIONS & INFECTIOUS DISEASES**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Salmonella Infection Incidence Rate	*cases/100,000 population*	57.0		11.4	14.9		**2.35**		8
2014	Adults with Influenza Vaccination	*percent*	29.5		70.0	41.7		**2.25**		8
2014	Chlamydia Incidence Rate	*cases/100,000 population*	570.3	431		458.9	456.1	**2.23**		8
2014	Gonorrhea Incidence Rate	*cases/100,000 population*	174.9			102.2	110.7	**2.08**		8
2014	Adults 65+ with Pneumonia Vaccination	*percent*	71.3		90.0	69.8	70.3	**1.43**		7
2014	Adults 65+ with Influenza Vaccination	*percent*	66.0			62.1	60.8	**1.28**		7
2014	Syphilis Incidence Rate	*cases/100,000 population*	3.8			7.5	6.3	**1.18**		8
2014	HIV Incidence Rate: Aged 13+	*cases/100,000 population*	9.0			24.6	16.5	**0.83**		8
2014	Tuberculosis Incidence Rate	*cases/100,000 population*	0.0		1.0	3.3	3.0	**0.83**		8

MEASUREMENT PERIOD	**MATERNAL, FETAL & INFANT HEALTH**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Babies with Low Birth Weight	*percent*	9.6	8.0	7.8	8.6		**2.15**	Black (16.3) White (5.5)	8
2010-2014	Infant Mortality Rate	*deaths/1,000 live births*	9.1	6.3	6.0	6.6		**2.15**		8
2014	Mothers who Received Early Prenatal Care	*percent*	75.3	66.9	77.9	61.5		**1.35**		8
2014	Teen Birth Rate	*live births/1,000 females aged 15-19*	17.7	17.8		17.8	24.2	**1.18**	Black (7.9) White (37.5)	8
2014	Preterm Births	*percent*	9.6		11.4	10.1		**1.10**		8

MEASUREMENT PERIOD	**MEN'S HEALTH**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2005-2009	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/100,000 males*	38.1		21.8	26.7		**2.33**		15

2010	Life Expectancy for Males	*years*	74.0			76.2	76.1	**1.85**	6
2008-2012	Prostate Cancer Incidence Rate	*cases/100,000 males*	136.1			141.1	131.7	**1.40**	15

MEASUREMENT PERIOD	**MENTAL HEALTH & MENTAL DISORDERS**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Age-Adjusted ER Rate due to Mental Health	*ER Visits/100,000 population*	5665.2			3442.6		**2.25**		8
2014	Frequent Mental Distress	*percent*	12.6			10.0		**2.18**		3
2014	Poor Mental Health Days	*days*	4.1			3.3		**2.18**		3
2014	Hospitalization Rate Related to Alzheimer's and Other Dementias	*hospitalizations/100,000 population*	228.7	199.4		194.1		**1.95**		8
2014	Self-Reported Good Mental Health	*percent*	72.7			76.7		**1.90**		7
2010	Adequate Social and Emotional Support	*percent*	80.7			82.9		**1.80**		7
2015	Mental Health Provider Rate	*providers/100,000 population*	193			215		**1.43**		3
2014	Depression: Medicare Population	*percent*	14.0			14.6	16.2	**1.15**		2
2014	Alzheimer's Disease or Dementia: Medicare Population	*percent*	8.5			10.1	10.0	**0.65**		2

MEASUREMENT PERIOD	**OLDER ADULTS & AGING**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Chronic Kidney Disease: Medicare Population	*percent*	19.3			16.6	16.6	**2.50**		2
2014	Diabetes: Medicare Population	*percent*	34.0			29.0	26.7	**2.50**		2
2014	Hypertension: Medicare Population	*percent*	66.2			59.2	55.1	**2.30**		2
2014	Hyperlipidemia: Medicare Population	*percent*	53.9			48.9	44.7	**2.25**		2
2014	COPD: Medicare Population	*percent*	13.8			9.7	11.0	**2.15**		2
2014	Stroke: Medicare Population	*percent*	4.4			4.3	3.7	**2.10**		2
2010-2014	People 65+ Living Below Poverty Level	*percent*	9.3			7.6	9.4	**2.05**	Black (6) White (10) Asian (0) AIAN (0) Mult (50)	1
2014	Hospitalization Rate Related to Alzheimer's and Other Dementias	*hospitalizations/100,000 population*	228.7	199.4		194.1		**1.95**		8
2010-2014	People 65+ Living Alone	*percent*	28.6			26.1	26.8	**1.95**		1
2014	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	29.5			29.4	29.4	**1.90**		2
2014	Heart Failure: Medicare Population	*percent*	14.5			12.6	13.7	**1.80**		2
2014	Cancer: Medicare Population	*percent*	8.5			8.5	7.8	**1.55**		2
2014	Ischemic Heart Disease: Medicare Population	*percent*	28.8			26.4	27.0	**1.50**		2
2014	Adults 65+ with Pneumonia Vaccination	*percent*	71.3		90.0	69.8	70.3	**1.43**		7
2010	People 65+ with Low Access to a Grocery Store	*percent*	2.0					**1.35**		20
2014	Atrial Fibrillation: Medicare Population	*percent*	7.7			7.9	8.0	**1.30**		2
2014	Adults 65+ with Influenza Vaccination	*percent*	66.0			62.1	60.8	**1.28**		7
2014	Depression: Medicare Population	*percent*	14.0			14.6	16.2	**1.15**		2

2013	Diabetic Screening: Medicare Population	*percent*	85.6		85.0		**1.13**	3
2014	Asthma: Medicare Population	*percent*	4.8		5.2	5.0	**1.05**	2
2014	Alzheimer's Disease or Dementia: Medicare Population	*percent*	8.5		10.1	10.0	**0.65**	2
2014	Osteoporosis: Medicare Population	*percent*	4.0		5.8	5.9	**0.50**	2

MEASUREMENT PERIOD	**ORAL HEALTH**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Age-Adjusted ER Visit Rate due to Dental Problems	*ER Visits/100,000 population*	1227.2			779.7		**2.25**		8
2014	Adults who Visited a Dentist	*percent*	59.3			70.2	65.3	**2.03**		7
2008-2012	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/100,000 population*	11.8			10.5	11.3	**1.80**		15
2014	Adults with No Tooth Extractions	*percent*	58.8			56.9	56.6	**0.98**		7
2013	Children who Visited a Dentist	*percent*	69.4	64.6		63.3		**0.80**		8
2014	Dentist Rate	*dentists/100,000 population*	132			74		**0.53**		3

MEASUREMENT PERIOD	**PREVENTION & SAFETY**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2013	Pedestrian Death Rate	*deaths/100,000 population*	3.8		1.4	0.9	1.5	**2.43**		4
2008-2012	Severe Housing Problems	*percent*	21.3			17.3		**2.18**		3
2012-2014	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/100,000 population*	33.7		36.4	26.6	39.7	**1.53**		8
2012-2014	Death Rate due to Drug Poisoning	*deaths/100,000 population*	15.3			15.7	14.0	**1.50**		3
2014	Pedestrian Injuries	*injuries/100,000 population*	23.2	35.6	20.3	42.5		**1.45**		8

MEASUREMENT PERIOD	**PUBLIC SAFETY**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2013	Pedestrian Death Rate	*deaths/100,000 population*	3.8		1.4	0.9	1.5	**2.43**		4
2014	Child Abuse Rate	*cases/1,000 children*	30.5			9.9		**2.25**		10
2014	Domestic Violence Offense Rate	*offenses/100,000 population*	549.1			455.8		**2.05**		8
2010-2014	Alcohol-Impaired Driving Deaths	*percent*	36.4			33.5		**1.73**		3
2014	Pedestrian Injuries	*injuries/100,000 population*	23.2	35.6	20.3	42.5		**1.45**		8
2011	ER Rate Related to Domestic Violence	*ER Visits/100,000 population*	94.9			107.4		**1.15**		8
2013	Violent Crime Rate	*crimes/100,000 population*	270.7			467.5	369.1	**0.68**		11

MEASUREMENT PERIOD	**RESPIRATORY DISEASES**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2008-2012	Lung and Bronchus Cancer Incidence Rate	*cases/100,000 population*	99.8			60.7	63.7	**2.70**		15
2008-2012	Age-Adjusted Death Rate due to Lung Cancer	*deaths/100,000 population*	68.0		45.5	46.4	45.0	**2.65**		15

2014	Adults with Influenza Vaccination	*percent*	29.5		70.0	41.7		**2.25**		8
2014	COPD: Medicare Population	*percent*	13.8			9.7	11.0	**2.15**		2
2014	ER Rate due to Asthma	*ER visits/10,000 population*	78.7	62.5		68.3		**2.00**		8
2013	Children with Asthma	*percent*	25.1			16.1		**1.95**	Black (38.9) White (19.5) Other (100)	7
2014	Adults with Asthma	*percent*	15.8			13.5	13.8	**1.93**	Black (25.7) White (11.6) Other (94.8)	7
2014	Adults 65+ with Pneumonia Vaccination	*percent*	71.3		90.0	69.8	70.3	**1.43**		7
2014	Adults 65+ with Influenza Vaccination	*percent*	66.0			62.1	60.8	**1.28**		7
2014	Asthma: Medicare Population	*percent*	4.8			5.2	5.0	**1.05**		2
2014	Tuberculosis Incidence Rate	*cases/100,000 population*	0.0		1.0	3.3	3.0	**0.83**		8

MEASUREMENT PERIOD	**SOCIAL ENVIRONMENT**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2010-2014	Children Living Below Poverty Level	*percent*	34.2			13.2	21.9	**2.70**		1
2010-2014	Single-Parent Households	*percent*	49.1			34.4	33.6	**2.40**		1
2014	Child Abuse Rate	*cases/1,000 children*	30.5			9.9		**2.25**		10
2010-2014	People 65+ Living Alone	*percent*	28.6			26.1	26.8	**1.95**		1
2012	Voter Registration	*percent*	62.7			81.4	71.2	**1.88**		12

MEASUREMENT PERIOD	**SUBSTANCE ABUSE**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Age-Adjusted ER Rate due to Alcohol/Substance Abuse	*ER visits/100,000 population*	1896.4			1591.3		**2.25**		8
2014	Adults who Smoke	*percent*	19.8	15.5	12.0	14.6	18.1	**2.23**		7
2014	Teens who Smoke	*percent*	16.5		16.0	8.7		**2.00**		14
2013	Adolescents who Use Tobacco	*percent*	23.0	15.2	21.0	16.9		**1.95**		8
2010-2014	Alcohol-Impaired Driving Deaths	*percent*	36.4			33.5		**1.73**		3
2012-2014	Death Rate due to Drug Poisoning	*deaths/100,000 population*	15.3			15.7	14.0	**1.50**		3
2013	Liquor Store Density	*stores/100,000 population*	11.4			20.1	10.4	**1.10**		19
2008-2010	Age-Adjusted Death Rate due to Drug Use	*deaths/100,000 population*	0.0		11.3	12.1		**0.90**		8
2014	Adults who Binge Drink	*percent*	10.8		24.4	15.4	16.0	**0.83**	Black (22.1) White (6.7) Hisp (37.9)	7

MEASUREMENT PERIOD	**TEEN & ADOLESCENT HEALTH**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2013	Adolescents who are Obese	*percent*	17.5	10.7	16.1	11.0		**2.15**		8
2014	Teens who Smoke	*percent*	16.5		16.0	8.7		**2.00**		14
2013	Adolescents who Use Tobacco	*percent*	23	15.2	21.0	16.9		**1.95**		8
2014	Teen Birth Rate	*live births/1,000 females aged 15-19*	17.7	17.8		17.8	24.2	**1.18**	Black (7.9) White (37.5)	8
2013	Adolescents who have had a Routine Checkup: Medicaid Population	*percent*	60.5	57.4		54.7		**0.95**		8

MEASUREMENT PERIOD	**TRANSPORTATION**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2010-2014	Households without a Vehicle	*percent*	10.3			9.4	9.1	**2.35**		1
2010	Households with No Car and Low Access to a Grocery Store	*percent*	5.6					**1.95**		20
2010-2014	Workers who Drive Alone to Work	*percent*	79.8			73.6	76.4	**1.60**		1
2010-2014	Workers Commuting by Public Transportation	*percent*	2.3		5.5	8.9	5.1	**1.50**	Black (5.2) White (0.3) Asian (31.1) AIAN (0) Mult (0) Other (0) Hisp (14.6)	1
2010-2014	Solo Drivers with a Long Commute	*percent*	29.7			47.6		**1.13**		3
2010-2014	Workers who Walk to Work	*percent*	3.4		3.1	2.3	2.8	**1.00**	Black (5.9) White (1.6) Asian (0) AIAN (0) Mult (22) Other (75) Hisp (0)	1
2010-2014	Mean Travel Time to Work	*minutes*	22.9			32.2	25.7	**0.80**		1

MEASUREMENT PERIOD	**WELLNESS & LIFESTYLE**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Insufficient Sleep	*percent*	42.7			38.0		**2.18**		3
2014	Frequent Physical Distress	*percent*	12.2			10.0		**2.03**		3
2010	Life Expectancy for Females	*years*	78.1			80.8	80.8	**2.00**		6
2010	Life Expectancy for Males	*years*	74			76.2	76.1	**1.85**		6
2012-2014	Average Life Expectancy	*years*	77.2	79.8		79.8		**1.75**		8
2014	Self-Reported Good Physical Health	*percent*	75.7			77.6		**1.75**		7
2014	Self-Reported General Health Assessment: Good or Better	*percent*	82.1			85.9	83.2	**1.73**		7

MEASUREMENT PERIOD	**WOMEN'S HEALTH**	UNITS	SOMERSET COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Pap Test History	*percent*	68.1		93.0	79.8	75.2	**2.18**		7
2010	Life Expectancy for Females	*years*	78.1			80.8	80.8	**2.00**		6
2014	Mammogram History	*percent*	86.4			82.0	75.6	**0.98**		7
2008-2012	Breast Cancer Incidence Rate	*cases/100,000 females*	110.0			129.9	123.0	**0.75**		15
2006-2010	Age-Adjusted Death Rate due to Breast Cancer	*deaths/100,000 females*	19.3		20.7	24.5	22.6	**0.25**		15

SOMERSET COUNTY
TOPIC SCORE TABLES

Health Topic	Score
Diabetes	1.99
Wellness & Lifestyle	1.90
Heart Disease & Stroke	1.86
Men's Health	1.86
Cancer	1.85
Respiratory Diseases	1.84
Exercise, Nutrition, & Weight	1.83
Prevention & Safety	1.82
Environmental & Occupational Health	1.75
Children's Health	1.75
Mental Health & Mental Disorders	1.72
Older Adults & Aging	1.65
Teen & Adolescent Health	1.65
Substance Abuse	1.61
Immunizations & Infectious Diseases	1.61
Maternal, Fetal & Infant Health	1.59
Oral Health	1.40
Access to Health Services	1.37
Women's Health	1.23

Quality of Life Topic	Score
Social Environment	2.24
Economy	2.19
Education	1.75
Public Safety	1.68
Environment	1.58
Transportation	1.48

WICOMICO
INDICATOR DATA SCORING BY TOPIC AREA

MEASUREMENT PERIOD	**ACCESS TO HEALTH SERVICES**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	Source
2014	Adults who Visited a Dentist	*percent*	62.7			70.2	65.3	**2.13**		7
2013	Persons with Health Insurance	*percent*	85.2		100	88.3	83.3	**1.85**		17
2013	Adults with Health Insurance	*percent*	81.9		100	85.7	79.7	**1.80**		17
2013	Children with Health Insurance	*percent*	94.3		100	95.2		**1.68**		17
2013	Primary Care Provider Rate	*providers/100,000 population*	75.0			89.0		**1.33**		3
2013	Adolescents who have had a Routine Checkup: Medicaid Population	*percent*	55.9	57.4		54.7		**1.20**		8
2013	Children who Visited a Dentist	*percent*	64.6	64.6		63.3		**1.15**		8
2014	Uninsured Emergency Department Visits	*percent*	9.9			11.0		**1.05**		8
2014	People with a Usual Primary Care Provider	*percent*	89.2			82.6		**1.05**		8
2015	Mental Health Provider Rate	*providers/100,000 population*	232			215		**0.98**		3
2014	Adults who have had a Routine Checkup	*percent*	92.8			89.6	13.2	**0.88**		7
2014	Dentist Rate	*dentists/100,000 population*	77			74		**0.88**		3
2014	Adults Unable to Afford to See a Doctor	*percent*	8.3			10.1	13.1	**0.83**	Black (5) White (10.6) Other (21.3) Hisp (1.7)	7
2015	Non-Physician Primary Care Provider Rate	*providers/100,000 population*	160			75		**0.83**		3

MEASUREMENT PERIOD	**CANCER**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2008-2012	Age-Adjusted Death Rate due to Cancer	*deaths/100,000 population*	206.8	147.4	161.4	171.7	166.4	**2.60**		15
2008-2012	Prostate Cancer Incidence Rate	*cases/100,000 males*	176.7			141.1	131.7	**2.50**		15
2008-2012	Age-Adjusted Death Rate due to Lung Cancer	*deaths/100,000 population*	60.8		45.5	46.4	45.0	**2.30**		15
2008-2012	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/100,000 population*	20.4		14.5	15.4	14.7	**2.25**		15
2014	Pap Test History	*percent*	67.7		93.0	79.8	75.2	**2.18**		7
2008-2012	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/100,000 males*	26.0		21.8	22.5	19.6	**2.15**		15
2008-2012	Colorectal Cancer Incidence Rate	*cases/100,000 population*	46.2		39.9	38.8	41.9	**2.10**		15
2008-2012	Lung and Bronchus Cancer Incidence Rate	*cases/100,000 population*	85.4			60.7	63.7	**2.10**		15
2008-2012	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/100,000 population*	11.0			10.5	11.3	**1.60**		15
2014	Cancer: Medicare Population	*percent*	8.3			8.5	7.8	**1.55**		2
2008-2012	Breast Cancer Incidence Rate	*cases/100,000 females*	125.4			129.9	123	**1.50**		15

2014	Mammogram History	*percent*	82.4			82.0	75.6	**1.28**		7
2008-2012	Cervical Cancer Incidence Rate	*cases/100,000 females*	7.2		7.2	6.7	7.7	**1.15**		15
2008-2012	Age-Adjusted Death Rate due to Breast Cancer	*deaths/100,000 females*	20.9		20.7	23.7	21.3	**0.85**		15
2014	Colon Cancer Screening	*percent*	81.7			73.0	69.3	**0.83**		7

MEASUREMENT PERIOD	**CHILDREN'S HEALTH**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Child Abuse Rate	*cases/1,000 children*	13.4			9.9		**2.10**		10
2013	Child Food Insecurity Rate	*percent*	23.6			19.1	21.4	**1.95**		5
2010	Children with Low Access to a Grocery Store	*percent*	6.3					**1.80**		20
2013	Children with Health Insurance	*percent*	94.3		100	95.2		**1.68**		17
2009-2011	Low-Income Preschool Obesity	*percent*	15.6					**1.50**		20
2013	Children who Visited a Dentist	*percent*	64.6	64.6		63.3		**1.15**		8
2014	Blood Lead Levels in Children	*percent*	0.21	0.28		0.33	0.53	**1.08**		9
2013	Children with Asthma	*percent*	9.7			16.1		**1.05**	Black (34.9) White (5.7)	7

MEASUREMENT PERIOD	**DIABETES**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Diabetes: Medicare Population	*percent*	31.3			29.0	26.7	**2.20**		2
2014	Adults with Diabetes	*percent*	12.9			10.2	10.0	**2.13**	Black (16.9) White (9.8) Asian (17.9) Other (33.1) Hisp (8)	7
2014	ER Rate due to Diabetes	*ER Visits/100,000 population*	372.7	186.3		204.0		**2.00**		8
2013	Diabetic Screening: Medicare Population	*percent*	84.6			85.0		**1.58**		3
2012-2014	Age-Adjusted Death Rate due to Diabetes	*deaths/100,000 population*	10.1			19.2	21.1	**0.53**		8

MEASUREMENT PERIOD	**ECONOMY**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2010-2014	Households with Cash Public Assistance Income	*percent*	3.2			2.6	2.8	**2.70**		1
Jan 2016	Unemployed Workers in Civilian Labor Force	*percent*	7.3			4.9	5.3	**2.70**		18
2010-2014	People Living Below Poverty Level	*percent*	17.4			10.0	15.6	**2.55**	Black (24.6) White (13.5) Asian (18.4) AIAN (58.9) NHPI (0) Mult (25) Other (23.7) Hisp (29.5)	1
2010-2014	Children Living Below Poverty Level	*percent*	23.3			13.2	21.9	**2.40**	Black (34.3) White (16) Asian (11.6) AIAN (100) Mult (29.8) Other (17.3) Hisp (33.9)	1
2013-2014	Students Eligible for the Free Lunch Program	*percent*	54.2			38.2		**2.33**		16
2010-2014	Families Living Below Poverty Level	*percent*	11.5			6.9	11.5	**2.25**	Black (20) White (7.8) Asian (9.6) AIAN (53.6) NHPI (0) Mult (18.1) Other (22) Hisp (24.9)	1

2008-2012	Severe Housing Problems	*percent*	20.5		17.3		**2.18**	3
2010-2014	Homeowner Vacancy Rate	*percent*	2.6		1.8	2.1	**2.10**	1
2010-2014	Homeownership	*percent*	55.5		60.3	56.3	**2.10**	1
2010-2014	People Living 200% Above Poverty Level	*percent*	63.3		76.7	65.5	**2.05**	1
2010-2014	Renters Spending 30% or More of Household Income on Rent	*percent*	55.5		51.8	52.3	**2.00**	1
2013	Child Food Insecurity Rate	*percent*	23.6		19.1	21.4	**1.95**	5
2013	Food Insecurity Rate	*percent*	15.5		12.8	15.8	**1.95**	5
2010	Low-Income and Low Access to a Grocery Store	*percent*	7.1				**1.95**	20
2010-2014	Per Capita Income	*dollars*	$26,298		$36,670	$28,555	**1.95**	1
2010-2014	Median Household Income	*dollars*	$52,301		$74,149	$53,482	**1.70**	1
2009-2011	Low-Income Preschool Obesity	*percent*	15.6				**1.50**	20
2012	SNAP Certified Stores	*stores/1,000 population*	0.8				**1.50**	20
2010-2014	People 65+ Living Below Poverty Level	*percent*	8.2		7.6	9.4	**1.20**	Black (15.2) White (6.6) Asian (8.3) Mult (30) Other (0) Hisp (9.5) 1
2014	Affordable Housing	*percent*	85.6		46.1		**0.80**	8

MEASUREMENT PERIOD	**EDUCATION**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014-2015	School Readiness at Kindergarten Entry	*percent*	43.0	85.5		47.0		**1.95**		13
2014	4th Grade Students Proficient in Reading	*percent*	85.3			86.3		**1.80**		13
2014	8th Grade Students Proficient in Reading	*percent*	70.4			76.9		**1.80**		13
2015	High School Graduation	*percent*	83.5	95.0	82.4	87.0		**1.75**		13
2010-2014	People 25+ with a Bachelor's Degree or Higher	*percent*	27.7			37.3	29.3	**1.55**		1
2010-2014	People 25+ with a High School Degree or Higher	*percent*	87.0			89.0	86.3	**1.40**		1
2013-2014	Student-to-Teacher Ratio	*students/teacher*	13.6			15.0		**1.28**		16

MEASUREMENT PERIOD	**ENVIRONMENT**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2008-2012	Severe Housing Problems	*percent*	20.5			17.3		**2.18**		3
2016	Food Environment Index	*0 (worst) to 10 (best)*	7.0			8.1		**2.03**		3
2012	Grocery Store Density	*stores/1,000 population*	0.1					**1.95**		20
2010	Low-Income and Low Access to a Grocery Store	*percent*	7.1					**1.95**		20
2012	Fast Food Restaurant Density	*restaurants/1,000 population*	0.9					**1.85**		20
2010	Children with Low Access to a Grocery Store	*percent*	6.30					**1.80**		20
2010	Households with No Car and Low Access to a Grocery Store	*percent*	2.8					**1.80**		20

2010	People 65+ with Low Access to a Grocery Store	*percent*	3.9				**1.80**		20
2016	Access to Exercise Opportunities	*percent*	82.5		93.4		**1.58**		3
2013	Farmers Market Density	*markets/1,000 population*	0.03			0.03	**1.58**		20
2012	Recreation and Fitness Facilities	*facilities/1,000 population*	0.09			0.06	**1.50**		20
2012	SNAP Certified Stores	*stores/1,000 population*	0.8				**1.50**		20
FY 2013-14	Drinking Water Violations	*percent*	1.7		16.2		**1.43**		3
2014	PBT Released	*pounds*	0				**1.40**		20
2014	Recognized Carcinogens Released into Air	*pounds*	49399				**1.40**		20
2014	Blood Lead Levels in Children	*percent*	0.21	0.28	0.33	0.53	**1.08**		9
2013	Liquor Store Density	*stores/100,000 population*	5.9		20.1	10.4	**0.50**		19

MEASUREMENT PERIOD	**ENVIRONMENTAL & OCCUPATIONAL HEALTH**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Adults with Asthma	*percent*	24.1			13.5	13.8	**2.28**	Black (29.9) White (21.3) Other (79.8)	7
2014	ER Rate due to Asthma	*ER visits/10,000 population*	91.5	62.5		68.3		**2.00**		8
2014	Asthma: Medicare Population	*percent*	4.8			5.2	5.0	**1.45**		2
2014	Blood Lead Levels in Children	*percent*	0.21	0.28		0.33	0.53	**1.08**		9
2013	Children with Asthma	*percent*	9.7			16.1		**1.05**	Black (34.9) White (5.7)	7

MEASUREMENT PERIOD	**EXERCISE, NUTRITION, & WEIGHT**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2010-2014	Workers who Walk to Work	*percent*	2.0		3.1	2.3	2.8	**2.15**	Black (3) White (1.8) Asian (0.2) AIAN (0) NHPI (0) Mult (0) Other (0) Hisp (3.6)	1
2014	Adults who are Obese	*percent*	34.5		30.5	29.6	29.6	**2.08**		7
2014	Adults with a Healthy Weight	*percent*	31.3			35.1	35.2	**2.08**		8
2016	Food Environment Index	*0 (worst) to 10 (best)*	7.0			8.1		**2.03**		3
2013	Child Food Insecurity Rate	*percent*	23.6			19.1	21.4	**1.95**		5
2013	Food Insecurity Rate	*percent*	15.5			12.8	15.8	**1.95**		5
2012	Grocery Store Density	*stores/1,000 population*	0.1					**1.95**		20
2010	Low-Income and Low Access to a Grocery Store	*percent*	7.1					**1.95**		20
2012	Fast Food Restaurant Density	*restaurants/1,000 population*	0.9					**1.85**		20
2010	Adult Fruit and Vegetable Consumption	*percent*	23.1			27.1		**1.80**		7
2010	Children with Low Access to a Grocery Store	*percent*	6.3					**1.80**		20
2010	Households with No Car and Low Access to a Grocery Store	*percent*	2.8					**1.80**		20
2010	People 65+ with Low Access to a Grocery Store	*percent*	3.9					**1.80**		20

2013	Adults Engaging in Regular Physical Activity	*percent*	45.6		47.9	48.0		**1.70**	7
2014	Adults who are Overweight or Obese	*percent*	68.7			64.9	65.0	**1.63**	7
2013	Adolescents who are Obese	*percent*	12.0	10.7	16.1	11.0		**1.60**	8
2016	Access to Exercise Opportunities	*percent*	82.5			93.4		**1.58**	3
2013	Farmers Market Density	*markets/1,000 population*	0.03				0.0	**1.58**	20
2009-2011	Low-Income Preschool Obesity	*percent*	15.6					**1.50**	20
2012	Recreation and Fitness Facilities	*facilities/1,000 population*	0.1				0.06	**1.50**	20
2012	SNAP Certified Stores	*stores/1,000 population*	0.8					**1.50**	20

MEASUREMENT PERIOD	**HEART DISEASE & STROKE**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Hyperlipidemia: Medicare Population	*percent*	56.4			48.9	44.7	**2.70**		2
2014	Hypertension: Medicare Population	*percent*	66.2			59.2	55.1	**2.70**		2
2012-2014	Age-Adjusted Death Rate due to Heart Disease	*deaths/100,000 population*	254.6	152.7		169.9	169.1	**2.63**		8
2014	Stroke: Medicare Population	*percent*	5.3			4.3	3.7	**2.30**		2
2013	High Cholesterol Prevalence	*percent*	41.5		13.5	37	38.4	**2.18**		7
2014	ER Rate due to Hypertension	*ER Visits/100,000 population*	383.7	234.9		252.2		**2.00**		8
2014	Atrial Fibrillation: Medicare Population	*percent*	8.4			7.9	8.0	**1.95**		2
2014	Heart Failure: Medicare Population	*percent*	14.8			12.6	13.7	**1.80**		2
2013	High Blood Pressure Prevalence	*percent*	33.9		26.9	33.6	31.4	**1.73**		7
2014	Ischemic Heart Disease: Medicare Population	*percent*	29.1			26.4	27.0	**1.65**		2
2012-2014	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/100,000 population*	28.9		34.8	36.3	36.5	**0.78**		8

MEASUREMENT PERIOD	**IMMUNIZATIONS & INFECTIOUS DISEASES**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Adults 65+ with Pneumonia Vaccination	*percent*	61.1		90.0	69.8	70.3	**2.43**		7
2014	Adults with Influenza Vaccination	*percent*	34.3		70.0	41.7		**2.35**		8
2014	Chlamydia Incidence Rate	*cases/100,000 population*	566.3	431.0		458.9	456.1	**2.23**		8
2014	Salmonella Infection Incidence Rate	*cases/100,000 population*	27.6		11.4	14.9		**2.15**		8
2014	Gonorrhea Incidence Rate	*cases/100,000 population*	185.2			102.2	110.7	**2.08**		8
2014	Adults 65+ with Influenza Vaccination	*percent*	56.2			62.1	60.8	**1.78**		7
2014	Tuberculosis Incidence Rate	*cases/100,000 population*	3.0		1.0	3.3	3.0	**1.73**		8
2014	Syphilis Incidence Rate	*cases/100,000 population*	3.0			7.5	6.3	**1.13**		8
2014	HIV Incidence Rate: Aged 13+	*cases/100,000 population*	13.3			24.6	16.5	**1.08**		8
2012-2014	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/100,000 population*	8.3			16.0	15.2	**0.73**		8

MEASUREMENT PERIOD	**MATERNAL, FETAL & INFANT HEALTH**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2010-2014	Infant Mortality Rate	*deaths/1,000 live births*	8.8	6.3	6.0	6.6		**2.35**		8
2014	Babies with Low Birth Weight	*percent*	9.3	8.0	7.8	8.6		**2.05**		8
2008-2012	Sudden Unexpected Infant Death Rate	*deaths/1,000 live births*	0.9		0.84	0.9	0.9	**1.68**		8
2014	Teen Birth Rate	*live births/1,000 females aged 15-19*	21.0	17.8		17.8	24.2	**1.48**	Black (54.9) White (8.7) Hisp (43.5)	8
2014	Preterm Births	*percent*	9.9		11.4	10.1		**1.25**		8
2014	Mothers who Received Early Prenatal Care	*percent*	73.2	66.9	77.9	61.5		**1.20**		8

MEASUREMENT PERIOD	**MEN'S HEALTH**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2008-2012	Prostate Cancer Incidence Rate	*cases/100,000 males*	176.7			141.1	131.7	**2.50**		15
2008-2012	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/100,000 males*	26.0		21.8	22.5	19.6	**2.15**		15
2010	Life Expectancy for Males	*years*	73.7			76.2	76.1	**1.65**		6

MEASUREMENT PERIOD	**MENTAL HEALTH & MENTAL DISORDERS**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Age-Adjusted ER Rate due to Mental Health	*ER Visits/100,000 population*	6207.9			3442.6		**2.40**		8
2012-2014	Age-Adjusted Death Rate due to Suicide	*deaths/100,000 population*	12.2	9.0	10.2	9.2	12.7	**2.13**		8
2014	Self-Reported Good Mental Health	*percent*	69.0			76.7		**2.05**		7
2014	Frequent Mental Distress	*percent*	11.4			10.0		**2.03**		3
2014	Poor Mental Health Days	*days*	3.9			3.3		**2.03**		3
2014	Depression: Medicare Population	*percent*	15.0			14.6	16.2	**1.60**		2
2010	Adequate Social and Emotional Support	*percent*	83.4			82.9		**1.50**		7
2014	Alzheimer's Disease or Dementia: Medicare Population	*percent*	9.9			10.1	10.0	**1.50**		2
2015	Mental Health Provider Rate	*providers/100,000 population*	232			215		**0.98**		3
2014	Hospitalization Rate Related to Alzheimer's and Other Dementias	*hospitalizations/100,000 population*	146.9	199.4		194.1		**0.95**		8

MEASUREMENT PERIOD	**OLDER ADULTS & AGING**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Chronic Kidney Disease: Medicare Population	*percent*	19.2			16.6	16.6	**2.70**		2
2014	Hyperlipidemia: Medicare Population	*percent*	56.4			48.9	44.7	**2.70**		2
2014	Hypertension: Medicare Population	*percent*	66.2			59.2	55.1	**2.70**		2
2014	Adults 65+ with Pneumonia Vaccination	*percent*	61.1		90.0	69.8	70.3	**2.43**		7
2014	Stroke: Medicare Population	*percent*	5.3			4.3	3.7	**2.30**		2
2014	Diabetes: Medicare Population	*percent*	31.3			29	26.7	**2.20**		2
2014	COPD: Medicare Population	*percent*	12.3			9.7	11.0	**2.15**		2

2012-2014	Age-Adjusted Death Rate due to Falls	*deaths/100,000 population*	8.6		7.2	8.5	8.5	**1.98**	8
2014	Atrial Fibrillation: Medicare Population	*percent*	8.4			7.9	8.0	**1.95**	2
2014	Heart Failure: Medicare Population	*percent*	14.8			12.6	13.7	**1.80**	2
2010	People 65+ with Low Access to a Grocery Store	*percent*	3.9					**1.80**	20
2014	Adults 65+ with Influenza Vaccination	*percent*	56.2			62.1	60.8	**1.78**	7
2014	Ischemic Heart Disease: Medicare Population	*percent*	29.1			26.4	27	**1.65**	2
2014	Depression: Medicare Population	*percent*	15.0			14.6	16.2	**1.60**	2
2010-2014	People 65+ Living Alone	*percent*	26.6			26.1	26.8	**1.60**	1
2013	Diabetic Screening: Medicare Population	*percent*	84.6			85.0		**1.58**	3
2014	Cancer: Medicare Population	*percent*	8.3			8.5	7.8	**1.55**	2
2014	Alzheimer's Disease or Dementia: Medicare Population	*percent*	9.9			10.1	10.0	**1.50**	2
2014	Asthma: Medicare Population	*percent*	4.8			5.2	5.0	**1.45**	2
2014	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	28.9			29.4	29.4	**1.30**	2
2010-2014	People 65+ Living Below Poverty Level	*percent*	8.2			7.6	9.4	**1.20**	Black (15.2) White (6.6) Asian (8.3) Mult (30) Other (0) Hisp (9.5) 1
2014	Osteoporosis: Medicare Population	*percent*	5.1			5.8	5.9	**1.10**	2
2014	Hospitalization Rate Related to Alzheimer's and Other Dementias	*hospitalizations/10 0,000 population*	146.9	199.4		194.1		**0.95**	8

MEASUREMENT PERIOD	**ORAL HEALTH**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Age-Adjusted ER Visit Rate due to Dental Problems	*ER Visits/100,000 population*	1886.7			779.7		**2.20**		8
2014	Adults who Visited a Dentist	*percent*	62.7			70.2	65.3	**2.13**		7
2014	Adults with No Tooth Extractions	*percent*	52.2			56.9	56.6	**1.73**		7
2008-2012	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/100,000 population*	11.0			10.5	11.3	**1.60**		15
2013	Children who Visited a Dentist	*percent*	64.6	64.6		63.3		**1.15**		8
2014	Dentist Rate	*dentists/100,000 population*	77			74		**0.88**		3

MEASUREMENT PERIOD	**PREVENTION & SAFETY**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2008-2012	Severe Housing Problems	*percent*	20.5			17.3		**2.18**		3
2014	Pedestrian Injuries	*injuries/100,000 population*	38.4	35.6	20.3	42.5		**2.00**		8
2012-2014	Age-Adjusted Death Rate due to Falls	*deaths/100,000 population*	8.6		7.2	8.5	8.5	**1.98**		8
2008-2010	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/100,000 population*	15.7			10.0		**1.80**		8

2012-2014	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/100,000 population*	31.3		36.4	26.6	39.7	**1.73**	8
2012-2014	Death Rate due to Drug Poisoning	*deaths/100,000 population*	14.5			15.7	14	**1.35**	3
2013	Pedestrian Death Rate	*deaths/100,000 population*	0.0		1.4	0.9	1.5	**0.93**	4

MEASUREMENT PERIOD	**PUBLIC SAFETY**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Domestic Violence Offense Rate	*offenses/100,000 population*	743.6			455.8		**2.40**		8
2014	Child Abuse Rate	*cases/1,000 children*	13.4			9.9		**2.10**		10
2014	Pedestrian Injuries	*injuries/100,000 population*	38.4	35.6	20.3	42.5		**2.00**		8
2008-2010	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/100,000 population*	15.7			10.0		**1.80**		8
2013	Violent Crime Rate	*crimes/100,000 population*	496.9			467.5	369.1	**1.73**		11
2008-2010	Age-Adjusted Death Rate due to Homicide	*deaths/100,000 population*	7.1		5.5	8.4	5.6	**1.65**		8
2010-2014	Alcohol-Impaired Driving Deaths	*percent*	32.1			33.5		**1.43**		3
2011	ER Rate Related to Domestic Violence	*ER Visits/100,000 population*	71.6			107.4		**1.05**		8
2013	Pedestrian Death Rate	*deaths/100,000 population*	0.0		1.4	0.9	1.5	**0.93**		4

MEASUREMENT PERIOD	**RESPIRATORY DISEASES**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Adults 65+ with Pneumonia Vaccination	*percent*	61.1		90.0	69.8	70.3	**2.43**		7
2014	Adults with Influenza Vaccination	*percent*	34.3		70.0	41.7		**2.35**		8
2008-2012	Age-Adjusted Death Rate due to Lung Cancer	*deaths/100,000 population*	60.8		45.5	46.4	45	**2.30**		15
2014	Adults with Asthma	*percent*	24.1			13.5	13.8	**2.28**	Black (29.9) White (21.3) Other (79.8)	7
2014	COPD: Medicare Population	*percent*	12.3			9.7	11	**2.15**		2
2008-2012	Lung and Bronchus Cancer Incidence Rate	*cases/100,000 population*	85.4			60.7	63.7	**2.10**		15
2014	ER Rate due to Asthma	*ER visits/10,000 population*	91.5	62.5		68.3		**2.00**		8
2014	Adults 65+ with Influenza Vaccination	*percent*	56.2			62.1	60.8	**1.78**		7
2014	Tuberculosis Incidence Rate	*cases/100,000 population*	3.0		1.0	3.3	3.0	**1.73**		8
2014	Asthma: Medicare Population	*percent*	4.8			5.2	5.0	**1.45**		2
2013	Children with Asthma	*percent*	9.7			16.1		**1.05**	Black (34.9) White (5.7)	7
2012-2014	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/100,000 population*	8.3			16.0	15.2	**0.73**		8

MEASUREMENT PERIOD	**SOCIAL ENVIRONMENT**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2010-2014	Single-Parent Households	*percent*	40.4			34.4	33.6	**2.50**		1

2010-2014	Children Living Below Poverty Level	*percent*	23.3			13.2	21.9	**2.40**	Black (34.3) White (16) Asian (11.6) AIAN (100) Mult (29.8) Other (17.3) Hisp (33.9)	1
2014	Child Abuse Rate	*cases/1,000 children*	13.4			9.9		**2.10**		10
2012	Voter Registration	*percent*	71.9			81.4	71.2	**1.78**		12
2010-2014	People 65+ Living Alone	*percent*	26.6			26.1	26.8	**1.60**		1

MEASUREMENT PERIOD	**SUBSTANCE ABUSE**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Adults who Smoke	*percent*	22.7	15.5	12.0	14.6	18.1	**2.48**	Black (32.1) White (18) Other (68.1) Hisp (7.8)	7
2014	Age-Adjusted ER Rate due to Alcohol/Substance Abuse	*ER visits/100,000 population*	2870.5			1591.3		**2.40**		8
2012-2014	Age-Adjusted Death Rate due to Drug Use	*deaths/100,000 population*	16.2		11.3	15.2	14.6	**2.18**		8
2013	Adolescents who Use Tobacco	*percent*	22.8	15.2	21.0	16.9		**1.95**		8
2014	Teens who Smoke	*percent*	12.7		16.0	8.7		**1.65**		14
2010-2014	Alcohol-Impaired Driving Deaths	*percent*	32.1			33.5		**1.43**		3
2012-2014	Death Rate due to Drug Poisoning	*deaths/100,000 population*	14.5			15.7	14.0	**1.35**		3
2014	Adults who Binge Drink	*percent*	9.2		24.4	15.4	16.0	**0.58**		7
2013	Liquor Store Density	*stores/100,000 population*	5.9			20.1	10.4	**0.50**		19

MEASUREMENT PERIOD	**TEEN & ADOLESCENT HEALTH**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2013	Adolescents who Use Tobacco	*percent*	22.8	15.2	21.0	16.9		**1.95**		8
2014	Teens who Smoke	*percent*	12.7		16.0	8.7		**1.65**		14
2013	Adolescents who are Obese	*percent*	12.0	10.7	16.1	11.0		**1.60**		8
2014	Teen Birth Rate	*live births/1,000 females aged 15-19*	21.0	17.8		17.8	24.2	**1.48**	Black (54.9) White (8.7) Hisp (43.5)	8
2013	Adolescents who have had a Routine Checkup: Medicaid Population	*percent*	55.9	57.4		54.7		**1.20**		8

MEASUREMENT PERIOD	**TRANSPORTATION**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2010-2014	Workers who Drive Alone to Work	*percent*	82.9			73.6	76.4	**2.20**		1
2010-2014	Workers who Walk to Work	*percent*	2.0		3.1	2.3	2.8	**2.15**	Black (3) White (1.8) Asian (0.2) AIAN (0) NHPI (0) Mult (0) Other (0) Hisp (3.6)	1
2010-2014	Workers Commuting by Public Transportation	*percent*	0.9		5.5	8.9	5.1	**2.00**	Black (2.9) White (0.2) Asian (0) AIAN (0) NHPI (0) Mult (0) Other (0) Hisp (2)	1

2010	Households with No Car and Low Access to a Grocery Store	*percent*	2.8				**1.80**	20
2010-2014	Households without a Vehicle	*percent*	7.5		9.4	9.1	**1.10**	1
2010-2014	Solo Drivers with a Long Commute	*percent*	22.5		47.6		**0.98**	3
2010-2014	Mean Travel Time to Work	*minutes*	21.5		32.2	25.7	**0.65**	1

MEASUREMENT PERIOD	**WELLNESS & LIFESTYLE**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2012-2014	Average Life Expectancy	*years*	77.3	79.8		79.8		**1.95**		8
2014	Insufficient Sleep	*percent*	36.8			38.0		**1.88**		3
2010	Life Expectancy for Females	*years*	79.1			80.8	80.8	**1.85**		6
2014	Frequent Physical Distress	*percent*	10.4			10.0		**1.73**		3
2010	Life Expectancy for Males	*years*	73.7			76.2	76.1	**1.65**		6
2014	Self-Reported Good Physical Health	*percent*	79.6			77.6		**1.25**		7
2014	Self-Reported General Health Assessment: Good or Better	*percent*	85.6			85.9	83.2	**1.13**		7

MEASUREMENT PERIOD	**WOMEN'S HEALTH**	UNITS	WICOMICO COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Pap Test History	*percent*	67.7		93.0	79.8	75.2	**2.18**		7
2010	Life Expectancy for Females	*years*	79.1			80.8	80.8	**1.85**		6
2008-2012	Breast Cancer Incidence Rate	*cases/100,000 females*	125.4			129.9	123	**1.50**		15
2014	Mammogram History	*percent*	82.4			82.0	75.6	**1.28**		7
2008-2012	Cervical Cancer Incidence Rate	*cases/100,000 females*	7.2		7.2	6.7	7.7	**1.15**		15
2008-2012	Age-Adjusted Death Rate due to Breast Cancer	*deaths/100,000 females*	20.9		20.7	23.7	21.3	**0.85**		15

WICOMICO COUNTY
TOPIC SCORE TABLES

Health Topic	Score
Men's Health	2.10
Heart Disease & Stroke	2.04
Respiratory Diseases	1.86
Older Adults & Aging	1.82
Exercise, Nutrition, & Weight	1.80
Cancer	1.80
Immunizations & Infectious Diseases	1.77
Mental Health & Mental Disorders	1.72
Prevention & Safety	1.71
Diabetes	1.69
Maternal, Fetal & Infant Health	1.67
Wellness & Lifestyle	1.63
Oral Health	1.62
Substance Abuse	1.61
Teen & Adolescent Health	1.58
Environmental & Occupational Health	1.57
Children's Health	1.54
Women's Health	1.47
Access to Health Services	1.26

Quality of Life Topic	Score
Social Environment	2.08
Economy	1.99
Public Safety	1.68
Education	1.65
Environment	1.61
Transportation	1.55

WORCESTER
INDICATOR DATA SCORING BY TOPIC AREA

MEASUREMENT PERIOD	**ACCESS TO HEALTH SERVICES**	UNITS	WORCESTER COUNTY	SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	Source
2014	Adults Unable to Afford to See a Doctor	*percent*	15.4			10.1	13.1	**2.33**		7
2013	Persons with Health Insurance	*percent*	86.1		100	88.3	83.3	**1.75**		17
2013	Adults with Health Insurance	*percent*	83.6		100	85.7	79.7	**1.70**		17
2014	Adults who have had a Routine Checkup	*percent*	85.5			89.6	13.2	**1.68**		7
2013	Children with Health Insurance	*percent*	93.6		100	95.2		**1.68**		17
2013	Adolescents who have had a Routine Checkup: Medicaid Population	*percent*	53.9	57.4		54.7		**1.55**		8
2014	People with a Usual Primary Care Provider	*percent*	83.1			82.6		**1.55**		8
2014	Adults who Visited a Dentist	*percent*	66.0			70.2	65.3	**1.48**		7
2013	Primary Care Provider Rate	*providers/100,000 population*	78			89		**1.33**		3
2014	Dentist Rate	*dentists/100,000 population*	56			74		**1.28**		3
2015	Mental Health Provider Rate	*providers/100,000 population*	194			215		**1.28**		3
2015	Non-Physician Primary Care Provider Rate	*providers/100,000 population*	77			75		**1.13**		3
2013	Children who Visited a Dentist	*percent*	65.8	64.6		63.3		**0.95**		8
2014	Uninsured Emergency Department Visits	*percent*	7.6			11.0		**0.75**		8

MEASUREMENT PERIOD	**CANCER**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2008-2012	Age-Adjusted Death Rate due to Breast Cancer	*deaths/100,000 females*	28.9		20.7	23.7	21.3	**2.65**		15
2008-2012	Age-Adjusted Death Rate due to Lung Cancer	*deaths/100,000 population*	59		45.5	46.4	45.0	**2.30**		15
2008-2012	Prostate Cancer Incidence Rate	*cases/100,000 males*	157.8			141.1	131.7	**2.30**		15
2008-2012	Breast Cancer Incidence Rate	*cases/100,000 females*	139.6			129.9	123.0	**2.15**		15
2008-2012	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/100,000 population*	13.3			10.5	11.3	**2.15**		15
2008-2012	Lung and Bronchus Cancer Incidence Rate	*cases/100,000 population*	73.6			60.7	63.7	**2.10**		15
2014	Pap Test History	*percent*	74.0		93.0	79.8	75.2	**2.03**		7
2008-2012	Age-Adjusted Death Rate due to Cancer	*deaths/100,000 population*	187.4	147.4	161.4	171.7	166.4	**1.95**		15
2014	Cancer: Medicare Population	*percent*	9.1			8.5	7.8	**1.95**		2
2008-2012	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/100,000 males*	23.0		21.8	22.5	19.6	**1.90**		15
2014	Colon Cancer Screening	*percent*	70.6			73.0	69.3	**1.73**		7
2008-2012	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/100,000 population*	14.4		14.5	15.4	14.7	**1.05**		15
2014	Mammogram History	*percent*	87.2			82.0	75.6	**0.98**		7
2008-2012	Colorectal Cancer Incidence Rate	*cases/100,000 population*	36.3		39.9	38.8	41.9	**0.55**		15

MEASUREMENT PERIOD	**CHILDREN'S HEALTH**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2013	Child Food Insecurity Rate	*percent*	24.3			19.1	21.4	**2.25**		5
2014	Child Abuse Rate	*cases/1,000 children*	29.0			9.9		**2.05**		10
2013	Children with Asthma	*percent*	18.5			16.1		**1.80**	Black (91.8) White (16.8)	7
2013	Children with Health Insurance	*percent*	93.6		100	95.2		**1.68**		17
2009-2011	Low-Income Preschool Obesity	*percent*	14.7					**1.55**		20
2010	Children with Low Access to a Grocery Store	*percent*	3.3					**1.35**		20
2013	Children who Visited a Dentist	*percent*	65.8	64.6		63.3		**0.95**		8
2014	Blood Lead Levels in Children	*percent*	0.13	0.28		0.33	0.53	**0.78**		9

MEASUREMENT PERIOD	**DIABETES**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Adults with Diabetes	*percent*	18.2			10.2	10.0	**2.18**		7
2014	ER Rate due to Diabetes	*ER Visits/100,000 population*	229.9	186.3		204.0		**1.70**		8
2014	Diabetes: Medicare Population	*percent*	25.6			29.0	26.7	**0.80**		2
2012-2014	Age-Adjusted Death Rate due to Diabetes	*deaths/100,000 population*	14.5			19.2	21.1	**0.68**		8
2013	Diabetic Screening: Medicare Population	*percent*	88.4			85.0		**0.68**		3

MEASUREMENT PERIOD	**ECONOMY**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2010-2014	Homeownership	*percent*	28.2			60.3	56.3	**2.70**		1
2010-2014	Households with Cash Public Assistance Income	*percent*	3.2			2.6	2.8	**2.50**		1
Jan 2016	Unemployed Workers in Civilian Labor Force	*percent*	14.0			4.9	5.3	**2.50**		18
2010-2014	Homeowner Vacancy Rate	*percent*	4.6			1.8	2.1	**2.30**		1
2013	Child Food Insecurity Rate	*percent*	24.3			19.1	21.4	**2.25**		5
2010-2014	Renters Spending 30% or More of Household Income on Rent	*percent*	53.3			51.8	52.3	**2.05**		1
2013-2014	Students Eligible for the Free Lunch Program	*percent*	39.5			38.2		**1.88**		16
2008-2012	Severe Housing Problems	*percent*	16.2			17.3		**1.58**		3
2009-2011	Low-Income Preschool Obesity	*percent*	14.7					**1.55**		20
2010-2014	People Living 200% Above Poverty Level	*percent*	71.1			76.7	65.5	**1.45**		1
2010-2014	People Living Below Poverty Level	*percent*	11.1			10.0	15.6	**1.45**	Black (23.5) White (8.7) Asian (0) AIAN (11.7) NHPI (0) Mult (15.5) Other (34.5) Hisp (26.6)	1
2010-2014	Median Household Income	*dollars*	$58,820			$74,149	$53,482	**1.40**		1
2013	Food Insecurity Rate	*percent*	13.6			12.8	15.8	**1.35**		5
2010	Low-Income and Low Access to a Grocery Store	*percent*	3.8					**1.35**		20

2010-2014	Families Living Below Poverty Level	*percent*	7.1		6.9	11.5	**1.30**	Black (21.5) White (5) Asian (0) AIAN (0) Mult (8.4) Other (0) Hisp (29.9)	1
2010-2014	Children Living Below Poverty Level	*percent*	$15		$13	$22	**1.25**	Black (31.1) White (10.2) Asian (0) AIAN (0) NHPI (0) Mult (12) Hisp (29.8)	1
2010-2014	Per Capita Income	*dollars*	$33,376		$36,670	$28,555	**1.10**		1
2012	SNAP Certified Stores	*stores/1,000 population*	1				**1.10**		20
2014	Affordable Housing	*percent*	56.9		46.1		**1.05**		8
2010-2014	People 65+ Living Below Poverty Level	*percent*	6.3		7.6	9.4	**0.65**	Black (21.9) White (4.7) Asian (0) AIAN (100) Mult (23.8) Hisp (0)	1

MEASUREMENT PERIOD	**EDUCATION**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014-2015	School Readiness at Kindergarten Entry	*percent*	48.0	85.5		47.0		**1.65**		13
2010-2014	People 25+ with a Bachelor's Degree or Higher	*percent*	28.2			37.3	29.3	**1.35**		1
2014	4th Grade Students Proficient in Reading	*percent*	94.4			86.3		**1.20**		13
2015	High School Graduation	*percent*	93.1	95.0	82.4	87.0		**1.10**		13
2010-2014	People 25+ with a High School Degree or Higher	*percent*	89.3			89.0	86.3	**1.10**		1
2014	8th Grade Students Proficient in Reading	*percent*	85.6			76.9		**1.05**		13
2013-2014	Student-to-Teacher Ratio	*students/teacher*	11.3			15.0		**0.83**		16

MEASUREMENT PERIOD	**ENVIRONMENT**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2013	Liquor Store Density	*stores/100,000 population*	36.8			20.1	10.4	**2.30**		19
2010	People 65+ with Low Access to a Grocery Store	*percent*	5.7					**1.95**		20
2012	Fast Food Restaurant Density	*restaurants/1,000 population*	1.7					**1.85**		20
2016	Food Environment Index	*0 (worst) to 10 (best)*	7.7			8.1		**1.58**		3
2008-2012	Severe Housing Problems	*percent*	16.2			17.3		**1.58**		3
2008-2010	Annual Ozone Air Quality	*grade*	D					**1.50**		1
2010	Children with Low Access to a Grocery Store	*percent*	3.30					**1.35**		20
2010	Households with No Car and Low Access to a Grocery Store	*percent*	2.0					**1.35**		20
2010	Low-Income and Low Access to a Grocery Store	*percent*	3.8					**1.35**		20
2012	Grocery Store Density	*stores/1,000 population*	0.2					**1.30**		20
2016	Access to Exercise Opportunities	*percent*	85.8			93.4		**1.28**		3
FY 2013-14	Drinking Water Violations	*percent*	0.0			16.2		**1.13**		3

2012	SNAP Certified Stores	*stores/1,000 population*	1.0				**1.10**		20
2012	Recreation and Fitness Facilities	*facilities/1,000 population*	0.19			0.06	**0.95**		20
2013	Farmers Market Density	*markets/1,000 population*	0.06			0.03	**0.88**		20
2014	Blood Lead Levels in Children	*percent*	0.13	0.28	0.33	0.53	**0.78**		9

MEASUREMENT PERIOD	**ENVIRONMENTAL & OCCUPATIONAL HEALTH**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Adults with Asthma	*percent*	17.3			13.5	13.8	**2.28**		7
2013	Children with Asthma	*percent*	18.5			16.1		**1.80**	Black (91.8) White (16.8)	7
2014	ER Rate due to Asthma	*ER visits/10,000 population*	64.1	62.5		68.3		**1.50**		8
2014	Asthma: Medicare Population	*percent*	3.9			5.2	5.0	**0.85**		2
2014	Blood Lead Levels in Children	*percent*	0.13	0.28		0.33	0.5	**0.78**		9

MEASUREMENT PERIOD	**EXERCISE, NUTRITION, & WEIGHT**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2013	Child Food Insecurity Rate	*percent*	24.3			19.1	21.4	**2.25**		5
2010	People 65+ with Low Access to a Grocery Store	*percent*	5.7					**1.95**		20
2014	Adults who are Obese	*percent*	31.5		30.5	29.6	29.6	**1.88**	Black (47) White (27.1) Other (90.4)	7
2012	Fast Food Restaurant Density	*restaurants/1,000 population*	1.7					**1.85**		20
2016	Food Environment Index	*0 (worst) to 10 (best)*	7.7			8.1		**1.58**		3
2009-2011	Low-Income Preschool Obesity	*percent*	14.7					**1.55**		20
2010	Children with Low Access to a Grocery Store	*percent*	3.3					**1.35**		20
2013	Food Insecurity Rate	*percent*	13.6			12.8	15.8	**1.35**		5
2010	Households with No Car and Low Access to a Grocery Store	*percent*	2.0					**1.35**		20
2010	Low-Income and Low Access to a Grocery Store	*percent*	3.8					**1.35**		20
2010-2014	Workers who Walk to Work	*percent*	2.5		3.1	2.3	2.8	**1.35**	Black (4.6) White (2.3) Asian (0) AIAN (0) NHPI (0) Mult (2.4) Other (0) Hisp (0.4)	1
2012	Grocery Store Density	*stores/1,000 population*	0.2					**1.30**		20
2016	Access to Exercise Opportunities	*percent*	85.8			93.4		**1.28**		3
2014	Adults with a Healthy Weight	*percent*	36.2			35.1	35.2	**1.28**		8
2014	Adults who are Overweight or Obese	*percent*	63.8			64.9	65.0	**1.23**		7
2013	Adolescents who are Obese	*percent*	10.8	10.7	16.1	11.0		**1.20**		8
2013	Adults Engaging in Regular Physical Activity	*percent*	51.9		47.9	48.0		**1.15**		7
2012	SNAP Certified Stores	*stores/1,000 population*	1.0					**1.10**		20
2010	Adult Fruit and Vegetable Consumption	*percent*	30.0			27.1		**1.05**		7

2012	Recreation and Fitness Facilities	*facilities/1,000 population*	0.19				0.1	**0.95**	20
2013	Farmers Market Density	*markets/1,000 population*	0.06				0.03	**0.88**	20

MEASUREMENT PERIOD	**HEART DISEASE & STROKE**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Atrial Fibrillation: Medicare Population	*percent*	9.6			7.9	8.0	**2.70**		2
2014	Hyperlipidemia: Medicare Population	*percent*	56.6			48.9	44.7	**2.30**		2
2014	Hypertension: Medicare Population	*percent*	64.0			59.2	55.1	**2.15**		2
2014	Stroke: Medicare Population	*percent*	4.5			4.3	3.7	**2.10**		2
2014	ER Rate due to Hypertension	*ER Visits/100,000 population*	286.2	234.9		252.2		**1.85**		8
2012-2014	Age-Adjusted Death Rate due to Heart Disease	*deaths/100,000 population*	183.1	152.7		169.9	169.1	**1.83**		8
2013	High Blood Pressure Prevalence	*percent*	34.4		26.9	33.6	31.4	**1.73**		7
2013	High Cholesterol Prevalence	*percent*	39.2		13.5	37.0	38.4	**1.73**		7
2014	Ischemic Heart Disease: Medicare Population	*percent*	27.3			26.4	27.0	**1.50**		2
2014	Heart Failure: Medicare Population	*percent*	12.5			12.6	13.7	**1.10**		2
2012-2014	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/100,000 population*	29.0		34.8	36.3	36.5	**0.58**		8

MEASUREMENT PERIOD	**IMMUNIZATIONS & INFECTIOUS DISEASES**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Salmonella Infection Incidence Rate	*cases/100,000 population*	25.1		11.4	14.9		**2.00**		8
2014	Adults with Influenza Vaccination	*percent*	42.6		70.0	41.7		**1.55**		8
2014	Adults 65+ with Influenza Vaccination	*percent*	64.2			62.1	60.8	**1.38**		7
2014	Adults 65+ with Pneumonia Vaccination	*percent*	72.2		90.0	69.8	70.3	**1.38**		7
2014	Chlamydia Incidence Rate	*cases/100,000 population*	412.6	431.0		458.9	456.1	**1.13**		8
2014	Gonorrhea Incidence Rate	*cases/100,000 population*	82.9			102.2	110.7	**1.13**		8
2012-2014	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/100,000 population*	13.3			16.0	15.2	**1.08**		8
2014	Syphilis Incidence Rate	*cases/100,000 population*	0.0			7.5	6.3	**0.88**		8
2014	Tuberculosis Incidence Rate	*cases/100,000 population*	0.0		1.0	3.3	3.0	**0.73**		8
2014	HIV Incidence Rate: Aged 13+	*cases/100,000 population*	0.0			24.6	16.5	**0.38**		8

MEASUREMENT PERIOD	**MATERNAL, FETAL & INFANT HEALTH**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2010-2014	Infant Mortality Rate	*deaths/1,000 live births*	8.6	6.3	6.0	6.6		**2.35**		8
2014	Babies with Low Birth Weight	*percent*	8.2	8.0	7.8	8.6		**1.45**		8
2014	Preterm Births	*percent*	9.7		11.4	10.1		**1.25**		8
2014	Mothers who Received Early Prenatal Care	*percent*	76.9	66.9	77.9	61.5		**1.15**		8
2014	Teen Birth Rate	*live births/1,000 females aged 15-19*	11.5	17.8		17.8	24.2	**0.58**	Black (22.2) White (8.5)	8

MEASUREMENT PERIOD	MEN'S HEALTH	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2008-2012	Prostate Cancer Incidence Rate	*cases/100,000 males*	157.8			141.1	131.7	**2.30**		15
2008-2012	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/100,000 males*	23.0		21.8	22.5	19.6	**1.90**		15
2010	Life Expectancy for Males	*years*	76.3			76.2	76.1	**0.90**		6

MEASUREMENT PERIOD	MENTAL HEALTH & MENTAL DISORDERS	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2011-2013	Age-Adjusted Death Rate due to Suicide	*deaths/100,000 population*	12.0	9.0	10.2	9.0	12.5	**1.93**		8
2014	Frequent Mental Distress	*percent*	10.4			10.0		**1.58**		3
2014	Poor Mental Health Days	*days*	3.5			3.3		**1.58**		3
2010	Adequate Social and Emotional Support	*percent*	83.3			82.9		**1.50**		7
2015	Mental Health Provider Rate	*providers/100,000 population*	194			215		**1.28**		3
2014	Self-Reported Good Mental Health	*percent*	78.5			76.7		**1.25**		7
2014	Hospitalization Rate Related to Alzheimer's and Other Dementias	*hospitalizations/10 0,000 population*	146.1	199.4		194.1		**0.90**		8
2014	Depression: Medicare Population	*percent*	12.4			14.6	16.2	**0.70**		2
2014	Alzheimer's Disease or Dementia: Medicare Population	*percent*	7.1			10.1	10.0	**0.60**		2

MEASUREMENT PERIOD	OLDER ADULTS & AGING	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Atrial Fibrillation: Medicare Population	*percent*	9.6			7.9	8.0	**2.70**		2
2014	Hyperlipidemia: Medicare Population	*percent*	56.6			48.9	44.7	**2.30**		2
2014	Hypertension: Medicare Population	*percent*	64.0			59.2	55.1	**2.15**		2
2014	Stroke: Medicare Population	*percent*	4.5			4.3	3.7	**2.10**		2
2014	Cancer: Medicare Population	*percent*	9.1			8.5	7.8	**1.95**		2
2010	People 65+ with Low Access to a Grocery Store	*percent*	5.7					**1.95**		20
2014	Ischemic Heart Disease: Medicare Population	*percent*	27.3			26.4	27.0	**1.50**		2
2014	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	28.9			29.4	29.4	**1.50**		2
2014	Chronic Kidney Disease: Medicare Population	*percent*	15.6			16.6	16.6	**1.45**		2
2014	Adults 65+ with Influenza Vaccination	*percent*	64.2			62.1	60.8	**1.38**		7
2014	Adults 65+ with Pneumonia Vaccination	*percent*	72.2		90.0	69.8	70.3	**1.38**		7
2014	Heart Failure: Medicare Population	*percent*	12.5			12.6	13.7	**1.10**		2
2014	Hospitalization Rate Related to Alzheimer's and Other Dementias	*hospitalizations/10 0,000 population*	146.1	199.4		194.1		**0.90**		8
2014	Asthma: Medicare Population	*percent*	3.9			5.2	5.0	**0.85**		2

2014	Diabetes: Medicare Population	*percent*	25.6			29.0	26.7	**0.80**		2
2014	Depression: Medicare Population	*percent*	12.4			14.6	16.2	**0.70**		2
2013	Diabetic Screening: Medicare Population	*percent*	88.4			85.0		**0.68**		3
2014	COPD: Medicare Population	*percent*	9.2			9.7	11.0	**0.65**		2
2014	Osteoporosis: Medicare Population	*percent*	4.3			5.8	5.9	**0.65**		2
2010-2014	People 65+ Living Below Poverty Level	*percent*	6.3			7.6	9.4	**0.65**	Black (21.9) White (4.7) Asian (0) AIAN (100) Mult (23.8) Hisp (0)	1
2014	Alzheimer's Disease or Dementia: Medicare Population	*percent*	7.1			10.1	10.0	**0.60**		2
2010-2014	People 65+ Living Alone	*percent*	22.4			26.1	26.8	**0.50**		1

MEASUREMENT PERIOD	**ORAL HEALTH**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Age-Adjusted ER Visit Rate due to Dental Problems	*ER Visits/100,000 population*	1441.5			779.7		**2.20**		8
2008-2012	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/100,000 population*	13.3			10.5	11.3	**2.15**		15
2014	Adults with No Tooth Extractions	*percent*	51.6			56.9	56.6	**1.58**		7
2014	Adults who Visited a Dentist	*percent*	66.0			70.2	65.3	**1.48**		7
2014	Dentist Rate	*dentists/100,000 population*	56			74		**1.28**		3
2013	Children who Visited a Dentist	*percent*	65.8	64.6		63.3		**0.95**		8

MEASUREMENT PERIOD	**PREVENTION & SAFETY**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2013	Pedestrian Death Rate	*deaths/100,000 population*	5.8		1.4	0.9	1.5	**2.43**		4
2014	Pedestrian Injuries	*injuries/100,000 population*	91.0	35.6	20.3	42.5		**2.35**		8
2008-2010	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/100,000 population*	17.6			10.0		**1.95**		8
2012-2014	Death Rate due to Drug Poisoning	*deaths/100,000 population*	15.5			15.7	14.0	**1.65**		3
2008-2012	Severe Housing Problems	*percent*	16.2			17.3		**1.58**		3
2012-2014	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/100,000 population*	26.5		36.4	26.6	39.7	**1.08**		8

MEASUREMENT PERIOD	**PUBLIC SAFETY**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2013	Pedestrian Death Rate	*deaths/100,000 population*	5.8		1.4	0.9	1.5	**2.43**		4
2014	Pedestrian Injuries	*injuries/100,000 population*	91.0	35.6	20.3	42.5		**2.35**		8
2014	Domestic Violence Offense Rate	*offenses/100,000 population*	646.3			455.8		**2.20**		8
2010	ER Rate Related to Domestic Violence	*ER Visits/100,000 population*	293.5			110.4		**2.10**		8
2014	Child Abuse Rate	*cases/1,000 children*	29.0			9.9		**2.05**		10

2008-2010	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/100,000 population*	17.6			10.0		**1.95**	8
2010-2014	Alcohol-Impaired Driving Deaths	*percent*	37.8			33.5		**1.88**	3
2013	Violent Crime Rate	*crimes/100,000 population*	419.6			467.5	369.1	**1.48**	11

MEASUREMENT PERIOD	**RESPIRATORY DISEASES**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2008-2012	Age-Adjusted Death Rate due to Lung Cancer	*deaths/100,000 population*	59.0		45.5	46.4	45.0	**2.30**		15
2014	Adults with Asthma	*percent*	17.3			13.5	13.8	**2.28**		7
2008-2012	Lung and Bronchus Cancer Incidence Rate	*cases/100,000 population*	73.6			60.7	63.7	**2.10**		15
2013	Children with Asthma	*percent*	18.5			16.1		**1.80**	Black (91.8) White (16.8)	7
2014	Adults with Influenza Vaccination	*percent*	42.6		70.0	41.7		**1.55**		8
2014	ER Rate due to Asthma	*ER visits/10,000 population*	64.1	62.5		68.3		**1.50**		8
2014	Adults 65+ with Influenza Vaccination	*percent*	64.2			62.1	60.8	**1.38**		7
2014	Adults 65+ with Pneumonia Vaccination	*percent*	72.2		90.0	69.8	70.3	**1.38**		7
2012-2014	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/100,000 population*	13.3			16.0	15.2	**1.08**		8
2014	Asthma: Medicare Population	*percent*	3.9			5.2	5.0	**0.85**		2
2014	Tuberculosis Incidence Rate	*cases/100,000 population*	0.0		1.0	3.3	3.0	**0.73**		8
2014	COPD: Medicare Population	*percent*	9.2			9.7	11.0	**0.65**		2

MEASUREMENT PERIOD	**SOCIAL ENVIRONMENT**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Child Abuse Rate	*cases/1,000 children*	29.0			9.9		**2.05**		10
2010-2014	Single-Parent Households	*percent*	34.7			34.4	33.6	**1.90**		1
2010-2014	Children Living Below Poverty Level	*percent*	15.3			13.2	21.9	**1.25**	Black (31.1) White (10.2) Asian (0) AIAN (0) NHPI (0) Mult (12) Hisp (29.8)	1
2012	Voter Registration	*percent*	85.1			81.4	71.2	**0.88**		12
2010-2014	People 65+ Living Alone	*percent*	22.4			26.1	26.8	**0.50**		1

MEASUREMENT PERIOD	**SUBSTANCE ABUSE**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Adults who Smoke	*percent*	19.6	15.5	12.0	14.6	18.1	**2.33**	Black (29.4) White (16.7) Other (90.4)	7
2013	Liquor Store Density	*stores/100,000 population*	36.8			20.1	10.4	**2.30**		19
2013	Adolescents who Use Tobacco	*percent*	27.4	15.2	21.0	16.9		**2.25**		8
2014	Age-Adjusted ER Rate due to Alcohol/Substance Abuse	*ER visits/100,000 population*	2296.8			1591.3		**2.20**		8
2014	Adults who Binge Drink	*percent*	22.1		24.4	15.4	16.0	**2.03**	Black (18.1) White (22.8) Hisp (77.7)	7

2010-2014	Alcohol-Impaired Driving Deaths	*percent*	37.8			33.5		**1.88**		3
2014	Teens who Smoke	*percent*	14.7		16.0	8.7		**1.75**		14
2012-2014	Age-Adjusted Death Rate due to Drug Use	*deaths/100,000 population*	15.6		11.3	15.2	14.6	**1.73**		8
2012-2014	Death Rate due to Drug Poisoning	*deaths/100,000 population*	15.5			15.7	14.0	**1.65**		3

MEASUREMENT PERIOD	**TEEN & ADOLESCENT HEALTH**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2013	Adolescents who Use Tobacco	*percent*	27.4	15.2	21.0	16.9		**2.25**		8
2014	Teens who Smoke	*percent*	14.7		16.0	8.7		**1.75**		14
2013	Adolescents who have had a Routine Checkup: Medicaid Population	*percent*	53.9	57.4		54.7		**1.55**		8
2013	Adolescents who are Obese	*percent*	10.8	10.7	16.1	11.0		**1.20**		8
2014	Teen Birth Rate	*live births/1,000 females aged 15-19*	11.5	17.8		17.8	24.2	**0.58**	Black (22.2) White (8.5)	8

MEASUREMENT PERIOD	**TRANSPORTATION**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2010-2014	Workers Commuting by Public Transportation	*percent*	1.8		5.5	8.9	5.1	**1.85**	Black (5.9) White (0.9) Asian (0) AIAN (0) NHPI (0) Mult (0) Other (34.5) Hisp (9.9)	1
2010-2014	Workers who Drive Alone to Work	*percent*	81.5			73.6	76.4	**1.80**		1
2010	Households with No Car and Low Access to a Grocery Store	*percent*	2.0					**1.35**		20
2010-2014	Households without a Vehicle	*percent*	6.1			9.4	9.1	**1.35**		1
2010-2014	Workers who Walk to Work	*percent*	2.5		3.1	2.3	2.8	**1.35**	Black (4.6) White (2.3) Asian (0) AIAN (0) NHPI (0) Mult (2.4) Other (0) Hisp (0.4)	1
2010-2014	Solo Drivers with a Long Commute	*percent*	30.4			47.6		**1.13**		3
2010-2014	Mean Travel Time to Work	*minutes*	23.1			32.2	25.7	**1.00**		1

MEASUREMENT PERIOD	**WELLNESS & LIFESTYLE**	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2014	Self-Reported General Health Assessment: Good or Better	*percent*	74.8			85.9	83.2	**2.28**		7
2014	Self-Reported Good Physical Health	*percent*	70.6			77.6		**2.10**		7
2014	Frequent Physical Distress	*percent*	9.7			10.0		**1.43**		3
2012-2014	Average Life Expectancy	*years*	80.0	79.8		79.8		**1.25**		8
2014	Insufficient Sleep	*percent*	31.9			38.0		**0.98**		3
2010	Life Expectancy for Males	*years*	76.3			76.2	76.1	**0.90**		6
2010	Life Expectancy for Females	*years*	81.4			80.8	80.8	**0.75**		6

MEASUREMENT PERIOD	WOMEN'S HEALTH	UNITS	WORCESTER COUNTY	MD SHIP 2017	HP2020	MARYLAND	U.S.	SCORE	HIGH RACE DISPARITY*	
2008-2012	Age-Adjusted Death Rate due to Breast Cancer	*deaths/100,000 females*	28.9		20.7	23.7	21.3	**2.65**		15
2008-2012	Breast Cancer Incidence Rate	*cases/100,000 females*	139.6			129.9	123.0	**2.15**		15
2014	Pap Test History	*percent*	74.0		93.0	79.8	75.2	**2.03**		7
2014	Mammogram History	*percent*	87.2			82.0	75.6	**0.98**		7
2010	Life Expectancy for Females	*years*	81.4			80.8	80.8	**0.75**		6

WORCESTER COUNTY TOPIC SCORE TABLES

Health Topic	Score
Substance Abuse	**2.01**
Cancer	**1.84**
Prevention & Safety	**1.84**
Heart Disease & Stroke	**1.78**
Women's Health	**1.71**
Men's Health	**1.70**
Oral Health	**1.61**
Children's Health	**1.55**
Respiratory Diseases	**1.47**
Teen & Adolescent Health	**1.47**
Access to Health Services	**1.46**
Environmental & Occupational Health	**1.44**
Exercise, Nutrition, & Weight	**1.39**
Wellness & Lifestyle	**1.38**
Maternal, Fetal & Infant Health	**1.36**
Older Adults & Aging	**1.29**
Mental Health & Mental Disorders	**1.26**
Diabetes	**1.21**
Immunizations & Infectious Diseases	**1.16**

Quality of Life Topic	Score
Public Safety	**2.06**
Economy	**1.64**
Transportation	**1.40**
Environment	**1.39**
Social Environment	**1.32**
Education	**1.18**

13.2.5 DEMOGRAPHIC TABLES

Population Count and Age Groups

Geography	Population Count	Age 0 - 4	Age 5-17	Age 18-24	Age 25-64	Age 65+
Somerset	25,583	5.02%	12.43%	17.85%	48.93%	15.78%
Wicomico	102,400	6.05%	16.04%	14.54%	48.38%	14.99%
Worcester	51,769	4.49%	13.07%	7.27%	49.02%	26.16%
Tri-County Service Area	179,752	5.45%	14.68%	12.92%	48.66%	18.30%
Maryland	6,041,139	6.07%	16.32%	9.44%	53.73%	14.46%
21875	7,206	5.61%	15.97%	11.23%	53.55%	13.64%
21874	2,224	7.24%	17.53%	8.86%	52.34%	14.02%
21872	633	3.63%	13.59%	9.96%	55.29%	17.53%
21871	5,023	1.99%	5.79%	14.27%	68.68%	9.26%
21865	505	3.96%	12.08%	7.72%	54.06%	22.18%
21864	544	5.51%	15.26%	9.74%	49.07%	20.40%
21863	4,745	5.12%	14.96%	9.92%	50.53%	19.46%
21861	568	4.58%	14.97%	10.03%	53.17%	17.26%
21856	925	4.76%	12.65%	8.65%	54.06%	19.89%
21853	11,115	5.56%	13.98%	25.14%	41.90%	13.42%
21851	6,898	6.25%	17.00%	9.20%	49.31%	18.24%
21850	2,906	6.47%	16.25%	8.61%	52.75%	15.94%
21849	3,002	5.40%	15.16%	9.13%	52.64%	17.69%
21842	12,537	3.32%	9.94%	5.41%	52.82%	28.51%
21841	788	5.08%	15.60%	9.14%	53.17%	17.00%
21840	367	3.00%	11.99%	8.45%	52.59%	23.97%
21838	1,623	5.85%	13.93%	8.50%	48.86%	22.86%
21837	2,888	5.57%	16.07%	10.63%	51.98%	15.76%
21830	4,323	5.60%	17.46%	10.69%	52.37%	13.88%
21829	514	5.45%	14.79%	8.75%	50.39%	20.63%
21826	4,674	7.25%	17.76%	9.88%	49.92%	15.20%
21824	264	3.41%	8.33%	6.82%	48.10%	33.33%
21822	2,926	5.40%	13.47%	18.63%	45.49%	17.02%
21821	981	4.79%	11.42%	6.02%	48.93%	28.85%
21817	4,921	6.99%	16.24%	8.49%	46.70%	21.57%
21814	308	3.25%	12.02%	8.12%	52.28%	24.35%
21813	2,638	4.13%	14.29%	8.98%	52.32%	20.29%
21811	22,755	4.45%	12.87%	6.71%	45.92%	30.07%
21804	40,405	5.93%	15.99%	16.23%	47.47%	14.37%
21801	30,546	6.34%	15.88%	17.01%	45.66%	15.12%

Population by Race/Ethnicity

Geography	Hisp/Lat	White	Black/Af Amer	Am Ind/AK Native	Asian	Native HI/PI	Some Other Race	2+ Races
Somerset	4.29%	51.84%	42.58%	0.42%	0.87%	0.05%	1.79%	2.47%
Wicomico	5.66%	66.75%	24.78%	0.30%	3.03%	0.06%	2.31%	2.76%
Worcester	3.52%	81.18%	13.83%	0.28%	1.41%	0.03%	1.35%	1.94%
Tri-County Service Area	4.85%	68.78%	24.16%	0.31%	2.26%	0.05%	1.96%	2.48%
Maryland	9.72%	56.02%	29.72%	0.37%	6.35%	0.06%	4.21%	3.26%
21875	4.48%	70.39%	20.70%	0.21%	4.12%	0.07%	1.75%	2.76%
21874	3.33%	89.43%	6.29%	0.49%	1.12%		0.94%	1.71%
21872	3.32%	79.94%	14.69%	0.63%	1.90%		1.74%	1.11%
21871	1.69%	43.32%	54.23%	0.20%	0.42%	0.04%	0.60%	1.19%
21865	2.77%	76.63%	18.81%	0.40%	0.59%		1.19%	2.38%
21864	3.68%	77.39%	17.28%	0.18%	1.65%		1.29%	2.21%
21863	2.11%	64.72%	31.02%	0.34%	1.18%		0.61%	2.13%
21861	2.29%	92.25%	5.63%		0.35%			1.76%
21856	2.16%	75.78%	20.54%	0.32%	0.76%		0.65%	1.95%
21853	4.83%	39.16%	54.48%	0.29%	1.02%	0.08%	1.89%	3.09%
21851	2.44%	58.06%	36.46%	0.28%	1.87%		0.75%	2.58%
21850	2.48%	92.09%	3.85%	0.10%	1.14%		0.69%	2.13%
21849	3.03%	88.77%	5.73%	0.20%	1.70%	0.03%	1.30%	2.27%
21842	5.57%	91.65%	2.75%	0.25%	1.55%	0.01%	2.03%	1.76%
21841	0.63%	80.33%	15.86%		1.27%		0.76%	1.78%
21840	4.09%	79.29%	15.26%	0.27%	0.27%		1.63%	3.27%
21838	8.56%	76.28%	15.03%	0.86%	1.36%		4.13%	2.34%
21837	2.60%	78.39%	16.83%	0.55%	0.38%	0.10%	0.66%	3.08%
21830	2.80%	82.49%	12.65%	0.23%	1.73%	0.02%	0.99%	1.87%
21829	2.53%	76.65%	19.65%	0.19%	0.97%		0.78%	1.75%
21826	4.09%	64.36%	27.54%	0.73%	2.89%		1.63%	2.87%
21824		94.70%	3.03%	0.76%	0.76%		0.38%	0.38%
21822	3.25%	67.09%	27.38%	0.51%	1.47%		1.13%	2.43%
21821	0.51%	85.83%	11.31%	0.31%	1.12%		0.51%	0.92%
21817	5.71%	71.35%	22.07%	0.87%	0.69%	0.02%	2.60%	2.40%
21814	3.90%	79.22%	15.26%	0.32%	0.32%		1.62%	3.25%
21813	3.30%	89.69%	6.48%	0.11%	1.21%	0.08%	0.68%	1.74%
21811	3.12%	84.94%	10.18%	0.29%	1.27%	0.04%	1.39%	1.89%
21804	7.22%	65.24%	24.57%	0.24%	3.46%	0.08%	3.22%	3.20%
21801	5.91%	56.78%	34.65%	0.33%	3.41%	0.07%	2.23%	2.54%

Socioeconomic Characteristics

Geography	Pop 5+: Speak Spanish at Home	Age 5+: Speak Asian/PI Lang at Home	Age 5+: Speak Indo-European Lang at Home	Age 5+: Speak Other Lang at Home	Occ HUs, No Vehicles	Families Below Poverty	Families Below Poverty with Children	Pop 25+ with Less Than High School Graduation	Unemployed	Median Household Income
Somerset	2.53%	0.49%	1.40%	1.01%	10.89%	19.91%	15.76%	19.57%	8.67%	$37,385
Wicomico	4.07%	1.90%	3.92%	0.67%	7.05%	11.68%	9.50%	13.34%	9.19%	$50,182
Worcester	2.74%	0.38%	3.28%	0.29%	6.37%	7.31%	4.54%	10.94%	11.42%	$60,834
Tri-County Service Area	3.46%	1.26%	3.37%	0.61%	7.30%	11.21%	8.61%	13.42%	9.79%	$52,090
Maryland	7.11%	3.63%	4.37%	1.89%	9.33%	7.10%	5.39%	10.92%	7.82%	$74,104
21875	2.06%	1.78%	1.34%	0.07%	6.47%	11.69%	9.26%	15.14%	9.15%	$44,334
21874	4.51%	0.44%	0.44%	0.10%	3.64%	7.23%	4.98%	13.48%	8.13%	$51,807
21872	0.66%		1.80%	0.98%	1.68%	5.14%	3.43%	15.18%	15.07%	$62,000
21871	4.47%	0.20%	1.58%	0.63%	9.57%	11.51%	6.79%	26.97%	6.63%	$45,635
21865	0.82%		1.65%		2.50%	7.25%	7.25%	13.25%	8.70%	$50,000
21864	1.36%	0.97%	0.58%		4.95%	9.15%	7.19%	14.81%	9.54%	$51,705
21863	1.09%	0.27%	0.40%	0.53%	6.45%	8.49%	5.50%	15.09%	13.44%	$50,000
21861	2.40%	0.55%	0.55%		1.35%	21.02%	16.56%	15.00%	6.51%	$41,000
21856	0.91%		1.59%		1.53%	6.72%	6.30%	13.89%	8.55%	$58,553
21853	2.81%	0.41%	1.94%	1.88%	10.58%	17.48%	13.65%	18.59%	8.01%	$32,529
21851	1.21%	0.82%	5.64%		12.37%	17.05%	10.09%	19.96%	18.35%	$44,565
21850	4.19%	0.66%	0.40%	0.04%	7.71%	10.98%	10.12%	14.73%	7.73%	$50,115
21849	3.13%	1.23%	1.13%	0.07%	4.20%	7.08%	6.28%	14.07%	6.88%	$56,443
21842	4.11%	0.15%	5.15%	0.37%	5.65%	4.67%	2.90%	6.68%	9.11%	$64,563
21841	0.53%		0.53%		5.18%	10.31%	8.07%	9.76%	19.50%	$52,557
21840	0.84%		1.69%		4.88%	6.48%	6.48%	12.81%	8.56%	$36,500
21838	1.05%	0.79%	0.52%		3.10%	7.77%	7.14%	12.29%	10.77%	$62,981
21837	2.31%	0.73%	0.48%		3.56%	4.11%	2.37%	12.37%	6.36%	$59,838
21830	2.40%	1.76%	1.13%	0.10%	2.04%	3.82%	3.41%	10.82%	9.75%	$65,563
21829	1.03%	0.41%	0.41%	0.21%	4.65%	8.11%	6.08%	13.70%	13.60%	$50,291
21826	2.47%	1.94%	3.74%	1.82%	9.16%	14.65%	8.02%	14.20%	7.09%	$57,065
21824	1.96%		0.39%		31.97%	28.40%	13.58%	24.19%	9.68%	$30,417
21822	1.88%	0.47%	1.91%	0.94%	3.80%	11.26%	8.24%	14.49%	8.01%	$55,045
21821	1.82%	0.21%	0.43%		17.23%	26.10%	14.58%	20.18%	10.27%	$32,727
21817	0.46%	1.01%	0.24%		14.29%	32.07%	28.04%	15.45%	10.54%	$34,256
21814	1.01%		1.34%		4.38%	6.67%	6.67%	12.29%	8.86%	$35,938
21813	0.71%		1.94%	0.99%	2.60%	10.17%	6.47%	11.96%	14.76%	$71,311
21811	3.20%	0.46%	2.57%	0.20%	5.71%	5.19%	3.21%	9.97%	9.22%	$64,997
21804	4.28%	2.05%	4.70%	0.79%	6.08%	11.67%	9.77%	11.42%	8.75%	$47,966
21801	5.37%	2.38%	5.43%	0.85%	10.27%	14.66%	12.25%	15.60%	10.93%	$48,875

13.3 COMMUNITY INPUT

13.3.1 KEY INFORMANT INTERVIEW GUIDE

Peninsula Regional Medical Center Key Informant Interview Guide

Q1. Could you tell me a little bit about yourself, your background, and your organization?

Q2. What is your vision for a healthy community?

Q3. What are the major health needs/issues you see in the community?

Q4a. Data Gaps:
Disabilities
Substance Abuse (Illicit Drugs)
Teen & Adolescent Health
- Alcohol Use
- Exercise
- Mental Health

Q4a: We have found that there is limited publically available data about [topic area] for _____ County, which may make it difficult to assess the extent of the community need. Could you please help fill in some of our data gaps by telling me a little about how [topic area] is impacting the community?

Q5. What are the barriers to receiving care and for building a healthy community?

Q6. Who in your community appears to struggle most with these issues you've identified and how does it impact their lives?

Q7. Could you tell me about some of the strengths and resources in your community that address these issues, such as groups, initiatives, services, or programs? Please name them.

Q8. What advice do you have for a group developing a plan to address the needs you've mentioned today?

Q9. Is there anything else you'd like us to note?

13.3.2 ONLINE COMMUNITY SURVEY

Peninsula Regional Medical Center Community Survey

1. Please tell us what county you live in.
   Somerset
   Wicomico
   Worcester
   Other (please specify) _____

2. Do you work in the health field?
   Health professional
   Not a health professional

3. What do you think are reasons that prevent you or others in your community from getting the health services they need? Check all that apply.

- No health insurance
- No transportation
- High cost
- Local doctors not "in-network" for health insurance plan
- Doctors are too far from home or work
- Unable to get appointment with a physician
- Specific/needed services not available
- Language barriers
- Other (please specify) _____

4. Please select the most important health issue(s) in your community from this list of health topics. (Select up to 5)

- Access to Health Services
- Cancer
- Diabetes
- Heart Disease & Stroke
- Immunization & Infectious Diseases
- Injury, Violence & Safety
- Maternal, Fetal, & Infant Health
- Mental Health & Mental Disorders
- Obesity/Overweight
- Oral Health
- Reproductive Health (family planning)
- Respiratory/Lung Diseases (asthma, COPD, etc.)
- Sexual Health (HIV, STD/I, etc.)
- Substance Abuse (alcohol, tobacco, e-cigs, drugs, etc.)
- Other (please specify) _____

5. Please select the population(s) below who is (are) most negatively affected by poor health outcomes in your community. (Select up to 5)

- Children
- Teen and Adolescent
- Low income populations
- Lesbian, Gay, Bisexual, and Transgender
- Mothers and Infants
- Men
- Older Adults
- Persons with Disabilities
- Racial or Ethnic Populations
- Refugees
- Women
- Other (please specify) _____

6. What are the conditions of daily life that have the most impact on your community? (Select up to 3)

- Economy (housing, etc.)
- Education
- Employment (jobs, etc.)
- Environmental Quality (exposure to secondhand smoke, etc.)
- Language Barriers
- Physical Activity and Exercise

Transportation
Social Environment (living situation, neighborhood, family structure, etc.)
Other (please specify) _____

7. Is there anything else you would like us to know about your community? Please feel free to tell us below.

_____

8. What is your gender identity?
Female
Male
Other (please specify) _____

9. What is your age?
17 or younger
18-24
25-34
35-44
45-54
55-64
65+

10. Select your race/ethnicity.
White
Hispanic / Latino
Black / African American
American Indian / Alaska Native
Asian
Native Hawaiian / Other Pacific Islander
Other (please specify) _____

13.3.3 COMMUNITY RESOURCES

RESOURCES	URL
Atlantic General Health System	http://www.atlanticgeneral.org/
Worcester County Health Department	http://www.worcesterhealth.org/
Integrated Health Literacy Program	http://www.worcesterk12.com/integrated-health-literacy-program-ihlp
Herschel S. Horowitz Center for Health Literacy	http://sph.umd.edu/center/hchl
University of Maryland College Park School of Public Health	http://sph.umd.edu/
Worcester Youth and Family Services	http://gowoyo.org/
Somerset Public Schools	http://www.somersetps.com/SchoolFrontEnd/
Worcester County Public Schools	http://www.worcesterk12.com/
Wicomico County Public Schools	http://www.wcboe.org/
Wicomico County Health Department	http://www.wicomicohealth.org/index.aspx?pageId=1
Somerset County Health Department	http://somersethealth.org/
It Takes A Village to Help Our Children, Inc.	http://villagetohelpourchildren.org/
McCready Memorial Hospital	http://www.mccreadyhealth.org/
Garland Hayward Youth Center	
The Center For Hispanic Development Rayo De Luz LLC	http://listings.findthecompany.com/l/33476229/The-Center-For-Hispanic-Development-Rayo-De-Luz-LLC-in-Salisbury-MD
Atlantic General Hospital We Care & Thrift Shop	http://www.atlanticgeneral.org/Volunteer/Thrift-Shop.aspx
Housing Authority of Crisfield Somerset County	
Worcester Housing Authority	http://www.worcester-housing.com/
Wicomico Housing Authority	http://www.wicomicocounty.org/403/Housing-Authority-Board-of-Commissioners
St. James A.M.E. Church-Zion House	
Maryland Food Bank – Eastern Shore	https://mdfoodbank.org/locations/eastern-shore-branch/
MAC Inc., Maintaining Active Citizens	http://www.macinc.org/
University of Maryland Eastern Shore	https://www.umes.edu/home/
Peninsula Regional Medical Center	https://www.peninsula.org/
NYU Lutheran Medical Center	http://www.lutheranhealthcare.org/Main/LutheranMedicalCenter.aspx
Pregnancy and Tobacco Cessation Help (PATCH) Initiative	
Living Well Education Center	
Hope And Life Outreach (HALO)	http://www.haloministry.org/
United Way	http://www.unitedway4us.org/
Lower Shore Clinic, Inc.	http://www.gogettersinc.org/Lower-Shore-Clinic.html
Three Lower Counties Community Service Inc.	http://www.tlccs.org/

13.4 PRIORITIZATION TOOLKIT

FIGURE A.3: PENINSULA REGIONAL MEDICAL CENTER HEALTH NEEDS PRIORITIZATION

Health Need	Importance of problem to the community 1 – does not meet criteria 2 – could meet criteria 3 - meets criteria	Alignment with Maryland SHIP 2017 objectives 1 – does not meet criteria 2 – could meet criteria 3 - meets criteria	Opportunity for partnership 1 – does not meet criteria 2 – could meet criteria 3 - meets criteria	Addresses disparities of subgroups 1 – does not meet criteria 2 – could meet criteria 3 - meets criteria	Existing resources/programs to address the problem 1 – does not meet criteria 2 – could meet criteria 3 - meets criteria	TOTAL
Access to Health Services						
Cancer						
Diabetes						
Exercise, Nutrition & Weight						
Heart Disease & Stroke						
Mental Health & Mental Disorders						
Prevention & Safety						
Substance Abuse						

PROJECT DESCRIPTION

Peninsula Regional Medical Center, the premier provider of tertiary and secondary hospital services on Maryland's Eastern Shore, proposes to renovate two locations in existing buildings located on its Salisbury campus for the purpose of initiating a specialized Child and Adolescent ("C&A") Behavioral Health Program. This Program is envisioned to initially provide needed inpatient acute care hospital services to the underserved residents of the entire Lower Eastern Shore of Maryland, Virginia and Southern Delaware. Currently, no such regional resource is available on Maryland's Eastern Shore.

The renovation plans for the Project include the construction of a new 15-bed inpatient unit to be located in South Tower adjacent to PRMC's existing 13-bed inpatient unit for adults. To free up the space for the C&A unit, vacant space located in East Tower will be renovated for displaced office space and related functions. To complete the renovations for the proposed unit, and other services located in the South Tower, a new air handler system will be installed on the roof of South Tower. The total cost of the project is $8.5 Million, and will be financed out of hospital cash reserves and charitable contributions.

The Project will permit the full integration of the behavioral health services for hospital inpatients of all ages at PRMC. The principal source of future patient referrals will initially be PRMC's Emergency Department, but over time, it is anticipated that referrals from community-based providers in the entire region will increase its utilization. PRMC also anticipates that a comprehensive set of outpatient behavioral health services and programs for Children and Adolescents will be initiated in the future; the planning for these services will commence upon the opening of the inpatient unit.

The proposed 15-bed unit will not increase the square footage of the Hospital, or establish a new Hospital Department. Nevertheless, the costs of staffing, supplying and supporting the new C&A unit will require an adjustment to PRMC's GBR agreement with the HSCRC. Ongoing discussions with the staff of the HSCRC will be conducted during the course of the review of this CON Application. The project is anticipated to be completed in two phases, and implemented under one construction contract.

Name of Applicant: Peninsula Regional Medical Center

Date of Submission: March 9 2018

Applicants should follow additional instructions included at the top of each of the following worksheets. Please ensure all green fields (see above) are filled.

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

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

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

Before the Project							After Project Completion						
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/2017	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity				
			Room Count			Bed Count			Room Count			Bed Count	
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity	
ACUTE CARE							**ACUTE CARE**						
General Medical/ Surgical*							**General Medical/ Surgical***						
General Medical/ Surgical	*5 East*	32	16	16	32	48	*General Medical/ Surgical*	5 East	16	16	32	48	
Othopedics/Medical	5 South	26	17	8	25	33	*Othopedics/Medical*	5 South	17	8	25	33	
General Surgery	5 West	32	16	16	32	48	*General Surgery*	5 West	16	16	32	48	
Neurology/Stroke/Spine	5 Layfield	28	26	2	28	30	*Neurology/Stroke/Spine*	5 Layfield	26	2	28	30	
Oncology	3 East	14	10	10	20	30	*Oncology*	3 East	10	10	20	30	
Medical-Surgical	3 West	30	14	16	30	46	*Medical-Surgical*	3 West	14	16	30	46	
Medical-Surgical	3 Layfield	28	26	2	28	30	*Medical-Surgical*	3 Layfield	26	2	28	30	
Cardiac Telemetry	2 West	16	8	8	16	24	*Cardiac Telemetry*	2 West	8	8	16	24	
					0	0					0	0	
SUBTOTAL Gen. Med/Surg*		**206**	**133**	**78**	**211**	**289**	**SUBTOTAL Gen. Med/Surg***		**133**	**78**	**211**	**289**	
ICU/CCU	2 Layfield/ 2 South	**42**	42	0	42	42	**ICU/CCU**	2 Layfield/ 2 South	42	0	42	42	
Other *(Specify/add rows as needed)*		**0**	0	0	0	0			0	0	0	0	
TOTAL MSGA		**248**	**175**	**78**	**253**	**331**	**TOTAL MSGA**		**175**	**78**	**253**	**331**	

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

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

Before the Project							After Project Completion						
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/2017	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity			
			Room Count			Bed Count			Room Count			Bed Count
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity
Obstetrics	4 West/South	**20**	37	0	37	37	**Obstetrics**	4 West/South	37	0	37	37
Pediatrics	1 Layfield	**8**	10	0	10	10	**Pediatrics**	1 Layfield	10	0	10	10
Psychiatric							**Psychiatric**					
Adult Psychiatric	3 South	**13**	3	5	8	13	**Adult Psychiatric**	3 South	3	5	8	13
Child & Adolescent Psychiatric	3 South	**0**	0	0	0	0	**Child & Adolescent Psychiatric**	3 South	3	6	9	15
TOTAL ACUTE		**289**	**225**	**83**	**308**	**391**	**TOTAL ACUTE**		**228**	**89**	**317**	**406**
NON-ACUTE CARE							**NON-ACUTE CARE**					
Dedicated Observation**		**0**	0	**0**	0	0	**Dedicated Observation****		0	**0**	0	0
Rehabilitation		**0**	0	**0**	0	0	**Rehabilitation**		0	**0**	0	0
Comprehensive Care		**0**	0	**0**	0	0	**Comprehensive Care**		0	**0**	0	0
Other *(Specify/add rows as needed)*		**0**	0	**0**	0	0	**Other** *(Specify/add rows as needed)*		0	**0**	0	0
TOTAL NON-ACUTE		**0**	**0**	**0**	**0**	**0**	**TOTAL NON-ACUTE**		**0**	**0**	**0**	**0**
HOSPITAL TOTAL		**289**	**225**	**83**	**308**	**391**	**HOSPITAL TOTAL**		**228**	**89**	**317**	**406**

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

** Include services included in the reporting of the “Observation Center”. Service furnished by the hospital on the hospital's promise, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

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

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Adult Psychiatry Unit (APU)	8,971		571	8,400	8,971
Child & Adolescent Psychiatry Unit (CAPU)	0	0	9,412	0	9,412
Mechanical Equipment Room (MER)	1,374		relocated to roof for CAPU space		0
Nursing Training Area	1,746		relocated to 4East for CAPU space		0
Pharmacist Work Room	713		relocated to 4East for CAPU space		0
Hospitalists, etc.	3,180		relocated to 4East for CAPU space		0
Corridors, etc.	2,399		relocated to 4East for CAPU space		0
Roof	0	1,374			1,374
4 East - Vacant nursing Unit	8,038		8,038		8,038
					0
					0
					0
					0
Total	26,421	1,374	18,021	8,400	27,795
					0
					0
Total					

TABLE C. CONSTRUCTION CHARACTERISTICS		

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

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

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement		
First Floor		
Second Floor		
Third Floor	0	9,983
Fourth Floor		8,038
Roof Top - Footprint for Air Handler	1,374	
Average Square Feet		
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		282
Fourth Floor		480
Roof Top - Footprint for Air Handler		N/A
Total Linear Feet		762
Average Linear Feet		
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		12'-8"
Fourth Floor		12'-8"
Average Wall Height		
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		
Freight		
Sprinklers	**Square Feet Covered**	
Wet System	0	18,021
Dry System	0	0
Other	**Describe Type**	
Type of HVAC System for proposed project	Rooftop Air Hanlding Unit serving Variable Air volume	
Type of Exterior Walls for proposed project		

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS
Not Applicable

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

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation		
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs		
Site Demolition Costs		
Storm Drains		
Rough Grading		
Hillside Foundation		
Paving		
Exterior Signs		
Landscaping		
Walls		
Yard Lighting		
Other *(Specify/add rows if needed)*		
Subtotal On-Site excluded from Marshall Valuation Costs		
OFFSITE COSTS		
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs		
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$0**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$0**	**$0**

*The combined total site and offsite cost included and excluded from Marshall Valuation Service should typically equal the estimated site preparation cost reported in Application Part II, Project Budget (see Table E. Project Budget). If these numbers are not equal, please reconcile the numbers in an explanation in an attachment to the application.

TABLE E. PROJECT BUDGET

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

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

	Hospital Building	Other Structure	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building			$0
(2) Fixed Equipment **(Rooftop Air Handling Unit)**	$2,000,000		$2,000,000
(3) Site and Infrastructure			$0
(4) Architect/Engineering Fees			$0
(5) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$2,000,000**	**$0**	**$2,000,000**
b. Renovations			
(1) Building	$3,759,741		$3,759,741
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees	$531,785		$531,785
(4) Permits (Building, Utilities, Etc.)	$112,792		$112,792
SUBTOTAL	**$4,404,318**	**$0**	**$4,404,318**
c. Other Capital Costs			
(1) Movable Equipment	$1,005,000		$1,005,000
(2) Contingency Allowance	$1,036,398		$1,036,398
(3) Gross interest during construction period			$0
(4) Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$2,041,398***	***$0***	**$2,041,398**
TOTAL CURRENT CAPITAL COSTS	**$8,445,716**	**$0**	**$8,445,716**
d. *Land Purchase*			
e. Inflation Allowance			$0
TOTAL CAPITAL COSTS	**$8,445,716**	**$0**	**$8,445,716**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c CON Application Assistance	**$55,000**		
c1. Legal Fees	**$20,000**		$20,000
c2. Other (Specify/add rows if needed)			
d. Non-CON Consulting Fees			
d1. Legal Fees			$0
d2. Other (Specify/add rows if needed)			$0
e. Debt Service Reserve Fund			$0
f Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$75,000***	***$0***	**$75,000**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$8,520,716***	***$0***	***$8,520,716***
B. Sources of Funds			
1. Cash	**$6,520,716**		$6,520,716
2. Philanthropy (to date and expected)	$2,000,000		$2,000,000
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$8,520,716***		**$8,520,716**
	Hospital Building	***Other Structure***	***Total***
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
1. DISCHARGES										
a. General Medical/Surgical*	13,238	13,739	13,644	13,644	13,644	13,644	13,644	13,644		
b. ICU/CCU	754	452	509	509	509	509	509	509		
Total MSGA	**13,992**	**14,191**	**14,153**	**14,153**	**14,153**	**14,153**	**14,153**	**14,153**	**0**	**0**
c. Pediatric	370	405	467	467	467	467	467	467		
d. Obstetric	1,998	1,930	1,964	1,964	1,964	1,964	1,964	1,964		
e. Acute Psychiatric	684	727	716	716	716	716	716	716		
f. Acute Psychiatric: Child and Adolescent	0	0	0	0	100	225	335	373		
Total Acute	***17,044***	***17,253***	***17,300***	***17,300***	***17,400***	***17,525***	***17,635***	***17,673***	***0***	***0***
f. Rehabilitation	0	0	0	0	0	0	0	0		
g. Comprehensive Care	0	0	0	0	0	0	0	0		
h. Other (Specify/add rows of needed)	0	0	0	0	0	0	0	0		
TOTAL DISCHARGES	***17,044***	***17,253***	***17,300***	***17,300***	***17,400***	***17,525***	***17,635***	***17,673***	***0***	***0***
2. PATIENT DAYS										
a. General Medical/Surgical*	52,085	59,427	59,453	59,453	59,453	59,453	59,453	59,453		
b. ICU/CCU	11,090	6,149	5,841	5,841	5,841	5,841	5,841	5,841		
Total MSGA	**63,175**	**65,576**	**65,294**	**65,294**	**65,294**	**65,294**	**65,294**	**65,294**	**0**	**0**
c. Pediatric	1,225	1,110	1,147	1,147	1,147	1,147	1,147	1,147		
d. Obstetric	5,259	5,092	4,797	4,797	4,797	4,797	4,797	4,797		
e. Acute Psychiatric	3,437	3,784	3,862	3,862	3,862	3,862	3,862	3,862		
f. Acute Psychiatric: Child and Adolescent	0	0	0	0	926	2,084	3,102	3,458		
Total Acute	***73,096***	***75,562***	***75,100***	***75,100***	***76,026***	***77,184***	***78,202***	***78,558***	***0***	***0***
f. Rehabilitation	0	0	0	0	0	0	0	0		
g. Comprehensive Care	0	0	0	0	0	0	0	0		
h. Other (Specify/add rows of needed)	0	0	0	0	0	0	0	0		
TOTAL PATIENT DAYS	***73,096***	***75,562***	***75,100***	***75,100***	***76,026***	***77,184***	***78,202***	***78,558***	***0***	***0***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	3.9	4.3	4.4	4.4	4.4	4.4	4.4	4.4	#DIV/0!	#DIV/0!
b. ICU/CCU	14.7	13.6	11.5	11.5	11.5	11.5	11.5	11.5	#DIV/0!	#DIV/0!
Total MSGA	4.5	4.6	4.6	4.6	4.6	4.6	4.6	4.6	#DIV/0!	#DIV/0!
c. Pediatric	3.3	2.7	2.5	2.5	2.5	2.5	2.5	2.5	#DIV/0!	#DIV/0!
d. Obstetric	2.6	2.6	2.4	2.4	2.4	2.4	2.4	2.4	#DIV/0!	#DIV/0!
e. Acute Psychiatric	5.0	5.2	5.4	5.4	5.4	5.4	5.4	5.4	#DIV/0!	#DIV/0!
f. Acute Psychiatric: Child and Adolescent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	9.3	9.3	9.3	9.3	#DIV/0!	#DIV/0!
Total Acute	4.3	4.4	4.3	4.3	4.4	4.4	4.4	4.4	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	4.3	4.4	4.3	4.3	4.4	4.4	4.4	4.4	#DIV/0!	#DIV/0!
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*	210	199	206	207	207	207	207	207		
b. ICU/CCU	42	42	42	42	42	42	42	42		
Total MSGA	**252**	**241**	**248**	**249**	**249**	**249**	**249**	**249**	**0**	**0**
c. Pediatric	8	8	8	8	8	8	8	8		
d. Obstetric	20	20	20	20	20	20	20	20		
e. Acute Psychiatric	12	12	13	13	13	13	13	13		
f. Acute Psychiatric: Child and Adolescent	0	0	0	0	15	15	15	15		
Total Acute	***292***	***281***	***289***	***290***	***305***	***305***	***305***	***305***	***0***	***0***
f. Rehabilitation	0	0	0	0	0	0	0	0		
g. Comprehensive Care	0	0	0	0	0	0	0	0		
h. Other (Specify/add rows of needed)	0	0	0	0	0	0	0	0		
TOTAL LICENSED BEDS	***292***	***281***	***289***	***290***	***305***	***305***	***305***	***305***	***0***	***0***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*	67.8%	81.8%	79.1%	78.7%	78.5%	78.7%	78.7%	78.7%	#DIV/0!	#DIV/0!
b. ICU/CCU	72.1%	40.1%	38.1%	38.1%	38.0%	38.1%	38.1%	38.1%	#DIV/0!	#DIV/0!
Total MSGA	**68.5%**	**74.5%**	**72.1%**	**71.8%**	**71.6%**	**71.8%**	**71.8%**	**71.8%**	**#DIV/0!**	**#DIV/0!**
c. Pediatric	41.8%	38.0%	39.3%	39.3%	39.2%	39.3%	39.3%	39.3%	#DIV/0!	#DIV/0!
d. Obstetric	71.8%	69.8%	65.7%	65.7%	65.5%	65.7%	65.7%	65.7%	#DIV/0!	#DIV/0!
e. Acute Psychiatric	78.3%	86.4%	81.4%	81.4%	81.2%	81.4%	81.4%	81.4%	#DIV/0!	#DIV/0!
f. Acute Psychiatric: Child and Adolescent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	16.9%	38.1%	56.7%	63.2%	#DIV/0!	#DIV/0!
Total Acute	**68.6%**	**73.7%**	**71.2%**	**70.9%**	**68.1%**	**69.3%**	**70.2%**	**70.6%**	**#DIV/0!**	**#DIV/0!**
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**68.4%**	**73.7%**	**71.2%**	**70.9%**	**68.1%**	**69.3%**	**70.2%**	**70.6%**	**#DIV/0!**	**#DIV/0!**
6. OUTPATIENT VISITS										
a. Emergency Department	81,141	79,930	76,974	76,974	76,974	76,974	76,974	76,974		
b. Same-day Surgery	10,147	8,519	8,485	8,485	8,485	8,485	8,485	8,485		
c. Laboratory	174,649	166,276	160,055	160,055	160,055	160,055	160,055	160,055		
d. Imaging	63,242	64,601	56,202	56,202	56,202	56,202	56,202	56,202		
e. Other (Specify/add rows of needed)	250,910	243,242	245,153	245,153	245,153	245,153	245,153	245,153		
TOTAL OUTPATIENT VISITS	***580,089***	***562,568***	***546,869***	***546,869***	***546,869***	***546,869***	***546,869***	***546,869***	***0***	***0***
7. OBSERVATIONS**										
a. Number of Patients	3,333	3,053	2,650	2,650	2,650	2,650	2,650	2,650		
b. Hours	103,635	90,615	72,557	72,557	72,557	72,557	72,557	72,557		

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

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

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
1. REVENUE										
a. Inpatient Services	$ 240,674,098	$ 242,490,752	$ 252,823,000	$ 251,377,000	$ 252,673,000	$ 254,805,000	$ 256,679,000	$ 257,334,000		
b. Outpatient Services	$ 267,694,601	$ 278,452,734	$ 288,188,000	$ 288,421,000	$ 289,033,000	$ 289,033,000	$ 289,033,000	$ 289,033,000		
Gross Patient Service Revenues	***$ 508,368,699***	***$ 520,943,486***	***$ 541,011,000***	***$ 539,798,000***	***$ 541,706,000***	***$ 543,838,000***	***$ 545,712,000***	***$ 546,367,000***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 11,448,645	$ 11,673,037	$ 12,231,000	$ 12,184,000	$ 12,210,000	$ 12,249,000	$ 12,284,000	$ 12,296,000		
d. Contractual Allowance	$ 86,167,319	$ 90,977,037	$ 94,517,000	$ 95,506,000	$ 96,312,508	$ 96,854,639	$ 97,331,601	$ 97,498,490		
e. Charity Care	$ 8,669,839	$ 9,225,353	$ 6,804,000	$ 6,791,000	$ 6,796,492	$ 6,803,361	$ 6,809,399	$ 6,811,510		
Net Patient Services Revenue	***$ 402,082,896***	***$ 409,068,059***	***$ 427,459,000***	***$ 425,317,000***	***$ 426,387,000***	***$ 427,931,000***	***$ 429,287,000***	***$ 429,761,000***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 2,738,969	$ 2,567,736	$ 2,718,000	$ 3,001,000	$ 3,001,000	$ 3,001,000	$ 3,001,000	$ 3,001,000		
NET OPERATING REVENUE	***$ 404,821,865***	***$ 411,635,795***	***$ 430,177,000***	***$ 428,318,000***	***$ 429,388,000***	***$ 430,932,000***	***$ 432,288,000***	***$ 432,762,000***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 200,194,716	$ 214,398,768	$ 220,782,000	$ 221,095,000	$ 221,672,000	$ 222,248,000	$ 222,794,000	$ 222,794,000		
b. Contractual Services	$ 48,180,712	$ 54,966,506	$ 45,045,000	$ 43,443,000	$ 43,087,000	$ 43,481,000	$ 43,397,000	$ 43,368,000		
c. Interest on Current Debt	**$ 4,918,161**	**$ 5,355,480**	**$ 5,250,000**	**$ 5,140,000**	**$ 5,027,000**	**$ 4,908,000**	**$ 5,091,000**	**$ 4,908,000**		
d. Interest on Project Debt										
e. Current Depreciation	$ 22,553,897	$ 26,231,978	$ 28,682,000	$ 29,854,000	$ 31,470,321	$ 32,481,643	$ 33,022,643	$ 34,421,643		
f. Project Depreciation					$ 259,679	$ 519,357	$ 519,357	$ 519,357		
g. Current Amortization	***$ 45,816***	***$ 187,488***	***$ 329,000***	***$ 329,000***	***$ 188,000***	***$ 46,000***	***$ 46,000***	***$ 46,000***		
h. Project Amortization										
i. Supplies	$ 105,129,494	$ 107,868,045	$ 104,827,000	$ 103,595,000	$ 103,628,000	$ 103,677,000	$ 103,720,000	$ 103,735,000		
j. Other Expenses (Specify/add rows if needed)	$ 24,616,889	$ 23,133,472	$ 21,400,000	$ 20,051,000	$ 20,425,000	$ 20,561,000	$ 20,561,000	$ 20,561,000		
TOTAL OPERATING EXPENSES	**$ 405,639,685**	**$ 432,141,737**	**$ 426,315,000**	**$ 423,507,000**	**$ 425,757,000**	**$ 427,922,000**	**$ 429,151,000**	**$ 430,353,000**	**$ -**	**$ -**
3. INCOME										
a. Income From Operation	**$ (817,820)**	**$ (20,505,942)**	**$ 3,862,000**	**$ 4,811,000**	**$ 3,631,000**	**$ 3,010,000**	**$ 3,137,000**	**$ 2,409,000**	**$ -**	**$ -**
b. Non-Operating Income	$ 7,654,887	$ 14,818,236	$ 26,976,000	$ 10,375,000	$ 10,651,000	$ 10,936,000	$ 11,228,000	$ 11,530,000		
SUBTOTAL	***$ 6,837,067***	***$ (5,687,706)***	***$ 30,838,000***	***$ 15,186,000***	***$ 14,282,000***	***$ 13,946,000***	***$ 14,365,000***	***$ 13,939,000***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 6,837,067***	***$ (5,687,706)***	***$ 30,838,000***	***$ 15,186,000***	***$ 14,282,000***	***$ 13,946,000***	***$ 14,365,000***	***$ 13,939,000***	***$ -***	***$ -***

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	48.5%	49.7%	50.0%	50.0%	49.9%	49.7%	49.5%	49.4%		
2) Medicaid	3.1%	2.2%	2.1%	2.1%	2.1%	2.1%	2.1%	2.1%		
3) Blue Cross	11.9%	11.8%	12.4%	12.4%	12.3%	12.3%	12.3%	12.3%		
4) Commercial Insurance	11.8%	11.7%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%		
5) Self-pay	4.9%	3.3%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%		
6) Other					0.0%	0.0%	0.0%	0.0%		
Medicare MCO	1.0%	2.0%	3.1%	3.1%	3.1%	3.1%	3.0%	3.0%		
Medicaid MCO	11.5%	13.6%	15.3%	15.3%	15.4%	15.7%	15.8%	15.9%		
Managed Care	6.8%	5.3%	7.0%	7.0%	7.0%	6.9%	6.9%	6.9%		
Workers Compensation	0.5%	0.4%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***74.2%***	***74.1%***	***73.9%***	***73.7%***	***73.7%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare	48.5%	49.7%	50.0%	50.0%	49.9%	49.7%	49.5%	49.4%		
2) Medicaid	3.1%	2.2%	2.1%	2.1%	2.1%	2.1%	2.1%	2.1%		
3) Blue Cross	11.9%	11.8%	12.4%	12.4%	12.3%	12.3%	12.3%	12.3%		
4) Commercial Insurance	11.8%	11.7%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%		
5) Self-pay	4.9%	3.3%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%		
6) Other					0.0%	0.0%	0.0%	0.0%		
Medicare MCO	1.0%	2.0%	3.1%	3.1%	3.1%	3.1%	3.0%	3.0%		
Medicaid MCO	11.5%	13.6%	15.3%	15.3%	15.4%	15.7%	15.8%	15.9%		
Managed Care	6.8%	5.3%	7.0%	7.0%	7.0%	6.9%	6.9%	6.9%		
Workers Compensation	0.5%	0.4%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
1. REVENUE										
a. Inpatient Services	$ 240,674,098	$ 242,490,752	$ 252,823,000	$ 256,217,000	$ 263,184,000	$ 272,048,000	$ 280,907,000	$ 288,667,000		
b. Outpatient Services	$ 267,694,601	$ 278,452,734	$ 288,188,000	$ 292,186,000	$ 297,148,000	$ 303,169,000	$ 309,327,000	$ 315,624,000		
Gross Patient Service Revenues	***$ 508,368,699***	***$ 520,943,486***	***$ 541,011,000***	***$ 548,403,000***	***$ 560,332,000***	***$ 575,217,000***	***$ 590,234,000***	***$ 604,291,000***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 11,448,645	$ 11,673,037	$ 12,231,000	$ 12,395,000	$ 12,666,000	$ 13,007,000	$ 13,351,000	$ 13,680,000		
d. Contractual Allowance	$ 86,167,319	$ 90,977,037	$ 94,517,000	$ 96,473,000	$ 98,421,000	$ 100,784,000	$ 103,141,000	$ 105,208,000		
e. Charity Care	$ 8,669,839	$ 9,225,353	$ 6,804,000	$ 6,903,000	$ 7,033,000	$ 7,194,000	$ 7,359,000	$ 7,528,000		
Net Patient Services Revenue	***$ 402,082,896***	***$ 409,068,059***	***$ 427,459,000***	***$ 432,632,000***	***$ 442,212,000***	***$ 454,232,000***	***$ 466,383,000***	***$ 477,875,000***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 2,738,969	$ 2,567,736	$ 2,718,000	$ 3,001,000	$ 3,001,000	$ 3,001,000	$ 3,001,000	$ 3,001,000		
NET OPERATING REVENUE	***$ 404,821,865***	***$ 411,635,795***	***$ 430,177,000***	***$ 435,633,000***	***$ 445,213,000***	***$ 457,233,000***	***$ 469,384,000***	***$ 480,876,000***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 200,194,716	$ 214,398,768	$ 220,782,000	$ 226,614,000	$ 232,885,000	$ 239,327,000	$ 245,913,000	$ 252,060,000		
b. Contractual Services	$ 48,180,712	$ 54,966,506	$ 45,045,000	$ 44,365,000	$ 45,298,000	$ 46,391,000	$ 47,345,000	$ 48,324,000		
c. Interest on Current Debt	**$ 4,918,161**	**$ 5,355,480**	**$ 5,250,000**	**$ 5,140,000**	**$ 5,027,000**	**$ 4,908,000**	**$ 5,091,000**	**$ 4,908,000**		
d. Interest on Project Debt										
e. Current Depreciation	$ 22,553,897	$ 26,231,978	$ 28,682,000	$ 29,854,000	$ 31,470,321	$ 32,481,643	$ 33,022,643	$ 34,421,643		
f. Project Depreciation					$ 259,679	$ 519,357	$ 519,357	$ 519,357		
g. Current Amortization	***$ 45,816***	***$ 187,488***	***$ 329,000***	***$ 329,000***	***$ 188,000***	***$ 46,000***	***$ 46,000***	***$ 46,000***		
h. Project Amortization										
i. Supplies	$ 105,129,494	$ 107,868,045	$ 104,827,000	$ 105,796,000	$ 108,019,000	$ 110,627,000	$ 112,898,000	$ 115,236,000		
j. Other Expenses (Specify/add rows if needed)	$ 24,616,889	$ 23,133,472	$ 21,400,000	$ 20,476,000	$ 20,907,000	$ 21,411,000	$ 21,851,000	$ 22,304,000		
TOTAL OPERATING EXPENSES	**$ 405,639,685**	**$ 432,141,737**	**$ 426,315,000**	**$ 432,574,000**	**$ 444,054,000**	**$ 455,711,000**	**$ 466,686,000**	**$ 477,819,000**	**$ -**	**$ -**
3. INCOME										
a. Income From Operation	**$ (817,820)**	**$ (20,505,942)**	**$ 3,862,000**	**$ 3,059,000**	**$ 1,159,000**	**$ 1,522,000**	**$ 2,698,000**	**$ 3,057,000**	**$ -**	**$ -**
b. Non-Operating Income	$ 7,654,887	$ 14,818,236	$ 26,976,000	$ 10,375,000	$ 10,651,000	$ 10,936,000	$ 11,229,000	$ 11,530,000		
SUBTOTAL	***$ 6,837,067***	***$ (5,687,706)***	***$ 30,838,000***	***$ 13,434,000***	***$ 11,810,000***	***$ 12,458,000***	***$ 13,927,000***	***$ 14,587,000***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 6,837,067***	***$ (5,687,706)***	***$ 30,838,000***	***$ 13,434,000***	***$ 11,810,000***	***$ 12,458,000***	***$ 13,927,000***	***$ 14,587,000***	***$ -***	***$ -***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	48.5%	49.7%	50.0%	50.0%	49.9%	49.7%	49.5%	49.4%		
2) Medicaid	3.1%	2.2%	2.1%	2.1%	2.1%	2.1%	2.1%	2.1%		
3) Blue Cross	11.9%	11.8%	12.4%	12.4%	12.3%	12.3%	12.3%	12.3%		
4) Commercial Insurance	11.8%	11.7%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%		
5) Self-pay	4.9%	3.3%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%		
6) Other					0.0%	0.0%	0.0%	0.0%		
Medicare MCO	1.0%	2.0%	3.1%	3.1%	3.1%	3.1%	3.0%	3.0%		
Medicaid MCO	11.5%	13.6%	15.3%	15.3%	15.4%	15.7%	15.8%	15.9%		
Managed Care	6.8%	5.3%	7.0%	7.0%	7.0%	6.9%	6.9%	6.9%		
Workers Compensation	0.5%	0.4%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	48.5%	49.7%	50.0%	50.0%	49.9%	49.7%	49.5%	49.4%		
2) Medicaid	3.1%	2.2%	2.1%	2.1%	2.1%	2.1%	2.1%	2.1%		
3) Blue Cross	11.9%	11.8%	12.4%	12.4%	12.3%	12.3%	12.3%	12.3%		
4) Commercial Insurance	11.8%	11.7%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%		
5) Self-pay	4.9%	3.3%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%		
6) Other					0.0%	0.0%	0.0%	0.0%		
Medicare MCO	1.0%	2.0%	3.1%	3.1%	3.1%	3.1%	3.0%	3.0%		
Medicaid MCO	11.5%	13.6%	15.3%	15.3%	15.4%	15.7%	15.8%	15.9%		
Managed Care	6.8%	5.3%	7.0%	7.0%	7.0%	6.9%	6.9%	6.9%		
Workers Compensation	0.5%	0.4%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
1. DISCHARGES							
a. General Medical/Surgical*	0	0	0	0	0		
b. ICU/CCU	0	0	0	0	0		
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0	0	0		
d. Obstetric	0	0	0	0	0		
e. Acute Psychiatric	0	0	0	0	0		
f. Acute Psychiatric: Child and Adolescent	0	100	225	335	373		
Total Acute	***0***	***100***	***225***	***335***	***373***	***0***	***0***
f. Rehabilitation	0	0	0	0	0		
g. Comprehensive Care	0	0	0	0	0		
h. Other (Specify/add rows of needed)	0	0	0	0	0		
TOTAL DISCHARGES	***0***	***100***	***225***	***335***	***373***	***0***	***0***
2. PATIENT DAYS							
a. General Medical/Surgical*	0	0	0	0	0		
b. ICU/CCU	0	0	0	0	0		
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0	0	0		
d. Obstetric	0	0	0	0	0		
e. Acute Psychiatric	0	0	0	0	0		
f. Acute Psychiatric: Child and Adolescent	0	926	2084	3102	3458		
Total Acute	***0***	***926***	***2084***	***3102***	***3458***	***0***	***0***
f. Rehabilitation	0	0	0	0	0		
g. Comprehensive Care	0	0	0	0	0		
h. Other (Specify/add rows of needed)	0	0	0	0	0		
TOTAL PATIENT DAYS	***0***	***926***	***2,084***	***3,102***	***3,458***	***0***	***0***

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
3. AVERAGE LENGTH OF STAY							
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Acute Psychiatric: Child and Adolescent	#DIV/0!	9.3	9.3	9.3	9.3	#DIV/0!	#DIV/0!
Total Acute	#DIV/0!	9.3	9.3	9.3	9.3	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	#DIV/0!	9.3	9.3	9.3	9.3	#DIV/0!	#DIV/0!
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*	0	0	0	0	0		
b. ICU/CCU	0	0	0	0	0		
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0	0	0		
d. Obstetric	0	0	0	0	0		
e. Acute Psychiatric	0	0	0	0	0		
f. Acute Psychiatric: Child and Adolescent	0	15	15	15	15		
Total Acute	***0***	***15***	***15***	***15***	***15***	***0***	***0***
f. Rehabilitation	0	0	0	0	0		
g. Comprehensive Care	0	0	0	0	0		
h. Other (Specify/add rows of needed)	0	0	0	0	0		
TOTAL LICENSED BEDS	***0***	***15***	***15***	***15***	***15***	***0***	***0***

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE: *Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Acute Psychiatric: Child and Adolescent	#DIV/0!	16.9%	38.1%	56.7%	63.2%	#DIV/0!	#DIV/0!
Total Acute	**#DIV/0!**	**16.9%**	**38.1%**	**56.7%**	**63.2%**	**#DIV/0!**	**#DIV/0!**
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**#DIV/0!**	**16.9%**	**38.1%**	**56.7%**	**63.2%**	**#DIV/0!**	**#DIV/0!**
6. OUTPATIENT VISITS							
a. Emergency Department	0	0	0	0	0		
b. Same-day Surgery	0	0	0	0	0		
c. Laboratory	0	0	0	0	0		
d. Imaging	0	0	0	0	0		
e. Other (Specify/add rows of needed)	0	0	0	0	0		
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***
7. OBSERVATIONS**							
a. Number of Patients	0	0	0	0	0		
b. Hours	0	0	0	0	0		

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

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

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
1. REVENUE							
a. Inpatient Services	$ -	$ 1,704,460	$ 3,835,915	$ 5,709,765	$ 6,364,711		
b. Outpatient Services	$ -	$ -	$ -	$ -	$ -		
Gross Patient Service Revenues	***$ -***	***$ 1,704,460***	***$ 3,835,915***	***$ 5,709,765***	***$ 6,364,711***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ -	$ 31,500	$ 70,891	$ 105,521	$ 117,625		
d. Contractual Allowance	$ -	$ 433,918	$ 976,538	$ 1,453,578	$ 1,620,312		
e. Charity Care	$ -	$ 5,492	$ 12,361	$ 18,399	$ 20,510		
Net Patient Services Revenue	***$ -***	***$ 1,233,550***	***$ 2,776,125***	***$ 4,132,267***	***$ 4,606,264***	***$ -***	***$ -***
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	***$ -***	***$ 1,233,550***	***$ 2,776,125***	***$ 4,132,267***	***$ 4,606,264***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ -	$ 576,419	$ 1,152,839	$ 1,698,668	$ 1,698,668		
b. Contractual Services	$ -	$ 413,257	$ 807,427	$ 723,445	$ 694,434		
c. Interest on Current Debt	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**		
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -		
e. Current Depreciation	$ -	$ -	$ -	$ -	$ -		
f. Project Depreciation	$ -	$ 259,679	$ 519,357	$ 519,357	$ 519,357		
g. Current Amortization	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**		
h. Project Amortization	$ -	$ -	$ -	$ -	$ -		
i. Supplies	$ -	$ 59,196	$ 108,202	$ 151,306	$ 166,291		
j. Other Expenses (Specify)	$ -	$ -	$ -	$ -	$ -		
TOTAL OPERATING EXPENSES	**$ -**	**$ 1,308,551**	**$ 2,587,825**	**$ 3,092,776**	**$ 3,078,750**	**$ -**	**$ -**

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
3. INCOME							
a. Income From Operation	**$ -**	**$ (75,001)**	**$ 188,300**	**$ 1,039,491**	**$ 1,527,514**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ -***	***$ (75,001)***	***$ 188,300***	***$ 1,039,491***	***$ 1,527,514***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ -***	***$ (75,001)***	***$ 188,300***	***$ 1,039,491***	***$ 1,527,514***	***$ -***	***$ -***
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%		
2) Medicaid	0.0%	9.6%	9.6%	9.6%	9.6%		
3) Blue Cross	0.0%	10.6%	10.6%	10.6%	10.6%		
4) Commercial Insurance	0.0%	7.8%	7.8%	7.8%	7.8%		
5) Self-pay	0.0%	1.3%	1.3%	1.3%	1.3%		
6) Other	0.0%						
Medicare MCO	0.0%	0.0%	0.0%	0.0%	0.0%		
Medicaid MCO	0.0%	70.6%	70.6%	70.6%	70.6%		
Managed Care	0.0%	0.1%	0.1%	0.1%	0.1%		
Workers Compensation	0.0%	0.0%	0.0%	0.0%	0.0%		
TOTAL	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%		
2) Medicaid	0.0%	9.6%	9.6%	9.6%	9.6%		
3) Blue Cross	0.0%	10.6%	10.6%	10.6%	10.6%		
4) Commercial Insurance	0.0%	7.8%	7.8%	7.8%	7.8%		
5) Self-pay	0.0%	1.3%	1.3%	1.3%	1.3%		
6) Other	0.0%						
Medicare MCO	0.0%	0.0%	0.0%	0.0%	0.0%		
Medicaid MCO	0.0%	70.6%	70.6%	70.6%	70.6%		
Managed Care	0.0%	0.1%	0.1%	0.1%	0.1%		
Workers Compensation	0.0%	0.0%	0.0%	0.0%	0.0%		
TOTAL	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
1. REVENUE							
a. Inpatient Services	$ -	$ 1,782,096	$ 4,110,902	$ 6,272,061	$ 7,166,293		
b. Outpatient Services	$ -	$ -	$ -				
Gross Patient Service Revenues	***$ -***	***$ 1,782,096***	***$ 4,110,902***	***$ 6,272,061***	***$ 7,166,293***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ -	$ 32,935	$ 75,973	$ 115,913	$ 132,439		
d. Contractual Allowance	$ -	$ 437,148	$ 1,008,405	$ 1,538,536	$ 1,757,891		
e. Charity Care	$ -	$ 22,276	$ 51,385	$ 78,401	$ 89,579		
Net Patient Services Revenue	***$ -***	***$ 1,289,737***	***$ 2,975,139***	***$ 4,539,211***	***$ 5,186,384***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)	$ -	$ -					
NET OPERATING REVENUE	***$ -***	***$ 1,289,737***	***$ 2,975,139***	***$ 4,539,211***	***$ 5,186,384***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ -	$ 605,241	$ 1,240,743	$ 1,873,897	$ 1,920,744		
b. Contractual Services	$ -	$ 413,257	$ 834,355	$ 778,042	$ 777,460		
c. Interest on Current Debt	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**		
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -		
e. Current Depreciation	$ -	$ -	$ -	$ -	$ -		
f. Project Depreciation	$ -	$ 259,679	$ 519,357	$ 519,357	$ 519,357		
g. Current Amortization	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***		
h. Project Amortization	$ -	$ -	$ -	$ -	$ -		
i. Supplies	$ -	$ 62,098	$ 116,343	$ 166,898	$ 188,252		
j. Other Expenses (Specify/add rows of needed)	$ -						
TOTAL OPERATING EXPENSES	***$ -***	***$ 1,340,275***	***$ 2,710,798***	***$ 3,338,194***	***$ 3,405,813***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ -**	**$ (50,538)**	**$ 264,341**	**$ 1,201,017**	**$ 1,780,571**	**$ -**	**$ -**
b. Non-Operating Income	$ -						
SUBTOTAL	***$ -***	***$ (50,538)***	***$ 264,341***	***$ 1,201,017***	***$ 1,780,571***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ -***	***$ (50,538)***	***$ 264,341***	***$ 1,201,017***	***$ 1,780,571***	***$ -***	***$ -***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%		
2) Medicaid	0.0%	9.6%	9.6%	9.6%	9.6%		
3) Blue Cross	0.0%	10.6%	10.6%	10.6%	10.6%		
4) Commercial Insurance	0.0%	7.8%	7.8%	7.8%	7.8%		
5) Self-pay	0.0%	1.3%	1.3%	1.3%	1.3%		
6) Other	0.0%						
Medicare MCO	0.0%	0.0%	0.0%	0.0%	0.0%		
Medicaid MCO	0.0%	70.6%	70.6%	70.6%	70.6%		
Managed Care	0.0%	0.1%	0.1%	0.1%	0.1%		
Workers Compensation	0.0%	0.0%	0.0%	0.0%	0.0%		
TOTAL	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%		
2) Medicaid	0.0%	9.6%	9.6%	9.6%	9.6%		
3) Blue Cross	0.0%	10.6%	10.6%	10.6%	10.6%		
4) Commercial Insurance	0.0%	7.8%	7.8%	7.8%	7.8%		
5) Self-pay	0.0%	1.3%	1.3%	1.3%	1.3%		
6) Other	0.0%						
Medicare MCO	0.0%	0.0%	0.0%	0.0%	0.0%		
Medicaid MCO	0.0%	70.6%	70.6%	70.6%	70.6%		
Managed Care	0.0%	0.1%	0.1%	0.1%	0.1%		
Workers Compensation	0.0%	0.0%	0.0%	0.0%	0.0%		
TOTAL	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***

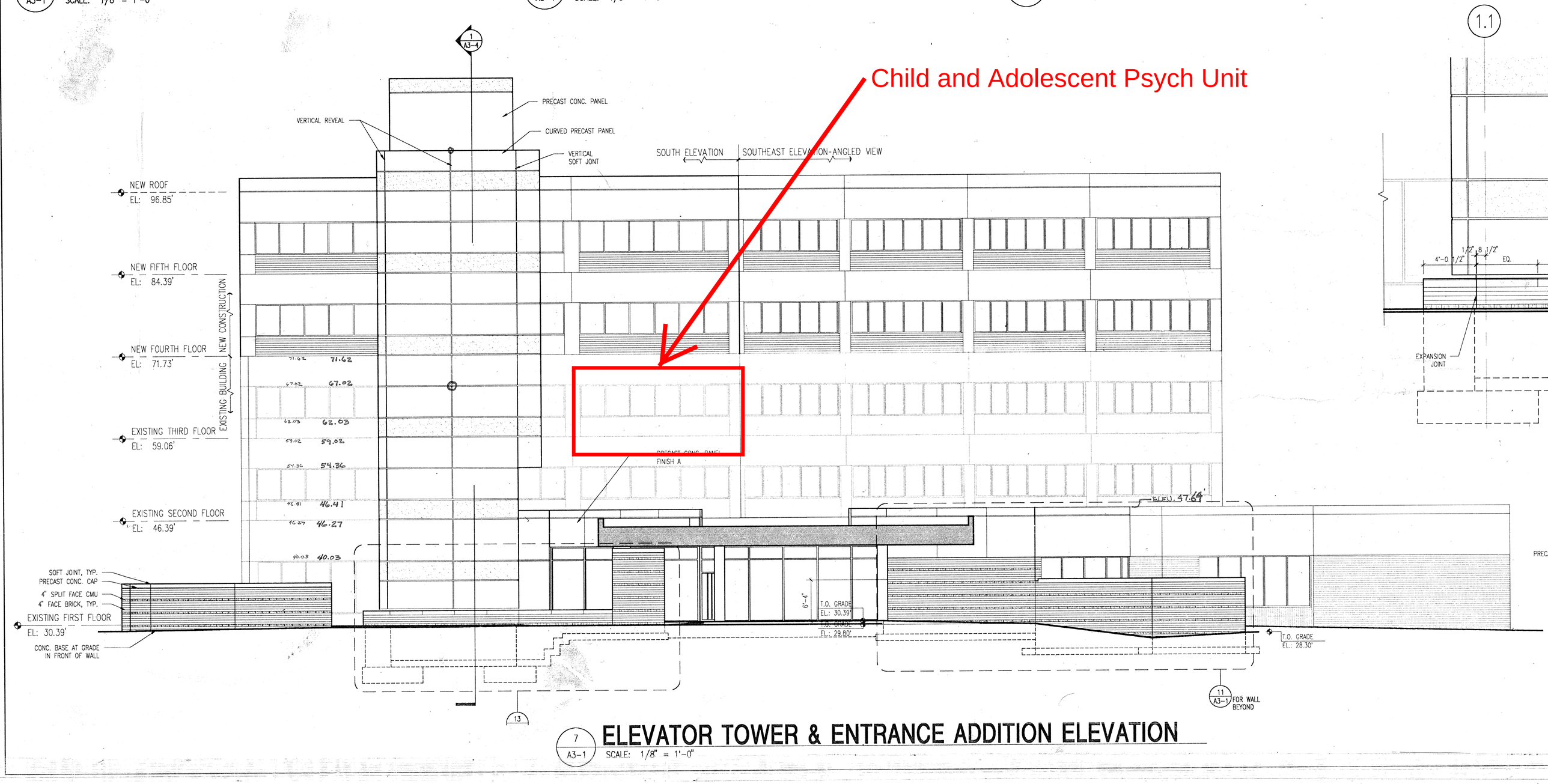
TABLE L. WORKFORCE INFORMATION

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

	CURRENT ENTIRE FACILITY(FY 2017)			***PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)***			***OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)***			***PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT***	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Administrative	137.9	$120,004	$16,548,598			$0			$0	137.9	$16,548,598
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration	137.9	$120,004	$16,548,598			$0			$0	137.9	$16,548,598
Direct Care Staff *(List general categories, add rows if needed)*											
Medical Social Worker	11.8	$58,336	$689,528	2.0	$65,244	$130,488			$0	13.8	$820,016
Nurse Manager	79.2	$96,838	$7,666,661	1.0	$110,026	$110,026			$0	80.2	$7,776,687
Patient Care/Nursing Aide II	66.8	$34,147	$2,279,964	10.0	$35,323	$353,230			$0	76.8	$2,633,194
Registered Nurse	631.9	$76,646	$48,431,275	10.0	$74,725	$747,252			$0	641.9	$49,178,527
Unit Clerk/Secretary	80.2	$29,423	$2,359,428	2.0	$29,546	$59,092			$0	82.2	$2,418,520
Art Therapist			$0	1.0	$47,491	$47,491			$0	1.0	$47,491
Direct Care	784.3	$75,683	$59,358,441								
Total Direct Care	1,654.1	$73,020	$120,785,297	26.0	$55,676	$1,447,579			$0	1,680.1	$122,232,876
Support Staff *(List general categories, add rows if needed)*											
Billing Clerk	65.4	$37,417	$2,448,222	1.0	$33,427	$33,427			$0	66.4	$2,481,649
Utilization Review	47.9	$84,862	$4,061,489	1.0	$60,151	$60,151			$0	48.9	$4,121,640
Support Staff	644.6	$48,527	$31,280,353			$0			$0	644.6	$31,280,353
Total Support	757.9	$49,862	$37,790,064	2.0	$46,789	$93,578			$0	759.9	$37,883,642
REGULAR EMPLOYEES TOTAL	***2,549.9***	***$68,678***	$175,123,959	***28.0***	***$55,041***	$1,541,157			$0	2,577.9	$176,665,116

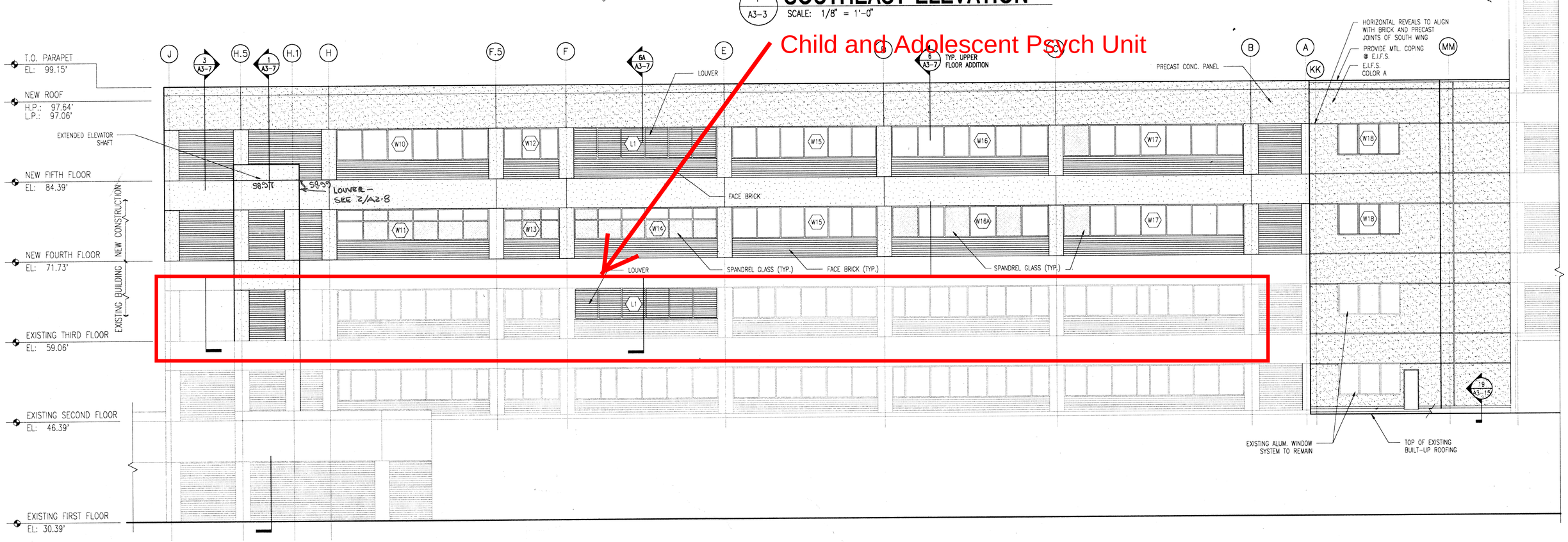
TABLE L. WORKFORCE INFORMATION

2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
Administrative	0.4	$314,932	$119,674			$0			$0	0.4	$119,674
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration	0.4		$119,674			$0			$0	0.4	$119,674
Direct Care Staff *(List general categories, add rows if needed)*											
Direct Care	12.3	$414,777	$5,101,763			$0			$0	12.3	$5,101,763
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff	12.3	$414,777	$5,101,763			$0			$0	12.3	$5,101,763
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTA	***12.7***	***$411,785***	$5,221,437			$0			$0	12.7	$5,221,437
Benefits *(State method of calculating benefits below)* **:**			**$39,274,810**			**$379,587**					**$39,654,397**
Actual;											
TOTAL COST	***2,562.6***		***$219,620,206***	***28.0***		***$1,920,744***	***0.0***		***$0***		***$221,540,950***



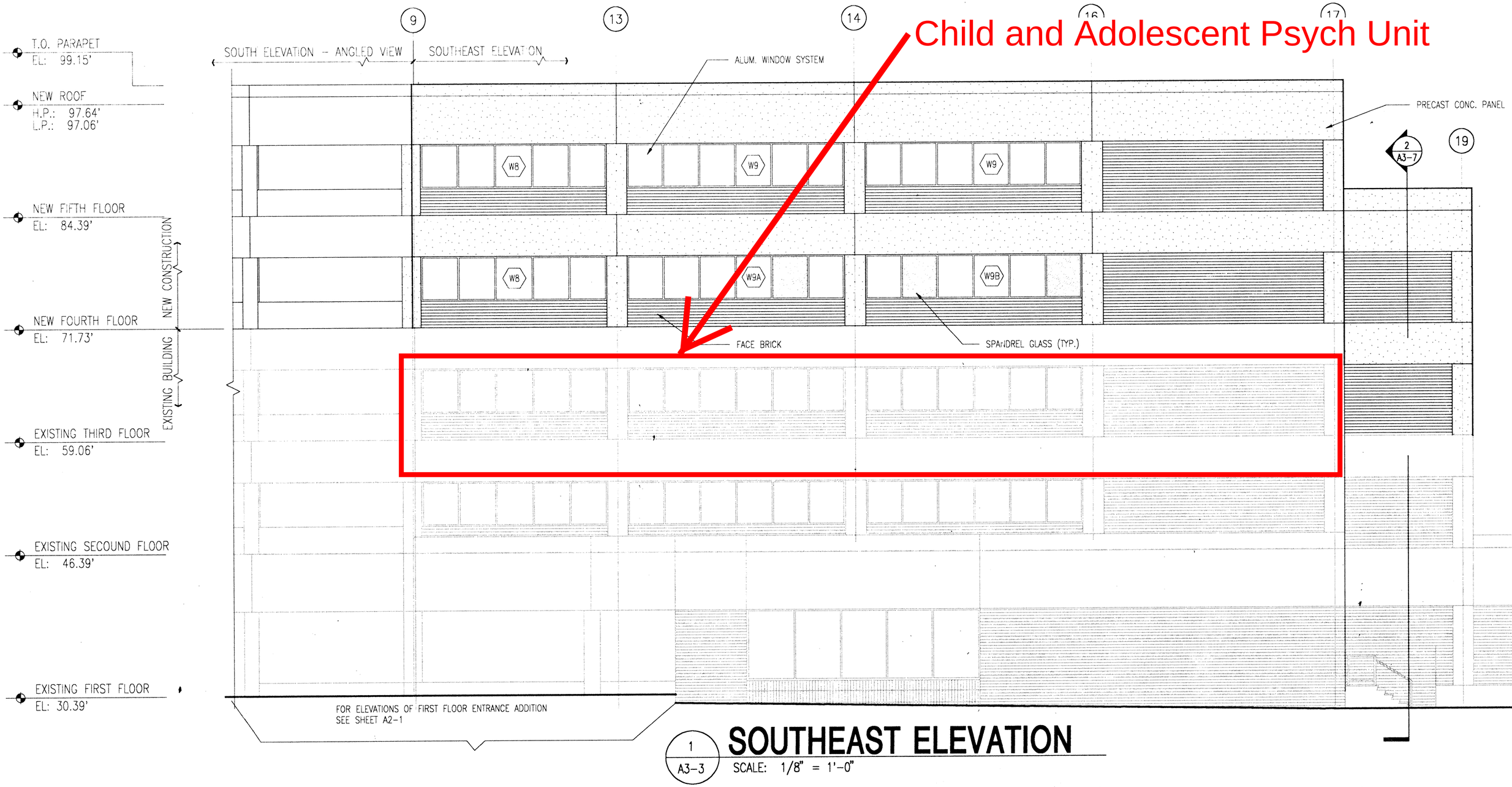
ELEVATOR TOWER & ENTRANCE ADDITION ELEVATION

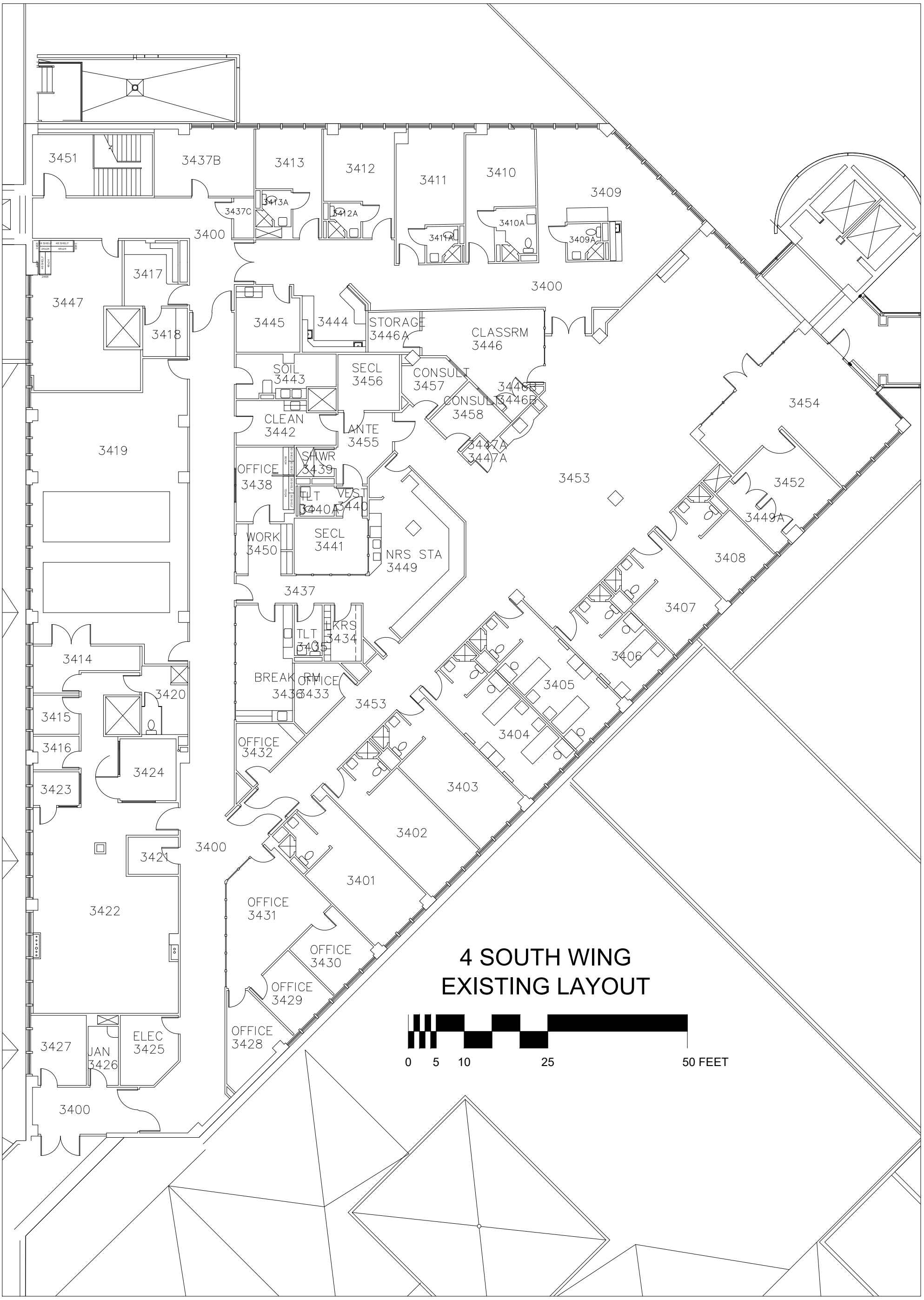
7 A3-1 SCALE: 1/8" = 1'-0"



1 A3-3 **SOUTHEAST ELEVATION**
SCALE: 1/8" = 1'-0"

2 A3-3 **NORTHEAST ELEVATION**
SCALE: 1/8" = 1'-0"


Child and Adolescent Psych Unit
T.O. PARAPET
EL: 99.15'
NEW ROOF
H.P.: 97.64'
L.P.: 97.06'
NEW FIFTH FLOOR
EL: 84.39'
NEW CONSTRUCTION
NEW FOURTH FLOOR
EL: 71.73'
EXISTING BUILDING
EXISTING THIRD FLOOR
EL: 59.06'
EXISTING SECOUND FLOOR
EL: 46.39'
EXISTING FIRST FLOOR
EL: 30.39'
9
13
14
16
17
19
SOUTH ELEVATION - ANGLED VIEW
SOUTHEAST ELEVATION
ALUM. WINDOW SYSTEM
PRECAST CONC. PANEL
2
A3-7
W8
W9
W9
W8
W9A
W9B
FACE BRICK
SPANDREL GLASS (TYP.)
FOR ELEVATIONS OF FIRST FLOOR ENTRANCE ADDITION
SEE SHEET A2-1
1
A3-3
SOUTHEAST ELEVATION
SCALE: 1/8" = 1'-0"



3 SOUTH
12 Beds

Seal

Issue Drawing Log

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

PRMC
Peds + Adol Psych Unit
Option 3_05

January 17, 2018

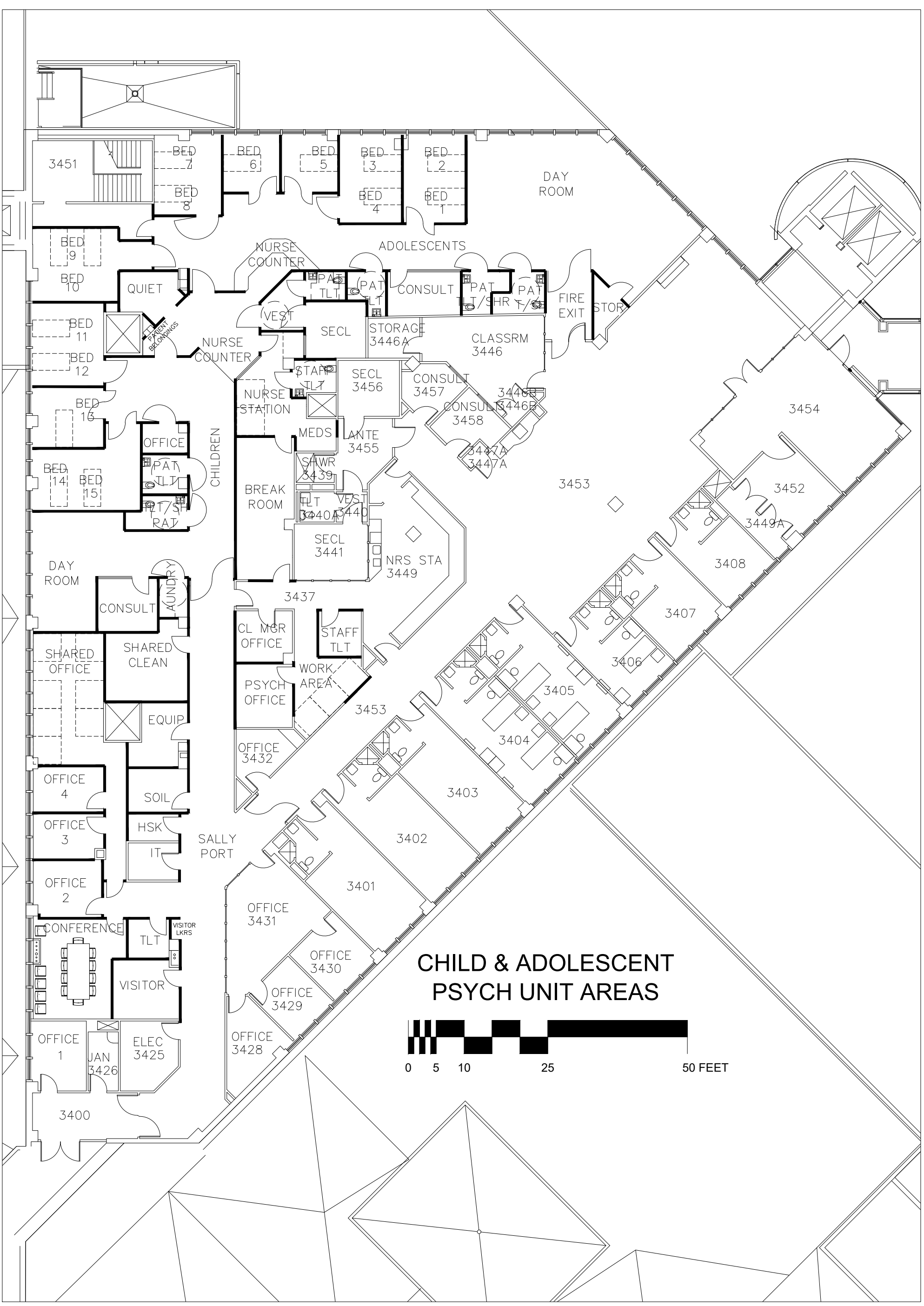
Consultants

Project No:
Project No:

CallisonRTKL Inc.
2101 L Street, NW
Suite 200
Washington, D.C. 20037
Tel: 202.833.4400
Fax: 202.887.5168

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3 SOUTH
12 Beds

Seal

Issue Drawing Log

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

PRMC
Peds + Adol Psych Unit
Option 3_05

January 17, 2018

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SPECIAL CARE NURSERY

CHILD & ADOLESCENT PSYCH UNIT

EQUIPMENT
EQUIPMENT
4158
OPEN INFANT AREA
MULTI-PURPOSE BREAK ROOM
STAFF DRESSING ROOM
STAFF DRESSING ROOM
STAFF CHANGING + LKRS
SOIL HOLDING
NURSE STATION
PAT
TLT
SHWR
JAN
LAUNDRY
HVAC
DAY ROOM
HVAC
15
14
13
12
HVAC
HVAC
11
10
9
PAT TLT
PAT TLT SHWR
PATIENT BELONGINGS
TLT PAT
VEST
SECL
HSK
OFFICE
CAP EQUIP
OFFICE
OFFICE
ELEC
TDR
VISITOR
GOWNING SCRUB
VISITOR BELONGINGS
SALLY PORT
CAP CLEAN
CAP SOIL
STAFF TLT
QUIET
PAT TLT SHWR
MEDS
NURSE STATION
NURSE
STAFF TLT SH
A.I.I.
NURSE STATION
EQUIPMENT
EQUIPMENT
STABILIZATION AREA
PRIVATE
PARENT SLEEPING
PARENT TLT SH
SHARED CONFERENCE
CLOSET
CAP STAFF LOCKERS
CAP BREAK ROOM
CAP STAFF LOCKERS
LACTATION COUNSELING
4310
4300
4300
4157
4305
4306
4100
4300
4300
PAT TLT
CONSULT
CONSULT
GROUP ROOM
EXAM
8
7
5
6
4
3
1
2
HVAC HVAC
HVAC HVAC
SHARED OFFICE 4301
WOMEN'S + CHILDREN'S DIRECTOR 4302
WOMEN'S + CHILDREN'S ADMIN ASSISTANT 4303
LACTATION CONSULTANT 4304
EXEC W & C 4309
CLINICAL NURSE COORDINATOR
NEONATAL NURSE PRACTITIONER
PHYSICIAN ASSISTANT
NICU, NEWBORNS, PEDIATRICS

C:\USERS\ROLAND.BINKER\DOCUMENTS\0DATA\PRMC\PSYCH AND SCN\SKETCHES

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Project No:

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PRMC Peds + Adol Psych Unit
Peds + Adol Psych Unit Option 10 (Rejected Option)
November 17, 2017

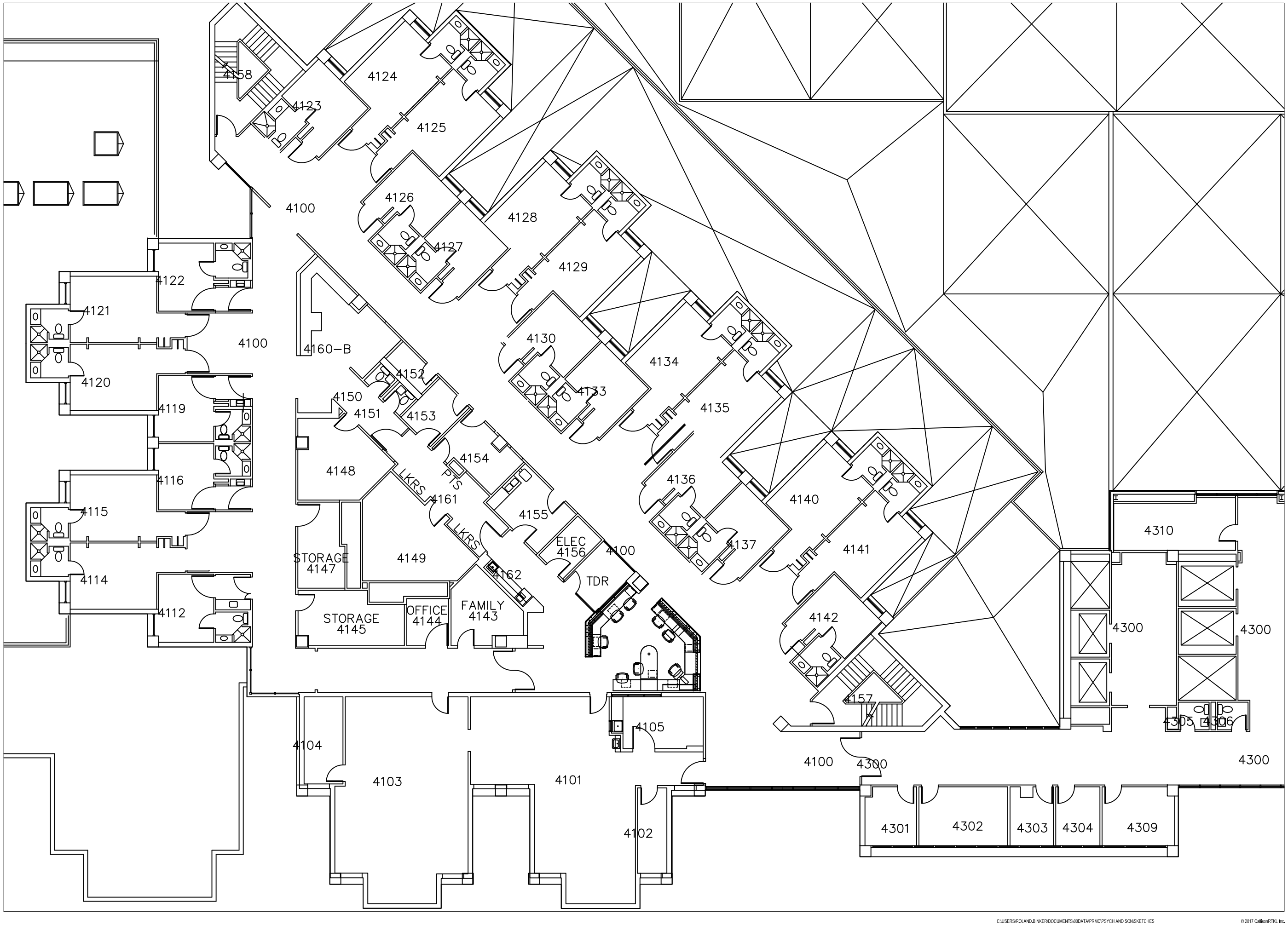
Peninsula Regional Medical Center
100 East Carroll Street
Salisbury, MD 21801

Issue Drawing Log

Seal

Sheet Identification

4 EAST
15 Beds



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Project No:

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PRMC
Peds + Adol Psych Unit
Existing Layout
November 21, 2017

Peninsula Regional Medical Center

100 East Carroll Street
Salisbury, MD 21801

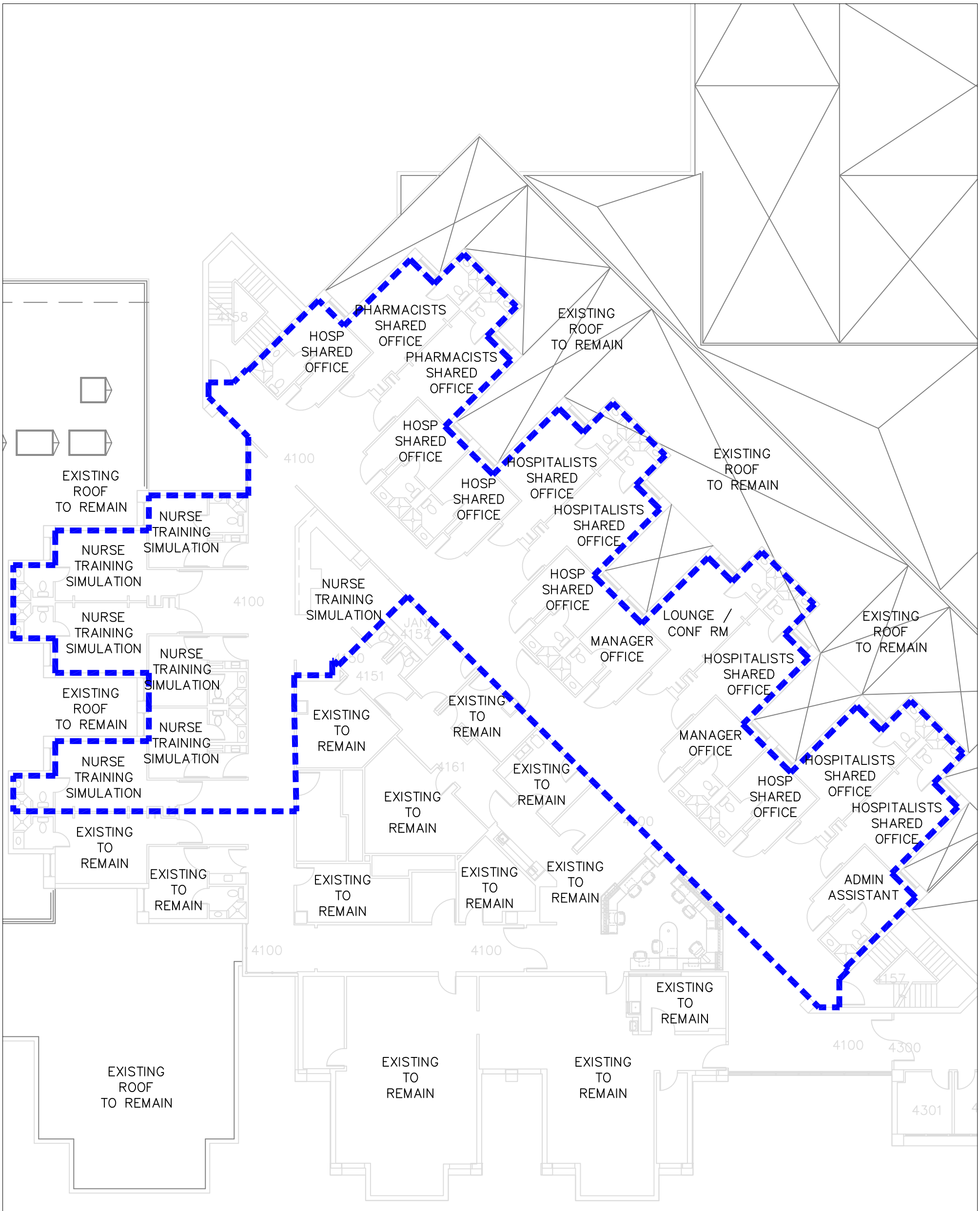
Issue Drawing Log

Seal

Sheet Identification

4 EAST
15 Beds

.



4 EAST RENOVATIONS
8,038 sf

Sheet Identification
4 EAST
STAFF SUPPORT AREAS

Seal

Issue Drawing Log

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

PRMC
Peds + Adol Psych Unit
Related Renovation Area

January 23, 2018

Consultants

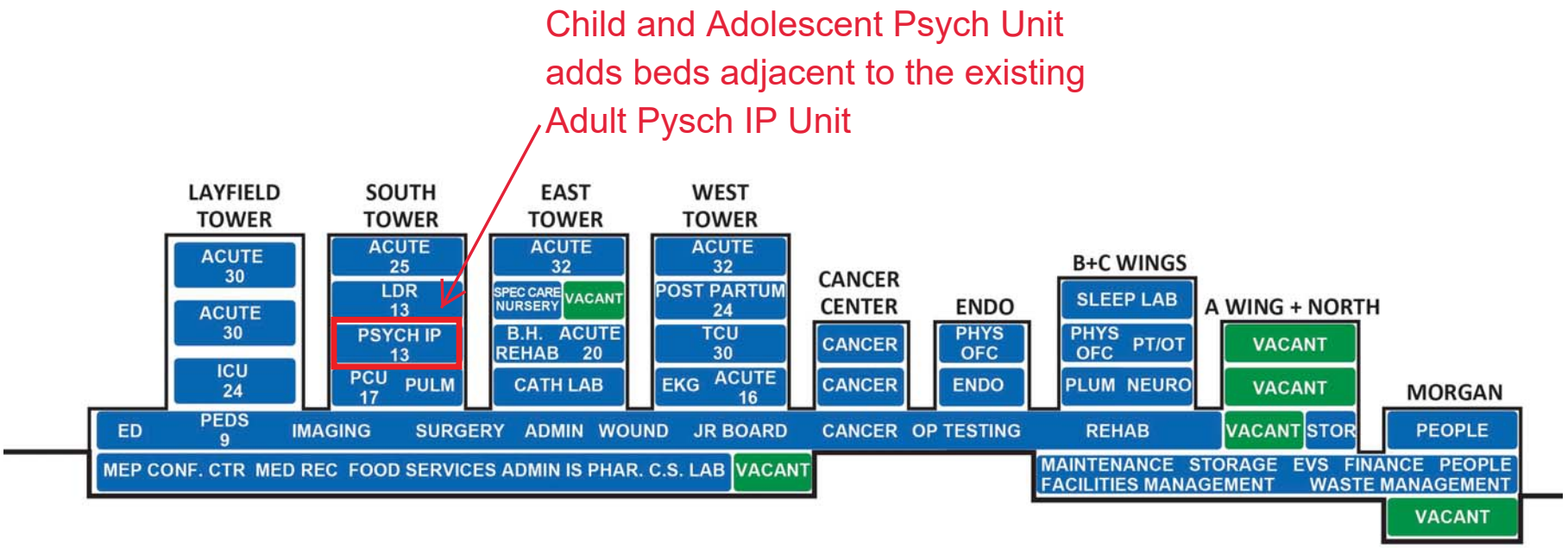
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Project No:
Project No:

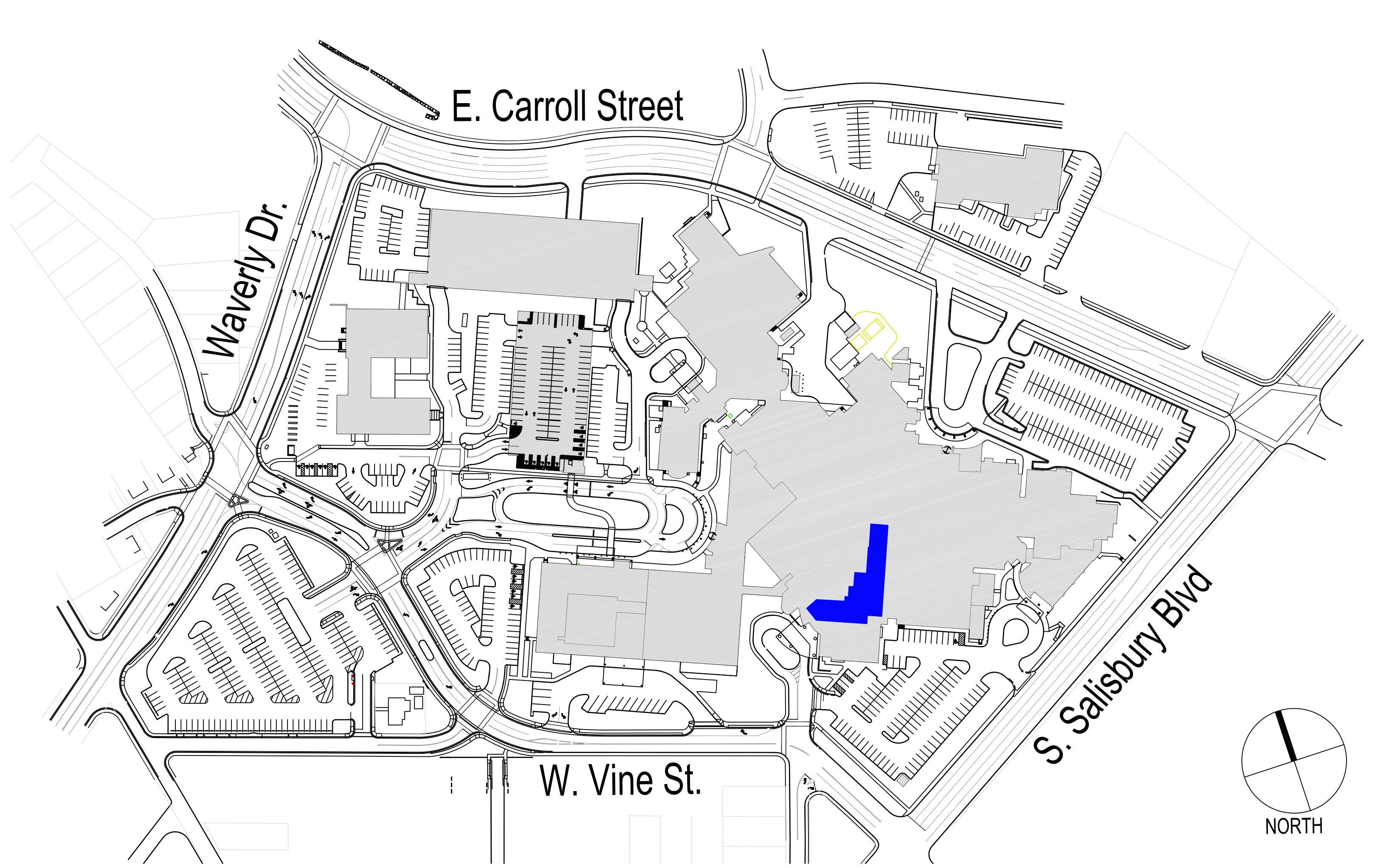
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J:\PRMC - IBHP\Child Adol Psych and Sp Care Nursery\Sketches\CAP_4_13.dwg



Existing Building Section


E. Carroll Street
Waverly Dr.
W. Vine St.
S. Salisbury Blvd
NORTH

Marshall and Swift Valuation

Calculator Method

Renovations+ Air Handler Rooftop Construction

MVS Base Square Foot Cost*	$374.00
Heating Cooling Ventilation	0
Elevator Deduction	-$8.51
TOTAL	$365.49
Multipliers	
Number of Stories	N/A
Height per Story	
Floor Area Perimeter Multiplier	0.94
Combined	0.94
Refined Square Foot Cost	$343.56
Current Cost Multiplier	1.01
Local Multiplier	0.99
Final Square Foot Cost	$343.53
Project Area Allocation (Square Feet)*****	19,395
MVS Cost Standard**	$6,662,691.50
PRMC Cost Estimate***	$5,447,325.00
Difference (Savings)	-$1,215,366.50

*Class A, Good "General Hospital" Construction

**Costs Estimated as of 1/2018

***Excudes Movable Equipment

****See TABLE E. Project Budget – Attachment 3

*****See TABLE B. Dept. Gross Sq. Ft. – Attachment 3

Peninsula Regional Medical Center
Policy/Procedure

Finance Division

Subject: Charges - Estimates and Information to Patients and Public

Affected Areas: Patient Accounting, Patient Financial Services, Patient Registration, Accounting

Policy/Procedure Number: FD-157

Policy:

Peninsula Regional Medical Center's Finance Department will post a representative list of services and charges on the PRMC website. PRMC will respond to individual requests for current charges for specific services/procedures. PRMC will provide staff training to ensure that inquiries for its services are appropriately handled.

Procedure:

The attached List of Representative Charges will be posted on the PRMC website by the Finance Budget, Cost & Reimbursement Office on a quarterly basis. The information will be updated each calendar quarter and posted within 45 days of the end of each quarter.

The List of Representative Charges will be distributed to staff each time prices change. This list is available to the public from the Financial Counselor upon request. Requests for estimates of charges for procedures/services are provided by the following:

Outpatient Diagnostic Testing –

- If requested in person – by the Financial Counselor
- If requested by phone – by the Centralized Scheduling Office

Outpatient Surgery and Procedures – by the Centralized Scheduling Office
Inpatient Services –

- If requested by phone – by the Patient Financial Services collection personnel
- If requested in person – by the Financial Counselor who will contact the collections team

Information available for charge estimation:

1. Rates sheet. This list is updated whenever prices are changed, and revisions will come from the Budget and Reimbursement Office.

2. Service item master listing for charges. This list is updated periodically and revisions will come from the Budget and Reimbursement Office.

3. Observation charges. This charge is updated periodically and revisions will come from the Budget and Reimbursement Office.

4. A listing of average OR minutes by procedure. Two lists are generated, one in ICD-10 order (worksheet = avg. min), the second list is in alphabetic description order (worksheet = avg. min-desc.). These lists are updated periodically and revisions will come from the Budget and Reimbursement Office.

Note: Contact Budget and Reimbursement Office if an annual update is not received.

Patient Correspondence

It is important that the patient understand that the estimate is subject to change and is only an estimate. The actual charges incurred may be higher or lower than shown. See example correspondence which may be formalized and sent via mail or may be used in phone conversations to ensure continuity of message presented.

Documentation

Document in EPIC, account notes; the estimated charges and the method and date of communication to patient.

Date: 9/24/01
Reviewed: 12/13, 12/14, 4/17
Revised: 8/23/10, 12/31/10, 3/24/11, 12/11, 12/12, 2/16

Advertising Receipt

The Daily Times
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ATTN: Keith Doughty

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Ad Text:

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Worcester County Times
11021 Nicholas Lane, Suite 10,
Ocean Pines, Maryland 21811

Chincoteague Beacon
23079 Courthouse Avenue,

Delaware Wave
33000 Coastal Highway,
Bethany Beach, Delaware 19930

Somerset Herald
618 Beam Street
Salisbury, MD 21801

Wicomico Weekly
618 Beam Street

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The Daily Times
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Ad Number: 0002476077 Run Dates: 10/17/17

NOTICE OF AVAILABILITY OF FINANCIAL ASSISTANC

Peninsula Regional Medical Center provides financial assistance to patients based on their income, assets, and financial needs. We may be able to help you access governmental programs or assist you with payment plans. A reasonable amount of our services are provided free or at a reduced charge to persons who cannot afford to pay for medical care.

If you would like information on our financial assistance policy, or are not able to pay for all or part of the care you need, please contact the financial services office at 410-543-7436 or 800-235-8640, visit our website at www.peninsula.org or write to:

Patient Financial Services
Peninsula Regional Medical Center
P.O. Box 2498
Salisbury, MD 21802-2498

10/17/17

0002476077-01

ADMINISTRATIVE POLICY MANUAL

Subject: Uncompensated Care / Financial Assistance

Effective Date:	August 1981
Approved by:	President/CEO and Vice President of Finance/CFO
Responsible Parties:	Senior Executive Director of Finance
Revised Date:	12/86, 6/88, 3/90, 3/91, 7/93, 7/94, 8/98, 12/05, 8/08, 5/10, 10/10, 12/14, 7/16, 11/16, 7/17
Reviewed Date:	8/83, 12/85, 2/88, 6/92, 8/95, 7/96, 9/97, 6/00, 6/01, 10/02, 10/04, 12/11, 12/12, 12/13
Key Words:	Financial Assistance, Federal Poverty Guidelines, Charity Care, Uncompensated

POLICY

Peninsula Regional Medical Center (PRMC) will provide emergency and medically necessary free and/or reduced-cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of their hospital bill. For purposes of this policy, PRMC shall include the hospital, medical center, and physician services billed by PRMC, commonly referred to as Peninsula Regional Medical Group (PRMG). A patient's payment for reduced-cost care shall not exceed the amount generally billed (AGB) as determined by the Health Services Cost Review Commission (HSCRC).

PRMC may use outsource vendors to provide patient collection and/or pre-collection services. Vendors act in accordance with PRMC policies and wherever policy notates employee, financial services department, or other such wording – vendor and/or vendor employees are included without such notation.

Definitions:

a. Elective Care: Care that can be postponed without harm to the patient or that is not medically necessary. An appropriate clinical or physician representative will be contacted for consultation in determining the patient status.
b. Medical Necessity: Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, resulting in illness or infirmity, threatening to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.
c. Immediate Family: A family unit is defined to include all individuals taken as exemptions on the income tax return for the individual completing the application, whether or not they were the individual filing the return or listed as a spouse or dependent. For homeless persons or in the event that a family member is not obtainable, the family unit size will be assumed to be one. If a tax return has not been filed, then income from all members living in the household will be considered.

d. Liquid Assets: Cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, rental properties etc. The availability of liquid assets plus annual income may be considered in relation to the current poverty guidelines published in the Federal Register.
e. Medical Debt: Out of pocket expenses, excluding copayments, coinsurance and deductibles, for medical costs for medical costs billed by PRMC.
f. Extraordinary Collection Actions (ECA): Any legal action and/or reporting the debt to a consumer reporting agency.

PRMC will provide free medically necessary care to patients with family income at or below 200% of the federal poverty level.

PRMC will provide reduced-cost medically necessary care to low-income patients with family income between 200% and 300% of the Federal poverty level.

PRMC will provide reduced-cost medically necessary care to low-income patients with family income between 301% and 500% of the Federal poverty level who have a medical hardship as defined by Maryland Law. Medical hardship is medical debt, incurred by a family over a 12 month period that exceeds 25% of the family income.

Other healthcare fees and professional fees that are not provided by PRMC/PRMG are not included in this policy. Pre-planned service may only be considered for financial assistance when the service is medically necessary. As an example, cosmetic surgery is excluded. Inpatient, outpatient, emergency services, and services rendered by PRMG are eligible.

PRMC's financial assistance is provided only to bills related to services provided at PRMC or at a PRMC site including services provided by physicians employed by PRMC. These services are generally referred to as PRMG. To determine if your physician services are covered by the PRMC financial assistance program, please see the roster of providers that deliver emergency and other medically necessary care, indicating which providers are covered under the policy and which are not. The list of providers is updated quarterly and available on the medical center website. If you prefer, you may contact any financial counselor or patient accounting representative by calling (410) 543-7436 or (800) 235-8640, or in person at the hospital.

PROCEDURE

If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies. In the event that the patient has applied for and kept all necessary appointments and third party assistance is not available, PRMC will provide care at reduced or zero cost. When no third party assistance is available to cover the total bill and the patient indicates that they have insufficient funds, Financial Assistance (FA) will be offered. The Maryland State Uniform Financial Assistance application, policy and plain language summary, can be obtained by one of the following ways:

a. Available free of charge and upon request by calling (410) 543-7436 or (800) 235-8640.
b. Are located in the registration areas.
c. Downloaded from the hospital website:
https://www.peninsula.org/patients-visitors/patient-forms
https://www.peninsula.org/patients-visitors/billing-center
https://www.peninsula.org/patients-visitors/billing-center/billing-information
d. The plain language summary is inserted in the Admission packet and with all patient statements.
e. Through signs posted in the main registration areas.

f. Annual notification in the local newspaper.
g. The application is available in English and Spanish. No other language constitutes a group that is 5% or more, or more than 1,000 residents (whichever is less) of the population in our primary service area (Worcester, Wicomico and Somerset Counties) based on U.S. Census data.
h. For patients who have difficulty in filling out an application, the information can be taken orally.

The patient's income will be compared to current Federal Poverty Guidelines (on file with the Collection Coordinator). The Collection Coordinator representative will consult with the patient as needed to make assessment of eligibility.

a. If the application is received within 240 days of the first post-discharge billing statement, and the account is with a collection agency, the agency will be notified to suspend all Extraordinary Collection Actions (ECA) until the application and all appeal rights have been processed.

b. If the application is incomplete, all ECA efforts will remain on hold for a reasonable amount of time and assistance will be provided to the patient in order to get the application completed. If there is not a phone contact to call, a written notice that describes the additional information and/or documentation required will be mailed which includes a phone contact to call for assistance.

c. Preliminary eligibility will be made within 2 business days of receipt of a completed application. If approved, a financial assistance discount will be applied to the patient's responsibility in accordance with Finance Division policy FD-030.

d. Patients who are beneficiaries/recipients of certain means-tested social services programs are deemed to have presumptive eligibility and are FA eligible without the completion of an application or submission of supporting documentation. It is the responsibility of the patient to notify the hospital that they are in a means-tested program. This information may be obtained from an outsourced vendor working the account.

e. A patient that has qualified for Maryland Medical Assistance is deemed to automatically qualify for Financial Assistance (FA). The amount due from a patient on these accounts may be written off to FA with verification of Medicaid eligibility. Standard documentation requirements are waived.

f. If the application is ineligible, normal dunning processes will resume, which includes notifying the agency if applicable to proceed with ECA efforts. A copy of the Medical Center Collections Policy may be obtained by calling (410) 543-7436 or (800) 235-8640.

g. The patient may request reconsideration by submitting a letter to the Director of Patient Financial Services indicating the reason for the request.

h. Only income and family size will be considered in approving applications for FA unless one of the following three scenarios occurs:
   - The amount requested is greater than $50,000
   - The tax return shows a significant amount of interest income, or the patient states they have been living off of their savings accounts
   - Documentation indicates significant wealth

i. If one of the above three scenarios are applicable, liquid assets may be considered including:
   - Checking and savings accounts
   - Stocks and bonds
   - CD's
   - Money market or any other financial accounts for the past three months
   - Last year's tax return
   - A credit report may also be reviewed

   The following assets are excluded:
   - The first $10,000 of monetary assets
   - Up to $150,000 in a primary residence
   - Certain retirement benefits such as a 401-K where the IRS has granted preferential tax treatment as a retirement account including but not limited to deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans where the patient potential could pay taxes and/or penalties by cashing in the benefit.

   If the balance due is sufficient to warrant it and the assets are suitable, a lien may be placed on the assets for the amount of the bill. Collection efforts will consist of placement of the lien which will result in payment to the hospital upon sale or transfer of the asset. Refer to the Medical Center Collection policy on filing liens.

Collection Coordinator

a. If eligible, and under $2,500, the account will be written off to FA when the "Request for Financial Assistance" form is finalized. A copy is retained in the patient's electronic file. If eligible, and the balance is $2,500 or above, the Collection Coordinator will obtain the appropriate adjustment signature(s) as defined in Finance Division Policy FD-30 and complete the process.

b. PRMC will review only those accounts where the patient or guarantor inquire about FA, based on mailing in an application, or in the normal working of the account there is indication that the patient may be eligible. Any patient/customer service representative, financial counselor, or collection representative may begin the application process.

c. Once a request has been approved, service three months before the approval and twelve months after the approval may be included in the adjustment. All encounters included with the application must reference the original encounter number where the electronic image of the application is stored. Service dates outside this fifteen month window may be included if approved by a Supervisor, Manager, or Director. Any amount exceeding $5 that has already been collected from the patient or guarantor for approved dates of service shall be refunded to the patient if the determination is made within two years of the date of care.

Note: Effective 7-1-16, FD-162 (Finance Division policy #162) Financial Assistance was combined into the Medical Center policy. A Division policy is no longer required or maintained.

Attachment I – Provider Roster
Attachment II – Plain Language Summary
Attachment III – Federal Poverty Guidelines
Attachment IV – Financial Assistance Application - English

_____	_____
Peggy Naleppa	Bruce Ritchie
President/CEO	Vice President of Finance/CFO

Peninsula Regional Medical Center
Physician List indicates whether the physician is part of Peninsula Regional which also means the physician services / bill is covered by the Peninsula Regional Medical Center Financial Assistance Policy
Excerpt for information purposes only

Provider (Physician and Mid-level)		Group Affiliation	PRMC Provider	Financial Assistance PRMC
Abdella	Sarah	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Acevedo	Jorge	Peninsula Regional Neurosurgery	PRMG Staff	Yes
AfsharImani	SeyedAmirHossein	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Ahmed	Andaleeb	PRMC - Department of Anesthesiology	PRMG Staff	Yes
Akers	Jeremy	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Alu-Parks	Nicole	Peninsula Regional Family Medicine Salisbury	PRMG Staff	Yes
Arnaout	Karim	Peninsula Regional Oncology & Hematology	PRMG Staff	Yes
Asrat	Habtamu	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Baibars	Mohammad Motaz	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Baker	Kathryn	Peninsula Regional Neurosurgery	PRMG Staff	Yes
Barbouletos	Sareen	Peninsula Regional Family Medicine Millsboro	PRMG Staff	Yes
Batool	Aisha	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Coker	Robert	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Crum	Michael	Peninsula Regional Family Medicine Snow Hill	PRMG Staff	Yes
Daniels	Daniel	Peninsula Regional Gastroenterology	PRMG Staff	Yes
Davidson	Michael	Peninsula Regional Pulmonary & Critical Care	PRMG Staff	Yes
Abbott	Trevor	Peninsula Orthopaedic Associates, PA	Independent	No
Achampong	Henry	Fairwood Spine and Pain Center	Independent	No
Acle	Fernando	Drs. Acle & Visioli, PA	Independent	No
Acs	George	TLCCS, Inc Dentistry	Independent	No
Adeyeye	Adeola	Peninsula Regional Hospitalists/Inpatient Providers	Independent	No
Adrignolo	Anthony	Peninsula Orthopaedic Associates, PA	Independent	No
Agarwal	Ramesh	Ramesh K. Agarwal, MD, PA	Independent	No
Ahmad	Zaaira	Retina Consultants of Delmarva	Independent	No
Ali	Shoaib	Peninsula Nephrology Associates, PA	Independent	No
Allen	Robert	Delmarva Internal & Family Medicine, PA	Independent	No
Alvarado	Jose	Jose F. Alvarado, MD & Associates	Independent	No
Amaka	Dorothy	PRMC - Department of Anesthesiology	Independent	No
Ames	Sheena	Alon Davis, MD, PA	Independent	No

Partial list for policy - full list is available on the Peninsula website

PLAIN LANGUAGE SUMMARY

Financial Assistance Policy

It is the intention of Peninsula Regional Medical Center (PRMC) to make available to all patients the highest quality of medical care possible within the resources available. If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies, or, if no help is available, to render care at a reduced or zero cost for emergency and medically necessary care.

Patients requiring elective services may, through consultation with their physician, have their procedure postponed until such time as the patient is able to make full payment or meet the established deposit. Elective procedure patients who, according to their diagnosis and/or their physician, cannot have their procedure postponed will be helped with obtaining assistance from agencies. If no assistance is available, and the patient requests, the account will be reviewed for possible financial assistance.

Peninsula Regional Medical Group (PRMG) physician charges are not included in the hospital bill and are billed separately, with the exception of self-pay balances. Self-pay balances for hospital services and PRMG services will appear on the same statement. Physician charges outside of the PRMG group are not included in the hospital bill and will be billed separately. Physician charges outside of PRMG are not covered by Peninsula Regional Medical Center's financial assistance policy. A list of providers that deliver emergency and other medically necessary care at PRMC is provided on the website, indicating which providers are covered under PRMC's financial assistance policy and which are not.

In the event that the patient has applied for and kept all necessary appointments and third party assistance is not available, the patient may be eligible for financial assistance.

Eligibility Determination Process

1. Interview patient and/or family
2. Obtain annual gross income
3. Determine eligibility *(preliminary eligibility within 2 business days)*
4. Screen for possible referral to external charitable programs
5. If the patient and/or family refuse to disclose financial resources or cooperate, the patient will be subject to standard collection efforts. No Extraordinary Collection Actions (ECA) will be taken for at least 120 days from the first post-discharge billing statement.
6. All applications received within 240 days of the first post-discharge billing statement will be reviewed. ECA actions will be suspended until the application has been processed.

How to Apply

- Applications can be taken orally by calling 1-800-235-8640 between 8:00 a.m. and 5:00 p.m., Monday through Friday
- In person at the Financial Counselor's office (located in the Frank B. Hanna Outpatient Center lobby) between 8:00 a.m. and 4:00 p.m., Monday through Friday
- On the internet at https://www.peninsula.org/patients-visitors/patient-forms
  https://www.peninsula.org/patients-visitors/billing-center
  https://www.peninsula.org/patients-visitors/billing-center/billing-information
- Applications are available in English and in Spanish

Qualifications

Peninsula Regional Medical Center compares the patient's income to the Federal Poverty Guidelines. In order to process your application we require the following information:

- An independent third party to verify your household income (one of the following)
  - Recent pay stub showing current and year-to-date earnings
  - Most recent tax return showing your Adjusted Gross Income or W-2 form

- Written documentation of Social Security benefits, SSI disability, VA benefits, etc.
- Letter from an independent source such as clergy, neighbor, former employer, etc.
- Completed application

This information, and any information obtained from external sources, is used to determine your eligibility for financial assistance. The more information provided, the easier it is for us to determine your financial need. Peninsula Regional may request a credit report to support a patient's application for assistance.

Need Assistance?

If, at any time, you have questions about obtaining financial assistance, your hospital bill, your rights and obligations with regard to the bill, or applying for the Maryland Medical Assistance Program, please contact Peninsula Regional Medical Center's Financial Services Department at 410-543-7436 or 1-800-235-8640.

Maryland Medical Assistance Program

To find out if you are eligible for Maryland Medical Assistance or other public assistance, please apply at your local Department of Social Services (DSS) office, or you may visit mmcp.dhmh.maryland.gov for information about the various Medicaid programs available. You may apply online for Maryland Medicaid at marylandhealthconnection.gov. If you are applying for assistance for a child or are pregnant, you may apply for the Maryland Children's Health Program (MCHP). If you are only applying for assistance with paying your Medicare premiums, co-payments, or deductibles, you may apply at your DSS for the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) Program. QMB/SLMB applications may be filed by mail or in person. Delaware Residents may obtain information online at dhss.delaware.gov or apply online at assist.dhss.delaware.gov. Virginia residents may obtain information at www.dmas.Virginia.gov.

Patients' Rights and Obligations

Rights:

- Prompt notification of their preliminary eligibility determination for financial assistance.
- Guidance from Peninsula Regional on how to apply for financial assistance and other programs which may help them with the payment of their hospital bill.
- Receipt of financial assistance for all services not payable by another program that meet the qualifications of Peninsula Regional Medical Center's Financial Assistance Policy.

Obligations:

- Submit complete and accurate information on the Uniform Financial Assistance Application in use in the state of Maryland.
- Attach supporting documentation and return the form to Peninsula Regional Medical Center in a timely manner.
- Make payment in full or establish a payment plan for services not qualified under Peninsula Regional's Financial Assistance Policy.

Cómo hacer la solicitud

- Llame al 1-800-235-8640 entre las 9:00 a.m. y las 4:00 p.m., de lunes a viernes
- Acuda en persona a la oficina del consejero financiero (Localizado en el vestibulo Frank B. Hanna del Centro de attencion de Pacientes Externos) entre las 8:30 a.m. y las 4:30 p.m., de lunes a viernes
- A través de Internet, visite www.peninsula.org. Haga clic en Patients & Visitors (Pacientes y vistantes), luego en Patient Financial Services (Servicios financieros para pacientes) y después en Billing Information (Información de facturación)

Date: 05/09/16 (effective 11/01/16)
Reviewed:
Revised: 07/01/17

2017 Federal Poverty Guidelines
Updated 04/17/2017

If your family size is:	And, your family income is at or below:		
Family Size	200% Federal Poverty Guideline	201% up to 300% Federal Poverty Guideline	301% - 500% Federal Poverty Guideline with Medical Hardship
1	$24,120	$36,180	$60,300
2	$32,480	$48,720	$81,200
3	$40,840	$61,260	$102,100
4	$49,200	$73,800	$123,000
5	$57,560	$86,340	$143,900
6	$65,920	$98,880	$164,800
7	$74,280	$111,420	$185,700
8	$82,640	$123,960	$206,600
You receive a discount off PRMC bills of:	**100%**	**50%**	**25%**

MARYLAND STATE UNIFORM FINANCIAL ASSISTANCE APPLICATION

Information About You

Name: _____
First Middle Last

Social Security Number _____-____-_____ Marital Status: Single Married Separated
US Citizen Yes No Permanent Resident: Yes No

Home Address _____

_____

_____ _____
City State Zip Code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip Code

Household Members:

Name	Age	Relationship

Have you applied for Medical Assistance ? Yes No
If yes, what was the date you applied? _____
If yes, what was the determination _____

Do you receive any state or County Assistance? Yes No

PRMC – Patient Accounts
100 East Carroll Street
Salisbury, MD 21801

PA-059 (12/05)

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/Pension Benefits	_____
Social Security Benefits	_____
Public Assistance Benefits	_____
Disability Benefits	_____
Unemployment Benefits	_____
Veterans Benefits	_____
Alimony	_____
Rental Property Income	_____
Strike Benefits	_____
Military Allotment	_____
Farm or Self-Employment	_____
Other Income Source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking Account	_____
Savings Account	_____
Stocks, Bonds, CD, or Money Market	_____
Other Accounts	_____
Total	_____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____		Approximate Value_____
Automobile	Make _____	Year_____	Approximate Value_____
Additional Vehicle	Make _____	Year_____	Approximate Value_____
Additional Vehicle	Make _____	Year_____	Approximate Value_____
Other Property			Approximate Value_____
		Total	_____

IV. Monthly Expense

	Amount
Rent or Mortgage	_____
Utilities	_____
Car Payment(s)	_____
Credit Card(s)	_____
Car Insurance	_____
Health Insurance	_____
Other Medical Expenses	_____
Other Expenses	_____
Total	_____

Do you have any other unpaid medical Bills? **Yes** **No**
For what service? _____
If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within 10 days.

Applicant Signature _____ Date _____

Relationship to Patient _____

PA-059 (12/05)

MARYLAND STATE UNIFORM FINANCIAL ASSISTANCE APPLICATION

Information About You

Name: _____
First Middle Last

Social Security Number _____-____-_____ Marital Status: Single
Married Separated
US Citizen Yes No Permanent Resident: Yes No

Home Address _____

_____

_____
_____
City State Zip Code
Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip Code

Household Members:

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

Have you applied for Medical Assistance ? Yes No
If yes, what was the date you applied? _____
If yes, what was the determination
_____

Do you receive any state or County Assistance? Yes No

PRMC – Patient Accounts
100 East Carroll Street
Salisbury, MD 21801

PA-059 (12/05)

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/Pension Benefits	_____
Social Security Benefits	_____
Public Assistance Benefits	_____
Disability Benefits	_____
Unemployment Benefits	_____
Veterans Benefits	_____
Alimony	_____
Rental Property Income	_____
Strike Benefits	_____
Military Allotment	_____
Farm or Self-Employment	_____
Other Income Source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking Account	_____
Savings Account	_____
Stocks, Bonds, CD, or Money Market	_____
Other Accounts	_____
Total	_____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home Loan Balance _____ Approximate Value_____

Automobile Make _____ Year_____ Approximate Value_____

Additional Vehicle Make _____ Year_____ Approximate Value_____

Additional Vehicle Make _____ Year_____ Approximate Value_____

Other Property Approximate Value_____

Total

_____

IV. Monthly Expense

	Amount
Rent or Mortgage	_____
Utilities	_____
Car Payment(s)	_____
Credit Card(s)	_____
Car Insurance	_____
Health Insurance	_____
Other Medical Expenses	_____
Other Expenses	_____
Total	_____

Do you have any other unpaid medical Bills? Yes No
For what service? _____
If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within 10 days.

Applicant Signature _____ Date _____

Relationship to Patient _____

PA-059 (12/05)

Maryland Hospital Community Benefit Report: FY 2016

May 8, 2017

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

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LIST OF ABREVIATIONS

ACA	Affordable Care Act
CBR	Community Benefit Report
CBSA	Community Benefit Service Area
CHNA	Community Health Needs Assessment
DME	Direct Medical Education
FPL	Federal Poverty Level
FY	Fiscal Year
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
IRC	Internal Revenue Code
IRS	Internal Revenue Service
LHIC	Local Health Improvement Coalition
MHA	Maryland Hospital Association
NSPI	Nurse Support Program I
PSA	Primary Service Area
VHA	Voluntary Hospitals of America
ZCTA	ZIP Code Tabulation Area

INTRODUCTION

Community benefit refers to initiatives, activities, and investments undertaken by tax-exempt hospitals to improve the health of the communities they serve. Maryland law defines community benefit as an activity that is intended to address community needs and priorities primarily through disease prevention and improvement of health status. Activities can include:

- Health services provided to vulnerable or underserved populations such as Medicaid, Medicare, or Maryland Children's Health Program enrollees
- Financial or in-kind support of public health programs
- Donations of funds, property, or other resources that contribute to a community priority
- Health care cost containment activities
- Health education, screening, and prevention services
- Financial or in-kind support of the Maryland Behavioral Health Crisis Response System[1]

In 2001, the Maryland General Assembly passed House Bill 15,[2] which created a responsibility for the Maryland Health Services Cost Review Commission (HSCRC) to collect hospital community benefit information from individual hospitals to compile into a statewide, publicly available Community Benefit Report (CBR). In response to this legislative mandate, the HSCRC initiated a community benefit reporting system for Maryland's nonprofit hospitals that included two components. The first component is the *Community Benefit Collection Tool*, a spreadsheet that inventories hospital community benefit expenses in specific categories defined by the HSCRC's *Community Benefit Reporting Guidelines and Standard Definitions*. These categories are similar—but not identical—to the federal community benefit reporting categories found in Part I of IRS Form 990, Schedule H.[3] The second component of Maryland's reporting system is the CBR narrative report. The HSCRC developed the *Community Benefit Narrative Reporting Instructions* to guide hospitals' preparation of these reports, which are intended to strengthen and supplement the quantitative community benefit data that hospitals report in their inventory spreadsheets.

This summary report provides background information on hospital community benefits and the history of CBRs in Maryland. It is followed by summaries of the community benefit narrative and financial reports for fiscal year (FY) 2016 and concludes with a summary of data reports from the past 13 years.

[1] MD. CODE. ANN., Health-Gen. §19-303(a)(3).
[2] H.B. 15, 2001 Gen. Assem., 415th Sess. (Md. 2001).
[3] https://www.irs.gov/pub/irs-pdf/f990sh.pdf

BACKGROUND

Section 501(c)(3) of the Internal Revenue Code (IRC) identifies tax-exempt, organizations as those that are organized and operated exclusively for specific purposes, including religious, charitable, scientific, and educational purposes.[4] Nonprofit hospitals receive many benefits from their tax-exempt status. They are generally exempted from federal income and unemployment taxes, as well as state and local income, property, and sales taxes. In addition, they are allowed to raise funds through tax-deductible donations and tax-exempt bond financing.

Originally, the Internal Revenue Service (IRS) considered hospitals to be "charitable" if they provided charity care to the extent of their financial ability to do so.[5] However, in 1969, the IRS issued Revenue Ruling 69-545, which modified the "charitable" standard to focus on "community benefits" rather than "charity care."[6] Under this IRS ruling, nonprofit hospitals are required to provide benefits to the community in order to be considered charitable. This has created the "community benefit standard," which is necessary for hospitals to satisfy in order to qualify for tax-exempt status.

In March 2010, Congress passed the Affordable Care Act (ACA).[7] Section 9007 of the ACA established IRC §501(r), which created additional requirements for hospitals to maintain tax-exempt status. Every §501(c)(3) hospital, whether independent or part of a hospital system, must conduct a community health needs assessment (CHNA) at least once every three years in order to maintain its tax-exempt status and avoid an annual penalty of up to $50,000.[8] The first CHNA was due by the end of FY 2013. Assessments must incorporate input from individuals who represent the broad interests of the communities served, including those with special knowledge or expertise in public health, and they must be made widely available to the public.[9] CHNAs must include an implementation strategy that describes how the hospital plans to meet the community's health needs, as well as a description of what the hospital has historically done to address its community's needs.[10] Further, the hospital must identify any needs that have not been met by the hospital and explain why they have not been addressed. Tax-exempt hospitals must report this information on Schedule H of IRS Form 990.

The IRS defines a CHNA as a written document developed for a hospital facility that includes a description of the community served by the hospital facility; the process used to conduct the assessment, including how the hospital took into account input from community members and public health experts; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process. In order to meet the requirement of the CHNA for any taxable year, the hospital facility must make the CHNA widely available to the public and adopt an implementation strategy to meet the health needs

[4] 26 U.S.C. §501(c)(3).
[5] Rev. Ruling 56-185, 1956-1 C.B. 202.
[6] Rev. Ruling 69-545, 1969-2 C.B. 117.
[7] The Patient Protection and Affordable Care Act, P.L. 111-148 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152.
[8] 26 U.S.C. §501(r)(3); 26 U.S.C. §4959.
[9] 26 U.S.C. §501(r)(3)(B).
[10] 26 U.S.C. §501(r)(3)(A).

identified by the CHNA by the end of the same taxable year. The implementation strategy must be approved by an authorized governing body of the hospital organization and either describe how the hospital facility plans to meet the health need(s) identified in the CHNA or explain why it does not intend to meet the health need(s) identified in the CHNA.

The Maryland CBR process was adopted by the Maryland General Assembly in 2001,[11] and the first data collection period was FY 2004. Under Maryland law, CBRs must include a list of the hospital's initiatives, the cost of each community benefit initiative, the objectives of each community benefit initiative, a description of efforts taken to evaluate the effectiveness of initiatives, a description of gaps in the availability of specialist providers, and a description of the hospital's efforts to track and reduce health disparities in the community.[12]

The HSCRC worked with the Maryland Hospital Association (MHA), interested hospitals, local health departments, and health policy organizations and associations to establish the details and format of the CBR. In developing the format for data collection, the group relied heavily on the experience of the Voluntary Hospitals of America (VHA) community benefit process. At the time, the VHA possessed more than ten years of voluntary hospital community benefit reporting experience across many states. The resulting data reporting spreadsheet and instructions were used by Maryland hospitals to submit their FY 2004 data to the HSCRC in January 2005. The HSCRC's first CBR was published in July 2005. The HSCRC continues to work with the MHA, public health officials, individual hospitals, and other stakeholders to further improve the reporting process and refine the definitions and periodically convenes a Community Benefit Work Group. The data collection process offers an opportunity for each Maryland nonprofit hospital to critically review and report the activities it has designed to benefit the community. This FY 2016 report represents the HSCRC's twelfth year of reporting on Maryland hospital community benefit data.

NARRATIVE REPORTS

This section of the document summarizes the findings of the narrative reports.

Hospitals Submitting Reports

The HSCRC received a total of 49 CBRs from all 52 hospitals in FY 2016. Please note that the University of Maryland Health System submits a single CBR for three of its hospitals. This CBR sometimes breaks out individual metrics for each of the three hospitals and sometimes combines responses. Therefore, the denominator for hospital response rates varies between 49 and 52 throughout the remainder of this document. Table 1 summarizes the hospitals submitting CBRs by hospital system.

[11] MD. CODE. ANN., Health-Gen. §19-303.
[12] MD. CODE. ANN., Health-Gen. §19-303(a)(3).

Table 1. List of Hospitals Submitting CBRs in FY 2016, by System

Independent Hospitals	**Johns Hopkins Medicine:**
1. Anne Arundel Medical Center	27. Howard County General Hospital
2. Atlantic General Hospital	28. Johns Hopkins Bayview Medical Center
3. Bon Secours Hospital	29. Johns Hopkins Hospital
4. Calvert Memorial Hospital	30. Suburban Hospital
5. Doctors Community Hospital	**Lifebridge Health:**
6. Fort Washington Medical Center	31. Carroll Hospital Center
7. Frederick Memorial Hospital	32. Levindale Hebrew Geriatric Center and Hospital
8. Garrett Regional Medical Center	
9. Greater Baltimore Medical Center	33. Northwest Hospital
10. McCready Health	34. Sinai Hospital
11. Mercy Medical Center	**MedStar Health:**
12. Meritus Health	35. MedStar Franklin Square Medical Center
13. Mt. Washington Pediatric Hospital	36. MedStar Good Samaritan Hospital
14. Peninsula Regional Medical Center	37. MedStar Harbor Hospital
15. Saint Agnes Hospital	38. MedStar Montgomery Medical Center
16. Sheppard Pratt Health System	39. MedStar Southern Maryland Hospital Center
17. Union Hospital	
18. Western Maryland Regional Medical Center	40. MedStar St. Mary's Hospital
Adventist HealthCare:	41. MedStar Union Memorial Hospital
19. Adventist Behavioral Health	**University of Maryland:**
20. Adventist Healthcare Rehabilitation	42. Baltimore Washington Medical Center
21. Adventist HealthCare Shady Grove	43. Charles Regional Medical Center
22. Washington Adventist Hospital	44. Shore Regional Health[13]
Dimensions Healthcare System:	45. St. Joseph Medical Center
23. Laurel Regional Hospital	46. UMMC Midtown Campus
24. Prince George's Hospital Center	47. University of Maryland Medical Center
Holy Cross Health:	48. University of Maryland Rehabilitation & Orthodpaedic Institute
25. Holy Cross Germantown Hospital	
26. Holy Cross Hospital	49. Upper Chesapeake Health[14]

Section I. General Hospital Demographics and Characteristics

Hospital-Specific Demographics

The first section of the CBR narrative requires hospitals to report on demographic and utilization statistics, as summarized in Table 2 below. Overall, the hospitals reported having 11,803 beds and 617,865 inpatient admissions. One hospital misinterpreted the bed designation question and did not report the actual number of beds, thus appearing as missing on the table. The reported percentage of hospital patients who are uninsured ranged from a low of 0.0 to 26.5 percent. The reported percentage of patients enrolled in Medicaid ranged from 6.2 to 79.1 percent. The reported percentage of patients enrolled in Medicare ranged from 10.8 to 78.6 percent. Please

[13] One report includes three facility locations: Easton, Chestertown, and Dorchester.
[14] One report includes two facility locations: Harford Memorial Hospital and Upper Chesapeake Medical Center.

note that some of the figures reported by the hospitals differ from those published by other sources.

Table 2. Hospital Bed Designation, Inpatient Admissions, and Patient Insurance Status, FY 2016

Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Patients who are Uninsured	Percentage of Patients in Medicaid	Percentage of Patients in Medicare
Independent Hospitals					
Anne Arundel Medical Center	415	26,074	**	14.4%	42.6%
Atlantic General Hospital	48	3,360	**	77.1%	71.8%
Bon Secours Hospital	152	3,940	5.5%	41.2%	24.8%
Calvert Memorial Hospital	130	6,207	1.8%	16.2%	36.8%
Doctors Community Hospital	183	9,725	20.0%	16.0%	42.6%
Fort Washington Medical Center	34	2,172	15.4%	24.4%	37.2%
Frederick Memorial Hospital	233	17,714	1.7%	20.0%	34.8%
Garrett Regional Medical Center	47	2,353	1.3%	25.8%	44.5%
Greater Baltimore Medical Center	345	20,552	1.7%	11.2%	32.6%
McCready Health	4	288	14.0%	24.8%	42.4%
Mercy Medical Center	184	13,680	**	19.0%	26.6%
Meritus Health	329	19,825	5.3%	27.3%	31.2%
Mt. Washington Pediatric Hospital	102	830	0.0%	79.1%	Did not provide
Peninsula Regional Medical Center	320	19,015	3.4%	**	**
Saint Agnes Hospital	251	18,354	**	**	**
Sheppard Pratt Health System	Did not provide	9,147	3.2%	39.9%	18.0%
Union Hospital	118	5,674	1.9%	23.1%	57.3%
Western Maryland Regional Medical Center	208	12,899	13.8%	19.7%	53.9%
Adventist HealthCare					
Adventist Behavioral Health	107	2,649	2.5%	32.1%	14.3%
Adventist Healthcare Rehabilitation	87	1,943	0.7%	8.3%	53.4%
Adventist HealthCare Shady Grove	305	21,212	7.0%	21.5%	18.0%
Washington Adventist Hospital	232	12,211	16.5%	27.9%	21.8%
Dimensions Healthcare System					
Laurel Regional Hospital	134	4,147	12.0%	22.4%	Did not provide
Prince Georges Hospital Center	237	14,315	19.0%	33.0%	Did not provide
Holy Cross Health					
Holy Cross Germantown Hospital	118	5,240	21.6%	23.6%	14.8%
Holy Cross Hospital	582	35,206	26.5%	23.0%	17.8%

Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Patients who are Uninsured	Percentage of Patients in Medicaid	Percentage of Patients in Medicare
Johns Hopkins Medicine					
Howard County General Hospital	264	17,431	**	**	**
Johns Hopkins Bayview Medical Center	447	20,273	**	**	**
Johns Hopkins Hospital	1,129	48,554	**	**	**
Suburban Hospital	236	13,265	**	7.4%	48.6%
Lifebridge Health					
Carroll Hospital Center	140	10,002	5.3%	15.3%	29.9%
Levindale Hebrew Geriatric Center and Hospital	330	2,397	5.0%	11.0%	74.0%
Northwest Hospital	238	11,610	0.5%	20.0%	51.1%
Sinai Hospital	505	12,823	0.5%	28.3%	42.6%
MedStar Health					
MedStar Franklin Square Medical Center	364	23,525	1.4%	32.0%	40.8%
MedStar Good Samaritan Hospital	246	9,580	**	6.2%	33.3%
MedStar Harbor Hospital	157	11,488	1.6%	40.9%	35.1%
MedStar Montgomery Medical Center	122	7,815	6.0%	19.3%	27.7%
MedStar Southern Maryland Hospital Center	256	12,148	**	**	**
MedStar St. Mary's Hospital	91	8,972	3.5%	12.3%	36.8%
MedStar Union Memorial Hospital	209	11,383	**	**	**
University of Maryland					
Baltimore Washington Medical Center	303	18,512	1.0%	17.9%	53.4%
Charles Regional Medical Center	115	7,610	6.1%	22.5%	41.9%
Shore Regional Health Easton	112	8,262	0.5%	23.2%	54.7%
Shore Regional Health Chestertown	30	1,531	0.9%	12.1%	78.6%
Shore Regional Health Dorchester	47	2,214	0.8%	25.7%	61.4%
St. Joseph Medical Center	247	17,821	1.6%	46.0%	10.8%
UMMC Midtown Campus	167	4,572	1.0%	47.0%	44.0%
University of Maryland Medical Center	750	28,864	1.0%	37.0%	32.0%
University of Maryland Rehabilitation & Orthodpaedic Institute	138	2,617	1.0%	21.0%	41.0%
Harford Memorial Hospital	85	4,384	1.8%	14.2%	39.4%
Upper Chesapeake Medical Center	170	11,480	1.8%	14.2%	39.4%
Total	**11,803**	**617,865**			

**Hospital supplied this data by county rather than as a percentage of their entire patient population.

Service Areas

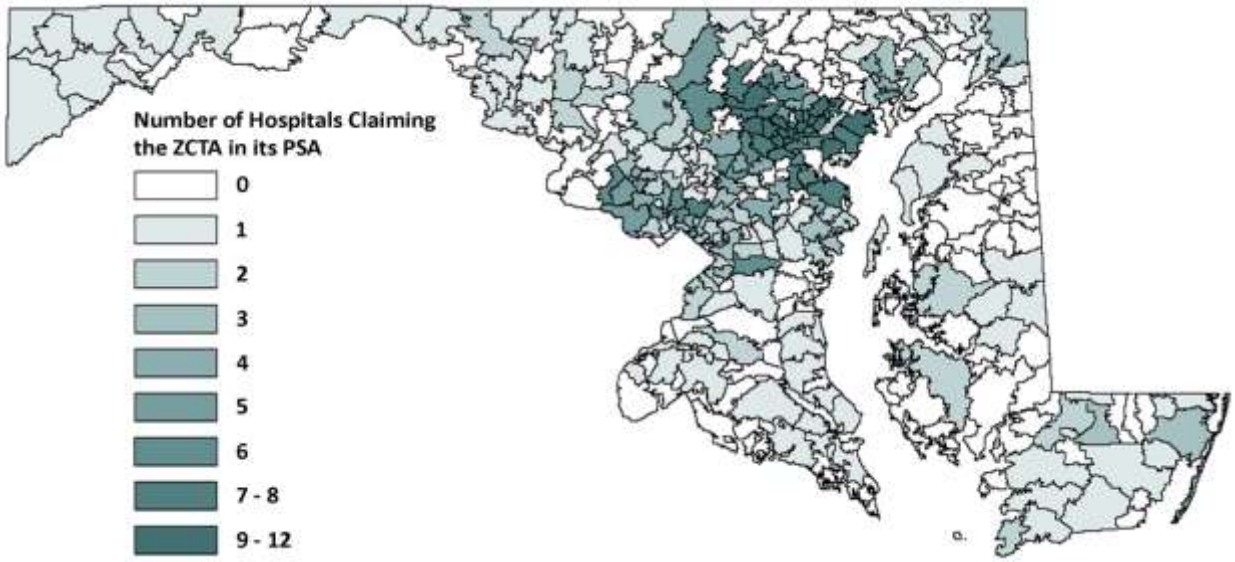
The CBR requires hospitals to report on two types of services area: (1) the primary service area (PSA), and (2) the community benefit service area (CBSA). It is important to note that the CBR

PSAs reported by the hospitals may not align with the PSAs used by the HSCRC for global budgeting purposes.

Primary Service Area

The CBR collects the ZIP codes included in each hospital's reported PSA, and all hospitals responded to this question. Figure 1 displays a map of Maryland split into ZIP Code Tabulation Areas (ZCTAs)[15]. Each ZCTA has a color indicating how many hospitals claim that area in its CBR PSA. A total of 280 ZCTAs, those that appear white on the map, are not covered by any hospital. A total of 13 ZCTAs are covered by 9 or more hospitals.

Figure 1. Number of Hospitals Claiming the ZCTA in its CBR PSA, FY 2016



Community Benefit Service Area

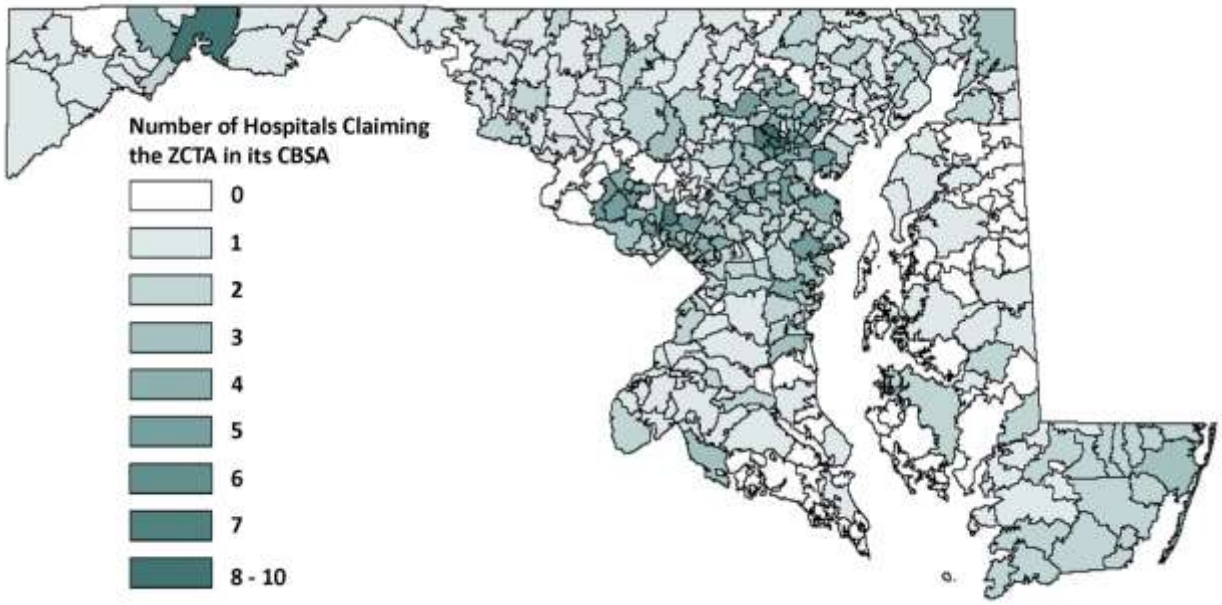
The CBR also collects the ZIP codes included in each hospital's CBSA, and all hospitals responded to this question. Each hospital defines its own CBSA and must disclose the methodology behind this definition in both their CBRs and their federally-mandated CHNAs[16]. While the methodology for determining the CBSA varied, many hospitals reported using measures of social determinants of health and health disparities, such as below average median family income, above average rates of unemployment, racial/ethnic disparities in infant mortality, and racial/ethnic disparities in diabetes mortality. Other methodologies examined utilization measures, such as areas with high emergency department utilization.

Figure 2 displays a map of Maryland split into ZCTAs. Each ZCTA has a color indicating how many hospitals claim that area in its CBSA. One hospital reports its CBSA at the Community

[15] The U.S. Census Bureau created ZCTAs based on ZIP codes for mapping purposes: https://www.census.gov/geo/reference/zctas.html.
[16] 26 CFR § 1.501(r)-3.

Statistical Area-level. For purposes of creating the map below, these were converted to ZCTAs. A total of 186 ZCTAs, those that appear white on the map, are not a part of any hospital's CBSA, and a total of 3 ZCTAs in Baltimore City are covered by eight or more hospitals. See Appendix A for lists of these ZIP codes.

Figure 2. Number of Hospitals Claiming the ZCTA in its CBSA, FY 2016



Other Demographic Characteristics of Service Areas

Hospitals are required to submit details about the communities in their CBSA. Because most of the required measures in this section of the report are not available at the ZIP code level, they are reported at the county level instead. Table 3 displays examples of the county-level demographic measures required in the CBR. Because hospitals varied in their approaches and completeness in providing the metrics for this section of the report, the data in Table 3 were retrieved independently. See Appendix B for other community health measures reported by the hospitals.

The following measures were prepared using the five-year (2011-2015) average estimates from the U.S. Census Bureau's American Community Survey: median household income, percentage of families below the federal poverty level (FPL), percentage uninsured, percentage of the civilian non-institutionalized population with public health insurance, mean travel time to work, percentage that speak a language other than English at home, percentage that speak a language other than English at home and speak English less than "very well," percentage by race categories, and percentage by ethnicity categories. The life expectancy three-year average (2013-2015) and the crude death rate (2015) measures are from the Maryland Department of Health and Mental Hygiene's Vital Statistics Administration.

Table 3. Community Statistics by County

County	# of Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race: % White	Race: % Black	Ethnicity: % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Maryland		**74,551**	**7.0**	**9.0**	**28.8**	**26.4**	**32.3**	**17.2**	**60.0**	**31.2**	**9.0**	**79.7**	**786.4**
Allegany	1	40,551	11.7	7.3	43.6	32.6	20.7	4.8	90.3	9.4	1.6	76.9	1300.2
Anne Arundel	7	89,860	3.8	6.4	25.1	18.7	29.7	10.5	77.7	17.6	6.9	79.8	725.8
Baltimore	9	67,095	6.3	8.1	29.7	26.1	29.1	13.6	65.4	28.6	4.8	79.1	978.7
Baltimore City	15	42,241	19.0	10.3	43.9	48.1	30.5	8.9	32.0	64.4	4.6	73.9	1037.7
Calvert	1	95,828	3.5	6.1	24.3	18.8	40.1	4.3	85.1	14.5	3.3	80.1	724.1
Caroline	1	52,465	12.3	11.3	41.2	39.4	32.9	6.5	83.4	15.2	6.1	76.1	1009.9
Carroll	2	85,385	3.4	4.7	23.9	15.7	35.2	5.2	94.3	4.2	2.9	79.3	904.4
Cecil	1	66,396	6.8	7.9	30.4	29.2	28.8	5.0	90.7	7.8	3.9	77.1	929.9
Charles	2	90,607	6.0	5.3	24.3	23.1	42.8	7.3	51.5	45.5	5.0	79.5	634.1
Dorchester	1	47,093	11.9	8.5	45.6	43.4	24.8	5.5	68.9	29.1	4.3	77.6	1222.8
Frederick	3	83,700	4.7	6.8	23.2	18.7	34.9	12.6	84.0	10.6	8.1	80.8	715.8
Garrett	1	45,432	9.6	10.7	41.4	32.5	23.7	3.4	98.6	1.4	0.9	78.8	1133.7
Harford	2	80,465	6.2	5.0	26.9	19.5	31.7	6.7	82.2	14.6	4.0	79.7	826.2
Howard	5	110,238	3.8	6.0	19.3	16.5	30.5	23.0	63.0	20.0	6.3	82.9	527.4
Kent	1	58,147	6.4	7.9	42.6	28.3	25.6	5.5	83.2	16.0	4.3	79.5	1248.3
Montgomery	9	99,435	4.6	10.3	23.0	21.0	34.5	39.6	58.9	19.3	18.3	84.6	573.2
Prince George's	10	74,260	6.9	13.8	27.3	29.4	36.5	22.5	22.2	65.2	16.2	79.9	630.0
Queen Anne's	1	85,963	5.2	5.1	28.8	20.3	34.7	4.7	90.6	8.1	3.4	79.6	799.5
Saint Mary's	1	86,987	6.1	6.4	25.2	23.1	29.3	7.4	81.9	15.9	4.5	79.1	709.1
Somerset	2	35,154	20.3	10.6	46.8	36.4	24.1	7.5	55.0	43.4	3.6	76.3	958.6
Talbot	1	58,228	7.8	9.7	40.1	24.6	26.0	7.8	85.6	12.8	6.0	80.8	1228.9

County	# of Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race: % White	Race: % Black	Ethnicity: % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Washington	1	56,228	9.7	8.4	36.3	31.7	28.4	7.0	86.8	12.7	4.0	77.4	1015.5
Wicomico	2	52,278	11.1	10.0	35.2	36.9	21.3	10.6	71.3	26.2	4.9	77.4	885.0
Worcester	2	56,773	7.6	9.5	43.6	29.2	23.4	5.9	83.7	14.8	3.3	79.4	1263.1
Source	[17]	[18]	[19]	[20]	[21]	[22]	[23]	[24]	[25]	[26]	[27]	[28]	[29]

[17] As reported by hospitals in their FY 2016 Community Benefit Narrative Reports
[18] American Community Survey 5-Year Estimates 2011 – 2015, Selected Economic Characteristics, Median Household Income (Dollars), https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t
[19] American Community Survey 5-Year Estimates 2011 – 2015, Selected Economic Characteristics, Percentage of Families and People Whose Income in the Past 12 Months is Below the Federal Poverty Level – All Families
[20] American Community Survey 5-Year Estimates 2011 – 2015, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – No Health Insurance Coverage
[21] American Community Survey 5-Year Estimates 2011 – 2015, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – With Public Coverage
[22] American Community Survey 5-Year Estimates, 2011-2015 (denominator) and The Hilltop Institute (numerator)
[23] American Community Survey 5-Year Estimates 2011 – 2015, Selected Economic Characteristics, Commuting to Work – Mean Travel Time to Work (Minutes)
[24] American Community Survey 5-Year Estimates 2011 – 2015, Language Spoken at Home, Speak a Language Other Than English
[25] American Community Survey 5-Year Estimates 2011 – 2015, ACS Demographic and Housing Estimates, Race - Race alone or in combination with one or more other races - Total Population - White
[26] American Community Survey 5-Year Estimates 2011 – 2015, ACS Demographic and Housing Estimates, Race - Race alone or in combination with one or more other races - Total Population – Black or African American
[27] American Community Survey 5-Year Estimates 2011 – 2015, ACS Demographic and Housing Estimates, Hispanic or Latino and race - Total Population - Hispanic or Latino (of any race)
[28] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2015, Table 7. Life Expectancy at Birth by Race, Region, and Political Subdivision, Maryland, 2013 – 2015.
[29] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2015, Table 39A. Crude Death Rates by Race, Hispanic Origin, Region, and Political Subdivision, Maryland, 2015.

Section II. Community Health Needs Assessment

Section II of the narrative CBR asks hospitals whether they conducted a CHNA, when they last conducted it, and whether they adopted an implementation strategy. All hospitals reported conducting a CHNA that conforms to the IRS definition within the past three fiscal years. All but one hospital reported adopting an implementation strategy. See Appendix B for the dates in which hospitals conducted their last CHNAs. These dates ranged from March 2013 to December 2016.

Section III. Community Benefit Administration

This section of the narrative CBR requires hospitals to report on the process of "determining which needs in the community would be addressed through community benefits activities." Hospitals must provide details of the planning, staffing, and oversight of their community benefit efforts.

Community Benefit Planning in Strategic Plan

This section of the CBR asks hospitals about the involvement of community benefit in strategic planning. Two hospitals provided an incomplete response to this question. All but one hospital indicated that their strategic plan includes community benefit considerations. Hospital narrative responses often mentioned that community benefit strengthens the hospital's culture and capabilities, and thereby strengthening community ties. For example, one hospital wrote that they "fully integrate [their] commitment to community service into [their] management and governance structures as well as strategic and operational plans." The community benefit plan is closely aligned with the hospital's population health management plan.

Stakeholders

This section of the CBR asks hospitals to indicate the stakeholders involved in the implementation and delivery of community benefit activities. Table 4 summarizes responses to this question across all 49 hospitals. The most common staff member involved in community benefit activities is the chief executive officer, reported by 46 of the 49 hospitals. The least common community benefit stakeholder across hospitals, with 10 out of 49, is a Community Benefit Task Force.

Table 4. Hospital Stakeholders Involved in Community Benefit Process

	Number of Hospitals		
Stakeholders	**Yes**	**No**	**Did not Provide**
Senior Leadership			
CEO	46 (93.9%)	2 (4.1%)	1 (2.0%)
CFO	42 (85.7%)	6 (12.2%)	1 (2.0%)
Other	43 (87.8%)	6 (12.2%)	0 (0.0%)
Clinical Leadership			
Physician	44 (89.8%)	4 (8.2%)	1 (2.0%)
Nurse	44 (89.8%)	4 (8.2%)	1 (2.0%)
Social Worker	19 (38.8%)	29 (59.2%)	1 (2.0%)
Other	24 (49.0%)	25 (51.0%)	0 (0.0%)
Population Health Leadership and Staff			
Population Health VP or Equivalent	29 (59.2%)	15 (30.6%)	5 (10.2%)
Other Population Health Staff	30 (61.2%)	13 (26.5%)	6 (12.2%)
Community Benefit Operations			
Individual	31 (63.3%)	17 (34.7%)	1 (2.0%)
Committee	27 (55.1%)	21 (42.9%)	1 (2.0%)
Department	24 (49.0%)	23 (46.9%)	2 (4.1%)
Task Force	10 (20.4%)	36 (73.5%)	3 (6.1%)
Other	20 (40.8%)	28 (57.1%)	1 (2.0%)

Senior leadership provided varying roles in the community benefit process. In general, most hospitals indicated that senior leadership had a role in defining the organization's population health objectives and creating the infrastructure that delivers health services to targeted populations. Some hospitals reported that senior leadership plays an active role in community benefit activities through a structured committee process with formal, regular meetings. Other hospitals reported senior leadership's role as providing the support and guidance necessary to develop the strategic framework underlying the community benefit activities. Often, senior leaders take an active role in annual organizational strategic planning that incorporates and aligns goals and initiatives, including those based on community health needs and the prior year's outcomes.

Clinical leadership appears to play an active role at most hospitals, with many hospitals reporting that clinical leaders provide community benefit implementation oversight. They provide input into each initiative as it relates to their area of expertise. Population health leaders and staff have varying amounts of responsibility among the hospitals, with some hospitals having dedicated population health personnel, teams, and/or departments.

Internal Audit and Board Review

This section asks whether the hospital conducts an internal audit of the CBR financial spreadsheet and narrative. All hospitals responded to this question. Table 5 shows that 45 out of 49 hospitals conduct an internal audit of the financial spreadsheet, and 40 conduct an internal audit of the narrative report. This section also asks hospitals to describe their internal audit process. Of the 45 hospitals that completed an internal audit, all of them also reported that the CBRs are reviewed by senior leadership. Most hospitals also had their community benefit team review the CBR. Senior leaders involved in the report review included the chief financial officer, the government and regulatory affairs department, the community/population health department, and the clinical integration department.

Table 5. Hospital Internal Audit of the CBR

	Number of Hospitals	
Internal Audit	**Yes**	**No**
Spreadsheet	45 (91.8%)	4 (8.2%)
Narrative	40 (81.6%)	9 (18.4%)

This section also asks whether the hospital board reviews and approves the CBR spreadsheet and narrative. All hospitals responded to this question. Table 6 shows that most hospital boards review and approve the CBR. Of the hospitals that reported that they did not submit their reports for board review, their reasons were largely timing issues. For instance, one hospital reported that their board meets twice a year, so they will not review the report until they meet in the first quarter of 2017. Another hospital reported that the board gives executive staff authority to complete and submit all forms.

Table 6. Hospital Board Review of the CBR

	Number of Hospitals	
Board Review	**Yes**	**No**
Spreadsheet	43 (87.8%)	6 (12.2%)
Narrative	42 (85.7%)	7 (14.3%)

Section IV. Community Benefit External Collaboration

The CBR requires Maryland hospitals to describe their engagement with external partners as follows.

> *"External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners."*

All hospitals indicated the categories of external partners with whom they collaborated. The results of this question are presented in Table 7. Local health departments and faith-based community organizations were the most common types of external partners, each with 47 out of 49 hospitals reporting such partnerships. The least common external partner category is behavioral health organizations, with 39 out of 49 hospitals reporting such partnerships. The Community Benefit Workgroup requested a list of the behavioral health organizations that are collaborating with hospitals on community benefit activities. See Appendix D for this list.

Table 7. Hospital External Collaboration with Partners

	Number of Hospitals	
Partners	**Yes**	**No**
Local Health Department	47 (95.9%)	2 (4.1%)
Faith-based community organizations	47 (95.9%)	2 (4.1%)
Schools	45 (91.8%)	4 (8.2%)
Other Hospital Organizations	43 (87.8%)	6 (12.2%)
Social service organizations	43 (87.8%)	6 (12.2%)
Local Health Improvement Coalitions	41 (83.7%)	8 (16.3%)
Behavioral Health Organizations	39 (79.6%)	10 (20.4%)

Hospitals were also asked whether their staff participate on their Local Health Improvement Coalition (LHIC). All hospitals responded to this question, and the results are presented in Table 8. Of the 49 hospitals submitting reports, 44 indicated that their staff participate on the LHIC. Of those, 18 hospitals reported that their staff member(s) co-chair the LHIC for their area.

Table 8. Hospital External Collaboration with LHICs

	Number of Hospitals	
Question	**Yes**	**No**
Is there a member of the hospital organization that is co-chairing the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?	18 (36.7%)	31 (63.3%)
Is there a member of the hospital organization that attends or is a member of the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?	44 (89.8%)	5 (10.2%)

Hospitals were asked to describe the collaborative activities with their partners. Hospitals provided varying levels of detail about these activities. Many hospitals reported hosting and co-hosting community events, community focus groups, and health education programs. Many also reported that partners assisted in the CHNA process.

Section V. Hospital Community Benefit Program and Initiatives

Primary Needs Identified Through the CHNA Process

This section of the CBR collects details about the community benefit initiatives the hospitals undertook during the fiscal year. These initiatives must target the community health needs identified through the CHNA process. Hospitals are asked to highlight the details of select initiatives; they are not asked to report on all initiatives. All but one hospital provided complete responses to these questions. Table 9 shows the number of hospitals that reported targeting initiatives at a number of community health needs. The most common CHNA-identified need targeted by hospitals' initiatives was cardiovascular health, with 29 hospitals. The least common need, targeted by one hospital, was brain injury diagnosis and treatment.

Table 9. Community Health Needs Targeted by Maryland Hospitals' Community Benefit Initiatives, FY 2016

Community Health Needs	Number of Hospitals Reporting CB Initiatives Targeting the Need
Cardiovascular Health (Includes Heart Disease, Hypertension, Stroke)	29
Obesity, Overweight, Nutrition, Exercise	24
Behavioral Health (Includes Mental Health and Substance Use Disorder)	22
Diabetes Prevention & Management	19
Multicultural Outreach & Community Integration/Health Education & Literacy	19
Maternal and Child Health (Includes Infant Mortality)	17
Access to Care - Overall/Comprehensive/Specialty	15
Chronic Illness/Disease - Care Coordination, Management, Palliative Care, etc.	15
Access to Care - Primary & Preventive	14
Cancer Diagnosis and Treatment	14
Respiratory Health (Includes Asthma, Smoking)	12
ED/EMS Usage Reduction	6
Senior Health	5
Healthy Economy (Includes Employment, Job Training, etc.)	4
Violence Prevention - Youth, Street, Domestic	4
Access to Safe, Affordable Housing	3
Provider Shortages	3
Access to Care - Dental	2
Education (Graduation Rate, Access, etc.)	2
HIV/AIDS Screening, Prevention, Treatment	2
Brain Injury Diagnosis and Treatment	1

Cardiovascular Health

Cardiovascular health was the top CHNA-identified need targeted by hospitals. Hospitals took varying approached to meet the goal of improving cardiovascular health in the community. Awareness was a key objective. Many hospitals reported providing community education opportunities in locations such as community centers, schools, and in collaboration with faith-based partners.

In addition to education and prevention, some hospitals targeted the transition between a patient's hospital stay and follow-up with health care providers in the community. For example, one hospital opened a clinic that focused on high risk patients with heart failure or chronic obstructive pulmonary disease who need assistance with the transition between their hospital stay and their follow-up with their health care provider. The clinic serves as a resource to help transition patients until they are able to see their provider for follow up care. The long-term goal of this program is to expand the offerings to patients facing other co-morbidities who are high risk for readmission.

Obesity, Overweight, Nutrition, Exercise

This was the second most common CHNA-identified need targeted by hospitals' initiatives. Many hospitals emphasized obesity and the risk for chronic health problems, such as heart disease, type 2 diabetes, cancer, stroke, asthma, and arthritis. Community benefit activities included public education and outreach on a variety of obesity-related health risks and prevention activities. Activities also included wellness exams, physicals, and exercise programs.

Behavioral Health

Hospitals had varying approaches to addressing behavioral health needs in their communities. Some reported engaging in education and outreach activities. Other hospitals undertook activities to address gaps in mental health professional availability by providing training and continued learning opportunities for such individuals as students, mental health professionals, and individuals such as guidance counselors and corrections officers who may not be mental health professionals, but who may often interact with individuals with mental health needs.

Primary Community Health Needs Not Addressed

The CBR asks hospitals about community health needs identified through the CHNA process that were not addressed. Thirty-nine hospitals reported that one or more primary community health needs were not addressed, ten reported that all were being addressed, and three hospitals did not respond to the question. Of the hospitals that reported that one or more primary community health needs were not addressed, the most frequently reported reason was inadequate resources to address all of the needs. For example, some hospitals reported that they are not currently focusing on top health concerns identified by the CHNA due to the lack of available resources necessary to make the most impactful changes in these areas. The needs were incorporated into the strategic plan, where appropriate. Specific needs not addressed by other

hospitals included oral health, injury and violence prevention, HIV and sexually transmitted diseases, alcohol abuse, and illiteracy.

Community Benefit Operations/Activities Related to State Initiatives

Hospitals were asked how their community benefit operations/activities work toward the state's initiatives for improvement in population health, as identified by the State Health Improvement Process (SHIP) and the Community Health Resources Commission. These include efforts to integrate medical care with community-based resources, a framework and measures (with targets) in distinct focus areas to continue to promote optimal health for all Maryland residents, promoting programs that enhance patient care and population health, and efforts to expand access to health care in underserved communities. Also, in the context of the state's All-Payer Model, hospitals are tasked with improving quality, including decreasing 30-day readmissions. Three hospitals did not respond to this question. Hospital responses varied from dedication to professional education, engagement with community-based organizations to provide resources at no cost, supporting tobacco cessation efforts in the hospital and in the community, flu vaccination programs, and utilizing electronic medical records for better patient tracking and to achieve health outcomes.

Section VI. Physicians

Gaps in Availability

Under Maryland law, hospitals are required to provide a written description of gaps in the availability of specialist providers to serve the uninsured cared for by the hospital.[30] All hospitals responded to this question. Table 10 shows the gaps in availability that were submitted and the number of hospitals reporting each gap. The most frequently reported gap was mental health/psychiatry (reported by 20 hospitals), and the least frequently reported gaps were intensive care, mammography, and wound care (each reported by 1 hospital). Six hospitals reported no gaps.

Table 10. Gaps in Availability

Physician Specialty Gap	Number of Hospitals
No Gaps	6
Mental Health/Psychiatry	20
Internal Medicine	16
Dermatology	13
Dental/Oral/Maxillofacial Surgery	11
Neurosurgery/Neurology	11
Primary Care	11
General Surgery	10

[30] MD. CODE. ANN., Health-Gen. §19-303(c)(2)(vi).

Physician Specialty Gap	Number of Hospitals
Otolaryngology	10
Orthopedic Specialties	9
Obstetrics	7
Ophthalmology	6
Substance Abuse/Detoxification	6
Vascular Surgery	6
Cardiac/Thoracic Surgery	2
Anesthesiology	4
ED Coverage	4
Inpatient and Outpatient Care Provider Shortage	4
Geriatrics	3
Gynecology	3
Occupational Therapy/Physical Therapy/ Speech Therapy	3
Pediatrics	3
Podiatry	3
Urology	3
Diagnostic Radiology	2
Medication Assistance	2
Nurse Practitioner	2
Physicians to Refer to after Community Screening Programs	2
Plastic Surgery	2
Intensive Care	1
Mammography	1
Wound Care	1

Physician Subsidies

Hospitals that report physician subsidies as a community benefit category are required to further explain why the services would not otherwise be available to meet patient demand. The physician subsidy categories include: hospital-based physicians with whom the hospital has an exclusive contract; non-resident house staff and hospitalists; coverage of emergency department call; physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and physician recruitment to meet community need. Forty-one hospitals listed at least one category of subsidy.

Section VII. Appendices

The CBR also requires the hospitals to submit two categories of appendices: financial assistance policies and their mission, vision, and values statements. All hospitals submitted copies of their mission, vision, and values statements.

Financial Assistance Policies

The CBR requires hospitals to submit four documents related to financial assistance policies:

- A description of the policy (submitted by all hospitals)
- A description of how the policy changed since the enactment of the coverage expansions under the Affordable Care Act (submitted by all but two hospitals)
- A copy of the financial assistance policy (submitted by all hospitals)
- A copy of the patient information sheet provided to patients in accordance with Health-General §19-214.1(e) (submitted all hospitals)

Maryland regulations set out the requirements for hospitals to provide free or reduced cost care as part of their financial assistance policies.[31] Patients with family income at or below 200 percent of the FPL qualify for free medically necessary care.[32] In FY 2016, 41 hospitals reported that they provide free care at the threshold required in regulation, 7 hospitals reported a higher/more generous threshold, 1 hospital reported a threshold lower than the regulatory requirement (150 percent of the FPL), 1 hospital provided financial assistance eligibility criteria that did not explicitly state that it provides free care below the threshold, and 2 hospitals did not include their thresholds in the policies.

Regulations also require hospitals to provide reduced-cost, medically necessary care to patients with family income between 200 and 300 percent of the FPL.[33] Twenty-one hospitals report providing reduced cost care at this threshold, 22 hospitals reported a more generous threshold (as high as 600 percent of the FPL), 2 hospitals provided information about their policy but not the specific FPL threshold, and 6 hospitals did not provide this information.

Hospitals must also provide for reduced-cost, medically-necessary care to patients with family income below 500 percent of the FPL who have a financial hardship; some hospitals call this the financial hardship policy.[34] In order to have a financial hardship, the medical debt incurred by a family over a 12-month period must exceed 25 percent of family income.[35] Thirty-five hospitals reported having policies at this threshold. Two hospitals reported a more generous policy, allowing for reduced-cost care at 500 percent of the FPL but when debt exceeds 20 percent of family income. One hospital did not state the FPL threshold but indicated that the policy applies

[31] COMAR 10.37.10.26.
[32] COMAR 10.37.10.26(A-2)(2)(a)(i).
[33] COMAR 10.37.10.26(A-2)(2)(a)(ii).
[34] COMAR 10.37.10.26(A-2)(3).
[35] COMAR 10.37.10.26(A-2)(1)(b)(i).

to debt exceeding only ten percent of family income. Two hospitals indicated that the policy applies to debt exceeding fifty percent of gross income without reference to FPL. Finally, 12 hospitals did not provide this information.

Conclusion

The Community Benefit Narrative Report provides the HSCRC with richer detail on hospital community benefit activities beyond what is included in the financial report. For FY 2016, all 52 hospitals submitted reports. Of those, 40 submitted complete reports with responses to every question, and 12 hospitals did not respond to one or more questions. Some of the missing elements could be obtained from other publicly available data sources. Encouraging findings of the review include senior-level commitment to community benefit activities and community engagement. For example, most hospitals reported that their senior leadership is involved in the implementation and delivery of community benefit activities, and most conduct internal audits and Board reviews and approvals of the CBRs. Roughly 90 percent of the hospitals have staff members participating in LHICs.

The review identified several policy areas for further analysis and/or improvement. In terms of service areas, the review identified 186 ZCTAs in Maryland that are not covered by any hospital CBSA. Further analysis could include: reviewing population health metrics of these gap areas, identifying the hospitals closest to these areas, and reviewing these hospitals' methodologies for defining their CBSAs. Further analysis could also compare the CHNA results and community benefit initiatives among hospitals that share CBSAs in more densely covered areas to help better target resources.

Behavioral health is another potential area for further policy review. Behavioral health was one of the top CHNA-identified needs, and it was identified as the top physician gap by hospitals. At the same time, behavioral health organizations were the least frequently reported community benefit external collaborator.

Finally, the review found that one hospital's reported financial assistance policy does not meet the minimum threshold required in regulation. The HSCRC may consider following up with this hospital.

This review also identified a number areas for improving the CBR reporting tool, including the reporting requirements, the format, and the content of the report. Revisions to the requirements could promote fairness across hospitals and improve report accuracy. Suggestions include:

- Requiring reports for each individual hospital so that report measures are consistent.
- Requiring hospitals to respond to all questions, or providing a justification for a non-response.

Revisions to the format could make the report easier to analyze and reduce reporting burden on the hospitals. Suggestions include:

- Reducing the number of free text questions and replacing with check boxes, response options, and numbers (where applicable).
- Developing an electronic reporting tool, such as through Survey Monkey.
- Pre-populating the report with data available from other sources, including the bed designation, number of admissions, percent Medicare/Medicaid/uninsured, PSAs, and community health measures. This would reduce burden on the hospitals and ensure consistent measurement across hospitals.
- Revising the formatting of the "Community Benefit Initiatives" table so that information for each individual community benefit initiative can be analyzed.

Finally, revisions to the report content could reduce redundancy and collect more targeted information as the state's All-Payer Model progresses. Suggestions include:

- Reviewing the measures and reporting requirements for other HSCRC reports, such as the Global Budget Revenue (GBR) report, and editing questions accordingly.
- Reviewing the community benefit questions on Schedule H and editing accordingly; staff could also explore with stakeholders the possibility of hospitals submitting their Schedule H as an attachment to this report.
- Collecting lists of the community health needs identified through the hospitals' most recent CHNA.
- Creating a specific section on financial assistance policies (these are currently reported as an appendix).
- Providing clarification in the instructions about the reporting of out-of-state community benefit activities.
- Aligning the PSA definition with the GBR PSAs.
- Removing the requirement for hospitals to attach their mission, vision, and values statements, as this information is not easily analyzable and is typically available online.
- Adding questions about community benefit decision-making authority within the hospital.
- Adding questions about community benefit and population health staffing within the hospital.

HSCRC staff have also requested feedback from and will continue to work with the Community Benefit Workgroup on these revisions.

FINANCIAL REPORTS

The financial reports collect information about staff hours, the number of encounters, and direct and indirect costs for community benefits, categorized by type of community benefit activity. The reporting period for these financial data is July 1, 2015, through June 30, 2016. Hospitals submitted their individual CBRs to the HSCRC by December 2016. Audited financial statements were used to calculate the cost of each of the community benefit categories contained in the data reports. Fifty-two hospitals submitted individual data reports.

FY 2016 Financial Reporting Highlights

Table 1 presents a statewide summary of community benefit expenditures for FY 2016. Maryland hospitals provided just over $1.5 billion in total community benefit activities in FY 2016—a total that is slightly higher than FY 2015 ($1.48 billion). The FY 2016 total comprises net community benefit expenses of $492.7 million in mission-driven health care services (subsidized health services), $469.3 million in health professions education, $320.9 million in charity care, $107.2 million in community health services, $56.5 million in unreimbursed Medicaid costs, $6.6 million for Medicaid expansion expenses, $24.7 million in community-building activities, $20.8 million in financial contributions, $13.4 million in community benefit operations, $9.6 million in research activities, and $1.7 million in foundation-funded community benefits. These totals include hospital-reported indirect costs, which vary by hospital and by category from a fixed dollar amount to a calculated percentage of the hospital's reported direct costs.

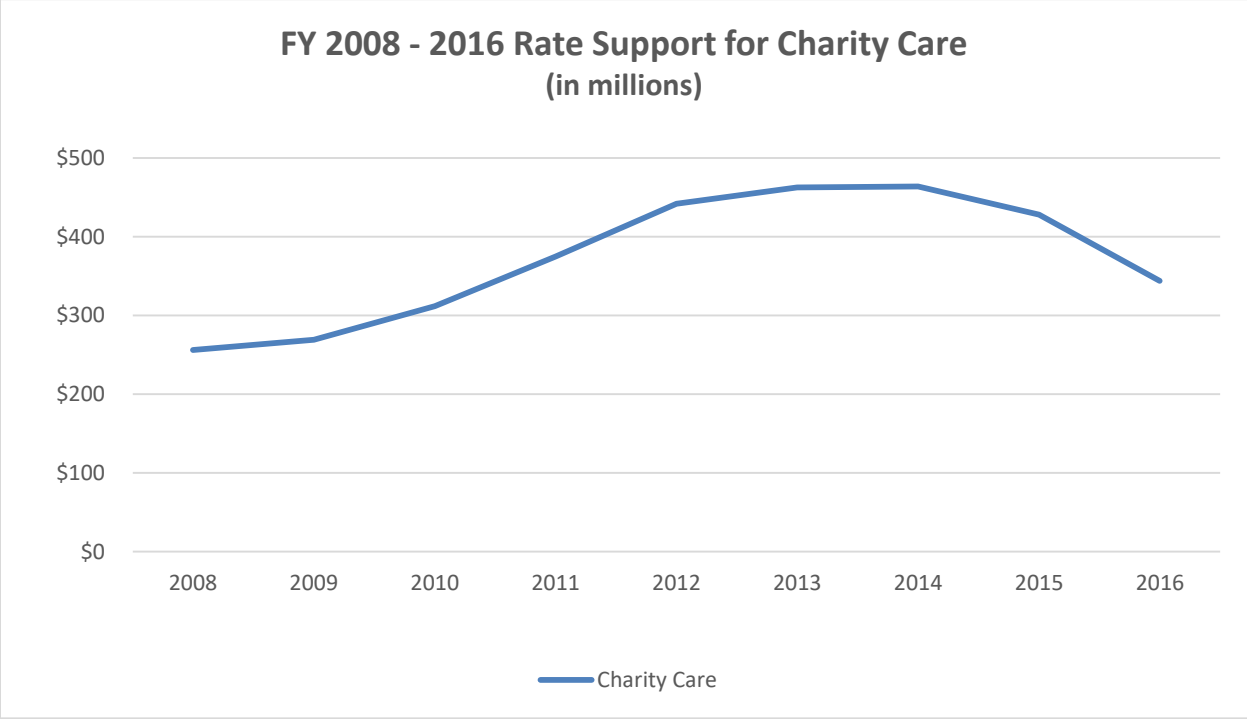
Table 11. Total Community Benefits, FY 2016

Community Benefit Category	Number of Staff Hours	Number of Encounters	Net Community Benefit Expense	% of Total Community Benefit Expenditures	Net Community Benefit Expense Less: Rate Support	% of Total Community Benefit Expenditures w/o Rate Support
Unreimbursed Medicaid Cost	N/A	N/A	$56,475,883	3.71%	$56,475,883	6.82%
Community Health Services	1,242,055	4,036,356	$107,226,253	7.04%	$107,226,253	12.96%
Health Professions Education	5,059,756	180,171	$469,283,494	30.80%	$117,157,540	14.16%
Mission Driven Health Services	2,283,557	937,072	$492,748,329	32.34%	$492,748,329	59.53%
Research	111,091	6,398	$9,649,972	0.63%	$9,649,972	1.17%
Financial Contributions	32,816	191,518	$20,827,391	1.37%	$20,827,391	2.52%
Community Building	253,490	453,394	$24,739,540	1.62%	$24,739,540	2.99%
Community Benefit Operations	113,808	2,531	$13,417,597	0.88%	$13,417,597	1.62%
Foundation	77,881	49,689	$1,742,933	0.11%	$1,742,933	0.21%
Charity Care	N/A	N/A	$320,932,030	21.06%	-$22,947,729	-2.77%
ACA Medicaid Expansion Expense	N/A	N/A	$6,629,446	0.44%	$6,629,446	0.80%
Total	**9,174,456**	**5,857,129**	**$1,523,672,867**	**100%**	**$827,667,153**	**100%**

In Maryland, the costs of uncompensated care (including charity care and bad debt) and graduate medical education are built into the rates for which hospitals are reimbursed by all payers, including Medicare and Medicaid. Additionally, the HSCRC rates include amounts for nurse support programs provided at Maryland hospitals. These costs are, in essence, "passed-through" to the purchasers and payers of hospital care. To comply with IRS Form 990 and avoid accounting confusion among programs that are not funded by hospital rate setting, the HSCRC requests that hospitals exclude from their reports all revenue that is included in rates as offsetting revenue on the CBR worksheet. Appendix E details the amounts that were included in rates and funded by all payers for charity care, direct graduate medical education, and nurse support programs in FY 2016.

As noted above, the HSCRC includes a provision in hospital rates for uncompensated care—which includes charity care—because it is considered to be a community benefit. It also includes bad debt, which is not considered to be a community benefit. Figure 3 shows the rate support for charity care from FY 2008 through FY 2016. The rate support for charity care continuously increased from FY 2008 through FY 2014 and then began to decrease in FY 2014 due to implementation of the ACA. See Appendix E for more details.

Figure 3. Rate Support for Charity Care, FY 2008 through FY 2016



Another social cost funded through Maryland's rate-setting system is the cost of graduate medical education, generally for interns and residents who are trained in Maryland hospitals. Included in graduate medical education costs are the direct costs (i.e., direct medical education,

or DME), which include the residents' and interns' wages and benefits, faculty supervisory expenses, and allocated overhead. The HSCRC's annual cost report quantifies the DME costs of physician training programs at Maryland hospitals. In FY 2016, DME costs totaled $336.4 million.

The HSCRC's Nurse Support Program I (NSPI) is aimed at addressing the short- and long-term nursing shortage affecting Maryland hospitals. In FY 2016, $15.7 million was provided in hospital rate adjustments for the NSPI. See Appendix E for detailed information about funding provided to specific hospitals.

When the reported community benefit costs for Maryland hospitals were offset by rate support, the net community benefits provided in FY 2016 totaled $827.7 million, or 5.07 percent of total hospital operating expenses. This is an increase from the $731.2 million in net benefits provided in FY 2015, which totaled 4.98 percent of hospital operating expenses. See Appendix F: FY 2016 Community Benefit Analysis for additional detail.

Table 12 presents staff hours, the number of encounters, and expenditures for health professional education by activity. The education of physicians and medical students makes up the majority of expenses in the category of health professions education, totaling $414 million. The second highest category is the education of nurses and nursing students, totaling $28.2 million. The education of other health professionals totaled $19.0 million.

Table 12. Health Professions Education Activities and Costs, FY 2016

Health Professions Education	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Physicians and Medical Students	4,020,097	39,858	$414,332,259
Nurses and Nursing Students	569,151	50,236	$28,203,306
Other Health Professionals	340,101	51,710	$18,997,589
Other	123,644	37,043	$4,441,604
Scholarships and Funding for Professional Education	6,763	1,324	$3,308,736
Total	**5,059,756**	**180,171**	**$469,283,494**

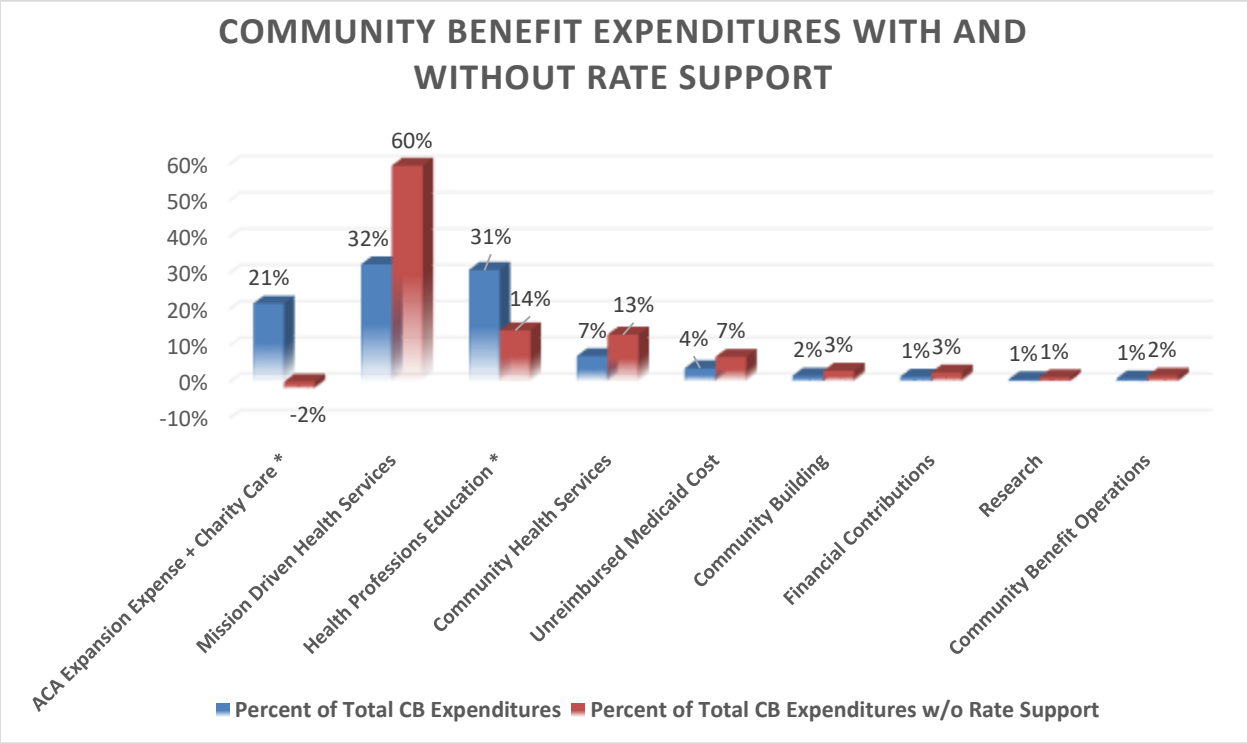
Table 13 presents staff hours, the number of encounters, and expenditures for community health services by activity. Health care support services comprise the largest portion of expenses in the category of community health services, totaling $42.2 million. Community health education is the second highest category, totaling $28.4 million, and community-based clinical services is the third highest, totaling $13.0 million. For additional detail, see Appendix G FY 2016 Hospital Community Benefit Aggregate Data.

Table 13. Community Health Services Activities and Costs, FY 2016

Community Health Services	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Health Care Support Services	269,924	204,933	$42,209,362
Community Health Education	382,161	3,038,413	$28,362,877
Community-Based Clinical Services	377,919	324,994	$13,000,587
Other	57,417	140,515	$9,676,518
Free Clinics	37,374	40,476	$6,745,598
Screenings	36,882	81,415	$2,745,610
Support Groups	16,359	36,353	$1,831,863
Self-Help	29,563	145,047	$1,555,894
Mobile Units	30,965	10,261	$759,321
One-Time/Occasionally Held Clinics	3,491	13,949	$338,621
Total	**1,242,055**	**4,036,356**	**$107,226,253**

Rate offsetting significantly affects the distribution of expenses by category. Figure 4 shows expenditures in each community benefit category as a percentage of total expenditures. Charity care, health professions education, and mission-driven health services represent the majority of the expenses, at 21 percent, 31 percent, and 32 percent, respectively. Figure 4 also shows the percentage of expenditures by category without rate support, which changes the configuration significantly: Mission-driven health services becomes the category with the highest percentage of expenditures, at 60 percent. Health professions education follows, with 14 percent of expenditures, and community health services accounts for 13 percent of expenditures.

Figure 4. Percentage of Community Benefit Expenditures by Category with and without Rate Support, FY 2016



*Rate Supported Activities

Utilizing the data reported, Appendix F compares hospitals on the total amount of community benefits reported, the amount of community benefits recovered through HSCRC-approved rate supports (i.e., charity care, direct medical education, and nurse support), and the number of staff and staff hours dedicated to community benefit operations. On average, in FY 2016, 2,189 staff hours were dedicated to community benefit operations, an increase of 21 percent from 1,803 staff hours in FY 2016. Seven hospitals reported zero staff hours dedicated to community benefit operations, the same number as in FY 2015. The HSCRC continues to encourage hospitals to incorporate community benefit operations into their overall strategic planning.

The total amount of community benefit expenditures as a percentage of total operating expenses ranged from 1.45 percent to 24.80 percent, with an average of 9.5 percent, the same as in FY 2015. Nineteen hospitals reported providing benefits in excess of 10 percent of their operating expenses, compared with 15 hospitals in FY 2015.

FY 2004 – FY 2016 13-Year Summary

FY 2016 marks the 13th year since the inception of the CBR. In FY 2004, community benefit expenses represented $586.5 million, or 6.9 percent of operating expenses. In FY 2016, these expenses represented over $1.5 billion, or 9.3 percent of operating expenses. As Maryland hospitals have increasingly focused on implementation of cost- and quality-improvement

strategies, an increasing percentage of operating expenses has been directed toward community benefit initiatives.

The reporting requirement for revenue offsets and rate support has changed since the inception of the CBR in FY 2004. For consistency purposes, the following figures illustrate community benefit expenses from FY 2008 through FY 2016. Figures 5 and 6 show the trend of community benefit expenses with and without rate support. On average, approximately 50 percent of expenses were reimbursed through the rate-setting system.

Figure 5. FY 2008 – FY 2016 Community Benefit Expenses with and without Rate Support

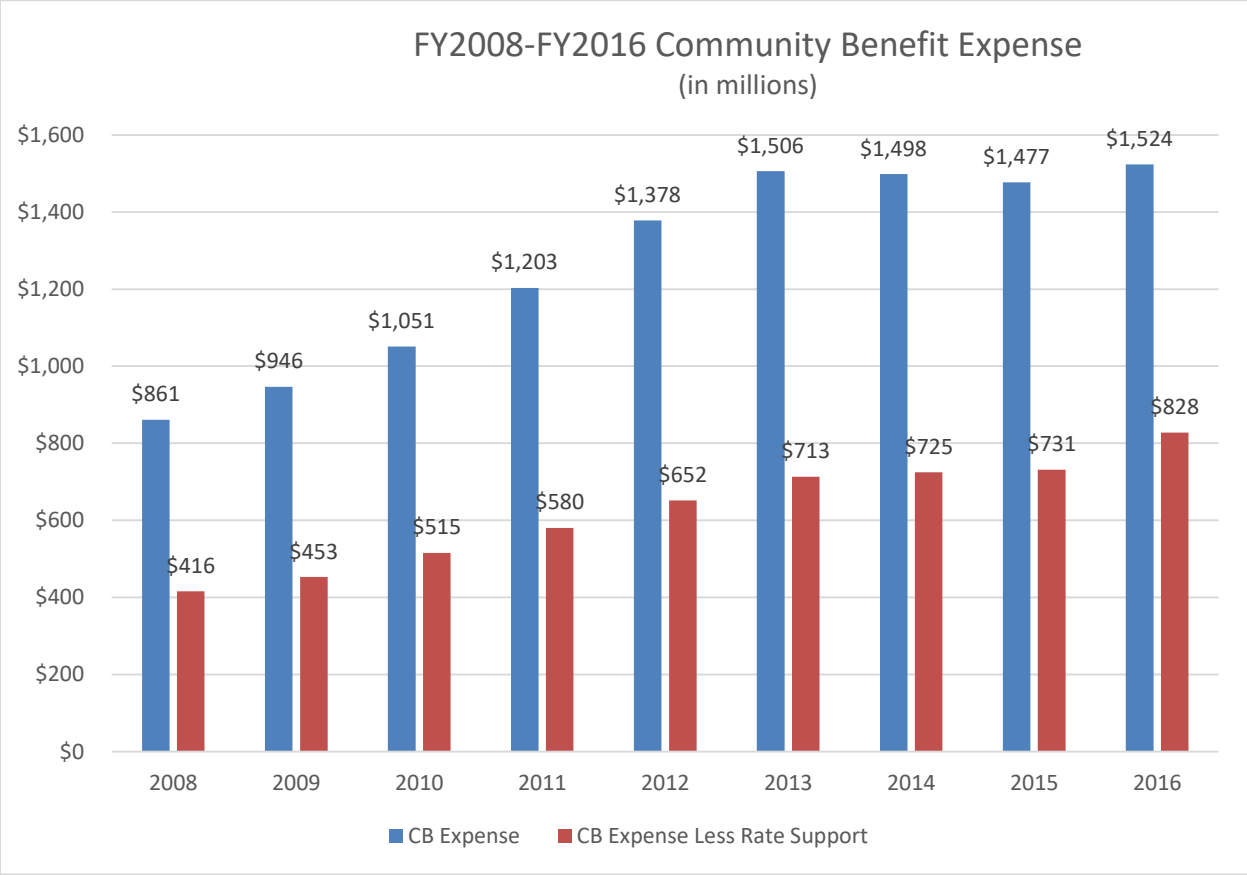
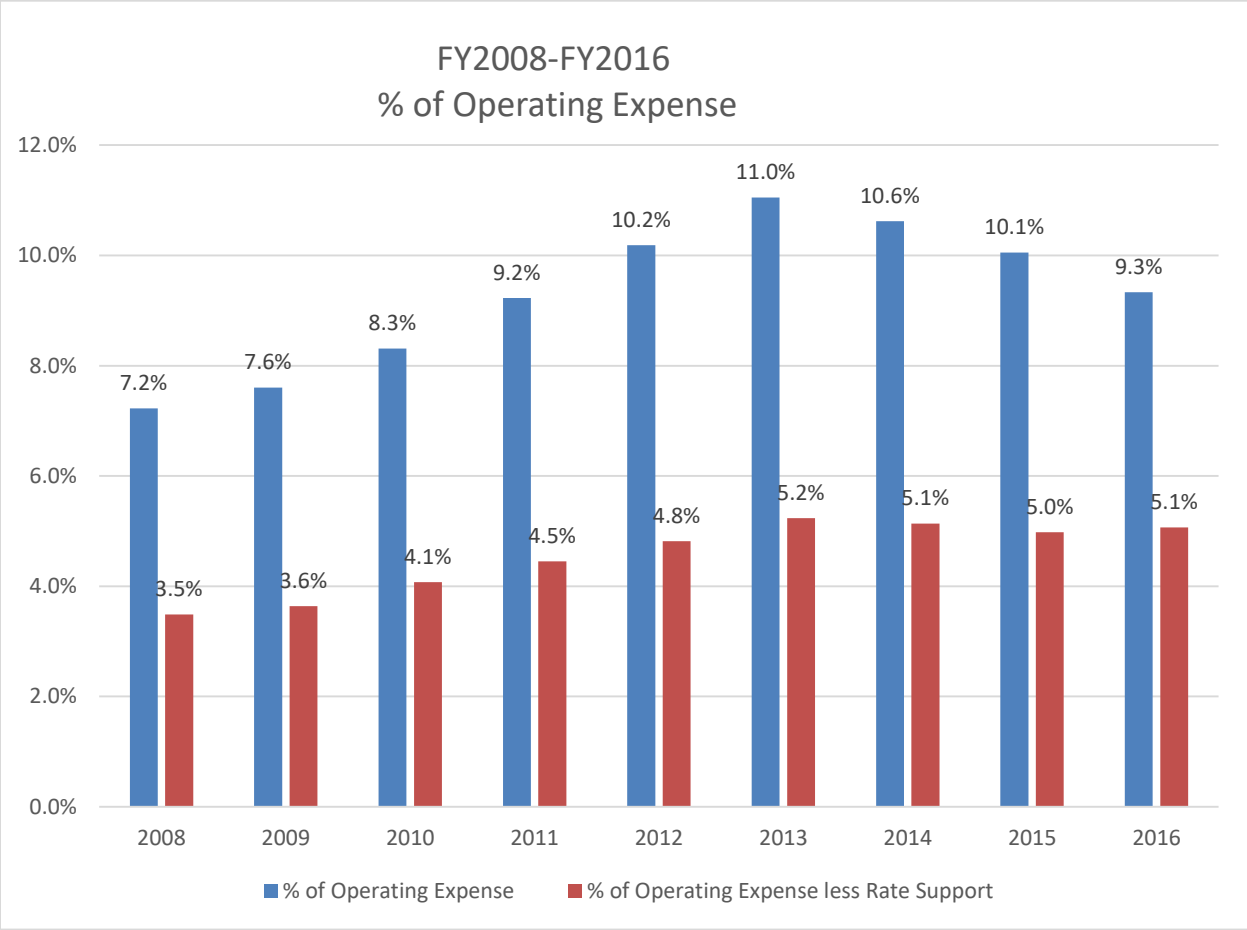


Figure 6. FY 2008 – FY 2016 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support



APPENDIX A. ZIP CODE LISTS

Appendix A Table 1. List of ZIP Codes not Covered by Any CBSA

ZIP Codes	ZCTA
20606	20606
20608	20608
20609	20609
20610	20678
20615	20615
20618	20618
20619	20619
20620	20620
20621	20621
20623	20623
20624	20624
20626	20626
20627	20650
20628	20628
20629	20657
20630	20630
20634	20634
20635	20659
20636	20636
20639	20639
20650	20650
20656	20656
20660	20659
20667	20667
20670	20670
20674	20674
20676	20676
20680	20680
20684	20684
20685	20685
20686	20653
20687	20687
20688	20688
20689	20689
20690	20690
20692	20692
20697	20877
20703	20785
20704	20705
20709	20708
20710	20710
20712	20712
20717	20716
20718	20715
20719	20715
20722	20722
20725	20707
20726	20707
20731	20743
20732	20732
20738	20737
20741	20740
20746	20746
20749	20744
20750	20745
20752	20746
20753	20747
20757	20748
20762	20762
20768	20770
20769	20769
20771	20770
20773	20772
20775	20772
20787	20783
20788	20782
20790	20748
20791	20748
20792	20774
20797	20743
20799	20743
20810	20814
20811	20814
20812	20812
20813	20815
20816	20816
20818	20818
20824	20814
20825	20815
20827	20817
20830	20832
20833	20833
20837	20837
20838	20838
20839	20839
20841	20841
20842	20842
20847	20852
20848	20851
20849	20850
20857	20852
20859	20854
20860	20860
20861	20861
20862	20862
20871	20871
20872	20872
20875	20874
20880	20877
20882	20882
20883	20878
20884	20877
20885	20877
20889	20814
20891	20895
20892	20814
20894	20814
20896	20895
20897	20877
20898	20877
20899	20878
20907	20910
20908	20906
20911	20910
20913	20912
20914	20904
20915	20902
20916	20903
20918	20901
20993	20855
20997	20878
21018	21001
21020	21155
21022	21204
21023	21152
21027	21220
21031	21031
21051	21051
21052	21219
21053	21053
21065	21031
21071	21071
21088	21102
21092	21057
21105	21053
21128	21128
21130	21001
21131	21131
21139	21204
21152	21152
21153	21153
21156	21156
21162	21162
21203	21202
21210	21210
21233	21202
21235	21207
21241	21207
21250	21204
21251	21204
21252	21204
21263	21202

ZIP Codes	ZCTA
21264	21201
21270	21215
21273	21218
21275	21202
21278	21218
21279	21202
21280	21202
21281	21286
21282	21204
21284	21204
21285	21286
21287	21205
21288	21202
21289	21207
21290	21207
21297	21202
21298	21202
21522	21522
21523	21523
21536	21536
21607	21607
21609	21655
21610	21610
21612	21612
21619	21619
21622	21622

ZIP Codes	ZCTA
21623	21623
21624	21663
21625	21625
21626	21626
21627	21627
21628	21651
21634	21634
21635	21635
21636	21636
21638	21638
21639	21639
21640	21640
21641	21629
21644	21644
21645	21645
21647	21647
21648	21648
21649	21649
21650	21650
21651	21651
21652	21612
21653	21663
21654	21654
21656	21623
21657	21657
21658	21658

ZIP Codes	ZCTA
21659	21659
21660	21660
21662	21662
21664	21631
21665	21665
21666	21666
21667	21667
21668	21668
21669	21669
21670	21649
21671	21671
21672	21672
21673	21673
21675	21675
21676	21676
21677	21677
21679	21679
21690	21660
21705	21702
21709	21702
21714	21703
21715	21758
21717	21703
21720	21783
21721	21742
21734	21742

ZIP Codes	ZCTA
21741	21740
21746	21740
21747	21740
21749	21742
21759	21757
21762	21701
21775	21757
21781	21733
21792	21776
21795	21795
21802	21801
21803	21801
21810	21801
21826	21826
21835	21835
21836	21871
21852	21850
21857	21838
21866	21866
21867	21871
21869	21869
21890	21871
21922	21921

Appendix A Table 2. List of CBSA ZIP Codes Covered by 8 or More Hospitals

ZIP Codes	ZCTA
21215	21215
21216	21216
21217	21217

APPENDIX B. COMMUNITY HEALTH MEASURES REPORTED BY HOSPITALS

In addition to the measures reported in Table 3 of the main body of this report, hospitals reported a number of other community health measures.

Measure	Source
% Below FPL/Uninsured By Race/Ethnicity	US Census, ACS
Infant Mortality Rate by Race/Ethnicity	DHMH SHIP
Fruit/Vegetable Consumption	CHNA; Healthy Montgomery
Food Insecurity Rate	Feeding America, Map the Meal Gap
Number of Grocery Stores	CHNA; US Census Bureau, County Business Patterns
Number of Fast Food Restaurants/Fast Food Density	CHNA; US Census, County Business Patterns
Means of Transportation to Work	US Census, ACS
Rate of Pedestrian Injuries	DHMH SHIP
Traffic Fatalities	National Highway Traffic Safety Administration, Safety Facts 2014
High School Graduation Rate by Race/Ethnicity	2016 Maryland Report Card
Bachelor's or Higher by Race/Ethnicity	US Census, ACS
12th Grade Students Proficient in English by Race/Ethnicity	2016 Maryland Report Card
12th Grade Students Proficient in Algebra by Race/Ethnicity	2016 Maryland Report Card
Readiness for Kindergarten by Race/Ethnicity	DHMH SHIP
Severity of Housing Problems by Race/Ethnicity	US Census, American Housing Serving, 2015
Homelessness	Metropolitan Washington Council on Governments Point-In-Time Survey, 2016; Community Health Needs Assessment, Anne Arundel County, 2016
Air Pollution	Healthy Communities Institute, 2016
Population 25+ w/o HS Diploma	US Census
Wait List for Public Housing/Section 8	Community Health Needs Assessment, Anne Arundel County, 2016
Death Rate: Coronary Heart Disease	DHMH SHIP
Death Rate: Stroke	DHMH SHIP
Death Rate: Diabetes	DHMH SHIP
ED Visits: General	DHMH SHIP
ED Visits: Diabetes	DHMH SHIP

ED Visits: Asthma	DHMH SHIP
ED Visits: Hypertension	DHMH SHIP
Food desert	Community Health Needs Assessment, Anne Arundel County, 2016
% on SNAP or Food Stamps	Community Health Needs Assessment, Anne Arundel County, 2016 / US Census
Food Insecurity Index	County Health Rankings
Annual Ozone Air Quality (2010)	American Lung Association
Severe Housing Problem	County Health Rankings
Population per Physician	Not provided
Liquor Outlet Density	US Census, County Business Patterns
Children's Blood Lead Levels	Not provided
% of Residents that Travel outside of County for Medical Care	Not provided
# of FQHCs	Not provided
% Physician Shortage Specialties	Not provided
Death rate: Breast cancer	Not provided
County health rankings table (quality of life, health behaviors, clinical care, social & economic factors, physical enviro)	County Health Rankings
Air Pollution: Particulate Matter	County Health Rankings
Water Pollution: Drinking water violations	Not provided
SNAP Retailers	US Dept. of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator
WIC Retailors	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.
% Substandard Housing Units	US Census, ACS
% Overcrowded Housing	US Census, ACS
Rate of Recreation and Fitness Facilities	US Census, County Business Patterns
% of Days Exceeding Emission Standards for Ozone Levels	CDC, EPHT
% of Days Exceeding the Particulate Matter 2.5* Standards	CDC, EPHT
All SHIP Indicators	DHMH SHIP
Free school lunch eligibility	County Health Rankings
# of Safety Net Clinics	PG County Health Improvement Plan
Limited Access to Healthy Foods	County Health Rankings
% Smokers	DHMH SHIP

% of renters who are paying 30% or more on their household income in rent:	Not provided
Teen Birth Rate	Not provided
% of Live Births with Inadequate Birth Spacing	Not provided
% of Women Receiving Prenatal Care in 1st Trimester	Not provided
Mental Health Providers to population	County Health Rankings
Violent Crime	County Health Rankings
Low Birth Weight	DHMH SHIP
Rate of Hospital Encounters for Newborns with Maternal Drug/Alcohol Exposure	HSCRC Hospital Data, 2000-2015, Maryland resident births only
Adolescents Who Use Tobacco Products	SHIP 2013, Maryland Youth Risk Behavior Survey (YRBS)
Percentage of Adults who currently smoke	Maryland DHMH Behavioral Risk Factor Surveillance System (BRFSS)
Physical Activity	Maryland DHMH Behavioral Risk Factor Surveillance System (BRFSS)

APPENDIX C. CHNA SCHEDULES

Hospital	Date Most Recent CHNA was Completed as Reported on Hospital Website or FY 16 CBR
GBMC	Mar 2013
Western Maryland	Dec 2013
McCready	Oct 2014
Calvert Memorial	Dec 2014
Charles Regional	Mar 2015
Lifebridge-Carroll Hospital	Jun 2015
UM-Midtown	Jun 2015
UMMC	Jun 2015
Mt. Washington Pediatrics	Jun 2015
UM-Rehab and Ortho	Jun 2015
MedStar Franklin Square	Jun 2015
MedStar Good Samaritan	Jun 2015
Medstar Harbor	Jun 2015
MedStar Montgomery	Jun 2015
MedStar Southern Maryland	Jun 2015
MedStar St. Mary's	Jun 2015
MedStar Union Memorial	Jun 2015
UM Harford Memorial	Jun 2015
UM Upper Chesapeake	Jun 2015
Meritus	Nov 2015
Anne Arundel	Feb 2016
UM-BWMC	Feb 2016
UM-St. Joseph	Apr 2016
Lifebridge-Northwest	Apr 2016
Lifebridge-Sinai	Apr 2016
Atlantic General	May 2016
Garrett Regional	May 2016
Sheppard Pratt	May 2016
Shore Health Chestertown	May 2016
Shore Health Dorchester	May 2016
Shore Health Easton	May 2016
Mercy	Jun 2016
Dimensions Laurel Regional Hospital	Jun 2016
Dimensions Prince Georges Hospital Center	Jun 2016
Doctors Community	Jun 2016

Hospital	Date Most Recent CHNA was Completed as Reported on Hospital Website or FY 16 CBR
Johns Hopkins Bayview	Jun 2016
Fort Washington	Jun 2016
Suburban	Jun 2016
Johns Hopkins Hospital	Jun 2016
St. Agnes	Jun 2016
Peninsula Regional	Jun 2016
Howard County General	Jun 2016
Lifebridge-Levindale	Jun 2016
Union Hospital of Cecil County	Jun 2016
Frederick Memorial	Sep 2016
Holy Cross Germantown	Oct 2016
Holy Cross Hospital	Oct 2016
Shady Grove	Nov 2016
Washington Adventist	Nov 2016
Adventist Behavioral Health	Nov 2016
Adventist Rehab	Nov 2016
Bon Secours	Dec 2016

*Data Source: As reported by hospitals on their FY 2016 Community Benefit Reports and edited according to hospital websites

APPENDIX D. BEHAVIORAL HEALTH PARTNER ORGANIZATIONS

The Community Benefit Workgroup requested information on the behavioral health organizations that are partnering with hospitals on community benefit activities. The following tables lists the behavioral health organizations reported in the CBRs.

Government Organizations	
Alcohol and Drug Abuse Administration	Kent County Department of Health Addiction Services
	Maryland Department of Education
Anne Arundel County Courts	Maryland Department of Health and Mental Hygiene
Anne Arundel County Department of Health	Mayor's Office of Human Services
Anne Arundel County Department of Juvenile Justice	Montgomery County Department of Health and Human Services
Anne Arundel County Executive's Office	Naval Air Station PAX River
Anne Arundel County Public Schools Staff	Office of Drug Control Policy
Anne Arundel Mental Health Agency	Office on Mental Health - Core Services Agency
Baltimore City Health Department	Partnership for Children Youth and Families
Baltimore City Office of Homeless Services	Queen Anne's County Department of Health - Addictions Treatment and Prevention Services
Baltimore City Police Department	St. Mary's County Alcohol Beverage Board
Behavioral Health Administration	St. Mary's County Core Services Agency
Carroll County Health Department	St. Mary's County Department of Aging and Human Services
Cecil County Health Department	St. Mary's County Department of Social Services
Charles County Commissioners	St. Mary's County Drug Court
Charles County Core Services Agency	St. Mary's County Health Department
Charles County Department of Health	St. Mary's County Public Schools
Charles County Public Schools	St. Mary's County Sherriff's Office
Charles County Sherriff's Office	State's Attorney's Opioid Task Force
Circuit Court of Talbot County, Problem Solving Court	Substance Abuse and Mental Health Services Administration
Department of Community Services	Talbot County Health Department Addictions Program (TCAP) and Prevention
	The Washington County Mental Health Authority (CSA)

Dorchester County Addictions Program	Washington County Health Department/LHIC
Frederick County Health Department	Wicomico County Health Department
Harford County Health Department	Worcester County Drug and Alcohol Board
Howard County Health Department	Worcester County Health Department
Howard County Mental Health Authority	Worcester County Public Schools
Faith-Based Organizations	
Helping Up Mission	Southern Baptist Church
Israel Baptist Church	Talbot Association of Clergy and Laity
Mount Lebanon Baptist Church	Zion Baptist Church
Providers, Hospitals, and Treatment Organizations	
Access Carroll	Lower Shore Health Clinic Go-Getters
Adult Substance Abuse Services	Maryland Quit Line
Adventist Behavioral Health	Medicine for the Greater Good
Alcoholics Anonymous	Mid-Shore Mental Health System
Anne Arundel Mobile Crisis Unit	Mosaic
Atlantic Health Clinic	Mountain Laurel Health Center
Baltimore Crisis Response, Inc.	Pathways Inc.
Behavioral Health Action Team	Potomac Case Management
Caroline Counseling Center	Prince George's Hospital Center, Family Medicine Residency Program
Caroline County Prevention Services	QCI Behavioral Health
Carroll County Youth Services Bureau	Riverside Health System
Catoctin Counseling	Sheppard Pratt
Chesapeake Treatment Services	
Chesapeake Voyagers, Inc.	Shoemaker Center
Cheverly Family Health & Wellness, Behavioral Services	St. Paul Place Specialists
Choptank Community Health System	Surfer's Healing Camps
Crisis Response Team Advisory Board	The Mental Health Center
Dayspring	Three Lower Counties Clinic
Dri-Dock Recovery and Wellness Center	University of Maryland Baltimore Washington Medical Center
Drug Overdose Fatality Review Team	University of Maryland Medical Center
Family Medicine Practice Family Health and Wellness Center, Cheverly	Vesta, Inc.
Freedom Landing	Walden Sierra
Grassroots Crisis Intervention Center	Warwick Manor Behavioral Health
Healthcare for the Homeless	Washington Adventist Hospital
Hudson Health Services	Way Station, Inc.

Johns Hopkins Medicine	West Cecil Health Center
Lower Shore Clinic	Worcester Youth and Family Services
Lower Shore Critical Incident Crisis Management	
Other Organizations	
The Horizon Foundation	WOW Committee
United Way of Central Maryland	
Alzheimer's Association, Prince George's County Chapter	Mental Health Association of Montgomery County
American Academy of Pediatrics	Minority Outreach Coalition
American Foundation for Suicide Prevention	National Alliance on Mental Illness
Autism Speaks	Ocean City Drug and Alcohol Abuse and Prevention Committee
	On Our Own
BACH/Baltimore Alliance for Careers in Healthcare	Parents Affected by Addiction
Beans and Bread	Patients Like Me
Behavioral Health Systems Baltimore	Play it Safe Committee
Charles County Substance Abuse Advisory Committee	Port Towns Community Health Partnership
Children's SMART	Postpartum Progress
Citizens for Substance Free Youth	Primary Care Coalition
County Overdose Prevention Plan	St. Mary's County License Beverage Association
Domestic Violence Coordinating Council	STAR/Sisters Together and Reaching
HC Drug Free	Suicide Awareness Board
Healthy Harford	Talbot Partnership for Alcohol and Other Drug Abuse Prevention
House of Ruth	The Center for Medical Technology Policy
Jesse's Paddle Organization	Tobacco and Cancer Coalition - Worcester County
Mental Health Association	Worcester County Warriors Against Opioid Use

APPENDIX E. HOSPITALS' FY 2016 FUNDING FOR NURSE SUPPORT PROGRAM I, DIRECT MEDICAL EDUCATION, AND CHARITY CARE

Hospital Name	Direct Medical Education (DME)	Nurse Support Program I (NSPI)	Charity Care in Rates	Total Rate Support
Meritus Medical Center	$0	$305,142	$4,323,873	$4,629,015
UMMC & Shock Trauma	$115,827,995	$1,498,576	$45,307,783	$162,634,354
Dimensions Prince Georges Hospital Center	$5,117,267	$267,282	$15,451,354	$20,835,903
Holy Cross Hospital	$2,708,039	$468,877	$22,196,553	$25,373,468
Frederick Memorial	$0	$339,661	$10,487,592	$10,827,253
UM Harford Memorial	$0	$53,719	$2,714,640	$2,768,359
Mercy Medical Center	$9,414,846	$489,187	$21,043,592	$30,947,625
Johns Hopkins Hospital	$108,442,934	$2,172,518	$32,624,031	$143,239,483
UM Shore Medical Dorchester	$0	$58,994	$406,423	$465,417
St. Agnes	$7,229,390	$410,191	$17,766,212	$25,405,792
LifeBridge Sinai	$14,784,200	$699,430	$6,287,935	$21,771,565
Bon Secours	$0	$129,714	$782,651	$912,365
MedStar Franklin Square	$9,890,754	$486,467	$5,710,667	$16,087,888
Adventist Washington Adventist	$0	$260,306	$18,531,753	$18,792,059
Garrett County Hospital	$0	$45,203	$2,308,692	$2,353,894
MedStar Montgomery General	$0	$167,893	$2,466,641	$2,634,534
Peninsula Regional	$0	$416,389	$8,413,535	$8,829,924
Suburban Hospital	$331,245	$289,287	$6,501,312	$7,121,843
Anne Arundel Medical Center	$0	$554,132	$4,636,381	$5,190,513
MedStar Union Memorial	$14,052,897	$415,164	$4,803,501	$19,271,563
Western Maryland Health System	$0	$317,899	$6,790,924	$7,108,823
MedStar St. Mary's Hospital	$0	$157,936	$1,403,612	$1,561,548
Johns Hopkins Bayview Medical Center	$23,141,000	$605,106	$13,491,671	$37,237,778
UM Shore Medical Chestertown	$0	$64,509	$526,810	$591,319
Union Hospital of Cecil County	$0	$157,914	$1,053,373	$1,211,287
Carroll Hospital Center	$0	$251,985	$1,596,917	$1,848,902
MedStar Harbor Hospital	$4,696,418	$205,146	$3,416,540	$8,318,105
UM Charles Regional Medical Center	$0	$144,786	$3,769,104	$3,913,890
UM Shore Medical Easton	$0	$187,483	$1,799,429	$1,986,913
UM Midtown	$3,073,957	$178,843	$10,196,092	$13,448,892
Calvert Hospital	$0	$120,604	$5,351,799	$5,472,403
Lifebridge Northwest Hospital	$0	$249,135	$3,573,557	$3,822,691
UM Baltimore Washington	$628,161	$393,182	$6,845,110	$7,866,453

Hospital Name	Direct Medical Education (DME)	Nurse Support Program I (NSPI)	Charity Care in Rates	Total Rate Support
GBMC	$5,237,160	$426,965	$2,603,763	$8,267,888
McCready	$0	$16,638	$392,686	$409,324
Howard County Hospital	$0	$281,806	$4,487,570	$4,769,375
UM Upper Chesapeake	$0	$157,472	$5,415,566	$5,573,038
Doctors Community	$0	$222,145	$11,635,983	$11,858,128
Dimensions Laurel Regional Hospital	$0	$118,865	$2,846,496	$2,965,361
Fort Washington Medical Center	$0	$48,566	$1,281,924	$1,330,490
Atlantic General	$0	$102,693	$3,759,190	$3,861,883
MedStar Southern Maryland	$0	$261,812	$2,196,073	$2,457,885
UM St. Joseph	$0	$362,416	$3,339,349	$3,701,765
Lifebridge Levindale	$4,088,269	$54,542	$383,646	$4,526,457
Holy Cross Germantown Hospital	$5,371,417	$0		$5,371,417
UM Rehabilitation and Ortho Institute	$0	$118,262	$1,507,076	$1,625,338
MedStar Good Samaritan	$0	$299,250	$3,426,984	$3,726,234
Adventist Rehab of Maryland	$0	$61,978	$0	$61,978
Sheppard Pratt	$0	$139,935	$0	$139,935
Adventist Behavioral Health Rockville	$2,415,214	$0	$0	$2,415,214
Mt. Washington Pediatrics	$0	$55,464	$0	$55,464
Adventist Shady Grove Hospital	$0	$383,323	$8,023,394	$8,406,717
Total	**$336,451,161**	**$15,674,793**	**$343,879,759**	**$696,005,714**

APPENDIX F. FY 2016 COMMUNITY BENEFIT ANALYSIS

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit W/Medicaid Expansion Expense	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI*	Net CB minus Charity Care, DME, NSPI in Rates + ACA Expansion Expense	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
Calvert Hospital	1,329	243	$1,128,684,174	$16,485,245	1.5%	$5,472,403	$11,012,841	1.0%	$3,808,206
McCready	294	5	$14,968,260	$275,197	1.8%	$409,324	-$134,127	-0.9%	$185,796
Mt. Washington Pediatrics	674	2,346	$54,438,547	$1,484,992	2.7%	$55,464	$1,429,528	2.6%	$88,862
Ft. Washington	432	0	$42,405,282	$1,507,390	3.5%	$1,330,490	$176,900	0.4%	$914,689
GBMC	2,561	5,826	$402,046,322	$14,937,451	3.7%	$8,267,888	$6,669,562	1.7%	$2,007,183
Union Hospital of Cecil County	1,149	2,208	$152,850,972	$6,643,655	4.3%	$1,211,287	$5,432,368	3.6%	$899,826
UM Upper Chesapeake	0	2,128	$261,076,000	$12,076,222	4.6%	$5,573,038	$6,503,184	2.5%	$3,818,000
MedStar Montgomery General	1,158	0	$151,876,735	$7,099,282	4.6%	$2,634,534	$4,464,748	2.9%	$1,821,317
MedStar Southern Maryland	1,451	14,020	$242,526,804	$11,610,090	4.7%	$2,457,885	$9,152,205	3.8%	$2,691,523
Levindale	863	520	$72,413,402	$3,701,218	5.1%	$4,526,457	-$825,239	-1.1%	$1,443,083
Lifebridge Northwest Hospital	1,768	2,260	$233,286,000	$15,548,424	6.5%	$3,822,691	$11,725,733	5.0%	$3,524,100
MedStar Franklin Square	3,283	2,676	$508,064,432	$34,272,215	6.7%	$16,087,888	$18,184,327	3.6%	$5,147,191
Holy Cross Germantown	654	180	$86,826,724	$5,917,376	6.8%	$5,371,417	$545,959	0.6%	$2,382,942
UM Harford Memorial	0	912	$82,723,000	$5,869,284	7.0%	$2,768,359	$3,100,925	3.7%	$1,915,000
Carroll Hospital Center	1,988	2,080	$216,062,000	$15,567,400	7.2%	$1,848,902	$13,718,497	6.3%	$1,303,875
Meritus Medical Center	2,294	816	$299,130,713	$21,982,139	7.3%	$4,629,015	$17,353,124	5.8%	$4,903,600
UM Baltimore Washington	2,200	3,117	$330,823,000	$24,523,875	7.3%	$7,866,453	$16,657,422	5.0%	$5,655,016
LifeBridge Sinai	4,778	7,128	$714,926,000	$53,250,243	7.4%	$21,771,565	$31,478,678	4.4%	$5,452,000
Howard County Hospital	1,856	2,622	$250,602,000	$19,400,167	7.7%	$4,769,375	$14,630,791	5.8%	$3,560,370
Suburban Hospital	1,755	2,351	$271,382,000	$21,570,933	7.9%	$7,121,843	$14,449,089	5.3%	$3,294,000
MedStar St. Mary's Hospital	1,200	6,040	$149,998,897	$12,157,877	8.0%	$1,561,548	$10,596,329	7.1%	$1,508,919

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit W/Medicaid Expansion Expense	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI*	Net CB minus Charity Care, DME, NSPI in Rates + ACA Expansion Expense	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
MedStar Good Samaritan	2,162	980	$302,367,777	$24,920,169	8.2%	$3,726,234	$21,193,935	7.0%	$3,308,833
MedStar Union Memorial	2,369	40	$424,392,626	$35,335,924	8.3%	$19,271,563	$16,064,362	3.8%	$4,012,263
Adventist Rehab of Maryland*	484	772	$38,791,987	$3,324,826	8.6%	$61,978	$3,262,848	8.4%	$964,421
Johns Hopkins Bayview Medical Center	3,398	1,035	$596,562,000	$52,422,558	8.7%	$37,237,778	$15,184,780	2.5%	$12,679,000
Sheppard Pratt	2,459	545	$213,531,372	$18,791,283	8.8%	$139,935	$18,651,348	8.7%	$6,451,134
Anne Arundel Medical Center	4,746	4,271	$531,698,000	$47,363,958	8.9%	$5,190,513	$42,173,445	7.9%	$3,486,700
Johns Hopkins Hospital	0	8,500	$2,173,349,000	$195,778,964	9.0%	$143,239,483	$52,539,481	2.4%	$22,047,000
Doctors Community	1,509	1,218	$186,693,541	$17,100,686	9.0%	$11,858,128	$5,242,558	2.8%	$12,200,284
Frederick Memorial	1,764	1,080	$330,320,000	$31,884,494	9.6%	$10,827,253	$21,057,242	6.4%	$11,277,000
Shady Grove*	2,037	10,080	$316,512,363	$30,571,076	9.6%	$8,406,717	$22,164,359	7.0%	$6,620,218
Garrett County Hospital	419	16	$42,622,790	$3,284,231	7.5%	$2,353,894	$930,336	2.2%	$2,316,474
UM St. Joseph	2,434	0	$330,061,000	$32,760,787	9.9%	$3,701,765	$29,059,022	8.8%	$3,488,000
MedStar Harbor Hospital	1,103	182	$190,376,563	$19,408,834	10.1%	$8,318,105	$11,090,729	5.8%	$2,995,264
UM Rehabilitation and Ortho Institute	625	520	$103,856,400	$10,662,155	10.2%	$1,625,338	$9,036,817	8.7%	$2,197,000
St. Agnes	2,805	0	$434,193,000	$46,549,340	10.6%	$25,405,792	$21,143,548	4.9%	$21,867,282
Peninsula Regional	2,829	361	$405,639,685	$43,315,440	10.7%	$8,829,924	$34,485,516	8.5%	$7,836,700
Atlantic General	930	101	$112,904,430	$12,786,633	11.3%	$3,861,883	$8,924,750	7.9%	$3,277,824
UM Shore Medical Dorchester	428	375	$39,677,059	$4,574,355	11.4%	$465,417	$4,108,938	10.4%	$499,553
UM Charles Regional Medical Center	979	1,048	$113,371,227	$13,457,175	11.8%	$3,913,890	$9,543,285	8.4%	$3,798,238
Holy Cross Hospital	3,555	4,431	$411,176,881	$53,488,786	12.9%	$25,373,468	$28,115,317	6.8%	$33,462,706
UM Shore Medical Easton	1,353	1,000	$174,850,678	$22,727,672	13.0%	$1,986,913	$20,740,759	11.9%	$1,575,225

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit W/Medicaid Expansion Expense	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI*	Net CB minus Charity Care, DME, NSPI in Rates + ACA Expansion Expense	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
Mercy Medical Center	3,915	2,617	$461,664,800	$60,092,759	13.0%	$30,947,625	$29,145,134	6.3%	$19,521,700
Bon Secours	697	7,033	$115,814,419	$16,364,154	14.0%	$912,365	$15,451,789	13.3%	$607,325
Western Maryland Health System	1,878	247	$314,069,685	$44,321,300	14.0%	$7,108,823	$37,212,478	11.8%	$9,670,307
UMMC	8,584	1,979	$1,445,705,000	$214,666,776	14.8%	$162,634,354	$52,032,422	3.6%	$28,945,000
Adventist Behavioral Health Rockville*	432	0	$35,253,036	$5,384,999	15.3%	$2,415,214	$2,969,785	8.4%	$1,866,300
Dimensions Prince Georges Hospital Center	0	0	$263,131,867	$46,449,141	17.7%	$20,835,903	$25,613,238	9.7%	$9,769,558
UM Shore Medical Chestertown	272	860	$48,488,291	$8,779,666	18.0%	$591,319	$8,188,347	16.9%	$407,715
Adventist Washington Adventist*	1,351	6,624	$217,955,646	$40,704,527	18.6%	$18,792,059	$21,912,468	10.1%	$14,800,908
UM Midtown	1,215	416	$191,264,500	$36,601,059	19.1%	$13,448,892	$23,152,167	12.1%	$9,787,000
Dimensions Laurel Regional Hospital	0	0	$95,998,834	$23,918,466	24.8%	$2,965,361	$20,953,106	21.8%	$2,869,600
Total	**86,655**	**113,808**	**$16,329,405,721**	**$1,523,672,867**	**9.3%**	**$696,005,714**	**$827,667,153**	**5.1%**	**$320,932,030**
Average	**1,699**	**2,189**	**$314,027,033**		**9.5%**			**6.2%**	**$6,171,770**

* The Adventist Hospital System requested and received permission to report its community benefit activities on a calendar year basis to more accurately reflect true activities during the community benefit cycle. The numbers listed in the "Total in Rates for Charity Care, DME, and NSPI*" column reflect the HSCRC's activities for FY 2015 and therefore are different from the numbers reported by the Adventist Hospitals.

APPENDIX G. FY 2016 HOSPITAL COMMUNITY BENEFIT AGGREGATE DATA

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
Unreimbursed Medicaid Costs								
T99	Medicaid Assessments	0	0	$389,825,000		$333,349,117	$56,475,883	$56,475,883
Community Health Services								
A10	Community Health Education	382,161	3,038,413	$20,338,261	$10,281,296	$2,256,680	$28,362,877	$18,081,581
A11	Support Groups	16,359	36,353	$1,169,208	$701,273	$38,618	$1,831,863	$1,130,590
A12	Self-Help	29,563	145,047	$1,249,291	$663,523	$356,920	$1,555,894	$892,371
A20	Community-Based Clinical Services	377,919	324,994	$12,706,209	$10,135,395	$9,841,016	$13,000,587	$2,865,193
A21	Screenings	36,882	81,415	$1,931,321	$1,034,008	$219,719	$2,745,610	$1,711,602
A22	One-Time/Occasionally Held Clinics	3,491	13,949	$271,189	$115,483	$48,051	$338,621	$223,138
A23	Free Clinics	37,374	40,476	$4,694,217	$2,290,034	$238,653	$6,745,598	$4,455,564
A24	Mobile Units	30,965	10,261	$1,344,251	$588,967	$1,173,897	$759,321	$170,354
A30	Health Care Support Services	269,924	204,933	$31,662,282	$14,511,490	$3,964,409	$42,209,362	$27,697,873
A40	Other	37,041	100,007	$4,210,910	$2,536,686	$1,204,900	$5,542,696	$3,006,010
A41	Other	18,569	29,038	$2,296,966	$1,501,723	$0	$3,798,689	$2,296,966
A42	Other	1,807	11,470	$228,348	$109,369	$2,584	$335,133	$225,764
A99	**Total**	**1,242,055**	**4,036,356**	**$82,102,454**	**$44,469,247**	**$19,345,448**	**$107,226,253**	**$62,757,005**
Health Professions Education								
B1	Physicians/Medical Students	4,020,097	39,858	$334,666,432	$79,790,838	$125,011	$414,332,259	$334,541,421
B2	Nurses/Nursing Students	569,151	50,236	$24,198,696	$4,293,690	$289,080	$28,203,306	$23,909,616
B3	Other Health Professionals	340,101	51,710	$15,596,506	$3,613,821	$212,738	$18,997,589	$15,383,768
B4	Scholarships/Funding for Professional Education	6,763	1,324	$3,210,803	$97,933	$0	$3,308,736	$3,210,803
B50	Other	95,552	22,842	$3,961,970	$316,537	$37,383	$4,241,124	$3,924,587

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
B51	Other	22,652	9,184	$1,435,827	$3,685	$1,425,707	$13,805	$10,120
B52	Other	5,440	5,017	$213,093	$49,827	$76,244	$186,676	$136,849
B99	**Total**	**5,059,756**	**180,171**	**$383,283,328**	**$88,166,329**	**$2,166,163**	**$469,283,494**	**$381,117,165**
Mission-Driven Health Services								
	Mission-Driven Health Services Total	**2,283,557**	**937,072**	**$566,171,842**	**$98,813,317**	**$172,236,829**	**$492,748,329**	**$393,935,012**
Research								
D1	Clinical Research	59,261	2,629	$8,944,723	$1,630,787	$4,689,642	$5,885,867	$4,255,080
D2	Community Health Research	24,188	3,751	$1,825,497	$707,111	$132,299	$2,400,309	$1,693,198
D3	Other	27,642	18	$2,757,361	$111,669	$1,505,236	$1,363,795	$1,252,126
D99	**Total**	**111,091**	**6,398**	**$13,527,582**	**$2,449,567**	**$6,327,177**	**$9,649,972**	**$7,200,405**
Financial Contributions								
E1	Cash Donations	1,285	25,803	$12,235,928	$317,295	$80,454	$12,472,769	$12,155,474
E2	Grants	0	36	$456,586	$101,434	$95,359	$462,661	$361,227
E3	In-Kind Donations	27,092	158,126	$7,887,385	$430,013	$975,812	$7,341,586	$6,911,573
E4	Cost of Fund Raising for Community Programs	4,439	7,553	$432,170	$118,205	$0	$550,375	$432,170
E99	**Total**	**32,816**	**191,518**	**$21,012,069**	**$966,947**	**$1,151,625**	**$20,827,391**	**$19,860,444**
Community-Building Activities								
F1	Physical Improvements/Housing	5,972	303,759	$3,306,158	$2,740,897	$2,384,571	$3,662,484	$921,587
F2	Economic Development	12,694	3,356	$799,088	$423,187	$331,264	$891,011	$467,824
F3	Support System Enhancements	74,697	16,059	$3,112,778	$1,653,681	$960,646	$3,805,813	$2,152,132
F4	Environmental Improvements	10,308	814	$592,824	$234,923	$105,251	$722,496	$487,573
F5	Leadership Development/Training for Community Members	10,609	1,046	$404,895	$249,144	$0	$654,039	$404,895
F6	Coalition Building	23,959	11,743	$2,160,833	$1,085,032	$77,101	$3,168,764	$2,083,732

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
F7	Community Health Improvement Advocacy	30,728	9,567	$2,766,062	$1,571,136	$549	$4,336,649	$2,765,513
F8	Workforce Enhancement	74,361	80,696	$4,590,711	$2,659,975	$387,960	$6,862,726	$4,202,751
F9	Other	2,452	26,271	$292,930	$134,478	$22,975	$404,433	$269,955
F10	Other	7,710	84	$135,786	$95,339	$0	$231,125	$135,786
F99	**Total**	**253,490**	**453,394**	**$18,162,064**	**$10,847,792**	**$4,270,317**	**$24,739,540**	**$13,891,747**
	Community Benefit Operations							
G1	Dedicated Staff	98,925	1,492	$6,246,229	$3,858,166	$63,136	$10,041,258	$6,183,092
G2	Community health/health assets assessments	5,585	490	$854,836	$312,751	$23,717	$1,143,870	$831,119
G3	Other Resources	9,293	516	$1,599,814	$674,718	$42,370	$2,232,162	$1,557,444
G4	Other	5	34	$178	$129	$0	$307	$178
G99	**Total**	**113,808**	**2,531**	**$8,701,057**	**$4,845,763**	**$129,223**	**$13,417,597**	**$8,571,834**
	Charity Care							
	Total Charity Care	$320,932,030						
	Foundation-Funded Community Benefits							
J1	Community Services	13,262	37,364	$866,266	$92,612	$456,606	$502,273	$409,661
J2	Community Building	63,599	11,707	$2,836,577	$63,348	$1,809,265	$1,090,660	$1,027,312
J3	Other	1,020	618	$150,000	$0	$0	$150,000	$150,000
J99	**Total**	**77,881**	**49,689**	**$3,852,843**	**$155,961**	**$2,265,871**	**$1,742,933**	**$1,586,973**
	Total Hospital Community Benefits							
A	Community Health Services	1,242,055	4,036,356	$82,102,454	$44,469,247	$19,345,448	$107,226,253	$62,757,005
B	Health Professions Education	5,059,756	180,171	$383,283,328	$88,166,329	$2,166,163	$469,283,494	$381,117,165
C	Mission Driven Health Care Services	2,283,557	937,072	$566,171,842	$98,813,317	$172,236,829	$492,748,329	$393,935,012
D	Research	111,091	6,398	$13,527,582	$2,449,567	$6,327,177	$9,649,972	$7,200,405
E	Financial Contributions	32,816	191,518	$21,012,069	$966,947	$1,151,625	$20,827,391	$19,860,444

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
F	Community Building Activities	253,490	453,394	$18,162,064	$10,847,792	$4,270,317	$24,739,540	$13,891,747
G	Community Benefit Operations	113,808	2,531	$8,701,057	$4,845,763	$129,223	$13,417,597	$8,571,834
H	Charity Care	0	0	$320,932,030	$0	$0	$320,932,030	$320,932,030
J	Foundation Funded Community Benefit	77,881	49,689	$3,852,843	$155,961	$2,265,871	$1,742,933	$1,586,973
T99	Medicaid Assessments	0	0	$389,825,000		$333,349,117	$56,475,883	$56,475,883
K99	**Total Hospital Community Benefit**	**9,174,456**	**5,857,129**	**1,807,570,268**	**250,714,924**	**541,241,771**	**1,517,043,421**	**1,266,328,498**
	Total Operating Expenses	**$16,329,405,721**						
	% Operating Expenses w/ Indirect Costs	**9.3%**						
	% Operating Expenses w/ o Indirect Costs	**7.8%**						

Peninsula Regional Medical Center

Salisbury, MD

has been Accredited by



The Joint Commission

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

Hospital Accreditation Program

June 11, 2016

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #6299
Print/Reprint Date: 08/31/2016

Mark R. Chassin, MD, FACP, MPP, MPH
President

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

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Van T. Mitchell, Secretary

September 19, 2016

Peggy Naippa, President and CEO
Peninsula Regional Medical Center
100 East Carroll Avenue
Salisbury, MD 21801

Dear Ms. Naippa:

This is to acknowledge receipt of a license fee of $3,000.00 and a completed application for a license to operate Peninsula Regional Medical Center. We have also received the survey findings of The Joint Commission which reports that your hospital has been granted accreditation effective for three years beginning June 11, 2016. This license is therefore issued to reflect the accreditation date.

In accordance with Health-General Article 19-323, this license will remain in effect for the term of accreditation by The Joint Commission. The Department of Health and Mental Hygiene retains the authorities as specified in Health-General Article 19-308, 308.2, 309, 310, and may revoke this license for failure to comply with its provisions. It is the hospital's authority to operate an Acute General Hospital.

This license should be displayed in a conspicuous place, at or near the entrance to the hospital, plainly visible and easily read by the public.

Sincerely,

Patricia Tomsko Nay, MD

Patricia Tomsko Nay, M.D., Executive Director
Office of Health Care Quality

cc: Christine Parent, Maryland Health Care Commission
Dianne Feeney, Maryland Health Care Commission
Amanda Vaughn, Maryland Health Services Cost Review Commission
Miryam Baharloo, Office of Health Services
Avi Glenner, Acting Chief, Division of Cost and Reimbursements
Lillian Taylor, Deputy Chief, Division of Cost and Reimbursements
Wicomico Health Department
Ann Elliott, CareFirst BlueCross BlueShield of Maryland
License File

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

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

License No. 22-003

Issued to:

Peninsula Regional Medical Center
100 East Carroll Avenue
Salisbury, MD 21801

Type of Facility: Acute General Hospital

Date Issued: June 11, 2016

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

Expiration Date: September 11, 2019

Patricia Tomasko May MD

Director

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

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REPORT RUN 03/06/2018		
COPD-Chronic Obstructive Pulmonary Disease		
Metric	**State Mean 8.2**	**Performance Improvement Action Plan**
Dying within 30 days after getting care in the hospital for chronic obstructive pulmonary disease (COPD)	**PRMC 7.8**	Average
Metric	**State Mean 19.6**	**Performance Improvement Action Plan**
Returning to the hospital after getting care for chronic obstructive pulmonary disease (COPD)	**PRMC 17.4**	Average
Childbirth		
Metric	**State Mean 31.8406**	**Performance Improvement Action Plan**
Percentage of births (deliveries) that are C-sections	**PRMC 33.2902**	Average
Metric	**State Mean 12.1917**	**Performance Improvement Action Plan**
How often babies in the hospital are delivered vaginally when the mother previously delivered by cesarean section (no complications)	**PRMC 5.6667**	**Below….**
Metric	**State Mean 20.0534**	**Performance Improvement Action Plan**
How often babies in the hospital are delivered using cesarean section when this is the mother's first birth	**PRMC 18.5691**	Average
Metric	**State Mean 11.9950**	**Performance Improvement Action Plan**
How often babies are born vaginally when the mother has had a C-section in the past (includes complications)	**PRMC 5.8824**	**Below….**
Metric	**State Mean 1.0**	**Performance Improvement Action Plan**
Newborn deliveries scheduled 1-3 weeks earlier than medically necessary	**PRMC 0%**	**Better than average**
Combined Quality and Safety Ratings		
Metric	**State Mean .9467**	**Performance Improvement Action Plan**
Patients who died in the hospital after having one of six common conditions	**PRMC .9911**	Average
Metric	**State Mean 0.7686**	**Performance Improvement Action Plan**
How well this hospital keeps patients safe based on eleven patient safety problems	**PRMC 0.5253**	**Better than average**
CONSUMER RATINGS		
Metric	**State Mean 76%**	**Performance Improvement Action Plan**
How often did nurses always communicate well with patients?	**PRMC 77%**	**Better than average**

Metric	State Mean 78%	Performance Improvement Action Plan
How often did doctors always communicate well with patients?	PRMC 76%	Below….
Metric	**State Mean 60%**	**Performance Improvement Action Plan**
How often did staff always explain about medicines before giving them to patients?	PRMC 62%	Better than average
Metric	**State Mean 87%**	**Performance Improvement Action Plan**
Were patients always given information about what to do during their recovery at home?	PRMC 90%	Better than average
Metric	**State Mean 47%**	**Performance Improvement Action Plan**
How well do patients understand their care when they leave the hospital?	PRMC 50%	Better than average
Metric	**State Mean 67%**	**Performance Improvement Action Plan**
How often were the patients' rooms and bathrooms always kept clean	PRMC 76%	Better than average
Metric	**State Mean 59%**	**Performance Improvement Action Plan**
How often did patients always receive help quickly from hospital staff?	PRMC 61%	Better than average
Metric	**State Mean 67%**	**Performance Improvement Action Plan**
How often was patients' pain always well-controlled?	PRMC 67%	Average
Metric	**State Mean 58%**	**Performance Improvement Action Plan**
How often was the area around patients' rooms always kept quiet at night?	PRMC 50%	Below…
Metric	**State Mean 66%**	**Performance Improvement Action Plan**
How do patients rate the hospital overall?	PRMC 69%	Better than average
Metric	**State Mean 66%**	**Performance Improvement Action Plan**
Would patients recommend the hospital to friends and family?	PRMC 71%	Better than average
Emergency Department (ED)		
Metric	**State Mean 398.2**	**Performance Improvement Action Plan**
How long patients spent in the emergency department before leaving for their hospital room	PRMC 335	Better than average

Metric	State Mean 165.0	Performance Improvement Action Plan
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	PRMC 161	Better than average
Metric	**State Mean 191.5**	**Performance Improvement Action Plan**
How long patients spent in the emergency department before being sent home	PRMC 142	Better than average
Metric	**State Mean 42.2**	**Performance Improvement Action Plan**
How long patients spent in the emergency department before they were seen by a healthcare professional	PRMC 35	Better than average
Metric	**State Mean 62.2**	**Performance Improvement Action Plan**
How long patients who came to the emergency department with broken bones had to wait before receiving pain medication	PRMC 68	Below…
Metric	**State Mean 2.9**	**Performance Improvement Action Plan**
Patients who left the emergency department without being seen	PRMC 2%	Better than average
Flu Prevention		
Metric	**State Mean 95.0**	**Performance Improvement Action Plan**
Patients in the hospital who got the flu vaccine if they were likely to get the flu	PRMC 72%	Below….
Heart Attack and Chest Pain		
Metric	**State Mean 63.7**	**Performance Improvement Action Plan**
How long patients with chest pain or possible heart attack waited to be transferred to another hospital for a procedure	PRMC	Not enough data to report
Metric	**State Mean 95.9**	**Performance Improvement Action Plan**
Patients with a heart attack who received aspirin on arrival to the hospital	PRMC	Not enough data to report
Metric	**State Mean 11.6**	**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	PRMC	Not enough data to report
Metric	**State Mean 6.8024**	**Performance Improvement Action Plan**
How often patients die in the hospital after heart attack	PRMC 8.5287	Average

Metric	State Mean 13.3	Performance Improvement Action Plan
Dying within 30-days after getting care in the hospital for a heart attack	PRMC 12.7	Average
Metric	**State Mean 16.3**	**Performance Improvement Action Plan**
Returning to the hospital after getting care for a heart attack	PRMC 14.5	Average
Heart Failure		
Metric	**State Mean 2.8002**	**Performance Improvement Action Plan**
How often patients die in the hospital after heart failure	PRMC 4.1564	Average
Metric	**State Mean 11.1**	**Performance Improvement Action Plan**
Dying within 30-days after getting care in the hospital for heart failure	PRMC 11.3	Average
Metric	**State Mean 21.7**	**Performance Improvement Action Plan**
Returning to the hospital after getting care for heart failure	PRMC 19.6	▲ Better than average
Heart Surgeries and Procedures		
Metric	**State Mean 2.3586**	**Performance Improvement Action Plan**
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	PRMC 0.4918	▲ Better than average
Metric	**State Mean 2.8**	**Performance Improvement Action Plan**
Death rate for CABG	PRMC 2.9	Average
Metric	**State Mean 14.9**	**Performance Improvement Action Plan**
Rate of unplanned readmission for CABG	PRMC 11.6	Average
Hip or Knee Replacement Surgery		
Metric	**State Mean 4.5**	**Performance Improvement Action Plan**
Returning to the hospital after getting hip or knee replacement surgery	PRMC 3.9	Average
Metric	**State Mean 2.8**	**Performance Improvement Action Plan**
Complications after hip or knee replacement surgery	PRMC 2.0	Average
Imaging		
Metric	**State Mean 38.5%**	**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 faci9lity is doing too many unnecessary MRIs for low back pain.	PRMC 31.4%	▲ Better than average

Metric	State Mean 3.5%	Performance Improvement Action Plan
Contrast material (dye) used during abdominal CT scan	PRMC 2.3%	Average
Metric	**State Mean .9%**	**Performance Improvement Action Plan**
Contrast material (dye) used during thorax CT scan	PRMC 0%	▲ Better than average
Metric	**State Mean 5.3%**	**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	PRMC 3.9%	Average
Metric	**State Mean 2.8%**	**Performance Improvement Action Plan**
Patients who came to the hospital for a scan of their brain and also got a scan of their sinuses	PRMC 1.3%	▲ Better than average
Patient Safety		
Metric	**State Mean 0.2647**	**Performance Improvement Action Plan**
How often the hospital accidentally makes a hole in a patient's lung	PRMC 0.4702	Average
Metric	**State Mean 1.1769**	**Performance Improvement Action Plan**
How often patients accidently get cut or have a hole poked in an organ that was not part of the surgery or procedure	PRMC 0.9833	Average
Metric	**State Mean None**	**Performance Improvement Action Plan**
Number of patients who get a blood transfusion and have a problem or reaction to the blood they get		Not enough data to report
Metric	**State Mean 15.3**	**Performance Improvement Action Plan**
Returning to the hospital for any unplanned reason within 30 days after being discharged	PRMC 14.2	▲ *Better than average*
Metric	**State Mean 1.2**	***Performance Improvement Action Plan***
Patients who developed a blood clot while in the hospital and did not get treatment that could have prevented it	PRMC 0%	▲ *Better than average*
Metric	**State Mean None**	**Performance**
Number of times a medical tool was accidentally left in a patient's body during surgery or procedure	PRMC 3	Not enough data to report
Metric	**State Mean 2.0995**	**Performance Improvement Action Plan**
How often patients die in the hospital after bleeding from stomach or intestines	PRMC 1.2168	Average

Metric	State Mean 4.0985	Performance Improvement Action Plan
How often patients die in the hospital after fractured hip	PRMC 3.7417	Average
Metric	**State Mean 0.2326**	**Performance Improvement Action Plan**
How often patients die in the hospital while getting care for a condition that rarely results in death	PRMC 0.0000	Average
Pneumonia		
Metric	**State Mean 3.1166**	**Performance Improvement Action Plan**
How often patients die in the hospital while getting care for pneumonia	PRMC 2.6032	Average
Metric	**State Mean 16.2**	**Performance Improvement Action Plan**
Dying within 30-days after getting care in the hospital for pneumonia	PRMC 15.6	Average
Metric	**State Mean 17.4**	**Performance Improvement Action Plan**
Returning to the hospital after getting care for pneumonia	PRMC 16.2	Average
Stroke		
Metric	**State Mean 7.5579**	**Performance Improvement Action Plan**
How often patients who came in after having stroke subsequently died in the hospital	PRMC 8.1747	Average
Metric	**State Mean 14.2**	**Performance Improvement Action Plan**
Death rate for stroke patients	PRMC 10.9	▲ *Better than average*
Metric	**State Mean 12.5**	**Performance Improvement Action Plan**
Rate of unplanned readmission for stroke patients	PRMC 12.6	Average
Surgeries for Specific Health Conditions		
Metric	**State Mean None**	**Performance Improvement Action**
Number of surgeries to remove part of the esophagus		Not enough data to report
Metric	**State Mean None**	**Performance Improvement Action**
Number of surgeries to remove part of the pancreas	PRMC 11	Not enough data to report
Metric	**State Mean None**	**Performance Improvement Action**
Number of surgeries to fix the artery that carries blood to the lower body when it gets too large	PRMC 26	Not enough data to report
Metric	**State Mean 3.1111**	**Performance Improvement Action**
How often patients die in the hospital during or after surgery on the esophagus	PRMC None	Not enough data to report

Metric	State Mean 3.9774	Performance Improvement Action Plan
How often patients die in the hospital during or after pancreas surgery	PRMC 23.9775	Below….
Metric	**State Mean 29.9056**	**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	PRMC 38.4426	Average
Surgical Patient Safety		
Metric	**State Mean 115.1260**	**Performance Improvement Action Plan**
How often surgical patients die in the hospital because a serious condition was not identified and treated	PRMC 142.5455	Average
Metric	**State Mean 4.8103**	**Performance Improvement Action Plan**
How often patients in the hospital had to use a breathing machine after surgery because they could not breathe on their own	PRMC 2.1323	Average
Metric	**State Mean 5.0932**	**Performance Improvement Action Plan**
How often patients in the hospital get a blood clot in the lung or leg vein after surgery	PRMC 1.4370	Better than average
Metric	**State Mean 1.1769**	**Performance Improvement Action Plan**
How often patients accidently get cut or have a hole poked in an organ that was not part of the surgery or procedure	PRMC 0.9833	Average
Metric	**State Mean None**	**Performance Improvement Action Plan**
Number of times a medical tool was accidentally left in a patient's body during surgery or procedure	PRMC 3	Not enough data to report
Health Care Associated Infections		
Metric	**State Mean**	**Performance Improvement Action Plan**
Surgical Site Infection	PRMC	Average
Metric	**State Mean**	**Performance Improvement Action Plan**
Central Line-Associated Blood Stream Infections (CLABSI)	PRMC	Average
Metric	**State Mean**	**Performance Improvement Action Plan**
Health Care Worker Vaccinations (HCW)	PRMC	99% Compliance

Metric	State Mean	Performance Improvement Action Plan
Clostridium Difficile Infections	**PRMC**	▲ **Better than average**
Metric	**State Mean**	**Performance Improvement Action Plan**
Methicillin-Resistant Staphylococcus Aureus Infections (MRSA)	**PRMC**	Average
Metric	**State Mean**	**Performance Improvement Action Plan**
Catheter-Associated Urinary Tract Infections (CAUTI)	**PRMC**	Average

Peninsula Regional Medical Center
Emergency Room Transfer Data

DHG Duplicate	No

Count of DHG Accounts	Column Labels					
Row Labels	**2014**	**2015**	**2016**	**2017**	**Grand Total**	
APRIA HEALTHCARE	1				1	0.25
BROOKLANE HEALTH SVS			1		1	0.25
CHILDRENS NAT'L MED	1	2	2		5	1.25
DOVER BEHAVIORAL HEALTH	17	24	24	40	105	26.25
Dover Mental Health				1	1	0.25
MEADOW WOOD BEHAVIORAL HEALTH	1	9	2	4	16	0.25
PSYCHIATRIC INSTITUTE OF WASHINGTON		3	1	5	9	0.25
ROCKFORD MED CTR	4	5	1	3	13	0.25
WASHINGTON HOSP CTR		2			2	0.25
Grand Total	**24**	**45**	**31**	**53**	**153**	38.25

Peninsula Regional Medical Center
Emergency Room Transfer Data

Count of DHG Accounts	Column Labels												
	2014				2015		2016			2017			Grand Total
Row Labels	Q3-2014	Q4-2(	Q1-2(	Q2-2(	Q3-2015	Q4-2015	Q1-2016	Q2-2016	Q3-2016	Q1-2017	Q2-2017	Q3-2017	
APRIA HEALTHCARE		1											1
Adolescents (Between 13 and 17)		1											1
BROOKLANE HEALTH SVS								1					1
Adolescents (Between 13 and 17)								1					1
CHILDRENS NAT'L MED	1		1		1		1		1				5
Adolescents (Between 13 and 17)	1		1				1		1				4
Children (Less than 13)					1								1
DOVER BEHAVIORAL HEALTH	10	7	11	4	4	5	11	8	5	16	13	11	105
Adolescents (Between 13 and 17)	9	5	9	4	3	5	8	8	4	14	13	10	92
Children (Less than 13)	1	2	2		1		3		1	2		1	13
Dover Mental Health											1		1
Adolescents (Between 13 and 17)											1		1
MEADOW WOOD BEHAVIORAL HEALTH		1	4	2		3	1	1		2	1	1	16
Adolescents (Between 13 and 17)		1	4	1		2	1	1		2	1	1	14
Children (Less than 13)				1		1							2
PSYCHIATRIC INSTITUTE OF WASHINGTON				1	1	1	1			1	3	1	9
Adolescents (Between 13 and 17)					1	1					3	1	6
Children (Less than 13)				1			1			1			3
ROCKFORD MED CTR	2	2	1		3	1			1		3		13
Adolescents (Between 13 and 17)	1	2	1								2		6
Children (Less than 13)	1				3	1			1		1		7
WASHINGTON HOSP CTR					2								2
Children (Less than 13)					2								2
Grand Total	13	11	17	7	11	10	15	9	7	19	21	13	153

Behavioral Health

MD - Psychiatric Hospitals
Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: 12 Month Ending (Alpha or Numeric Group, 0) and Provider (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Somerset County, *SMA - Worcester County, *SMA - Wicomico County, *SMA - Sussex DE, *SMA - Dorchester County, *SMA - Accomack, VA
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	%Grp Cases	% of Cases	CumIt %Cases	% of Days	CumIt. % Days	% of Charge	CumIt %Charge
1) 12 Month Ending 2q 2010												
Potomac Ridge - East.Shore	229	2,603	11.37	1,891,050	8,258	86.74%	13.05%	13.05%	15.85%	15.85%	12.10%	12.10%
Sheppard Pratt - Towson	28	271	9.68	377,462	13,481	10.61%	1.60%	14.64%	1.65%	17.50%	2.42%	14.51%
Sheppard Pratt - Ellicott City	4	20	5.00	24,928	6,232	1.52%	0.23%	14.87%	0.12%	17.62%	0.16%	14.67%
Potomac Ridge - Montgome	3	40	13.33	41,708	13,903	1.14%	0.17%	15.04%	0.24%	17.87%	0.27%	14.94%
Total for: 12 Month Ending 2q 2010	**264**	**2,934**	**11.11**	**2,335,148**	**8,845**	**100.00%**	**15.04%**		**17.87%**		**14.94%**	
2) 12 Month Ending 2q 2011												
Potomac Ridge - East.Shore	246	1,759	7.15	1,501,000	6,102	89.13%	14.02%	29.06%	10.71%	28.58%	9.60%	24.55%
Sheppard Pratt - Towson	28	350	12.50	467,569	16,699	10.14%	1.60%	30.66%	2.13%	30.71%	2.99%	27.54%
Sheppard Pratt - Ellicott City	2	13	6.50	15,281	7,641	0.72%	0.11%	30.77%	0.08%	30.79%	0.10%	27.63%
Total for: 12 Month Ending 2q 2011	**276**	**2,122**	**7.69**	**1,983,850**	**7,188**	**100.00%**	**15.73%**		**12.92%**		**12.69%**	
3) 12 Month Ending 2q 2012												
Potomac Ridge - East.Shore	265	2,036	7.68	1,698,600	6,410	87.75%	15.10%	45.87%	12.40%	43.19%	10.87%	38.50%
Sheppard Pratt - Towson	35	502	14.34	676,397	19,326	11.59%	1.99%	47.86%	3.06%	46.25%	4.33%	42.83%
Brook Lane	1	7	7.00	8,748	8,748	0.33%	0.06%	47.92%	0.04%	46.29%	0.06%	42.89%
Sheppard Pratt - Ellicott City	1	6	6.00	7,025	7,025	0.33%	0.06%	47.98%	0.04%	46.32%	0.04%	42.93%
Total for: 12 Month Ending 2q 2012	**302**	**2,551**	**8.45**	**2,390,771**	**7,916**	**100.00%**	**17.21%**		**15.53%**		**15.30%**	
4) 12 Month Ending 2q 2013												
Potomac Ridge - East.Shore	197	1,721	8.74	1,392,700	7,070	85.65%	11.23%	59.20%	10.48%	56.81%	8.91%	51.84%
Sheppard Pratt - Towson	31	363	11.71	499,630	16,117	13.48%	1.77%	60.97%	2.21%	59.02%	3.20%	55.04%
Brook Lane	1	5	5.00	5,534	5,534	0.43%	0.06%	61.03%	0.03%	59.05%	0.04%	55.08%
Sheppard Pratt - Ellicott City	1	3	3.00	4,362	4,362	0.43%	0.06%	61.08%	0.02%	59.06%	0.03%	55.10%
Total for: 12 Month Ending 2q 2013	**230**	**2,092**	**9.10**	**1,902,226**	**8,271**	**100.00%**	**13.11%**		**12.74%**		**12.17%**	
5) 12 Month Ending 2q 2014												
Potomac Ridge - East.Shore	212	1,827	8.62	1,433,550	6,762	84.13%	12.08%	73.16%	11.13%	70.19%	9.17%	64.28%
Sheppard Pratt - Towson	32	452	14.13	644,796	20,150	12.70%	1.82%	74.99%	2.75%	72.94%	4.13%	68.40%
Sheppard Pratt - Ellicott City	4	35	8.75	42,018	10,504	1.59%	0.23%	75.21%	0.21%	73.16%	0.27%	68.67%
Potomac Ridge - Montgome	3	26	8.67	32,915	10,972	1.19%	0.17%	75.38%	0.16%	73.31%	0.21%	68.88%
Brook Lane	1	7	7.00	8,703	8,703	0.40%	0.06%	75.44%	0.04%	73.36%	0.06%	68.94%
Total for: 12 Month Ending 2q 2014	**252**	**2,347**	**9.31**	**2,161,981**	**8,579**	**100.00%**	**14.36%**		**14.29%**		**13.83%**	
6) 12 Month Ending 2q 2015												
Potomac Ridge - East.Shore	178	1,535	8.62	1,418,600	7,970	83.96%	10.14%	85.58%	9.35%	82.71%	9.08%	78.01%
Sheppard Pratt - Towson	31	459	14.81	648,187	20,909	14.62%	1.77%	87.35%	2.80%	85.50%	4.15%	82.16%
Sheppard Pratt - Ellicott City	2	12	6.00	14,387	7,193	0.94%	0.11%	87.46%	0.07%	85.57%	0.09%	82.25%

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Behavioral Health

MD - Psychiatric Hospitals
Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: 12 Month Ending (Alpha or Numeric Group, 0) and Provider (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Somerset County, *SMA - Worcester County, *SMA - Wicomico County, *SMA - Sussex DE, *SMA - Dorchester County, *SMA - Accomack, VA
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	%Grp Cases	% of Cases	CumIt %Cases	% of Days	CumIt. % Days	% of Charge	CumIt %Charge
6) 12 Month Ending 2q 2015												
Potomac Ridge - Montgome	1	19	19.00	28,912	28,912	0.47%	0.06%	87.52%	0.12%	85.69%	0.18%	82.44%
Total for: 12 Month Ending 2q 2015	**212**	**2,025**	**9.55**	**2,110,086**	**9,953**	**100.00%**	**12.08%**		**12.33%**		**13.50%**	
7) 12 Month Ending 2q 2016												
Potomac Ridge - East.Shore	188	1,870	9.95	2,090,694	11,121	85.84%	10.71%	98.23%	11.39%	97.08%	13.38%	95.81%
Sheppard Pratt - Towson	24	404	16.83	560,078	23,337	10.96%	1.37%	99.60%	2.46%	99.54%	3.58%	99.40%
Sheppard Pratt - Ellicott City	6	65	10.83	77,805	12,967	2.74%	0.34%	99.94%	0.40%	99.93%	0.50%	99.90%
Potomac Ridge - Montgome	1	11	11.00	16,192	16,192	0.46%	0.06%	100.00%	0.07%	100.00%	0.10%	100.00%
Total for: 12 Month Ending 2q 2016	**219**	**2,350**	**10.73**	**2,744,769**	**12,533**	**100.00%**	**12.48%**		**14.31%**		**17.56%**	
Totals:	**1,755**	**16,421**	**9.36**	**15,628,831**	**8,905**		**100.00%**		**100.00%**		**100.00%**	

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Behavioral Health Adolescents

MD - Inpatient (APR DRG)
Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: 12 Month Ending (Alpha or Numeric Group, 0) and Provider (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: Acute Hospitals
DRG: All
ZIP: Group: *SMA - Dorchester County, *SMA - Somerset County, *SMA - Sussex DE, *SMA - Wicomico County, *SMA - Worcester County, *SMA - Accomack, VA
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	%Grp Cases	% of Cases	CumIt %Cases	% of Days	CumIt. % Days	% of Charge	CumIt %Charge
1) 12 Month Ending 2q 2010												
Johns Hopkins	4	100	25.00	187,121	46,780	44.44%	5.88%	5.88%	18.25%	18.25%	17.84%	17.84%
University of Maryland	2	29	14.50	98,182	49,091	22.22%	2.94%	8.82%	5.29%	23.54%	9.36%	27.20%
Shore Medical Center at Easton	2	4	2.00	12,213	6,107	22.22%	2.94%	11.76%	0.73%	24.27%	1.16%	28.36%
Shore Medical Center at Dorchester	1	1	1.00	2,712	2,712	11.11%	1.47%	13.24%	0.18%	24.45%	0.26%	28.62%
Total for: 12 Month Ending 2q 2010	**9**	**134**	**14.89**	**300,228**	**33,359**	**100.00%**	**13.24%**		**24.45%**		**28.62%**	
2) 12 Month Ending 2q 2011												
Peninsula Regional	3	4	1.33	9,700	3,233	50.00%	4.41%	17.65%	0.73%	25.18%	0.92%	29.54%
University of Maryland	2	9	4.50	27,627	13,814	33.33%	2.94%	20.59%	1.64%	26.82%	2.63%	32.18%
Johns Hopkins	1	1	1.00	3,966	3,966	16.67%	1.47%	22.06%	0.18%	27.01%	0.38%	32.56%
Total for: 12 Month Ending 2q 2011	**6**	**14**	**2.33**	**41,293**	**6,882**	**100.00%**	**8.82%**		**2.55%**		**3.94%**	
3) 12 Month Ending 2q 2012												
Johns Hopkins	5	34	6.80	61,053	12,211	45.45%	7.35%	29.41%	6.20%	33.21%	5.82%	38.38%
Peninsula Regional	3	27	9.00	50,520	16,840	27.27%	4.41%	33.82%	4.93%	38.14%	4.82%	43.19%
University of Maryland	2	4	2.00	13,119	6,560	18.18%	2.94%	36.76%	0.73%	38.87%	1.25%	44.44%
Braddock(Sacred Heart)	1	3	3.00	3,300	3,300	9.09%	1.47%	38.24%	0.55%	39.42%	0.31%	44.76%
Total for: 12 Month Ending 2q 2012	**11**	**68**	**6.18**	**127,992**	**11,636**	**100.00%**	**16.18%**		**12.41%**		**12.20%**	
4) 12 Month Ending 2q 2013												
Johns Hopkins	10	87	8.70	157,908	15,791	71.43%	14.71%	52.94%	15.88%	55.29%	15.05%	59.81%
Mount Washington Pediatric	2	20	10.00	19,957	9,979	14.29%	2.94%	55.88%	3.65%	58.94%	1.90%	61.71%
University of Maryland	1	2	2.00	4,417	4,417	7.14%	1.47%	57.35%	0.36%	59.31%	0.42%	62.13%
Peninsula Regional	1	3	3.00	8,015	8,015	7.14%	1.47%	58.82%	0.55%	59.85%	0.76%	62.90%
Total for: 12 Month Ending 2q 2013	**14**	**112**	**8.00**	**190,297**	**13,593**	**100.00%**	**20.59%**		**20.44%**		**18.14%**	
5) 12 Month Ending 2q 2014												
Johns Hopkins	6	71	11.83	102,795	17,133	60.00%	8.82%	67.65%	12.96%	72.81%	9.80%	72.70%
University of Maryland	4	15	3.75	37,370	9,343	40.00%	5.88%	73.53%	2.74%	75.55%	3.56%	76.26%
Total for: 12 Month Ending 2q 2014	**10**	**86**	**8.60**	**140,165**	**14,017**	**100.00%**	**14.71%**		**15.69%**		**13.36%**	
6) 12 Month Ending 2q 2015												
Johns Hopkins	6	41	6.83	87,665	14,611	46.15%	8.82%	82.35%	7.48%	83.03%	8.36%	84.62%
Franklin Square	3	62	20.67	85,159	28,386	23.08%	4.41%	86.76%	11.31%	94.34%	8.12%	92.73%
University of Maryland	3	8	2.67	21,127	7,042	23.08%	4.41%	91.18%	1.46%	95.80%	2.01%	94.75%
Peninsula Regional	1	1	1.00	2,240	2,240	7.69%	1.47%	92.65%	0.18%	95.99%	0.21%	94.96%
Total for: 12 Month Ending 2q 2015	**13**	**112**	**8.62**	**196,191**	**15,092**	**100.00%**	**19.12%**		**20.44%**		**18.70%**	
7) 12 Month Ending 2q 2016												
University of Maryland	3	14	4.67	39,723	13,241	60.00%	4.41%	97.06%	2.55%	98.54%	3.79%	98.75%
Montgomery General	1	2	2.00	2,969	2,969	20.00%	1.47%	98.53%	0.36%	98.91%	0.28%	99.03%

10/5/2017

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Behavioral Health Adolescents

MD - Inpatient (APR DRG)
Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: 12 Month Ending (Alpha or Numeric Group, 0) and Provider (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: Acute Hospitals
DRG: All
ZIP: Group: *SMA - Dorchester County, *SMA - Somerset County, *SMA - Sussex DE, *SMA - Wicomico County, *SMA - Worcester County, *SMA - Accomack, VA
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	%Grp Cases	% of Cases	Cumlt %Cases	% of Days	Cumlt. % Days	% of Charge	Cumlt %Charge
7) 12 Month Ending 2q 2016												
Johns Hopkins	1	6	6.00	10,163	10,163	20.00%	1.47%	100.00%	1.09%	100.00%	0.97%	100.00%
Total for: 12 Month Ending 2q 2016	**5**	**22**	**4.40**	**52,855**	**10,571**	**100.00%**	**7.35%**		**4.01%**		**5.04%**	
Totals:	**68**	**548**	**8.06**	**1,049,021**	**15,427**		**100.00%**		**100.00%**		**100.00%**	

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Behavioral Health Adolescents MD Psychiatric Hospitals

MD - Psychiatric Hospitals

Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: 12 Month Ending (Alpha or Numeric Group, 0) and Patient County (Cases, 0) and Provider (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Somerset County, *SMA - Worcester County, *SMA - Wicomico County, *SMA - Sussex DE, *SMA - Dorchester County, *SMA - Accomack, VA
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	%Grp Cases	% of Cases	CumIt %Cases	% of Days	CumIt. % Days	% of Charge	CumIt %Charge
1) 12 Month Ending 2q 2010												
Wicomico, MD (86708)												
Potomac Ridge - East.Shore	94	1,196	12.72	858,800	9,136	35.61%	5.44%	5.44%	7.43%	7.43%	5.64%	5.64%
Sheppard Pratt - Towson	9	77	8.56	108,085	12,009	3.41%	0.52%	5.96%	0.48%	7.91%	0.71%	6.35%
Total for: Wicomico, MD (86708)	***103***	***1,273***	***12.36***	***966,885***	***9,387***	***39.02%***	***5.96%***		***7.91%***		***6.35%***	
Dorchester, MD (29671)												
Potomac Ridge - East.Shore	61	559	9.16	471,750	7,734	23.11%	3.53%	9.50%	3.47%	11.39%	3.10%	9.45%
Sheppard Pratt - Towson	5	61	12.20	83,877	16,775	1.89%	0.29%	9.79%	0.38%	11.77%	0.55%	10.00%
Sheppard Pratt - Ellicott City	4	20	5.00	24,928	6,232	1.52%	0.23%	10.02%	0.12%	11.89%	0.16%	10.16%
Total for: Dorchester, MD (29671)	***70***	***640***	***9.14***	***580,555***	***8,294***	***26.52%***	***4.05%***		***3.98%***		***3.81%***	
Worcester, MD (49796)												
Potomac Ridge - East.Shore	39	515	13.21	320,150	8,209	14.77%	2.26%	12.28%	3.20%	15.09%	2.10%	12.27%
Sheppard Pratt - Towson	10	75	7.50	108,098	10,810	3.79%	0.58%	12.85%	0.47%	15.56%	0.71%	12.98%
Potomac Ridge - Montgome	2	20	10.00	20,416	10,208	0.76%	0.12%	12.97%	0.12%	15.68%	0.13%	13.11%
Total for: Worcester, MD (49796)	***51***	***610***	***11.96***	***448,664***	***8,797***	***19.32%***	***2.95%***		***3.79%***		***2.95%***	
Somerset, MD (26315)												
Potomac Ridge - East.Shore	27	293	10.85	202,350	7,494	10.23%	1.56%	14.53%	1.82%	17.50%	1.33%	14.44%
Sheppard Pratt - Towson	2	47	23.50	65,183	32,592	0.76%	0.12%	14.65%	0.29%	17.80%	0.43%	14.87%
Total for: Somerset, MD (26315)	***29***	***340***	***11.72***	***267,533***	***9,225***	***10.98%***	***1.68%***		***2.11%***		***1.76%***	
Delaware												
Potomac Ridge - East.Shore	8	40	5.00	38,000	4,750	3.03%	0.46%	15.11%	0.25%	18.04%	0.25%	15.12%
Sheppard Pratt - Towson	1	5	5.00	5,597	5,597	0.38%	0.06%	15.17%	0.03%	18.08%	0.04%	15.15%
Total for: Delaware	***9***	***45***	***5.00***	***43,597***	***4,844***	***3.41%***	***0.52%***		***0.28%***		***0.29%***	
Montgomery, MD (937507)												
Potomac Ridge - Montgome	1	20	20.00	21,292	21,292	0.38%	0.06%	15.23%	0.12%	18.20%	0.14%	15.29%
Total for: Montgomery, MD (937507)	***1***	***20***	***20.00***	***21,292***	***21,292***	***0.38%***	***0.06%***		***0.12%***		***0.14%***	

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Behavioral Health Adolescents MD Psychiatric Hospitals

MD - Psychiatric Hospitals

Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: 12 Month Ending (Alpha or Numeric Group, 0) and Patient County (Cases, 0) and Provider (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Somerset County, *SMA - Worcester County, *SMA - Wicomico County, *SMA - Sussex DE, *SMA - Dorchester County, *SMA - Accomack, VA
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	%Grp Cases	% of Cases	Cumlt %Cases	% of Days	Cumlt. % Days	% of Charge	Cumlt %Charge
1) 12 Month Ending 2q 2010												
Virginia												
Sheppard Pratt - Towson	1	6	6.00	6,621	6,621	0.38%	0.06%	15.29%	0.04%	18.24%	0.04%	15.34%
Total for: Virginia	***1***	***6***	***6.00***	***6,621***	***6,621***	***0.38%***	***0.06%***		***0.04%***		***0.04%***	
Total for: 12 Month Ending 2q 2010	264	2,934	11.11	2,335,148	8,845	100.00%	15.29%		18.24%		15.34%	
2) 12 Month Ending 2q 2011												
Wicomico, MD (86708)												
Potomac Ridge - East.Shore	118	912	7.73	741,950	6,288	42.75%	6.83%	22.12%	5.67%	23.91%	4.87%	20.21%
Sheppard Pratt - Towson	12	160	13.33	209,057	17,421	4.35%	0.69%	22.81%	0.99%	24.90%	1.37%	21.58%
Sheppard Pratt - Ellicott City	1	7	7.00	7,950	7,950	0.36%	0.06%	22.87%	0.04%	24.94%	0.05%	21.63%
Total for: Wicomico, MD (86708)	***131***	***1,079***	***8.24***	***958,957***	***7,320***	***47.46%***	***7.59%***		***6.71%***		***6.30%***	
Dorchester, MD (29671)												
Potomac Ridge - East.Shore	71	447	6.30	383,800	5,406	25.72%	4.11%	26.98%	2.78%	27.72%	2.52%	24.16%
Sheppard Pratt - Towson	5	64	12.80	89,710	17,942	1.81%	0.29%	27.27%	0.40%	28.12%	0.59%	24.74%
Sheppard Pratt - Ellicott City	1	6	6.00	7,331	7,331	0.36%	0.06%	27.33%	0.04%	28.16%	0.05%	24.79%
Total for: Dorchester, MD (29671)	***77***	***517***	***6.71***	***480,841***	***6,245***	***27.90%***	***4.46%***		***3.21%***		***3.16%***	
Worcester, MD (49796)												
Potomac Ridge - East.Shore	30	202	6.73	188,100	6,270	10.87%	1.74%	29.07%	1.26%	29.41%	1.24%	26.03%
Sheppard Pratt - Towson	8	101	12.63	136,805	17,101	2.90%	0.46%	29.53%	0.63%	30.04%	0.90%	26.93%
Total for: Worcester, MD (49796)	***38***	***303***	***7.97***	***324,905***	***8,550***	***13.77%***	***2.20%***		***1.88%***		***2.13%***	
Somerset, MD (26315)												
Potomac Ridge - East.Shore	25	186	7.44	175,750	7,030	9.06%	1.45%	30.98%	1.16%	31.20%	1.15%	28.08%
Sheppard Pratt - Towson	1	9	9.00	12,292	12,292	0.36%	0.06%	31.04%	0.06%	31.25%	0.08%	28.16%
Total for: Somerset, MD (26315)	***26***	***195***	***7.50***	***188,042***	***7,232***	***9.42%***	***1.51%***		***1.21%***		***1.24%***	
Delaware												
Sheppard Pratt - Towson	2	16	8.00	19,704	9,852	0.72%	0.12%	31.15%	0.10%	31.35%	0.13%	28.29%
Potomac Ridge - East.Shore	2	12	6.00	11,400	5,700	0.72%	0.12%	31.27%	0.07%	31.43%	0.07%	28.37%
Total for: Delaware	***4***	***28***	***7.00***	***31,104***	***7,776***	***1.45%***	***0.23%***		***0.17%***		***0.20%***	
Total for: 12 Month Ending 2q 2011	276	2,122	7.69	1,983,850	7,188	100.00%	15.98%		13.19%		13.03%	

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Behavioral Health Adolescents MD Psychiatric Hospitals

MD - Psychiatric Hospitals

Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: 12 Month Ending (Alpha or Numeric Group, 0) and Patient County (Cases, 0) and Provider (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Somerset County, *SMA - Worcester County, *SMA - Wicomico County, *SMA - Sussex DE, *SMA - Dorchester County, *SMA - Accomack, VA
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	%Grp Cases	% of Cases	CumIt %Cases	% of Days	CumIt. % Days	% of Charge	CumIt %Charge
3) 12 Month Ending 2q 2012												
Wicomico, MD (86708)												
Potomac Ridge - East.Shore	133	1,106	8.32	902,500	6,786	44.04%	7.70%	38.97%	6.87%	38.30%	5.93%	34.29%
Sheppard Pratt - Towson	18	241	13.39	326,004	18,111	5.96%	1.04%	40.01%	1.50%	39.80%	2.14%	36.43%
Total for: Wicomico, MD (86708)	***151***	***1,347***	***8.92***	***1,228,504***	***8,136***	***50.00%***	***8.74%***		***8.37%***		***8.07%***	
Dorchester, MD (29671)												
Potomac Ridge - East.Shore	73	493	6.75	432,250	5,921	24.17%	4.23%	44.24%	3.06%	42.86%	2.84%	39.27%
Sheppard Pratt - Towson	5	52	10.40	62,324	12,465	1.66%	0.29%	44.53%	0.32%	43.19%	0.41%	39.68%
Total for: Dorchester, MD (29671)	***78***	***545***	***6.99***	***494,574***	***6,341***	***25.83%***	***4.52%***		***3.39%***		***3.25%***	
Somerset, MD (26315)												
Potomac Ridge - East.Shore	31	247	7.97	191,900	6,190	10.26%	1.80%	46.32%	1.54%	44.72%	1.26%	40.94%
Sheppard Pratt - Towson	1	28	28.00	32,187	32,187	0.33%	0.06%	46.38%	0.17%	44.90%	0.21%	41.15%
Brook Lane	1	7	7.00	8,748	8,748	0.33%	0.06%	46.44%	0.04%	44.94%	0.06%	41.21%
Total for: Somerset, MD (26315)	***33***	***282***	***8.55***	***232,835***	***7,056***	***10.93%***	***1.91%***		***1.75%***		***1.53%***	
Worcester, MD (49796)												
Potomac Ridge - East.Shore	21	145	6.90	129,200	6,152	6.95%	1.22%	47.65%	0.90%	45.84%	0.85%	42.06%
Sheppard Pratt - Towson	10	171	17.10	244,098	24,410	3.31%	0.58%	48.23%	1.06%	46.90%	1.60%	43.66%
Sheppard Pratt - Ellicott City	1	6	6.00	7,025	7,025	0.33%	0.06%	48.29%	0.04%	46.94%	0.05%	43.71%
Total for: Worcester, MD (49796)	***32***	***322***	***10.06***	***380,324***	***11,885***	***10.60%***	***1.85%***		***2.00%***		***2.50%***	
Delaware												
Potomac Ridge - East.Shore	5	32	6.40	30,400	6,080	1.66%	0.29%	48.58%	0.20%	47.14%	0.20%	43.91%
Sheppard Pratt - Towson	1	10	10.00	11,784	11,784	0.33%	0.06%	48.64%	0.06%	47.20%	0.08%	43.99%
Total for: Delaware	***6***	***42***	***7.00***	***42,184***	***7,031***	***1.99%***	***0.35%***		***0.26%***		***0.28%***	
Virginia												
Potomac Ridge - East.Shore	2	13	6.50	12,350	6,175	0.66%	0.12%	48.76%	0.08%	47.28%	0.08%	44.07%
Total for: Virginia	***2***	***13***	***6.50***	***12,350***	***6,175***	***0.66%***	***0.12%***		***0.08%***		***0.08%***	
Total for: 12 Month Ending 2q 2012	**302**	**2,551**	**8.45**	**2,390,771**	**7,916**	**100.00%**	**17.49%**		**15.86%**		**15.70%**	

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Behavioral Health Adolescents MD Psychiatric Hospitals

MD - Psychiatric Hospitals

Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: 12 Month Ending (Alpha or Numeric Group, 0) and Patient County (Cases, 0) and Provider (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Somerset County, *SMA - Worcester County, *SMA - Wicomico County, *SMA - Sussex DE, *SMA - Dorchester County, *SMA - Accomack, VA
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	%Grp Cases	% of Cases	CumIt %Cases	% of Days	CumIt. % Days	% of Charge	CumIt %Charge
4) 12 Month Ending 2q 2013												
Wicomico, MD (86708)												
Potomac Ridge - East.Shore	100	892	8.92	736,250	7,363	43.48%	5.79%	54.55%	5.54%	52.83%	4.84%	48.90%
Sheppard Pratt - Towson	11	129	11.73	185,659	16,878	4.78%	0.64%	55.18%	0.80%	53.63%	1.22%	50.12%
Brook Lane	1	5	5.00	5,534	5,534	0.43%	0.06%	55.24%	0.03%	53.66%	0.04%	50.16%
Total for: Wicomico, MD (86708)	***112***	***1,026***	***9.16***	***927,442***	***8,281***	***48.70%***	***6.49%***		***6.38%***		***6.09%***	
Dorchester, MD (29671)												
Potomac Ridge - East.Shore	49	429	8.76	341,050	6,960	21.30%	2.84%	58.08%	2.67%	56.33%	2.24%	52.40%
Sheppard Pratt - Towson	5	50	10.00	57,098	11,420	2.17%	0.29%	58.37%	0.31%	56.64%	0.38%	52.77%
Total for: Dorchester, MD (29671)	***54***	***479***	***8.87***	***398,148***	***7,373***	***23.48%***	***3.13%***		***2.98%***		***2.61%***	
Worcester, MD (49796)												
Potomac Ridge - East.Shore	25	196	7.84	160,550	6,422	10.87%	1.45%	59.81%	1.22%	57.86%	1.05%	53.83%
Sheppard Pratt - Towson	14	178	12.71	249,263	17,804	6.09%	0.81%	60.63%	1.11%	58.96%	1.64%	55.47%
Total for: Worcester, MD (49796)	***39***	***374***	***9.59***	***409,813***	***10,508***	***16.96%***	***2.26%***		***2.32%***		***2.69%***	
Somerset, MD (26315)												
Potomac Ridge - East.Shore	15	144	9.60	103,550	6,903	6.52%	0.87%	61.49%	0.90%	59.86%	0.68%	56.15%
Sheppard Pratt - Ellicott City	1	3	3.00	4,362	4,362	0.43%	0.06%	61.55%	0.02%	59.88%	0.03%	56.17%
Total for: Somerset, MD (26315)	***16***	***147***	***9.19***	***107,912***	***6,745***	***6.96%***	***0.93%***		***0.91%***		***0.71%***	
Delaware												
Potomac Ridge - East.Shore	7	54	7.71	45,600	6,514	3.04%	0.41%	61.96%	0.34%	60.21%	0.30%	56.47%
Sheppard Pratt - Towson	1	6	6.00	7,611	7,611	0.43%	0.06%	62.02%	0.04%	60.25%	0.05%	56.52%
Total for: Delaware	***8***	***60***	***7.50***	***53,211***	***6,651***	***3.48%***	***0.46%***		***0.37%***		***0.35%***	
Virginia												
Potomac Ridge - East.Shore	1	6	6.00	5,700	5,700	0.43%	0.06%	62.07%	0.04%	60.29%	0.04%	56.56%
Total for: Virginia	***1***	***6***	***6.00***	***5,700***	***5,700***	***0.43%***	***0.06%***		***0.04%***		***0.04%***	
Total for: 12 Month Ending 2q 2013	**230**	**2,092**	**9.10**	**1,902,226**	**8,271**	**100.00%**	**13.32%**		**13.00%**		**12.49%**	
5) 12 Month Ending 2q 2014												
Wicomico, MD (86708)												
Potomac Ridge - East.Shore	96	840	8.75	650,750	6,779	38.10%	5.56%	67.63%	5.22%	65.51%	4.27%	60.84%

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Behavioral Health Adolescents MD Psychiatric Hospitals

MD - Psychiatric Hospitals

Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: 12 Month Ending (Alpha or Numeric Group, 0) and Patient County (Cases, 0) and Provider (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Somerset County, *SMA - Worcester County, *SMA - Wicomico County, *SMA - Sussex DE, *SMA - Dorchester County, *SMA - Accomack, VA
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	%Grp Cases	% of Cases	Cumlt %Cases	% of Days	Cumlt. % Days	% of Charge	Cumlt %Charge
5) 12 Month Ending 2q 2014												
Wicomico, MD (86708)												
Sheppard Pratt - Towson	13	145	11.15	200,662	15,436	5.16%	0.75%	68.38%	0.90%	66.41%	1.32%	62.15%
Sheppard Pratt - Ellicott City	2	24	12.00	28,626	14,313	0.79%	0.12%	68.50%	0.15%	66.56%	0.19%	62.34%
Potomac Ridge - Montgome	2	22	11.00	29,201	14,601	0.79%	0.12%	68.62%	0.14%	66.70%	0.19%	62.53%
Brook Lane	1	7	7.00	8,703	8,703	0.40%	0.06%	68.67%	0.04%	66.74%	0.06%	62.59%
Total for: Wicomico, MD (86708)	***114***	***1,038***	***9.11***	***917,942***	***8,052***	***45.24%***	***6.60%***		***6.45%***		***6.03%***	
Dorchester, MD (29671)												
Potomac Ridge - East.Shore	59	411	6.97	361,950	6,135	23.41%	3.42%	72.09%	2.55%	69.29%	2.38%	64.97%
Sheppard Pratt - Towson	6	106	17.67	154,760	25,793	2.38%	0.35%	72.44%	0.66%	69.95%	1.02%	65.98%
Total for: Dorchester, MD (29671)	***65***	***517***	***7.95***	***516,710***	***7,949***	***25.79%***	***3.76%***		***3.21%***		***3.39%***	
Worcester, MD (49796)												
Potomac Ridge - East.Shore	33	274	8.30	226,100	6,852	13.10%	1.91%	74.35%	1.70%	71.66%	1.48%	67.47%
Sheppard Pratt - Towson	7	77	11.00	109,367	15,624	2.78%	0.41%	74.75%	0.48%	72.13%	0.72%	68.19%
Sheppard Pratt - Ellicott City	2	11	5.50	13,392	6,696	0.79%	0.12%	74.87%	0.07%	72.20%	0.09%	68.28%
Total for: Worcester, MD (49796)	***42***	***362***	***8.62***	***348,859***	***8,306***	***16.67%***	***2.43%***		***2.25%***		***2.29%***	
Somerset, MD (26315)												
Potomac Ridge - East.Shore	22	286	13.00	179,550	8,161	8.73%	1.27%	76.14%	1.78%	73.98%	1.18%	69.45%
Potomac Ridge - Montgome	1	4	4.00	3,714	3,714	0.40%	0.06%	76.20%	0.02%	74.01%	0.02%	69.48%
Total for: Somerset, MD (26315)	***23***	***290***	***12.61***	***183,264***	***7,968***	***9.13%***	***1.33%***		***1.80%***		***1.20%***	
Delaware												
Sheppard Pratt - Towson	6	124	20.67	180,007	30,001	2.38%	0.35%	76.55%	0.77%	74.78%	1.18%	70.66%
Potomac Ridge - East.Shore	2	16	8.00	15,200	7,600	0.79%	0.12%	76.66%	0.10%	74.88%	0.10%	70.76%
Total for: Delaware	***8***	***140***	***17.50***	***195,207***	***24,401***	***3.17%***	***0.46%***		***0.87%***		***1.28%***	
Total for: 12 Month Ending 2q 2014	**252**	**2,347**	**9.31**	**2,161,981**	**8,579**	**100.00%**	**14.59%**		**14.59%**		**14.20%**	
6) 12 Month Ending 2q 2015												
Dorchester, MD (29671)												
Potomac Ridge - East.Shore	66	458	6.94	437,550	6,630	31.13%	3.82%	80.49%	2.85%	77.72%	2.87%	73.63%
Sheppard Pratt - Towson	5	83	16.60	119,084	23,817	2.36%	0.29%	80.78%	0.52%	78.24%	0.78%	74.42%

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Behavioral Health Adolescents MD Psychiatric Hospitals

MD - Psychiatric Hospitals

Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: 12 Month Ending (Alpha or Numeric Group, 0) and Patient County (Cases, 0) and Provider (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Somerset County, *SMA - Worcester County, *SMA - Wicomico County, *SMA - Sussex DE, *SMA - Dorchester County, *SMA - Accomack, VA
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	%Grp Cases	% of Cases	CumIt %Cases	% of Days	CumIt. % Days	% of Charge	CumIt %Charge
6) 12 Month Ending 2q 2015												
Dorchester, MD (29671)												
Sheppard Pratt - Ellicott City	2	12	6.00	14,387	7,193	0.94%	0.12%	80.89%	0.07%	78.31%	0.09%	74.51%
Total for: Dorchester, MD (29671)	***73***	***553***	***7.58***	***571,020***	***7,822***	***34.43%***	***4.23%***		***3.44%***		***3.75%***	
Wicomico, MD (86708)												
Potomac Ridge - East.Shore	51	404	7.92	384,750	7,544	24.06%	2.95%	83.84%	2.51%	80.82%	2.53%	77.04%
Sheppard Pratt - Towson	9	92	10.22	125,294	13,922	4.25%	0.52%	84.37%	0.57%	81.40%	0.82%	77.86%
Potomac Ridge - Montgome	1	19	19.00	28,912	28,912	0.47%	0.06%	84.42%	0.12%	81.51%	0.19%	78.05%
Total for: Wicomico, MD (86708)	***61***	***515***	***8.44***	***538,956***	***8,835***	***28.77%***	***3.53%***		***3.20%***		***3.54%***	
Worcester, MD (49796)												
Potomac Ridge - East.Shore	29	414	14.28	353,500	12,190	13.68%	1.68%	86.10%	2.57%	84.09%	2.32%	80.37%
Sheppard Pratt - Towson	11	193	17.55	281,906	25,628	5.19%	0.64%	86.74%	1.20%	85.29%	1.85%	82.22%
Total for: Worcester, MD (49796)	***40***	***607***	***15.18***	***635,406***	***15,885***	***18.87%***	***2.32%***		***3.77%***		***4.17%***	
Somerset, MD (26315)												
Potomac Ridge - East.Shore	29	241	8.31	224,750	7,750	13.68%	1.68%	88.42%	1.50%	86.79%	1.48%	83.70%
Sheppard Pratt - Towson	3	34	11.33	40,157	13,386	1.42%	0.17%	88.59%	0.21%	87.00%	0.26%	83.96%
Total for: Somerset, MD (26315)	***32***	***275***	***8.59***	***264,907***	***8,278***	***15.09%***	***1.85%***		***1.71%***		***1.74%***	
Delaware												
Potomac Ridge - East.Shore	2	12	6.00	12,350	6,175	0.94%	0.12%	88.71%	0.07%	87.07%	0.08%	84.05%
Sheppard Pratt - Towson	1	39	39.00	53,294	53,294	0.47%	0.06%	88.77%	0.24%	87.31%	0.35%	84.40%
Total for: Delaware	***3***	***51***	***17.00***	***65,644***	***21,881***	***1.42%***	***0.17%***		***0.32%***		***0.43%***	
Queen Annes, MD (42537)												
Sheppard Pratt - Towson	1	4	4.00	5,701	5,701	0.47%	0.06%	88.82%	0.02%	87.34%	0.04%	84.43%
Total for: Queen Annes, MD (42537)	***1***	***4***	***4.00***	***5,701***	***5,701***	***0.47%***	***0.06%***		***0.02%***		***0.04%***	
Unknown ()												
Sheppard Pratt - Towson	1	14	14.00	22,752	22,752	0.47%	0.06%	88.88%	0.09%	87.43%	0.15%	84.58%
Total for: Unknown ()	***1***	***14***	***14.00***	***22,752***	***22,752***	***0.47%***	***0.06%***		***0.09%***		***0.15%***	

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Behavioral Health Adolescents MD Psychiatric Hospitals

MD - Psychiatric Hospitals

Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: 12 Month Ending (Alpha or Numeric Group, 0) and Patient County (Cases, 0) and Provider (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Somerset County, *SMA - Worcester County, *SMA - Wicomico County, *SMA - Sussex DE, *SMA - Dorchester County, *SMA - Accomack, VA
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	%Grp Cases	% of Cases	CumIt %Cases	% of Days	CumIt. % Days	% of Charge	CumIt %Charge
6) 12 Month Ending 2q 2015												
Virginia												
Potomac Ridge - East.Shore	1	6	6.00	5,700	5,700	0.47%	0.06%	88.94%	0.04%	87.46%	0.04%	84.62%
Total for: Virginia	***1***	***6***	***6.00***	***5,700***	***5,700***	***0.47%***	***0.06%***		***0.04%***		***0.04%***	
Total for: 12 Month Ending 2q 2015	**212**	**2,025**	**9.55**	**2,110,086**	**9,953**	**100.00%**	**12.28%**		**12.59%**		**13.86%**	
7) 12 Month Ending 2q 2016												
Wicomico, MD (86708)												
Potomac Ridge - East.Shore	90	789	8.77	885,904	9,843	47.12%	5.21%	94.15%	4.90%	92.37%	5.82%	90.44%
Sheppard Pratt - Towson	11	171	15.55	227,546	20,686	5.76%	0.64%	94.79%	1.06%	93.43%	1.49%	91.93%
Sheppard Pratt - Ellicott City	2	18	9.00	21,528	10,764	1.05%	0.12%	94.90%	0.11%	93.54%	0.14%	92.07%
Total for: Wicomico, MD (86708)	***103***	***978***	***9.50***	***1,134,978***	***11,019***	***53.93%***	***5.96%***		***6.08%***		***7.45%***	
Worcester, MD (49796)												
Potomac Ridge - East.Shore	27	280	10.37	313,520	11,612	14.14%	1.56%	96.47%	1.74%	95.28%	2.06%	94.13%
Sheppard Pratt - Towson	8	132	16.50	190,369	23,796	4.19%	0.46%	96.93%	0.82%	96.10%	1.25%	95.38%
Sheppard Pratt - Ellicott City	2	21	10.50	25,173	12,587	1.05%	0.12%	97.05%	0.13%	96.23%	0.17%	95.55%
Total for: Worcester, MD (49796)	***37***	***433***	***11.70***	***529,062***	***14,299***	***19.37%***	***2.14%***		***2.69%***		***3.47%***	
Dorchester, MD (29671)												
Potomac Ridge - East.Shore	30	442	14.73	486,380	16,213	15.71%	1.74%	98.78%	2.75%	98.98%	3.19%	98.74%
Sheppard Pratt - Towson	2	13	6.50	17,043	8,522	1.05%	0.12%	98.90%	0.08%	99.06%	0.11%	98.85%
Sheppard Pratt - Ellicott City	1	5	5.00	6,387	6,387	0.52%	0.06%	98.96%	0.03%	99.09%	0.04%	98.90%
Potomac Ridge - Montgome	1	11	11.00	16,192	16,192	0.52%	0.06%	99.02%	0.07%	99.16%	0.11%	99.00%
Total for: Dorchester, MD (29671)	***34***	***471***	***13.85***	***526,002***	***15,471***	***17.80%***	***1.97%***		***2.93%***		***3.45%***	
Somerset, MD (26315)												
Potomac Ridge - East.Shore	13	98	7.54	109,960	8,458	6.81%	0.75%	99.77%	0.61%	99.77%	0.72%	99.73%
Total for: Somerset, MD (26315)	***13***	***98***	***7.54***	***109,960***	***8,458***	***6.81%***	***0.75%***		***0.61%***		***0.72%***	
Delaware												
Potomac Ridge - East.Shore	3	29	9.67	32,770	10,923	1.57%	0.17%	99.94%	0.18%	99.95%	0.22%	99.94%
Total for: Delaware	***3***	***29***	***9.67***	***32,770***	***10,923***	***1.57%***	***0.17%***		***0.18%***		***0.22%***	

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Behavioral Health Adolescents MD Psychiatric Hospitals

MD - Psychiatric Hospitals

Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: 12 Month Ending (Alpha or Numeric Group, 0) and Patient County (Cases, 0) and Provider (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Somerset County, *SMA - Worcester County, *SMA - Wicomico County, *SMA - Sussex DE, *SMA - Dorchester County, *SMA - Accomack, VA
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	%Grp Cases	% of Cases	CumIt %Cases	% of Days	CumIt. % Days	% of Charge	CumIt %Charge
7) 12 Month Ending 2q 2016												
Virginia												
Potomac Ridge - East.Shore	1	8	8.00	9,040	9,040	0.52%	0.06%	00.00%	0.05%	100.00%	0.06%	100.00%
Total for: Virginia	***1***	***8***	***8.00***	***9,040***	***9,040***	***0.52%***	***0.06%***		***0.05%***		***0.06%***	
Total for: 12 Month Ending 2q 2016	**191**	**2,017**	**10.56**	**2,341,812**	**12,261**	**100.00%**	**11.06%**		**12.54%**		**15.38%**	
Totals:	**1,727**	**16,088**	**9.32**	**15,225,874**	**8,816**		**100.00%**		**100.00%**		**100.00%**	

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Behavioral Health Adolescents Acute Care Hospitals Extended Service Area

MD - Inpatient (APR DRG)
Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: 12 Month Ending (Cases, 0) and Provider (, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: Acute Hospitals
DRG: All
ZIP: Group: *SMA - North Hampton, *SMA - Kent County, *SMA - Caroline County, *SMA - Queen Annes County, *SMA - Talbot County
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	%Grp Cases	% of Cases	CumIt %Cases	% of Days	CumIt. % Days	% of Charge	CumIt %Charge
1) 12 Month Ending 2q 2010												
University of Maryland	4	25	6.25	89,688	22,422	40.00%	4.71%	4.71%	4.77%	4.77%	8.77%	8.77%
Johns Hopkins	3	14	4.67	41,627	13,876	30.00%	3.53%	8.24%	2.67%	7.44%	4.07%	12.84%
Braddock(Sacred Heart)	1	1	1.00	1,935	1,935	10.00%	1.18%	9.41%	0.19%	7.63%	0.19%	13.03%
Anne Arundel Medical Center	1	1	1.00	2,670	2,670	10.00%	1.18%	10.59%	0.19%	7.82%	0.26%	13.29%
Shore Medical Center at Easton	1	0	0.00	930	930	10.00%	1.18%	11.76%	0.00%	7.82%	0.09%	13.38%
Total for: 12 Month Ending 2q 2010	**10**	**41**	**4.10**	**136,850**	**13,685**	**100.00%**	**11.76%**		**7.82%**		**13.38%**	
2) 12 Month Ending 2q 2011												
University of Maryland	3	19	6.33	54,346	18,115	50.00%	3.53%	15.29%	3.63%	11.45%	5.32%	18.70%
Johns Hopkins	1	1	1.00	4,995	4,995	16.67%	1.18%	16.47%	0.19%	11.64%	0.49%	19.19%
Shore Medical Center at Easton	1	0	0.00	3,031	3,031	16.67%	1.18%	17.65%	0.00%	11.64%	0.30%	19.48%
Southern Maryland	1	5	5.00	5,373	5,373	16.67%	1.18%	18.82%	0.95%	12.60%	0.53%	20.01%
Total for: 12 Month Ending 2q 2011	**6**	**25**	**4.17**	**67,745**	**11,291**	**100.00%**	**7.06%**		**4.77%**		**6.63%**	
3) 12 Month Ending 2q 2012												
Johns Hopkins	8	41	5.13	84,688	10,586	57.14%	9.41%	28.24%	7.82%	20.42%	8.28%	28.29%
University of Maryland	3	17	5.67	37,199	12,400	21.43%	3.53%	31.76%	3.24%	23.66%	3.64%	31.93%
Calvert Memorial	1	5	5.00	7,875	7,875	7.14%	1.18%	32.94%	0.95%	24.62%	0.77%	32.70%
Franklin Square	1	6	6.00	6,817	6,817	7.14%	1.18%	34.12%	1.15%	25.76%	0.67%	33.37%
Anne Arundel Medical Center	1	0	0.00	3,365	3,365	7.14%	1.18%	35.29%	0.00%	25.76%	0.33%	33.70%
Total for: 12 Month Ending 2q 2012	**14**	**69**	**4.93**	**139,944**	**9,996**	**100.00%**	**16.47%**		**13.17%**		**13.69%**	
4) 12 Month Ending 2q 2013												
Johns Hopkins	8	84	10.50	149,542	18,693	50.00%	9.41%	44.71%	16.03%	41.79%	14.63%	48.32%
Mount Washington Pediatric	4	49	12.25	55,666	13,917	25.00%	4.71%	49.41%	9.35%	51.15%	5.44%	53.77%
University of Maryland	2	5	2.50	10,465	5,233	12.50%	2.35%	51.76%	0.95%	52.10%	1.02%	54.79%
Montgomery General	1	1	1.00	1,516	1,516	6.25%	1.18%	52.94%	0.19%	52.29%	0.15%	54.94%
Franklin Square	1	3	3.00	5,108	5,108	6.25%	1.18%	54.12%	0.57%	52.86%	0.50%	55.44%
Total for: 12 Month Ending 2q 2013	**16**	**142**	**8.88**	**222,297**	**13,894**	**100.00%**	**18.82%**		**27.10%**		**21.74%**	
5) 12 Month Ending 2q 2014												
Johns Hopkins	7	59	8.43	93,774	13,396	63.64%	8.24%	62.35%	11.26%	64.12%	9.17%	64.61%
Mount Washington Pediatric	1	8	8.00	8,114	8,114	9.09%	1.18%	63.53%	1.53%	65.65%	0.79%	65.40%
Shore Medical Center at Easton	1	2	2.00	6,262	6,262	9.09%	1.18%	64.71%	0.38%	66.03%	0.61%	66.01%
Anne Arundel Medical Center	1	4	4.00	5,738	5,738	9.09%	1.18%	65.88%	0.76%	66.79%	0.56%	66.58%
Calvert Memorial	1	9	9.00	10,751	10,751	9.09%	1.18%	67.06%	1.72%	68.51%	1.05%	67.63%
Total for: 12 Month Ending 2q 2014	**11**	**82**	**7.45**	**124,639**	**11,331**	**100.00%**	**12.94%**		**15.65%**		**12.19%**	

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Behavioral Health Adolescents Acute Care Hospitals Extended Service Area

MD - Inpatient (APR DRG)
Quarter 3, 2009 Through Quarter 2, 2016



Group/Sort/RollUp: 12 Month Ending (Cases, 0) and Provider (, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: Acute Hospitals
DRG: All
ZIP: Group: *SMA - North Hampton, *SMA - Kent County, *SMA - Caroline County, *SMA - Queen Annes County, *SMA - Talbot County
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	%Grp Cases	% of Cases	CumIt %Cases	% of Days	CumIt. % Days	% of Charge	CumIt %Charge
6) 12 Month Ending 2q 2015												
University of Maryland	11	62	5.64	155,202	14,109	61.11%	12.94%	80.00%	11.83%	80.34%	15.18%	82.81%
Johns Hopkins	3	16	5.33	28,605	9,535	16.67%	3.53%	83.53%	3.05%	83.40%	2.80%	85.60%
Mount Washington Pediatric	2	32	16.00	29,847	14,924	11.11%	2.35%	85.88%	6.11%	89.50%	2.92%	88.52%
Shore Medical Center at Chestertown	1	0	0.00	6,045	6,045	5.56%	1.18%	87.06%	0.00%	89.50%	0.59%	89.11%
Shore Medical Center at Easton	1	4	4.00	4,525	4,525	5.56%	1.18%	88.24%	0.76%	90.27%	0.44%	89.56%
Total for: 12 Month Ending 2q 2015	**18**	**114**	**6.33**	**224,224**	**12,457**	**100.00%**	**21.18%**		**21.76%**		**21.93%**	
7) 12 Month Ending 2q 2016												
Johns Hopkins	5	28	5.60	50,107	10,021	50.00%	5.88%	94.12%	5.34%	95.61%	4.90%	94.46%
University of Maryland	4	18	4.50	49,904	12,476	40.00%	4.71%	98.82%	3.44%	99.05%	4.88%	99.34%
Franklin Square	1	5	5.00	6,780	6,780	10.00%	1.18%	100.00%	0.95%	100.00%	0.66%	100.00%
Total for: 12 Month Ending 2q 2016	**10**	**51**	**5.10**	**106,791**	**10,679**	**100.00%**	**11.76%**		**9.73%**		**10.44%**	
Totals:	**85**	**524**	**6.16**	**1,022,490**	**12,029**		**100.00%**		**100.00%**		**100.00%**	

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Behavioral Health Psych Hospitals 0 - 17 ESA

MD - Psychiatric Hospitals
Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: 12 Month Ending (Cases, 0) and Provider (, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Kent County, *SMA - Queen Annes County, *SMA - Caroline County, *SMA - Talbot County, *SMA - North Hampton
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	%Grp Cases	% of Cases	CumIt %Cases	% of Days	CumIt. % Days	% of Charge	CumIt %Charge
1) 12 Month Ending 2q 2010												
Potomac Ridge - East.Shore	97	1,033	10.65	720,100	7,424	78.23%	13.22%	13.22%	14.65%	14.65%	10.24%	10.24%
Sheppard Pratt - Towson	17	231	13.59	284,411	16,730	13.71%	2.32%	15.53%	3.28%	17.93%	4.05%	14.29%
Sheppard Pratt - Ellicott City	7	41	5.86	47,620	6,803	5.65%	0.95%	16.49%	0.58%	18.51%	0.68%	14.97%
Potomac Ridge - Montgome	2	30	15.00	34,488	17,244	1.61%	0.27%	16.76%	0.43%	18.94%	0.49%	15.46%
Brook Lane	1	8	8.00	8,218	8,218	0.81%	0.14%	16.89%	0.11%	19.05%	0.12%	15.57%
Total for: 12 Month Ending 2q 2010	**124**	**1,343**	**10.83**	**1,094,838**	**8,829**	**100.00%**	**16.89%**		**19.05%**		**15.57%**	
2) 12 Month Ending 2q 2011												
Potomac Ridge - East.Shore	96	703	7.32	608,000	6,333	84.96%	13.08%	29.97%	9.97%	29.03%	8.65%	24.22%
Sheppard Pratt - Towson	14	153	10.93	202,048	14,432	12.39%	1.91%	31.88%	2.17%	31.20%	2.87%	27.10%
Sheppard Pratt - Ellicott City	2	11	5.50	12,838	6,419	1.77%	0.27%	32.15%	0.16%	31.35%	0.18%	27.28%
Potomac Ridge - Montgome	1	5	5.00	5,503	5,503	0.88%	0.14%	32.29%	0.07%	31.42%	0.08%	27.36%
Total for: 12 Month Ending 2q 2011	**113**	**872**	**7.72**	**828,390**	**7,331**	**100.00%**	**15.40%**		**12.37%**		**11.78%**	
3) 12 Month Ending 2q 2012												
Potomac Ridge - East.Shore	91	662	7.27	554,800	6,097	81.25%	12.40%	44.69%	9.39%	40.81%	7.89%	35.25%
Sheppard Pratt - Towson	15	236	15.73	319,756	21,317	13.39%	2.04%	46.73%	3.35%	44.16%	4.55%	39.80%
Sheppard Pratt - Ellicott City	6	83	13.83	95,081	15,847	5.36%	0.82%	47.55%	1.18%	45.34%	1.35%	41.15%
Total for: 12 Month Ending 2q 2012	**112**	**981**	**8.76**	**969,638**	**8,657**	**100.00%**	**15.26%**		**13.92%**		**13.79%**	
4) 12 Month Ending 2q 2013												
Potomac Ridge - East.Shore	60	572	9.53	432,250	7,204	74.07%	8.17%	55.72%	8.11%	53.45%	6.15%	47.30%
Sheppard Pratt - Towson	14	170	12.14	231,223	16,516	17.28%	1.91%	57.63%	2.41%	55.87%	3.29%	50.59%
Sheppard Pratt - Ellicott City	5	55	11.00	61,723	12,345	6.17%	0.68%	58.31%	0.78%	56.65%	0.88%	51.47%
Brook Lane	2	10	5.00	12,737	6,368	2.47%	0.27%	58.58%	0.14%	56.79%	0.18%	51.65%
Total for: 12 Month Ending 2q 2013	**81**	**807**	**9.96**	**737,933**	**9,110**	**100.00%**	**11.04%**		**11.45%**		**10.50%**	
5) 12 Month Ending 2q 2014												
Potomac Ridge - East.Shore	52	477	9.17	376,200	7,235	70.27%	7.08%	65.67%	6.77%	63.56%	5.35%	57.00%
Sheppard Pratt - Towson	15	263	17.53	368,485	24,566	20.27%	2.04%	67.71%	3.73%	67.29%	5.24%	62.24%
Sheppard Pratt - Ellicott City	7	56	8.00	66,407	9,487	9.46%	0.95%	68.66%	0.79%	68.08%	0.94%	63.19%
Total for: 12 Month Ending 2q 2014	**74**	**796**	**10.76**	**811,092**	**10,961**	**100.00%**	**10.08%**		**11.29%**		**11.54%**	
6) 12 Month Ending 2q 2015												
Potomac Ridge - East.Shore	64	558	8.72	532,800	8,325	61.54%	8.72%	77.38%	7.92%	76.00%	7.58%	70.77%
Sheppard Pratt - Towson	27	350	12.96	480,489	17,796	25.96%	3.68%	81.06%	4.97%	80.96%	6.84%	77.60%
Sheppard Pratt - Ellicott City	11	67	6.09	80,474	7,316	10.58%	1.50%	82.56%	0.95%	81.91%	1.14%	78.75%
Brook Lane	1	8	8.00	9,534	9,534	0.96%	0.14%	82.70%	0.11%	82.03%	0.14%	78.88%

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Behavioral Health Psych Hospitals 0 - 17 ESA

MD - Psychiatric Hospitals
Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: 12 Month Ending (Cases, 0) and Provider (, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Kent County, *SMA - Queen Annes County, *SMA - Caroline County, *SMA - Talbot County, *SMA - North Hampton
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	%Grp Cases	% of Cases	CumIt %Cases	% of Days	CumIt. % Days	% of Charge	CumIt %Charge
6) 12 Month Ending 2q 2015												
Potomac Ridge - Montgome	1	12	12.00	17,614	17,614	0.96%	0.14%	82.83%	0.17%	82.20%	0.25%	79.14%
Total for: 12 Month Ending 2q 2015	**104**	**995**	**9.57**	**1,120,911**	**10,778**	**100.00%**	**14.17%**		**14.12%**		**15.95%**	
7) 12 Month Ending 2q 2016												
Potomac Ridge - East.Shore	90	958	10.64	1,074,280	11,936	71.43%	12.26%	95.10%	13.59%	95.79%	15.28%	94.42%
Sheppard Pratt - Towson	22	191	8.68	256,252	11,648	17.46%	3.00%	98.09%	2.71%	98.50%	3.65%	98.06%
Sheppard Pratt - Ellicott City	10	77	7.70	94,724	9,472	7.94%	1.36%	99.46%	1.09%	99.59%	1.35%	99.41%
Potomac Ridge - Montgome	4	29	7.25	41,409	10,352	3.17%	0.54%	100.00%	0.41%	100.00%	0.59%	100.00%
Total for: 12 Month Ending 2q 2016	**126**	**1,255**	**9.96**	**1,466,664**	**11,640**	**100.00%**	**17.17%**		**17.80%**		**20.86%**	
Totals:	**734**	**7,049**	**9.60**	**7,029,465**	**9,577**		**100.00%**		**100.00%**		**100.00%**	

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Behavioral Health

MD - Psychiatric Hospitals

Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: Primary Diagnosis (ICD) (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Somerset County, *SMA - Worcester County, *SMA - Wicomico County, *SMA - Sussex DE, *SMA - Dorchester County, *SMA - Accomack, VA
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Primary Diagnosis (ICD)	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	% of Cases	CumIt% Cases	% of Days	CumIt% Days	% of Charge	CumIt% Charge
1)	296.90 - EPISODIC MOOD DISORD NOS	328	2,985	9.10	2,897,553	8,834	22.7%	22.7%	22.6%	22.6%	23.7%	23.7%
2)	314.01 - ATTN DEFICIT W HYPERACT	207	1,641	7.93	1,532,160	7,402	14.3%	37.1%	12.4%	35.0%	12.5%	36.3%
3)	311 - DEPRESSIVE DISORDER NEC	105	810	7.71	689,096	6,563	7.3%	44.4%	6.1%	41.1%	5.6%	41.9%
4)	296.80 - BIPOLAR DISORDER NOS	103	1,131	10.98	991,245	9,624	7.1%	51.5%	8.6%	49.7%	8.1%	50.0%
5)	296.33 - RECUR DEPR PSYCH-SEVERE	98	775	7.91	721,441	7,362	6.8%	58.3%	5.9%	55.6%	5.9%	55.9%
6)	309.9 - ADJUSTMENT REACTION NOS	46	290	6.30	245,852	5,345	3.2%	61.5%	2.2%	57.8%	2.0%	57.9%
7)	314.9 - HYPERKINETIC SYND NOS	39	307	7.87	255,550	6,553	2.7%	64.2%	2.3%	60.1%	2.1%	60.0%
8)	309.81 - POSTTRAUMATIC STRESS DIS	35	391	11.17	355,309	10,152	2.4%	66.6%	3.0%	63.0%	2.9%	62.9%
9)	296.99 - EPISODIC MOOD DISORD NEC	33	384	11.64	436,950	13,241	2.3%	68.9%	2.9%	66.0%	3.6%	66.5%
10)	309.4 - ADJ DIS-EMOTION/CONDUCT	31	283	9.13	236,855	7,640	2.1%	71.0%	2.1%	68.1%	1.9%	68.4%
11)	313.89 - EMOTIONAL DIS CHILD NEC	29	229	7.90	210,900	7,272	2.0%	73.0%	1.7%	69.8%	1.7%	70.2%
12)	298.9 - PSYCHOSIS NOS	28	382	13.64	232,039	8,287	1.9%	75.0%	2.9%	72.7%	1.9%	72.1%
13)	312.34 - INTERMITT EXPLOSIVE DIS	27	185	6.85	168,453	6,239	1.9%	76.9%	1.4%	74.1%	1.4%	73.4%
14)	296.53 - BIPOL I CURR DEP W/O PSY	25	268	10.72	177,650	7,106	1.7%	78.6%	2.0%	76.1%	1.5%	74.9%
15)	296.20 - DEPRESS PSYCHOSIS-UNSPEC	20	148	7.40	129,500	6,475	1.4%	80.0%	1.1%	77.3%	1.1%	76.0%
16)	300.00 - ANXIETY STATE NOS	19	119	6.26	124,870	6,572	1.3%	81.3%	0.9%	78.2%	1.0%	77.0%
17)	307.1 - ANOREXIA NERVOSA	18	360	20.00	542,071	30,115	1.2%	82.5%	2.7%	80.9%	4.4%	81.4%
18)	313.81 - OPPOSITION DEFIANT DISOR	16	87	5.44	79,800	4,988	1.1%	83.6%	0.7%	81.5%	0.7%	82.1%
19)	296.30 - RECURR DEPR PSYCHOS-UNSP	14	108	7.71	82,650	5,904	1.0%	84.6%	0.8%	82.4%	0.7%	82.7%
20)	300.02 - GENERALIZED ANXIETY DIS	14	92	6.57	94,158	6,726	1.0%	85.6%	0.7%	83.1%	0.8%	83.5%
21)	296.34 - REC DEPR PSYCH-PSYCHOTIC	13	182	14.00	113,511	8,732	0.9%	86.5%	1.4%	84.4%	0.9%	84.4%
22)	296.23 - DEPRESS PSYCHOSIS-SEVERE	12	96	8.00	109,878	9,156	0.8%	87.3%	0.7%	85.2%	0.9%	85.3%
23)	296.32 - RECURR DEPR PSYCHOS-MOD	12	65	5.42	63,814	5,318	0.8%	88.1%	0.5%	85.7%	0.5%	85.9%
24)	296.50 - BIPOL I CUR DEPRES NOS	11	85	7.73	78,770	7,161	0.8%	88.9%	0.6%	86.3%	0.6%	86.5%
25)	296.7 - BIPOLOR I CURRENT NOS	10	49	4.90	50,016	5,002	0.7%	89.6%	0.4%	86.7%	0.4%	86.9%

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Behavioral Health

MD - Psychiatric Hospitals

Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: Primary Diagnosis (ICD) (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Somerset County, *SMA - Worcester County, *SMA - Wicomico County, *SMA - Sussex DE, *SMA - Dorchester County, *SMA - Accomack, VA
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Primary Diagnosis (ICD)	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	% of Cases	Cumlt% Cases	% of Days	Cumlt% Days	% of Charge	Cumlt% Charge
26)	309.0 - ADJUSTMNT DIS W DEPRESSN	10	61	6.10	53,200	5,320	0.7%	90.3%	0.5%	87.1%	0.4%	87.4%
27)	299.80 - PERVASV DEV DIS-CUR NEC	10	94	9.40	61,750	6,175	0.7%	91.0%	0.7%	87.8%	0.5%	87.9%
28)	296.54 - BIPOL I CURRNT DEP W PSY	8	88	11.00	83,600	10,450	0.6%	91.5%	0.7%	88.5%	0.7%	88.5%
29)	307.50 - EATING DISORDER NOS	7	172	24.57	255,877	36,554	0.5%	92.0%	1.3%	89.8%	2.1%	90.6%
30)	296.24 - DEPR PSYCHOS-SEV W PSYCH	7	50	7.14	48,871	6,982	0.5%	92.5%	0.4%	90.2%	0.4%	91.0%
31)	312.30 - IMPULSE CONTROL DIS NOS	6	85	14.17	95,657	15,943	0.4%	92.9%	0.6%	90.8%	0.8%	91.8%
32)	296.52 - BIPOL I CUR DEPRESS-MOD	6	44	7.33	38,950	6,492	0.4%	93.3%	0.3%	91.2%	0.3%	92.1%
33)	296.63 - BIPOL I CUR MIX W/O PSY	6	94	15.67	73,250	12,208	0.4%	93.8%	0.7%	91.9%	0.6%	92.7%
34)	312.9 - CONDUCT DISTURBANCE NOS	5	126	25.20	51,114	10,223	0.3%	94.1%	1.0%	92.8%	0.4%	93.2%
35)	296.89 - BIPOLAR DISORDER NEC	5	50	10.00	60,389	12,078	0.3%	94.5%	0.4%	93.2%	0.5%	93.7%
36)	296.44 - BIPOL I MANIC-SEV W PSY	4	46	11.50	43,700	10,925	0.3%	94.7%	0.3%	93.6%	0.4%	94.0%
37)	296.64 - BIPOL I CUR MIXED W PSY	4	31	7.75	31,442	7,861	0.3%	95.0%	0.2%	93.8%	0.3%	94.3%
38)	296.60 - BIPOL I CURRNT MIXED NOS	4	55	13.75	54,398	13,600	0.3%	95.3%	0.4%	94.2%	0.4%	94.7%
39)	296.40 - BIPOL I CURRNT MANIC NOS	4	102	25.50	69,500	17,375	0.3%	95.6%	0.8%	95.0%	0.6%	95.3%
40)	296.41 - BIPOL I CURNT MANIC-MILD	3	19	6.33	16,150	5,383	0.2%	95.8%	0.1%	95.1%	0.1%	95.4%
41)	307.51 - BULIMIA NERVOSA	3	78	26.00	118,677	39,559	0.2%	96.0%	0.6%	95.7%	1.0%	96.4%
42)	295.70 - SCHIZOAFFECTIVE DIS NOS	3	47	15.67	28,500	9,500	0.2%	96.2%	0.4%	96.1%	0.2%	96.6%
43)	295.90 - SCHIZOPHRENIA NOS-UNSPEC	3	33	11.00	31,350	10,450	0.2%	96.4%	0.2%	96.3%	0.3%	96.9%
44)	296.22 - DEPRESSIVE PSYCHOSIS-MOD	3	18	6.00	16,900	5,633	0.2%	96.6%	0.1%	96.5%	0.1%	97.0%
45)	296.51 - BIPOL I CUR DEPRESS-MILD	3	41	13.67	29,450	9,817	0.2%	96.8%	0.3%	96.8%	0.2%	97.3%
46)	300.4 - DYSTHYMIC DISORDER	3	17	5.67	20,613	6,871	0.2%	97.0%	0.1%	96.9%	0.2%	97.4%
47)	309.28 - ADJUST DIS W ANXIETY/DEP	3	9	3.00	9,000	3,000	0.2%	97.2%	0.1%	97.0%	0.1%	97.5%
48)	299.00 - AUTISTIC DISORD-CURRENT	2	19	9.50	18,050	9,025	0.1%	97.4%	0.1%	97.1%	0.1%	97.6%
49)	295.10 - HEBEPHRENIA-UNSPEC	2	64	32.00	34,200	17,100	0.1%	97.5%	0.5%	97.6%	0.3%	97.9%

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Behavioral Health

MD - Psychiatric Hospitals

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Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
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ZIP: Group: *SMA - Somerset County, *SMA - Worcester County, *SMA - Wicomico County, *SMA - Sussex DE, *SMA - Dorchester County, *SMA - Accomack, VA
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Primary Diagnosis (ICD)	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	% of Cases	CumIt% Cases	% of Days	CumIt% Days	% of Charge	CumIt% Charge
50)	309.3 - ADJUST DISOR/DIS CONDUCT	2	18	9.00	12,350	6,175	0.1%	97.6%	0.1%	97.7%	0.1%	98.0%
51)	299.90 - PERVASV DEV DIS-CUR NOS	2	19	9.50	7,600	3,800	0.1%	97.8%	0.1%	97.9%	0.1%	98.1%
52)	292.84 - DRUG-INDUCED MOOD DISORD	2	7	3.50	6,650	3,325	0.1%	97.9%	0.1%	97.9%	0.1%	98.1%
53)	312.82 - CNDCT DSRDR ADLSCNT ONST	2	14	7.00	15,086	7,543	0.1%	98.1%	0.1%	98.0%	0.1%	98.3%
54)	293.83 - MOOD DISORDER OTHER DIS	2	14	7.00	13,300	6,650	0.1%	98.2%	0.1%	98.1%	0.1%	98.4%
55)	296.45 - BIPOL I CUR MAN PART REM	2	20	10.00	22,000	11,000	0.1%	98.3%	0.2%	98.3%	0.2%	98.6%
56)	293.9 - TRANSIENT MENTAL DIS NOS	2	11	5.50	6,650	3,325	0.1%	98.5%	0.1%	98.4%	0.1%	98.6%
57)	307.23 - TOURETTE'S DISORDER	1	7	7.00	6,650	6,650	0.1%	98.5%	0.1%	98.4%	0.1%	98.7%
58)	295.30 - PARANOID SCHIZO-UNSPEC	1	8	8.00	7,600	7,600	0.1%	98.6%	0.1%	98.5%	0.1%	98.7%
59)	296.00 - BIPOL I SINGLE MANIC NOS	1	7	7.00	6,650	6,650	0.1%	98.7%	0.1%	98.5%	0.1%	98.8%
60)	296.31 - RECURR DEPR PSYCHOS-MILD	1	9	9.00	8,550	8,550	0.1%	98.8%	0.1%	98.6%	0.1%	98.8%
61)	300.3 - OBSESSIVE-COMPULSIVE DIS	1	3	3.00	2,850	2,850	0.1%	98.8%	0.0%	98.6%	0.0%	98.9%
62)	293.81 - PSY DIS W DELUS OTH DIS	1	11	11.00	10,450	10,450	0.1%	98.9%	0.1%	98.7%	0.1%	99.0%
63)	312.81 - CNDCT DSRDR CHLDHD ONST	1	4	4.00	4,970	4,970	0.1%	99.0%	0.0%	98.7%	0.0%	99.0%
64)	300.21 - AGORAPHOBIA W PANIC DIS	1	3	3.00	2,850	2,850	0.1%	99.0%	0.0%	98.8%	0.0%	99.0%
65)	309.24 - ADJUSTMENT DIS W ANXIETY	1	7	7.00	6,650	6,650	0.1%	99.1%	0.1%	98.8%	0.1%	99.1%
66)	312.00 - UNSOCIAL AGGRESS-UNSPEC	1	8	8.00	7,600	7,600	0.1%	99.2%	0.1%	98.9%	0.1%	99.1%
67)	300.9 - NONPSYCHOTIC DISORD NOS	1	21	21.00	19,000	19,000	0.1%	99.2%	0.2%	99.0%	0.2%	99.3%
68)	296.62 - BIPOL I CURRNT MIXED-MOD	1	7	7.00	6,650	6,650	0.1%	99.3%	0.1%	99.1%	0.1%	99.3%
69)	295.75 - SCHIZOAFFECTVE DIS-REMIS	1	9	9.00	7,600	7,600	0.1%	99.4%	0.1%	99.2%	0.1%	99.4%
70)	295.40 - SCHIZOPHRENIFORM DIS NOS	1	7	7.00	6,650	6,650	0.1%	99.4%	0.1%	99.2%	0.1%	99.5%
71)	296.42 - BIPOL I CURRNT MANIC-MOD	1	7	7.00	6,650	6,650	0.1%	99.5%	0.1%	99.3%	0.1%	99.5%
72)	296.35 - RECUR DEPR PSYC-PART REM	1	7	7.00	6,650	6,650	0.1%	99.6%	0.1%	99.3%	0.1%	99.6%
73)	304.80 - COMB DRUG DEP NEC-UNSPEC	1	5	5.00	4,750	4,750	0.1%	99.7%	0.0%	99.4%	0.0%	99.6%

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Behavioral Health

MD - Psychiatric Hospitals

Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: Primary Diagnosis (ICD) (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Somerset County, *SMA - Worcester County, *SMA - Wicomico County, *SMA - Sussex DE, *SMA - Dorchester County, *SMA - Accomack, VA
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Primary Diagnosis (ICD)	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	% of Cases	CumIt% Cases	% of Days	CumIt% Days	% of Charge	CumIt% Charge
74)	300.11 - CONVERSION DISORDER	1	8	8.00	10,172	10,172	0.1%	99.7%	0.1%	99.4%	0.1%	99.7%
75)	296.04 - BIPO I SIN MAN-SEV W PSY	1	53	53.00	13,300	13,300	0.1%	99.8%	0.4%	99.8%	0.1%	99.8%
76)	296.25 - DEPR PSYCHOS-PART REMISS	1	7	7.00	7,700	7,700	0.1%	99.9%	0.1%	99.9%	0.1%	99.9%
77)	305.90 - DRUG ABUSE NEC-UNSPEC	1	6	6.00	5,700	5,700	0.1%	99.9%	0.0%	99.9%	0.0%	99.9%
78)	308.3 - ACUTE STRESS REACT NEC	1	11	11.00	10,450	10,450	0.1%	100.0%	0.1%	100.0%	0.1%	100.0%
	Total for Primary Diagnosis (ICD):	**1,443**	**13,213**	**9.16**	**12,218,406**	**8,467**	**100%**		**100%**		**100%**	

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Behavioral Health Psych Hospitals 0 - 17 ESA

MD - Psychiatric Hospitals

Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: Primary Diagnosis (ICD) (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Kent County, *SMA - Queen Annes County, *SMA - Caroline County, *SMA - Talbot County, *SMA - North Hampton
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Primary Diagnosis (ICD)	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	% of Cases	CumIt% Cases	% of Days	CumIt% Days	% of Charge	CumIt% Charge
1)	296.90 - EPISODIC MOOD DISORD NOS	133	1,163	8.74	1,154,941	8,684	22.4%	22.4%	20.7%	20.7%	20.9%	20.9%
2)	311 - DEPRESSIVE DISORDER NEC	54	357	6.61	345,898	6,406	9.1%	31.5%	6.4%	27.1%	6.3%	27.2%
3)	314.01 - ATTN DEFICIT W HYPERACT	53	539	10.17	464,900	8,772	8.9%	40.4%	9.6%	36.7%	8.4%	35.6%
4)	296.80 - BIPOLAR DISORDER NOS	48	532	11.08	509,137	10,607	8.1%	48.5%	9.5%	46.1%	9.2%	44.8%
5)	296.33 - RECUR DEPR PSYCH-SEVERE	35	303	8.66	295,335	8,438	5.9%	54.4%	5.4%	51.5%	5.3%	50.1%
6)	296.20 - DEPRESS PSYCHOSIS-UNSPEC	21	147	7.00	126,791	6,038	3.5%	57.9%	2.6%	54.1%	2.3%	52.4%
7)	296.99 - EPISODIC MOOD DISORD NEC	18	214	11.89	247,633	13,757	3.0%	60.9%	3.8%	57.9%	4.5%	56.9%
8)	309.81 - POSTTRAUMATIC STRESS DIS	16	169	10.56	126,350	7,897	2.7%	63.6%	3.0%	61.0%	2.3%	59.2%
9)	296.32 - RECURR DEPR PSYCHOS-MOD	16	97	6.06	98,205	6,138	2.7%	66.3%	1.7%	62.7%	1.8%	61.0%
10)	296.30 - RECURR DEPR PSYCHOS-UNSP	14	138	9.86	135,583	9,685	2.4%	68.7%	2.5%	65.1%	2.5%	63.4%
11)	307.1 - ANOREXIA NERVOSA	14	374	26.71	559,739	39,981	2.4%	71.0%	6.7%	71.8%	10.1%	73.6%
12)	300.00 - ANXIETY STATE NOS	12	82	6.83	80,939	6,745	2.0%	73.1%	1.5%	73.3%	1.5%	75.0%
13)	296.23 - DEPRESS PSYCHOSIS-SEVERE	11	74	6.73	72,024	6,548	1.9%	74.9%	1.3%	74.6%	1.3%	76.3%
14)	296.34 - REC DEPR PSYCH-PSYCHOTIC	9	65	7.22	67,059	7,451	1.5%	76.4%	1.2%	75.7%	1.2%	77.6%
15)	313.81 - OPPOSITION DEFIANT DISOR	9	46	5.11	41,742	4,638	1.5%	77.9%	0.8%	76.6%	0.8%	78.3%
16)	309.4 - ADJ DIS-EMOTION/CONDUCT	9	55	6.11	55,051	6,117	1.5%	79.5%	1.0%	77.5%	1.0%	79.3%
17)	309.9 - ADJUSTMENT REACTION NOS	8	46	5.75	39,900	4,988	1.3%	80.8%	0.8%	78.4%	0.7%	80.0%
18)	309.0 - ADJUSTMNT DIS W DEPRESSN	7	42	6.00	39,900	5,700	1.2%	82.0%	0.7%	79.1%	0.7%	80.7%
19)	296.22 - DEPRESSIVE PSYCHOSIS-MOD	7	42	6.00	47,665	6,809	1.2%	83.2%	0.7%	79.8%	0.9%	81.6%
20)	313.89 - EMOTIONAL DIS CHILD NEC	7	55	7.86	52,250	7,464	1.2%	84.3%	1.0%	80.8%	0.9%	82.6%
21)	296.44 - BIPOL I MANIC-SEV W PSY	6	112	18.67	72,824	12,137	1.0%	85.4%	2.0%	82.8%	1.3%	83.9%
22)	296.64 - BIPOL I CUR MIXED W PSY	6	91	15.17	57,183	9,530	1.0%	86.4%	1.6%	84.4%	1.0%	84.9%
23)	298.9 - PSYCHOSIS NOS	6	54	9.00	55,213	9,202	1.0%	87.4%	1.0%	85.4%	1.0%	85.9%
24)	300.02 - GENERALIZED ANXIETY DIS	6	91	15.17	111,579	18,597	1.0%	88.4%	1.6%	87.0%	2.0%	87.9%
25)	314.9 - HYPERKINETIC SYND NOS	5	46	9.20	43,700	8,740	0.8%	89.2%	0.8%	87.8%	0.8%	88.7%

11/15/2017

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Behavioral Health Psych Hospitals 0 - 17 ESA

MD - Psychiatric Hospitals

Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: Primary Diagnosis (ICD) (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Kent County, *SMA - Queen Annes County, *SMA - Caroline County, *SMA - Talbot County, *SMA - North Hampton
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Primary Diagnosis (ICD)	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	% of Cases	CumIt% Cases	% of Days	CumIt% Days	% of Charge	CumIt% Charge
26)	307.50 - EATING DISORDER NOS	5	61	12.20	92,583	18,517	0.8%	90.1%	1.1%	88.9%	1.7%	90.4%
27)	296.60 - BIPOL I CURRNT MIXED NOS	4	48	12.00	53,254	13,314	0.7%	90.7%	0.9%	89.8%	1.0%	91.4%
28)	307.51 - BULIMIA NERVOSA	4	53	13.25	84,804	21,201	0.7%	91.4%	0.9%	90.7%	1.5%	92.9%
29)	296.89 - BIPOLAR DISORDER NEC	4	43	10.75	45,200	11,300	0.7%	92.1%	0.8%	91.5%	0.8%	93.7%
30)	296.50 - BIPOL I CUR DEPRES NOS	4	19	4.75	16,150	4,038	0.7%	92.8%	0.3%	91.8%	0.3%	94.0%
31)	296.24 - DEPR PSYCHOS-SEV W PSYCH	3	20	6.67	20,807	6,936	0.5%	93.3%	0.4%	92.2%	0.4%	94.4%
32)	312.34 - INTERMITT EXPLOSIVE DIS	3	20	6.67	19,000	6,333	0.5%	93.8%	0.4%	92.5%	0.3%	94.7%
33)	299.80 - PERVASV DEV DIS-CUR NEC	3	23	7.67	13,300	4,433	0.5%	94.3%	0.4%	92.9%	0.2%	95.0%
34)	296.63 - BIPOL I CUR MIX W/O PSY	3	15	5.00	15,216	5,072	0.5%	94.8%	0.3%	93.2%	0.3%	95.2%
35)	312.81 - CNDCT DSRDR CHLDHD ONST	3	18	6.00	14,663	4,888	0.5%	95.3%	0.3%	93.5%	0.3%	95.5%
36)	300.4 - DYSTHYMIC DISORDER	3	32	10.67	27,585	9,195	0.5%	95.8%	0.6%	94.1%	0.5%	96.0%
37)	300.3 - OBSESSIVE-COMPULSIVE DIS	3	17	5.67	16,150	5,383	0.5%	96.3%	0.3%	94.4%	0.3%	96.3%
38)	296.53 - BIPOL I CURR DEP W/O PSY	2	14	7.00	15,156	7,578	0.3%	96.6%	0.2%	94.7%	0.3%	96.6%
39)	296.36 - RECUR DEPR PSYC-FULL REM	2	50	25.00	12,350	6,175	0.3%	97.0%	0.9%	95.5%	0.2%	96.8%
40)	296.7 - BIPOLOR I CURRENT NOS	2	31	15.50	33,716	16,858	0.3%	97.3%	0.6%	96.1%	0.6%	97.4%
41)	296.54 - BIPOL I CURRNT DEP W PSY	2	12	6.00	13,455	6,727	0.3%	97.6%	0.2%	96.3%	0.2%	97.7%
42)	295.40 - SCHIZOPHRENIFORM DIS NOS	2	119	59.50	42,750	21,375	0.3%	98.0%	2.1%	98.4%	0.8%	98.4%
43)	296.43 - BIPOL I MANC-SEV W/O PSY	2	28	14.00	28,300	14,150	0.3%	98.3%	0.5%	98.9%	0.5%	98.9%
44)	312.9 - CONDUCT DISTURBANCE NOS	2	3	1.50	1,900	950	0.3%	98.7%	0.1%	99.0%	0.0%	99.0%
45)	314.00 - ATTN DEFIC NONHYPERACT	1	10	10.00	9,500	9,500	0.2%	98.8%	0.2%	99.2%	0.2%	99.1%
46)	V61.20 - CNSL PRNT-CHLD PROB NOS	1	5	5.00	4,750	4,750	0.2%	99.0%	0.1%	99.3%	0.1%	99.2%
47)	304.80 - COMB DRUG DEP NEC-UNSPEC	1	3	3.00	2,850	2,850	0.2%	99.2%	0.1%	99.3%	0.1%	99.3%
48)	296.52 - BIPOL I CUR DEPRESS-MOD	1	8	8.00	6,650	6,650	0.2%	99.3%	0.1%	99.4%	0.1%	99.4%
49)	309.21 - SEPARATION ANXIETY	1	9	9.00	8,550	8,550	0.2%	99.5%	0.2%	99.6%	0.2%	99.6%

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Behavioral Health Psych Hospitals 0 - 17 ESA

MD - Psychiatric Hospitals

Quarter 3, 2009 Through Quarter 2, 2016

Group/Sort/RollUp: Primary Diagnosis (ICD) (Cases, 0)
Report Criteria: LOS 0 - 999 Total Charges $0 - 9,999,999
Provider: Group: MD Psychiatric Hospitals
DRG: All
ZIP: Group: *SMA - Kent County, *SMA - Queen Annes County, *SMA - Caroline County, *SMA - Talbot County, *SMA - North Hampton
ICD-9 Diag: All (Level 1 - 1)
ICD-9 Proc: All (Level 1 - 1)
Atten Phys: All
Oper Phys: All
Payor: All
CPT-4: All (Level 1 - 1)
Disposition: All
Admission Source: All
ER Admission: All
Age Groups: Individual Value: 0 to 9, 10 to 14, 15 to 17
Race: All
Ethnicity: All
Gender: All

	Primary Diagnosis (ICD)	Total Cases	Total Pat. Day	Avg. LOS	Total Charge	Avg. Charge	% of Cases	CumIt% Cases	% of Days	CumIt% Days	% of Charge	CumIt% Charge
50)	296.25 - DEPR PSYCHOS-PART REMISS	1	6	6.00	6,600	6,600	0.2%	99.7%	0.1%	99.7%	0.1%	99.7%
51)	299.00 - AUTISTIC DISORD-CURRENT	1	7	7.00	6,650	6,650	0.2%	99.8%	0.1%	99.8%	0.1%	99.8%
52)	312.30 - IMPULSE CONTROL DIS NOS	1	9	9.00	11,242	11,242	0.2%	100.0%	0.2%	100.0%	0.2%	100.0%
	Total for Primary Diagnosis (ICD):	**594**	**5,617**	**9.46**	**5,524,672**	**9,301**	**100%**		**100%**		**100%**	

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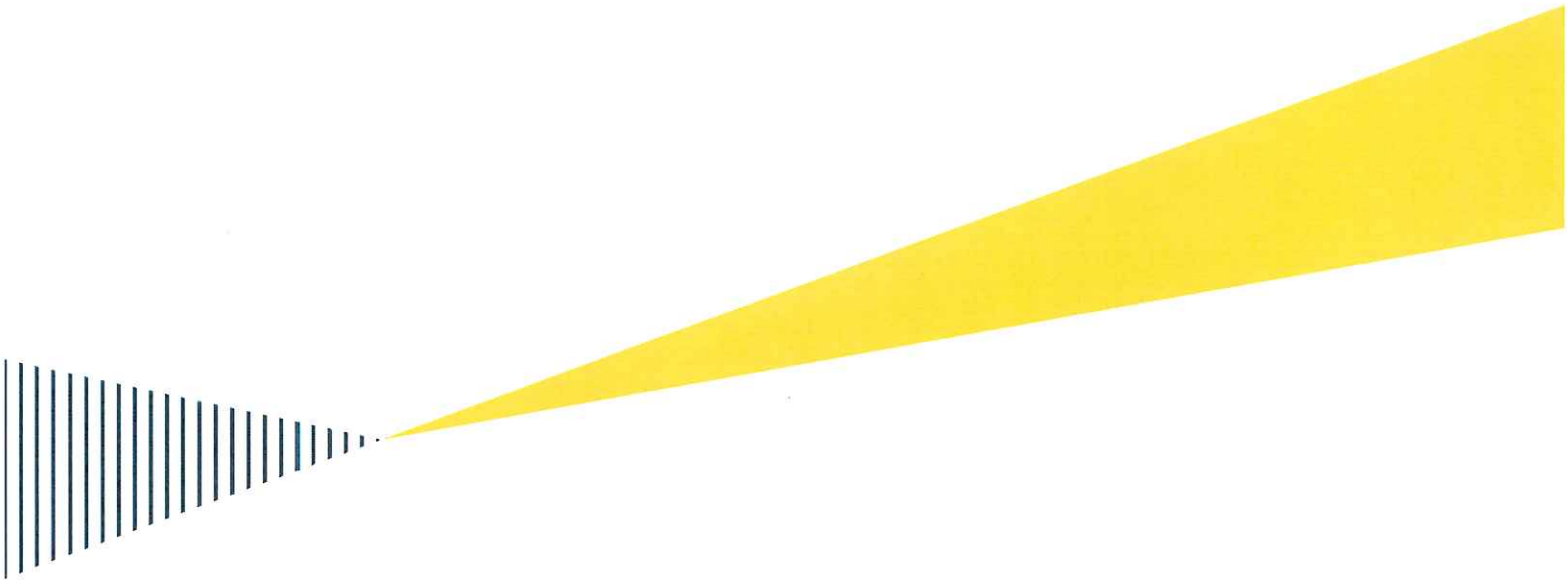
NSF AREAS OF PRMC CAP UNIT

Room/Space	NSF	NSF/15 beds
CAP Locked Unit		
Adol Day Room	705	
Storage	33	
Beds 1 + 2	170	
Beds 3 + 4	169	
Bed 5	100	
Bed 6	102	
Beds 7 + 8	170	
Beds 9 + 10	226	
Quiet Room	80	
Beds 11 + 12	187	
Bed 13	133	
Beds 14 + 15	235	
Child Day Room	296	
Consultation	100	
Laundry	35	
TltShwwr	57	
Pat Tlt	51	
Office	39	
Nurse Counter	52	
Nurse Station	173	
Meds	41	
Staff Toilet	46	
Seclusion	107	
Pat Tlt	35	
Nurse Counter	84	
Pat Tlt	43	
Consultation	102	
Pat Tlt/Shr	50	
Pat Tlt/Shr	56	
Subtotal CAP Locked Unit:	**3,677**	245
Shared Support Areas		
Shared Clean	188	
Equip Storage	96	
Soiled Holding	81	
Housekeeping	43	
Shared Office	387	
Office 4	100	
Office 3	98	
Office 2	121	
Conference	261	
Visitor Tlt	50	
Visitor Lkrs	8	
Visitor Room	122	
Subtotal shared support:	**1,555**	104
Areas in Renovation of Adult Unit		
Break Room	256	
Clin Mgr Office	90	
Psych office	114	
Staff Tlt	61	
Work Area	108	
Subtotal Adult Unit Renovations:	**629**	42
Total NSF for entire renovation areas:	**5,861**	391

Consolidated Financial Statements and Supplementary Information

Peninsula Regional Health System, Inc.
Years Ended June 30, 2017 and 2016
With Report of Independent Auditors

Ernst & Young LLP



Building a better working world

Peninsula Regional Health System, Inc.

Consolidated Financial Statements and Supplementary Information

Years Ended June 30, 2017 and 2016

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Building a better working world

Report of Independent Auditors

The Board of Trustees
Peninsula Regional Health System, Inc.

We have audited the accompanying consolidated financial statements of Peninsula Regional Health System, Inc. and subsidiaries (the Health System), which comprise the consolidated balance sheets as of June 30, 2017 and 2016, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We did not audit the financial statements of certain subsidiaries and joint ventures of both Peninsula Health Ventures, Inc. and Peninsula Regional Medical Center, both of which are wholly owned subsidiaries of the Heath System. Two of the entities, Delmarva Peninsula Insurance Company (DPIC) and Delmarva Surgery Center, LLC, (Delmarva), reflect total assets constituting 4.2% and 4.1% in 2017 and 2016, respectively, and total revenues constituting 1.2% in 2017 and 2016 of the related consolidated totals. Those statements were audited by other auditors whose reports have been furnished to us, and our opinion, insofar as it relates to the amounts included for DPIC and Delmarva, is based solely on the reports of the other auditors. Additionally, we did not audit the financial statements of Peninsula Imaging, LLC (Imaging), in which the Health System has a 50% interest. In the consolidated financial statements, the Health System's investment in Imaging is stated at $3.3 million and $2.1 million as of June 30, 2017 and 2016, respectively, and the Health System's equity in the excess of unrestricted revenue and other support over expenses of Imaging is stated at $993 thousand and $1.1 million for the years ended June 30, 2017 and 2016, respectively. Those statements were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Imaging, is based solely on the report of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

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An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Health System's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audits and the reports of other auditors, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Peninsula Regional Health System, Inc. and subsidiaries at June 30, 2017 and 2016, and the consolidated results of their operations and changes in net assets and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating supplementary information is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Ernst & Young LLP

September 27, 2017

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Peninsula Regional Health System, Inc.

Consolidated Balance Sheets
(In Thousands)

	June 30 2017	2016
Assets		
Current assets:		
Cash and cash equivalents	$ **37,525**	$ 36,755
Short-term investments	**6,899**	6,760
Accounts receivable, less allowance for uncollectible accounts (2017 – $9,355; 2016 – $8,278)	**39,599**	42,234
Inventories and other assets	**9,259**	10,226
Prepaids	**6,360**	6,327
Total current assets	**99,642**	102,302
Long-term investments	**241,087**	226,353
Board-designated investments	**26,947**	23,584
Assets limited as to use:		
Construction fund	**760**	10,228
Donor-restricted fund	**34,842**	33,217
Self-insurance fund	**21,376**	19,713
	56,978	63,158
Property and equipment, net	**228,303**	224,843
Other assets	**23,265**	19,663
Total assets	$ **676,222**	$ 659,903

(continued on next page)

Peninsula Regional Health System, Inc.

Consolidated Balance Sheets (continued)
(In Thousands)

	June 30	
	2017	**2016**
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	**$ 2,172**	$ 2,068
Current portion of accrued self-insured liabilities	**2,495**	2,495
Accounts payable	**20,769**	18,088
Accrued liabilities	**13,730**	14,936
Advances from third-party payors	**9,806**	11,401
Total current liabilities	**48,972**	48,988
Long-term debt, net	**139,008**	141,970
Other liabilities	**32,416**	38,537
Total liabilities	**220,396**	229,495
Net assets:		
Unrestricted	**418,548**	395,287
Temporarily restricted	**27,123**	25,058
Permanently restricted	**8,255**	8,245
Peninsula Regional Health System, Inc. net assets	**453,926**	428,590
Minority interest	**1,900**	1,818
Total net assets	**455,826**	430,408
Total liabilities and net assets	**$ 676,222**	$ 659,903

See accompanying notes.

Peninsula Regional Health System, Inc.

Consolidated Statements of Operations and Changes in Net Assets
(In Thousands)

	Year Ended June 30	
	2017	**2016**
Unrestricted revenue and other support:		
Net patient service revenue	**$ 425,802**	$ 418,423
Provision for bad debts	**(11,686)**	(11,477)
Net patient service revenue less provision for bad debts	**414,116**	406,946
Other operating revenue	**2,576**	2,749
Total unrestricted revenue and other support	**416,692**	409,695
Operating expenses:		
Salaries and wages	**175,710**	165,766
Supplies and other expenses	**192,798**	184,578
Employee benefits	**39,337**	34,429
Depreciation	**26,749**	22,804
Interest	**5,627**	5,052
Total operating expenses	**440,221**	412,629
Loss from operations	**(23,529)**	(2,934)
Non-operating income:		
Investment income	**16,706**	10,690
Total non-operating income	**16,706**	10,690
(Deficit) excess of unrestricted revenue and other support over expenses	**(6,823)**	7,756
Minority interest in earnings of controlled subsidiaries	**(82)**	(31)
(Deficit) excess of unrestricted revenue and other support over expenses attributable to Peninsula Regional Health System, Inc.	**(6,905)**	7,725

(continued on next page)

Peninsula Regional Health System, Inc.

Consolidated Statements of Operations and Changes in Net Assets (continued)

(In Thousands)

	Year Ended June 30	
	2017	**2016**
Unrestricted net assets:		
(Deficit) excess of unrestricted revenue and other support over expenses attributable to Peninsula Regional Health System, Inc.	**$ (6,905)**	$ 7,725
Net assets released from restrictions used for purchase of property and equipment	**3,309**	–
Unrealized gains (losses) on investments	**16,153**	(9,251)
Pension adjustment	**10,704**	(16,514)
Increase (decrease) in unrestricted net assets	**23,261**	(18,040)
Temporarily restricted net assets:		
Donations	**2,324**	1,673
Net realized gains on investments	**1,506**	1,266
Unrealized gains (losses) on investments	**1,742**	(1,130)
Net assets released from restrictions	**(3,507)**	(271)
Increase in temporarily restricted net assets	**2,065**	1,538
Permanently restricted net assets:		
Net realized gains on investments	**5**	2
Unrealized gains (losses) on investments	**5**	(3)
Increase (decrease) in permanently restricted net assets	**10**	(1)
Increase (decrease) in net assets	**25,336**	(16,503)
Net assets at beginning of year	**428,590**	445,093
Net assets at end of year	**$ 453,926**	$ 428,590

See accompanying notes.

Peninsula Regional Health System, Inc.

Consolidated Statements of Cash Flows
(In Thousands)

	Year Ended June 30	
	2017	**2016**
Operating activities		
Change in net assets	**$ 25,336**	$ (16,503)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation of property and equipment	**26,749**	22,804
Amortization of original issue premium	**(836)**	(1,105)
Equity in losses of joint ventures	**1,233**	–
Amortization of financing costs	**46**	46
Gains on sale of property and equipment	**(320)**	–
Net unrealized (gains) losses on investments	**(17,940)**	7,358
Net realized gains on investments	**(13,594)**	(7,251)
Proceeds from restricted contributions and realized gains on restricted investments	**(3,830)**	(2,939)
Minority interest in earnings of controlled subsidiaries	**82**	31
Changes in operating assets and liabilities:		
Accounts receivable	**2,055**	(2,587)
Inventories and other assets	**(3,861)**	(1,205)
Accounts payable and accrued liabilities	**1,702**	(4,981)
Self-insurance and other liabilities	**(6,121)**	18,568
Advances from third-party payors	**(1,595)**	1,555
Net cash provided by operating activities	**9,106**	13,791
Investing activities		
Purchase of investments	**(199,022)**	(154,630)
Proceeds from sales of investments	**211,215**	162,126
Purchases of property and equipment	**(30,229)**	(37,283)
Proceeds from disposal of assets	**340**	–
Change in assets limited to use	**7,598**	(1,160)
Net cash used in investing activities	**(10,098)**	(30,947)
Financing activities		
Proceeds from restricted contributions and realized losses on restricted investments	**3,830**	2,939
Repayments of long-term debt	**(2,068)**	(2,004)
Net cash provided by financing activities	**1,762**	935
Net increase (decrease) in cash and cash equivalents	**770**	(16,221)
Cash and cash equivalents at beginning of year	**36,755**	52,976
Cash and cash equivalents at end of year	**$ 37,525**	$ 36,755

See accompanying notes.

Peninsula Regional Health System, Inc.

Notes to Consolidated Financial Statements
(Dollar Amounts in Thousands)

June 30, 2017

1. Organization and Mission

Peninsula Regional Health System, Inc. (the Health System) serves as the parent company to Peninsula Regional Medical Center (the Hospital); Peninsula Regional Medical Center Foundation, Inc. (the Foundation); Peninsula Health Ventures, Inc. (Health Ventures); Peninsula Women's Surgery Center, LLC; and Peninsula Regional Clinically Integrated Network, LLC. The Health System is a not-for-profit Maryland membership corporation established to manage the integrated delivery of health care services to the community. The Health System is the sole corporate member of the Hospital and the Foundation. In its capacity as sole corporate member, the Health System will appoint trustees, approve major expenditures, and approve long-term borrowings.

The Hospital is a not-for-profit, non-stock corporation founded in 1897 to serve the health care needs of its region. Primary service areas include the Maryland counties of Wicomico, Somerset, and Worcester; southern Delaware; and the northern Eastern Shore of Virginia. The Hospital's mission is to improve the health care of the community by providing exceptional quality primary, secondary, and selected tertiary health care services to patients in a competent and compassionate manner, designed to elicit a high degree of customer satisfaction. The Hospital provides services regardless of race, creed, sex, national origin, handicap, or age. In May 2013, Delmarva Peninsula Insurance Company (DPIC) was incorporated as a wholly owned subsidiary of the Hospital. DPIC was formed as captive insurer to provide professional and general liability (GL) insurance.

The Foundation is a not-for-profit, non-stock corporation organized to raise contributions exclusively for the benefit of charitable, educational, medical, and scientific purposes for the Hospital.

Health Ventures is a for-profit corporation organized for the purpose of owning, developing, operating, and investing in health care enterprises on the Delmarva Peninsula. The Health System owns all of the outstanding shares of common stock of Health Ventures.

2. Significant Accounting Policies

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Health System and all wholly owned subsidiaries, principally the Hospital, the Foundation, and Health Ventures. Additionally, the Health System has consolidated a 55%-owned affiliate, Delmarva Surgery Center, LLC, and recorded minority interest equal to the remaining ownership interest.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual amounts could differ from those estimates.

Fair Value of Financial Instruments

The carrying amounts of financial instruments, including cash and cash equivalents, accounts receivable, accounts payable, and advances from third-party payors, approximate fair value given the short-term nature of these financial instruments.

Cash and Cash Equivalents

Cash and cash equivalents include surplus operating funds invested in money market funds and highly liquid corporate, U.S. government, and agency obligations, all with maturities of less than three months when purchased.

Investments and Investment Income

Investments are carried at fair value. All such investments are considered available for sale and are classified as current or non-current assets based on management's intention as to use. Short-term investments represent investments with contractual maturities within one year and current investments in money market funds that have been designated for investment purposes. Assets limited as to use by donor restriction are recorded at fair value at the date of donation, and changes in fair value are recognized in the period in which the change occurs. Investment income

2. Significant Accounting Policies (continued)

from all unrestricted investments is reported as non-operating income. Investment income on investments of restricted assets is added to or deducted from the appropriate restricted net assets when restricted as to use by the donor.

The value of securities sold is based on the specific identification method.

The Health System periodically evaluates whether any declines in the fair value of investments are other than temporary. This evaluation consists of a review of several factors, including, but not limited to, length of time and extent that a security has been in an unrealized loss position, the existence of an event that would impair the issuer's future earnings potential, the near-term prospects for recovery of the market value of a security, and the intent and ability of the Health System to hold the security until the market value recovers. Realized gains or losses are included in non-operating income on the accompanying consolidated statements of operations and changes in net assets. Declines in fair value below cost that are deemed to be other than temporary would be recorded as realized losses within non-operating income. Based on its evaluation, the Health System has recorded no other-than-temporary impairments for the years ended June 30, 2017 or 2016.

Accounts Receivable and Contractual Allowances

The Health System, through its member companies, provides services to patients in the Eastern Shore area of Maryland, Delaware, and Virginia, the majority of whom are covered by third-party health insurance. The Health System bills the insurer directly for services provided.

Insurance coverage and financial information is obtained from patients upon admission when available. The Health System's policy is to perform in-house collection procedures for approximately 85 days. A determination is made at that time as to which additional collection efforts to pursue. A provision for uncollectible accounts is recorded for amounts not yet written off, which are expected to become uncollectible.

Discounts ranging from 2% to 6% of charges are given to Medicare, Medicaid, and certain approved commercial health insurance and health maintenance organization programs for regulated services. Discounts in varying percentages are given for certain unregulated services.

2. Significant Accounting Policies (continued)

These major payors routinely review patient billings and deny payment for certain charges as medically unnecessary or as performed without appropriate preauthorization. Discounts and denials are recorded as reductions of net patient service revenue. Revenue and accounts receivable from these third-party payors have been adjusted to reflect the difference between charges and the estimated reimbursable amounts.

Approximately 35% of accounts receivable were due from the Medicare program as of June 30, 2017 and 2016.

The Medicare and Medicaid reimbursement programs represent a substantial portion of the Health System's revenues. The Health System's operations are subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services and Medicare, and Medicaid fraud and abuse.

Over the past several years, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs, together with the imposition of fines and penalties, as well as repayments for patient services previously billed. Compliance with fraud and abuse standards and other government regulations can be subject to future government review and interpretation. Also, future changes in federal and state reimbursement funding mechanisms and related government budgeting constraints could have an adverse effect on the Health System.

Inventories, Prepaids, and Other

Inventories, prepaids, and other primarily include inventories of supplies and prepaid expenses. Inventories of supplies are carried at the lower of cost or market, using the first-in, first-out method.

2. Significant Accounting Policies (continued)

Other Assets

Other assets primarily include a 50% non-controlling interest in each of the following entities, which are accounted for as equity method investments: Peninsula Imaging, LLC; AHP Delmarva, LLP; Genesis Healthcare; Peninsula-NRH Regional Rehabilitation, LLC; and Peninsula Home Care, LLC. The Hospital also has a 33.3% non-controlling interest in Peninsula Home Care, LLC at Nanticoke, which is accounted for as an equity method investment. Additionally, other assets include a reinsurance receivable asset in 2017 and 2016.

Assets Limited as to Use

Assets limited as to use primarily include assets held by trustees under indenture agreements; assets held by trustees under irrevocable self-insurance trust agreements; and assets, including pledges receivable, whose use has been limited by the donor of the underlying funds. Amounts required to meet current liabilities have been classified on the consolidated balance sheets as current assets.

Board-Designated Investments

Board-designated investments include assets set aside by the Board of Trustees for future capital improvements and expansion. The Board of Trustees retains control of these assets and may, at its discretion, subsequently use them for other purposes.

Property and Equipment

Property and equipment consist of furniture, fixtures, equipment, and capitalized internal use software and acquired software development costs. Property acquired and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

2. Significant Accounting Policies (continued)

Software development costs that are incurred in the preliminary project stage for internal use software are expensed as incurred. During the development stage, direct consulting costs and payroll and payroll-related costs for employees that are directly associated with each project are capitalized and amortized over the estimated useful life of the software once the software is ready for its intended use. Capitalized software is amortized using the straight-line method over its estimated useful life, which is generally seven years. Replacements and upgrades and enhancements to existing systems that result in added functionality are capitalized, while maintenance and repairs are charged to expense as incurred.

Gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted donations. Absent explicit donor stipulations about how long those assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Construction Fund

The Construction Fund was created as a result the proceeds of the 2015 Maryland Health and Higher Educational Facilities Authority (MHHEFA) Revenue Bond Offering, net of the advance refunding of the 2006 MHHEFA bond offering. The net proceeds are required to be spent on capital improvements and used for the acquisition, renovation, or equipping of certain facilities of the Hospital.

Unamortized Financing Costs

Financing costs incurred in issuing the Maryland Health and Higher Educational Facilities Authority Project and Refunding Revenue Bonds have been capitalized and are being amortized using the straight-line method over the life of the bonds, which approximates the effective interest method. The amount amortized is recorded as an operating expense.

The Health System adopted Accounting Standards Update (ASU) 2015-03, *Interest – Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs*, in the current year. The new standard has been applied retrospectively.

2. Significant Accounting Policies (continued)

Estimated Self-Insurance Liabilities and Workers' Compensation

The provision for estimated professional liability claims, general liability claims, and workers' compensation claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

Pension Benefits

Pension benefits are recorded in accordance with Accounting Standards Codification Topic (ASC) 715, *Compensation – Retirement Benefits*, which requires the recognition of the funded status of pension plans on the accompanying consolidated balance sheets. As of June 30, 2017 and 2016, the funded status of the pension plan has been recorded within other long-term liabilities and other assets, respectively.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Health System has been limited by donors to a specific time period or purpose. Temporarily restricted net assets are to be used for capital purposes and other health care services.

Permanently restricted net assets have been restricted by donors to be maintained by the Health System in perpetuity.

Net Patient Service Revenue

Net patient service revenue is reported at the estimated realizable amounts from patients, third-party payors, and others for services rendered. During 2017 and 2016, approximately 52% and 49%, respectively, of net patient service revenue was received under the Medicare program; 12% and 13%, respectively, from CareFirst Blue Cross Blue Shield; 33% and 30%, respectively, from contracts with other third parties; and 3% and 8% from other sources.

2. Significant Accounting Policies (continued)

The following table sets forth the detail of net patient service revenue:

	Year Ended June 30	
	2017	**2016**
Gross patient service revenue	$ **534,960**	$ 522,069
Revenue deductions:		
Charity care	**9,226**	8,670
Contractual and other allowances	**99,932**	94,976
Patient revenue, net of deductions	**425,802**	418,423
Less provision for bad debts	**11,686**	11,477
Net patient service revenue less bad debts	$ **414,116**	$ 406,946

The Health System employs physicians in several hospital-based specialties. The Health System bills for the services provided by these physicians. Net physician revenue is recognized when the services are provided and recorded at the estimated net realizable amount based on the contractual arrangements with third-party payors and the expected payments from the third-party payors and the patients. The difference between the billed charges and the estimated net realizable amounts is recorded as a reduction in physician revenue when the services are provided. For the years ended June 30, 2017 and 2016, the Health System recorded $31,572 and $33,388 of net physician revenue, respectively.

Patient accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectibility of accounts receivable, the Health System analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Health System analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary. For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Health System records a provision for bad debts in the period of service on the basis of its past experience. The difference between the standard rates (or the discounted rates if negotiated) and

2. Significant Accounting Policies (continued)

the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts. The Health System has not changed its charity care or uninsured discount policies during fiscal years 2017 or 2016.

Other Operating Revenue

The American Recovery and Reinvestment Act of 2009 provides for Medicare and Medicaid incentive payments for eligible hospitals and professionals that implement and achieve meaningful use of certified electronic health record (EHR) technology. For Medicare and Medicaid EHR incentive payments, the Hospital uses a gain contingency accounting method to recognize the revenues. Under this accounting policy, EHR incentive payments are recognized as revenue upon the completion of the meaningful use period and completion of the related 12-month cost report. Accordingly, the Hospital recognized approximately $240 and $790 of EHR revenues for the years ended June 30, 2017 and 2016, respectively. This is based on cost report data that is subject to audit by the Centers for Medicare & Medicaid Services (CMS) or its intermediaries, and the amounts recognized are subject to change.

These amounts are included in other operating revenue on the consolidated statements of operations and changes in net assets. The Hospital's attestation of compliance with the meaningful use criteria is subject to audit by the federal government or its designee. The recognition of revenues is based on management's best estimate. Any subsequent changes in the recognition of revenue will impact the results of operations in the period in which they occur.

Charity Care

The Health System provided care to patients who met certain criteria under its charity care policy, without charge or at amounts less than its approved rates. Because the Health System did not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The amounts written off as charity care for 2017 and 2016 were $7,859 and $7,113, respectively. These amounts represent direct and indirect charity care costs, which are calculated using the Health System's cost to charge ratio. The state of Maryland's rate system includes components within the rates to partially compensate health systems for uncompensated care.

2. Significant Accounting Policies (continued)

Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Health System are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted donations if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or the purpose of the restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported on the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying consolidated financial statements.

Investment Income

Investment income primarily includes income from short-term and long-term investments, board-designated investments, and investments within assets limited as to use. In addition, investment income is also recorded for certain equity method investments that are included within other assets.

The components of investment income are as follows:

	Year Ended June 30	
	2017	**2016**
Interest and dividend income	**$ 4,239**	$ 5,587
Realized gains, net	**10,233**	1,837
Income earned on equity method investments	**2,137**	3,168
Other	**97**	98
Total	**$ 16,706**	$ 10,690

2. Significant Accounting Policies (continued)

Income Taxes

The Health System is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code.

Performance Indicator

The performance indicator for the Health System is (deficit) excess of unrestricted revenue and other support over expenses, which includes all changes in unrestricted net assets except for changes in unrealized gains and losses on investments; pension adjustments in accordance with ASC 958-715, *Not-for-Profit Entities – Compensation – Retirement Benefits*; and net assets released from restrictions for property acquisitions.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606).* This guidance is intended to improve and converge with international standards the financial reporting requirements for revenue from contracts with customers. It will be effective for fiscal year 2019, and early adoption is permitted beginning in fiscal year 2018. The Health System is currently assessing the potential impact this ASU will have on the Health System's consolidated results of operations, financial position, and cash flows.

In August 2014, the FASB issued ASU 2014-15, *Presentation of Financial Statements – Going Concern (Subtopic 205-40): Disclosure of Uncertainties about an Entity's Ability to Continue as a Going Concern*, which provides guidance in GAAP about management's responsibility to evaluate whether there is substantial doubt about an entity's ability to continue as a going concern and to provide related footnote disclosures. This amendment should reduce diversity in the timing and content of footnote disclosures. The Health System implemented this guidance as of June 30, 2017, and it did not materially impact the Health System's consolidated results of operations, net assets, or cash flows.

2. Significant Accounting Policies (continued)

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842)*. This ASU amends the existing accounting standards for lease accounting, including requiring lessees to recognize most leases on their balance sheets. This guidance is effective for fiscal year 2020. The Health System is currently assessing the potential impact this ASU will have on the Health System's consolidated results of operations, financial position, and cash flows.

In March 2017, the FASB issued ASU 2017-07, *Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*, which changes the presentation of net periodic pension cost and net periodic postretirement benefit cost requiring that an employer report the service cost component in the same line item or items as other compensation costs arising from services rendered by the pertinent employees during the period. The other components of net benefit cost as defined in paragraphs 715-30-35-4 and 715-60-35-9 are required to be presented on the income statement separately from the service cost component and outside a subtotal of income from operations, if one is presented. This guidance is effective for fiscal year 2018. The Health System is currently assessing the potential impact this ASU will have on the Health System's consolidated results of operations.

3. Property and Equipment

A summary of property and equipment follows:

	Estimated Useful Lives (in Years)	June 30 2017	2016
Land	–	**$ 11,410**	$ 11,385
Land improvements	20	**12,702**	11,711
Buildings and improvements	15–40	**238,578**	233,272
Fixed equipment	20	**33,822**	33,822
Movable equipment	7–10	**245,248**	209,822
		541,760	500,012
Less accumulated depreciation		**(326,283)**	(301,092)
		215,477	198,920
Construction in progress		**12,826**	25,923
Property and equipment, net		**$ 228,303**	$ 224,843

3. Property and Equipment (continued)

As of June 30, 2017, the Hospital was committed to building and equipment purchases totaling approximately $6,749.

In the current year, the Hospital transitioned to a new billing and accounts receivable platform. The system went live on November 1, 2016. The Hospital has capitalized $31,389 of software development costs associated with the implementation of the EPIC system as of June 30, 2017 ($12,533 and $18,856 during the years ended June 30, 2017 and 2016, respectively). Amortization of software development costs associated with the EPIC System began on November 1, 2016. At June 30, 2017, $28,322 remain as unamortized costs associated with the development of capitalized software and are classified in moveable equipment. These costs are to be amortized over estimated useful lives of 5–10 years. The Hospital recognized an expense related to the amortization of costs of $3,067 for the year ended June 30, 2017.

4. Other Liabilities

The components of other liabilities are as follows:

	June 30	
	2017	**2016**
Self-insurance obligations	**$ 17,071**	$ 17,898
Long-term pension benefit obligation	**10,952**	16,306
Other	**4,393**	4,333
Total	**$ 32,416**	$ 38,537

5. Long-Term Debt

Long-term debt consists of the following:

	June 30, 2017
Maryland Health and Higher Educational Facilities Authority Revenue Bonds Series 2015:	
Series 2015 serial bonds with interest rates ranging from 3.00% to 5.00% and effective rates ranging from 2.57% to 3.01% due in various annual amounts on July 1 of each year from 2018 through 2034	$ 53,975
Series 2015 5.00% term bonds with effective rate of 3.99% due July 1, 2039	26,445
Series 2015 5.00% term bonds with effective rate of 4.13% due July 1, 2045	41,550
Building and equipment collateral loans:	
4.40% fixed rate due monthly from 2012 to 2022	1,695
	123,665
Less current portion of Maryland Health and Higher Educational Facilities Authority Series 2015 serial bonds	2,090
Less current portion of building and equipment collateral loans	82
	121,493
Original issue premium	18,812
Unamortized debt issue costs	(1,297)
Long-term debt, net	$ 139,008

5. Long-Term Debt (continued)

	June 30, 2016
Maryland Health and Higher Educational Facilities Authority Revenue Bonds Series 2015:	
Series 2015 serial bonds with interest rates ranging from 3.00% to 5.00% and effective rates ranging from 2.57% to 3.01% due in various annual amounts on July 1 of each year from 2017 through 2034	$ 55,964
Series 2015 5.00% term bonds with effective rate of 3.99% due July 1, 2039	26,444
Series 2015 5.00% term bonds with effective rate of 4.13% due July 1, 2045	41,550
Building and equipment collateral loans:	
4.40% fixed rate due monthly from 2012 to 2022	1,774
	125,732
Less current portion of Maryland Health and Higher Educational Facilities Authority Series 2015 serial bonds	1,990
Less current portion of building and equipment collateral loans	78
	123,664
Original issue premium	19,655
Unamortized debt issue costs	(1,349)
Long-term debt, net	$ 141,970

Series 2015 Revenue Bonds

On February 5, 2015, MHHEFA authorized the issuance of $126,665 aggregate principal amount of Revenue Bonds (Series 2006 Revenue Bonds) at a premium of $20,770. The proceeds of the issue, after payment of financing costs, were used primarily (i) to advance refund outstanding 2006 bonds and (ii) to finance $25,000 of capital purchases.

The Hospital is required to make semiannual payments to the trustee sufficient to meet the annual debt service requirements of the refunding bond issue for the succeeding year. Annual sinking fund installments for the term bonds range from $3,322 on July 1, 2015, to $8,189 on July 1, 2020. The premium on the Series 2015 Bonds is being amortized over the life of the bonds using the effective interest method.

5. Long-Term Debt (continued)

As security for the debt service requirements of the Series 2015 Bonds, MHHEFA has a first lien and claim on all receipts of the Hospital. The terms of the indenture agreement restrict the Hospital's ability to create additional indebtedness and its use of the facilities, and require the Hospital to maintain stipulated insurance coverage and a rate structure in each year sufficient to meet certain rate covenant requirements.

Delmarva Surgery Center, LLC Building Loan

On June 1, 2012, Delmarva Surgery Center, LLC, a 55%-owned subsidiary of Health Ventures, entered into a fixed rate loan agreement with BB&T Bank in the amount of $2,059 ($1,695 outstanding at June 30, 2017), with fixed monthly payments through June 1, 2022.

Scheduled principal repayments on long-term debt for the years ending June 30 are as follows:

2018	$ 2,172
2019	2,282
2020	2,396
2021	2,515
2022	2,640
2023 and thereafter	111,660
	$ 123,665

Fair values of long-term debt are estimated using discounted cash flow analyses, based on current incremental borrowing rates for similar types of borrowing arrangements.

The fair value of the Health System's long-term debt outstanding as of June 30, 2017 and 2016, was approximately $137,498 and $148,928, respectively.

Total interest paid for fiscal years 2017 and 2016 was $5,433 and $4,999, respectively.

6. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes:

	June 30 2017	2016
Health care services:		
Capital purposes	$ **17,434**	$ 17,390
Patient services	**8,340**	6,569
Educational purposes	**1,349**	1,099
	$ **27,123**	$ 25,058

Permanently restricted net assets are restricted as follows:

	June 30 2017	2016
Investments to be held in perpetuity, the income from which is expendable to support health care services	$ **8,255**	$ 8,245

The Foundation initiated a major fundraising campaign for capital funds during fiscal year 2005 to support the Hospital's capital plans that include expansion and modernization of facilities. The Foundation has raised approximately $14,629 as of June 30, 2017, which includes net pledges receivable presently valued at approximately $540. The Foundation expects to receive payment on the majority of the pledges by 2020 and all payments by 2025. During 2011, the Foundation launched a fundraising campaign to support the operating room expansion. This campaign has raised $2,894 as of June 30, 2017, which includes net pledges receivable presently valued at $57. Additionally during 2016, the Foundation initiated a behavioral health campaign that has raised $1,744 as of June 30, 2017, and includes net pledges receivable presently valued at $398. During fiscal year 2017, the Foundation began a campaign to support the Richard A. Henson Cancer Institute in Ocean Pines. This campaign has raised $1,017 as of June 30, 2017, which includes net pledges receivable presently valued at $579. Pledges receivable are included in assets limited

6. Temporarily and Permanently Restricted Net Assets (continued)

as to use on the accompanying consolidated balance sheets. Scheduled payments on pledges receivable for the years ending June 30 are as follows:

2018	$ 480
2019–2022	1,075
2023 and thereafter	281
	1,836
Less:	
Impact of discounting of pledges receivable to net present value	(91)
Allowance for uncollectible pledges	(171)
Net pledges receivable, capital campaign	$ 1,574

7. Functional Expenses

The Health System considers health care services and management and general to be its primary functional categories for purposes of expense classification. Depreciation and interest costs are included in health care services. The Health System's operating expenses by functional classification are as follows:

	Year Ended June 30	
	2017	**2016**
Health care services	**$ 385,506**	$ 353,874
Management and general	**54,715**	58,755
	$ 440,221	$ 412,629

8. Malpractice Insurance Costs, Self-Insured Professional Liability, and Workers' Compensation

Effective July 1, 2013, Delmarva Peninsula Insurance Captive (DPIC) was formed as a captive insurer to provide professional liability insurance. DPIC is a wholly owned subsidiary of the Hospital. The primary layer of professional and GL insurance coverage is self-insured through DPIC, and the secondary layer is fully insured through a commercial carrier.

8. Malpractice Insurance Costs, Self-Insured Professional Liability, and Workers' Compensation (continued)

Effective July 1, 2013, under a loss portfolio transfer agreement, DPIC assumed the medical professional liability (MPL) and GL coverage previously included under the Hospital's self-insurance plan for incidents occurring between March 1, 1986 and June 30, 2013, for MPL and for occurrences between March 1, 2004 and June 30, 2013, for GL that were reported to the Hospital prior to June 30, 2013. The policy provides MPL coverage limits varying from $1,000 to $2,000 for each and every medical incident, with policy aggregates varying from $3,000 to $8,000. The policy provides GL coverage limits of $1,000 per occurrence and $3,000 policy aggregates. This policy is retrospectively rated.

DPIC is fully insured by commercial carriers in excess of the coverage limits discussed above up to $25,000 per claim and in the aggregate. As of June 30, 2017 and 2016, the accrued self-insured professional liability losses have been undiscounted for both years. As of June 30, 2017 and 2016, $10,033 and $11,546, respectively, has been reserved for professional liability loss contingencies, including excess coverage. A related reinsurance receivable of $5,793 and $5,100 has been recorded in other assets as of June 30, 2017 and 2016, respectively.

Effective July 1, 2013, DPIC provides excess umbrella liability coverage on a mature claims-made basis with a retroactive date of March 1, 2005. The excess MPL tower follows the form of the underlying primary MPL coverage providing a total of $25,000 limits of liability. The umbrella liability coverage provides $25,000 limits of liability excess of scheduled underlying coverages, including the primary GL coverage. The excess umbrella liability coverage is 100% reinsured with Darwin for the first $10,000 limit and OneBeacon for the second $15,000 limit.

The Hospital is also self-insured for workers' compensation up to an annual limit of $500 per occurrence. The Hospital carries an excess liability insurance policy for workers' compensation claims above this limit. As of June 30, 2017 and 2016, $3,695 and $3,701, respectively, has been reserved for workers' compensation loss contingencies.

9. Investments

The following methods and assumptions were used by the Health System in estimating the fair value of its financial instruments:

Fair values of all investments, including short-term investments, long-term investments, board-designated investments, and assets limited as to use are based on quoted market prices and/or prices obtained from a third party using other market data for the same or comparable instruments and transactions in establishing the prices. Certain long-term pledges receivable have been discounted.

Fair value of investments and certain assets limited as to use held by the Health System is summarized as follows. The below table includes $3,407 and $5,584 in money market funds classified as cash and cash equivalents as of June 30, 2017 and 2016, respectively.

	June 30	
	2017	**2016**
Investments:		
Money market funds	**$ 19,020**	$ 22,692
U.S. Treasury securities	**19,736**	16,592
Corporate bonds	**57,951**	58,267
Mortgage-backed securities	**19,670**	25,879
Equity securities	**216,625**	194,893
Other (including pledges receivable held at the Foundation)	**2,316**	1,533
Total	**$ 335,318**	$ 319,856

ASC 320, *Investments – Debt and Equity Securities*, provides guidance on the recognition and presentation of other-than-temporary impairments. If a debt security is in an unrealized loss position and the Health System has the intent to sell the debt security, or it is more likely than not that the Health System will have to sell the debt security before recovery of its amortized cost basis, the decline in value is deemed to be other than temporary and is recorded to other-than-temporary impairment losses recognized in the performance indicator on the consolidated statements of operations and changes in net assets. For impaired debt securities that the Health System does not intend to sell or it is more likely than not that the Health System will not have to sell such securities, but the Health System expects that it will not fully recover the amortized cost basis, the credit component of the other-than-temporary impairment is recognized in other-than-temporary impairment losses recognized in income on the consolidated statements of operations and changes in net assets and the non-credit component of the other-than-temporary impairment is recognized as a change in unrestricted net assets.

9. Investments (continued)

The credit component of other-than-temporary impairment is determined by comparing the net present value of projected future cash flows with the amortized cost basis of the debt security. The net present value is calculated by discounting the best estimate of projected future cash flows at the effective interest rate implicit in the debt security at the date of acquisition. Cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings, and estimates regarding timing and amount of recoveries associated with a default. Furthermore, unrealized losses entirely caused by non-credit-related factors related to debt securities for which the Health System expects to fully recover the amortized cost basis continue to be recognized as an unrealized loss on investments within the changes in unrestricted net assets.

The following table shows the gross unrealized losses and fair value of the Health System's investments with unrealized losses that are not deemed to be other than temporarily impaired, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position:

	Fair Value < 1 Year	Unrealized Losses < 1 Year	Fair Value > 1 Year	Unrealized Losses > 1 Year	Total Unrealized Losses
June 30, 2017					
U.S. Treasury	**$ 14,008**	**$ 290**	**$ –**	**$ –**	**$ 290**
Mortgage-backed securities	**5,216**	**35**	**4,891**	**271**	**306**
Corporate bonds	**18,482**	**197**	**2,309**	**137**	**334**
Equity securities	**20,994**	**1,329**	**215**	**56**	**1,385**
Total investments	**$ 58,700**	**$ 1,851**	**$ 7,415**	**$ 464**	**$ 2,315**
June 30, 2016					
U.S. Treasury	$ –	$ –	$ 3,255	$ 213	$ 213
Mortgage-backed securities	542	23	1,486	55	78
Corporate bonds	5,154	65	8,041	488	553
Equity securities	37,776	3,215	2,664	206	3,421
Total investments	$ 43,472	$ 3,303	$ 15,446	$ 962	$ 4,265

10. Fair Value Measurements

ASC 820, *Fair Value Measurement*, establishes a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under ASC 820 are described below.

- Level 1 – Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Health System has the ability to access.

- Level 2 – Inputs to the valuation methodology include:

  - Quoted prices for similar assets or liabilities in active markets

  - Quoted prices for identical or similar assets or liabilities in inactive markets

  - Inputs other than quoted prices that are observable for the asset or liability

  - Inputs that are derived principally from or corroborated by observable market data by correlation or other means

- Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

10. Fair Value Measurements (continued)

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Health System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following table presents the Health System's assets and liabilities measured at fair value, aggregated by level in the fair value hierarchy within which those measurements fall:

	Assets at Fair Value as of June 30, 2017			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Money market funds	**$ 19,020**	**$ –**	**$ –**	**$ 19,020**
U.S. government securities	**19,736**	**–**	**–**	**19,736**
Corporate bonds	**–**	**57,952**	**–**	**57,952**
Government-sponsored mortgage-backed securities	**–**	**19,670**	**–**	**19,670**
Equity securities	**216,625**	**–**	**–**	**216,625**
Other	**741**	**–**	**1,574**	**2,315**
Total assets	**$ 256,122**	**$ 77,622**	**$ 1,574**	**$ 335,318**

	Assets at Fair Value as of June 30, 2016			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Money market funds	$ 22,692	$ –	$ –	$ 22,692
U.S. government securities	16,592	–	–	16,592
Corporate bonds	–	58,267	–	58,267
Government-sponsored mortgage-backed securities	–	25,879	–	25,879
Equity securities	194,893	–	–	194,893
Other	269	–	1,264	1,533
Total assets	$ 234,446	$ 84,146	$ 1,264	$ 319,856

10. Fair Value Measurements (continued)

The fair values of securities are determined by third-party service providers utilizing various methods dependent upon the specific type of investment. Where quoted prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. Where significant inputs, including benchmark yields, broker-dealer quotes, issuer spreads, bids, offers, the London Interbank Offered Rate curve, and measures of volatility, are used by these third-party dealers or independent pricing services to determine fair values, the securities are classified within Level 2.

Long-term pledges receivable, which are measured at fair value on a nonrecurring basis, are discounted to net present value upon receipt using an appropriate risk-free discount rate based on the term of the receivable. Pledges receivable are recorded net of an allowance for uncollectible pledges. The following table provides a reconciliation of the beginning and ending balances of pledges receivable at fair value that used significant unobservable inputs (Level 3):

	Year Ended June 30	
	2017	**2016**
Pledges receivable		
Balance at July 1	**$ 1,264**	$ 1,113
New pledges	**821**	725
Collections on pledges	**(523)**	(601)
Changes in reserves	**12**	27
Balance at June 30	**$ 1,574**	$ 1,264

11. Pension Plan

The Health System has a cash balance-type defined benefit pension plan covering substantially all of its employees. Plan benefits are based on years of service and the employees' compensation during the last five years of covered employment. The Health System's funding policy is to make sufficient contributions to the plan to comply with the minimum funding provisions of the Employee Retirement Income Security Act of 1974. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future.

11. Pension Plan (continued)

The Peninsula Regional Medical Center Pension Plus Plan (the Plan) provides annual allocations to a participant's hypothetical account. When a participant retires, the participant has the choice to receive a lump-sum distribution equal to the value of the hypothetical account or to receive an annuity based on the value of the hypothetical account.

Prior to January 1, 2009, the Plan provided three different allocations: (i) a service-related allocation, (ii) an age-related allocation, and (iii) a matching allocation. Both the service-related allocation and the age-related allocation were determined by multiplying a participant's annual compensation by a certain percentage. The matching allocation operated to provide an annual allocation in the Plan based on the participant's contribution to the Health System's 403(b) plan.

The Internal Revenue Service issued new regulations that were effective as of January 1, 2009. The new regulations prohibited a pension plan from providing a matching allocation based on a participant's contributions to a different plan. The Plan provided a matching allocation based on a participant's contribution to a 403(b) plan. In order to comply with the new tax law requirements, the Plan was amended effective as of December 31, 2008, to eliminate future matching allocations in the Plan. At the same time, the Health System adopted a 403(b) plan effective as of January 1, 2009, and provided a replacement matching contribution in the 403(b) plan.

11. Pension Plan (continued)

The following provides a reconciliation of the changes in fair value of the Plan's assets and projected benefit obligations, and the Plan's funded status:

	June 30	
	2017	**2016**
Accumulated benefit obligation	**$ 123,227**	$ 121,840
Projected benefit obligation, beginning of year	**$ 134,431**	$ 117,330
Service cost	**6,745**	5,825
Interest cost	**4,130**	4,584
Actuarial (gain) loss	**(2,084)**	9,819
Benefits paid	**(6,982)**	(3,127)
Projected benefit obligation, end of year	**136,240**	134,431
Fair value of plan assets, beginning of year	**118,125**	119,411
Actual gain on plan assets	**14,145**	(1,159)
Employer contributions	**–**	3,000
Benefits paid	**(6,982)**	(3,127)
Fair value of plan assets, end of year	**125,288**	118,125
Fair value of plan assets less than the projected benefit obligation	**$ (10,952)**	$ (16,306)
Pension liability recorded on the consolidated balance sheet	**$ (10,952)**	$ (16,306)

11. Pension Plan (continued)

Components of net periodic benefit cost are as follows:

	Year Ended June 30	
	2017	**2016**
Service cost	**$ 6,745**	$ 5,825
Interest cost	**4,130**	4,584
Expected return on plan assets	**(8,257)**	(7,725)
Amortization of prior service credit	**(63)**	(126)
Recognized net actuarial loss	**2,795**	2,314
Net periodic benefit cost	**$ 5,350**	$ 4,872

Net amounts recognized in unrestricted net assets that have not been recognized in net periodic benefit cost are as follows:

	2017	**2016**
Net actuarial loss	**$ 35,041**	$ 45,808
Prior service credit	**–**	(63)
Total recognized in unrestricted net assets	**$ 35,041**	$ 45,745

The net actuarial loss that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year is approximately $2,226.

11. Pension Plan (continued)

Weighted average assumptions used to determine projected benefit obligations and net periodic benefit costs were as follows:

	June 30	
	2017	**2016**
Projected benefit obligation		
Discount rate	**3.50%**	3.15%
Rates of increase in compensation levels:		
Service:		
<11	**8.00**	8.00
11<21	**5.00**	5.00
21=<	**3.00**	3.00
Net periodic benefit cost		
Discount rate	**3.15**	4.00
Expected long-term return on plan assets	**7.00%**	7.00%
Rate of increase in compensation levels:		
Service:		
<11	**8.00**	8.00
11<21	**5.00**	5.00
21=<	**3.00**	3.00

The defined benefit pension plan asset allocation as of the measurement date and the target asset allocation, presented as a percentage of total plan assets, were as follows:

	2017	**2016**	**Target Allocation**
Debt securities	**28%**	27%	25%–40%
Equity securities	**70**	70	45%–75%
Cash and cash equivalents	**2**	3	1%–10%
Total	**100%**	100%	

11. Pension Plan (continued)

The Health System's defined benefit plan invests in a diversified mix of traditional asset classes. Investments in U.S. equity securities and fixed income securities are made to maximize long-term results while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. Risk tolerance of unexpected investment and actuarial outcomes is continually evaluated by understanding the pension plan's liability characteristics. This is performed through forecasting and assessing ranges of investment outcomes over short-term and long-term horizons, and by assessing the Health System's financial condition and its future potential obligations from both the pension and general operational requirements. Complementary investment styles, such as growth and value equity investing techniques, are utilized by the Health System's investment advisors to further improve portfolio and operational risk characteristics. Equity investments, both actively and passively managed, are used primarily to increase overall plan returns. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

Asset allocations and investment performance are formally reviewed at regularly scheduled meetings of the Health System's Financial Resources Committee.

The overall rate of expected return on assets assumption was based on historical returns, with adjustments made to reflect expectations of future returns. The extent to which the future expectations were recognized included the target rates of return for the future, which have not historically changed.

11. Pension Plan (continued)

The fair values of the Health System's pension plan assets as of June 30, by asset category (see Note 10, *Fair Value Measurements*, for a description of the asset categories), are as follows:

	2017			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Investments at fair value:				
Cash and cash equivalents	**$ 3,482**	**$ –**	**$ –**	**$ 3,482**
U.S. Treasuries	**8,336**	**–**	**–**	**8,336**
Government-sponsored mortgage-backed securities	**–**	**8,162**	**–**	**8,162**
Corporate debt securities	**–**	**17,754**	**–**	**17,754**
Publicly traded equity securities	**87,250**	**11**	**–**	**87,261**
Other	**293**	**–**	**–**	**293**
Total investments	**$ 99,361**	**$ 25,927**	**$ –**	**$ 125,288**

	2016			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Investments at fair value:				
Cash and cash equivalents	$ 3,621	$ –	$ –	$ 3,621
U.S. Treasuries	7,021	–	–	7,021
Government-sponsored mortgage-backed securities	–	8,875	–	8,875
Corporate debt securities	–	16,419	–	16,419
Publicly traded equity securities	81,870	–	–	81,870
Other	319	–	–	319
Total investments	$ 92,831	$ 25,294	$ –	$ 118,125

11. Pension Plan (continued)

The following methods and assumptions were used to estimate fair value of each class of financial instrument:

U.S. Treasuries: The fair value is determined by an active price for an identical security in an observable market.

Corporate debt securities and government-sponsored mortgage-backed securities: The fair value is estimated using quoted prices for similar assets in active markets or quoted prices for identical or similar assets in non-active markets (few transactions, limited information, non-current prices, and high variability over time).

Money market funds: The carrying value of these money market funds approximates fair value as the maturities are less than three months.

Publicly traded equity securities: The fair value is determined by market quotes for an identical security in an observable market.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Health System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

Cash Flows

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid as follows for the years ending June 30:

2018	$ 8,335
2019	8,092
2020	8,453
2021	9,445
2022	9,581
2023–2027	52,192

The Health System does not intend to make voluntary contributions to the defined benefit pension plan for the year ending June 30, 2018.

12. Commitments and Contingencies

Other

The Health System has been named as a defendant in various lawsuits arising from the performance of its normal activities. In the opinion of the Health System's management, after discussion with legal counsel, the amount, if any, of the Health System's ultimate liability under these lawsuits will not have a material adverse effect on the consolidated financial position of the Health System.

A portion of the Health System's revenues is received from health maintenance organizations and other managed care payors. Managed care payors generally use case management activities to control utilization. These payors also have the ability to select providers offering the most cost-effective care. Management does not believe that the organization has undue exposure to any one managed care payor.

The Health System's revenues may be subject to adjustment as a result of examination by government agencies or contractors based upon differing interpretation of government regulations, medical diagnosis, charge coding, medical necessity, or other contract terms. The resolution of these matters, if any, often is not finalized until subsequent to the period during which the services were rendered. Section 302 of the Tax Relief and Health Care Act of 2006 authorized a permanent program involving the use of third-party recovery audit contractors (RACs) to identify Medicare overpayments and underpayments made to providers. The Health System has established protocols to respond to RAC requests and payment denials. Payment recoveries resulting from RAC reviews are appealable through administrative and judicial processes, and the Health System intends to pursue the reversal of adverse determinations where appropriate. In addition to overpayments that are not reversed on appeal, the Health System will incur additional costs to respond to requests for records and pursue the reversal of payment denials. As of June 30, 2016, the Health System recorded an estimated reserve regarding the Medicare overpayments. However, a reserve was not considered necessary as of June 30, 2017. In the opinion of the Health System's management, the ultimate settlement of this matter will not have a material adverse effect on the consolidated financial position of the Health System.

As part of a national investigation, the Health System has been working with the Department of Justice (DOJ) regarding the Medicare programs' coverage guidelines for the implantation of implantable cardioverter defibrillators. On June 15, 2015, the Health System executed a settlement agreement with the DOJ for $2,910. Upon settlement, the Health System accrued the settlement balance as accrued liabilities. Payment was made in July 2015.

12. Commitments and Contingencies (continued)

On June 22, 2012, the Health System filed a self-disclosure to CMS, reporting technical violations of the self-referral regulations (referred to as Stark). As of June 30, 2017, the Health System does not believe the settlement of this issue will have a material adverse effect on its consolidated financial statements.

Operating Leases

The Health System leases certain of its operating facilities and equipment. These leases, which expire through 2028, generally require the Health System to pay all maintenance, property tax, and insurance costs.

At June 30, 2017, aggregate amounts of future minimum payments under operating leases were as follows:

2018	$ 2,670
2019	2,113
2020	1,805
2021	1,660
2022 and thereafter	7,350

Rent expense is recognized on a straight-line basis over the terms of the leases. Rent expense was $2,828 and $2,695 for the years ended June 30, 2017 and 2016, respectively.

13. Maryland Health Services Cost Review Commission

Certain hospital charges are subject to review and approval by the Maryland Health Services Cost Review Commission (the Commission). Hospital management has filed the required forms with the Commission and believes the Hospital to be in compliance with Commission requirements.

The current rate of reimbursement for principally all inpatient services and certain other services to patients under the Medicare and Medicaid programs is based on an agreement between CMS and the Commission. This agreement is based upon a waiver from Medicare prospective payment system reimbursement principles granted to the state of Maryland under Section 1814(b) of the Social Security Act. As of January 2014, the CMS approved a modernized waiver

13. Maryland Health Services Cost Review Commission (continued)

that will be in place as long as Maryland hospitals commit to achieving significant quality improvements, limits on all-payor capita hospital growth, and limits on annual Medicare per capita hospital cost growth to a rate lower than the national annual per capita growth rate. This model is projected to save Medicare at least $330,000 over the next five years.

Beginning in fiscal year 2014, the Hospital entered into an agreement with the Commission to participate in the Global Budgeted Revenue (GBR) program. GBR methodology encourages hospitals to focus on population health strategies by establishing a fixed annual revenue cap for each GBR hospital. The agreement is evergreen in nature and covers both regulated inpatient and outpatient revenues.

Under GBR, hospital revenue is known at the beginning of each fiscal year. Annual revenue is calculated from a base year and is adjusted annually for inflation, infrastructure requirements, population changes, performance in quality-based programs, and changes in levels of uncompensated care. Revenue may also be adjusted annually for market levels and shifts of services to unregulated services.

The Commission's rate-setting methodology for hospital service centers that provide both inpatient and outpatient services or only outpatient services consists of establishing an acceptable unit rate for defined inpatient and outpatient service centers within a hospital. The actual average unit charge for each service center is compared to the approved rate monthly and annually. Overcharges and undercharges due to either patient volume or price variances, adjusted for penalties where applicable, are applied to decrease (in the case of overcharges) or increase (in the case of undercharges) future approved rates on an annual basis. The Hospital undercharged by $696 as of June 30, 2017, which is within the allowable corridor as specified in the GBR Agreement.

The timing of the Commission's rate adjustments for the Hospital could result in an increase or reduction in rates due to the variances and penalties described above in a year subsequent to the year in which such items occur, and there is at least a possibility that the amounts may be material. The Hospital's policy is to record revenue based on actual charges for services to patients in the year in which the services are performed. The Hospital recognizes unbilled revenue for in-house patient services.

14. Subsequent Events

The Health System has evaluated subsequent events through September 27, 2017, the date the accompanying consolidated financial statements were issued.

Supplementary Information

Peninsula Regional Health System, Inc.

Consolidating Balance Sheet
(In Thousands)

June 30, 2017

	Peninsula Regional Medical Center	Peninsula Regional Medical Center Foundation, Inc.	Peninsula Health Ventures, Inc.	Peninsula Regional Clinically Integrated Network, LLC	Peninsula Surgery Center	Peninsula Regional Health System, Inc.	Eliminations	Consolidated
Assets								
Current assets:								
Cash and cash equivalents	$ 33,596	$ 1,181	$ 2,723	$ –	$ 10	$ 15	$ –	$ 37,525
Short-term investments	6,899	–	–	–	–	–	–	6,899
Intercompany receivables	739	–	–	–	–	–	(739)	–
Accounts receivable, less allowance for uncollectible accounts	38,957	–	544	–	98	–	–	39,599
Inventories and other assets	8,928	–	331	–	–	–	–	9,259
Prepaids	6,326	–	34	–	–	–	–	6,360
Total current assets	95,445	1,181	3,632	–	108	15	(739)	99,642
Long-term investments	241,087	–	–	–	–	–	–	241,087
Investment in subsidiaries	–	–	–	–	–	458,250	(458,250)	–
Board-designated investments	26,947	–	–	–	–	–	–	26,947
Assets limited as to use:								
Construction fund	760	–	–	–	–	–	–	760
Donor-restricted fund	34,842	5,116	–	–	–	–	(5,116)	34,842
Self-insurance fund	21,376	–	–	–	–	–	–	21,376
Total assets limited as to use	56,978	5,116	–	–	–	–	(5,116)	56,978
Property and equipment, net	222,927	–	3,652	–	1,724	–	–	228,303
Other assets	12,127	–	9,918	–	–	1,220	–	23,265
Total assets	$ 655,511	$ 6,297	$ 17,202	$ –	$ 1,832	$ 459,485	$ (464,105)	$ 676,222

Peninsula Regional Health System, Inc.

Consolidating Balance Sheet (continued)
(In Thousands)

June 30, 2017

	Peninsula Regional Medical Center	Peninsula Regional Medical Center Foundation, Inc.	Peninsula Health Ventures, Inc.	Peninsula Regional Clinically Integrated Network, LLC	Peninsula Surgery Center	Peninsula Regional Health System, Inc.	Eliminations	Consolidated
Liabilities and net assets								
Current liabilities:								
Current portion of long-term debt	$ 2,090	$ –	$ 82	$ –	$ –	$ –	$ –	$ 2,172
Current portion of accrued self-insured liabilities	2,495	–	–	–	–	–	–	2,495
Intercompany payables	–	15	17	77	188	442	(739)	–
Accounts payable	20,398	–	371	–	–	–	–	20,769
Accrued liabilities	13,730	–	–	–	–	–	–	13,730
Advances from third-party payors	9,806	–	–	–	–	–	–	9,806
Total current liabilities	48,519	15	470	77	188	442	(739)	48,972
Long-term debt, net	137,428	–	1,580	–	–	–	–	139,008
Other liabilities	32,416	–	–	–	–	–	–	32,416
Total liabilities	218,363	15	2,050	77	188	442	(739)	220,396
Net assets:								
Unrestricted	401,770	1,166	13,252	(77)	1,644	418,549	(417,756)	418,548
Temporarily restricted	27,123	5,116	–	–	–	32,239	(37,355)	27,123
Permanently restricted	8,255	–	–	–	–	8,255	(8,255)	8,255
Peninsula Regional Health System, Inc. net assets	437,148	6,282	13,252	(77)	1,644	459,043	(463,366)	453,926
Minority interest	–	–	1,900	–	–	–	–	1,900
Total net assets	437,148	6,282	15,152	(77)	1,644	459,043	(463,366)	455,826
Total liabilities and net assets	$ 655,511	$ 6,297	$ 17,202	$ –	$ 1,832	$ 459,485	$ (464,105)	$ 676,222

Peninsula Regional Health System, Inc.

Consolidating Statement of Operations
(In Thousands)

Year Ended June 30, 2017

	Peninsula Regional Medical Center	Peninsula Regional Medical Center Foundation, Inc.	Peninsula Health Ventures, Inc.	Peninsula Regional Clinically Integrated Network, LLC	Peninsula Surgery Center	Peninsula Regional Health System, Inc.	Eliminations	Consolidated
Unrestricted revenue and other support:								
Net patient service revenue	$ 420,741	$ –	$ 4,954	$ –	$ 107	$ –	$ –	$ 425,802
Provision for bad debts	(11,673)	–	(13)	–	–	–	–	(11,686)
Net patient service revenue less provision for bad debts	409,068	–	4,941	–	107	–	–	414,116
Other operating revenue	2,568	–	8	–	–	–	–	2,576
Net assets released from restrictions	–	3,507	–	–	–	–	(3,507)	–
Total unrestricted revenue and other support	411,636	3,507	4,949	–	107	–	(3,507)	416,692
Operating expenses:								
Salaries and wages	175,124	–	–	567	19	–	–	175,710
Supplies and other expenses	185,968	6	6,020	368	436	–	–	192,798
Employee benefits	39,275	–	–	61	1	–	–	39,337
Depreciation	26,232	–	241	–	276	–	–	26,749
Interest	5,543	–	84	–	–	–	–	5,627
Contributions to Hospital		3,507	–	–	–	–	(3,507)	–
Total operating expenses	432,142	3,513	6,345	996	732	–	(3,507)	440,221
Loss from operations	(20,506)	(6)	(1,396)	(996)	(625)	–	–	(23,529)
Non-operating income (expense):								
Investment income	14,818	6	3,115	–	–	(1,233)	–	16,706
Total non-operating income (loss)	14,818	6	3,115	–	–	(1,233)	–	16,706
(Deficit) excess of unrestricted revenue and other support over expenses	(5,688)	–	1,719	(996)	(625)	(1,233)	–	(6,823)
Minority interest in earnings of controlled subsidiaries	–	–	(82)	–	–	–	–	(82)
(Deficit) excess of unrestricted revenue and other support over expenses attributable to the Health System	$ (5,688)	$ –	$ 1,637	$ (996)	$ (625)	$ (1,233)	$ –	$ (6,905)

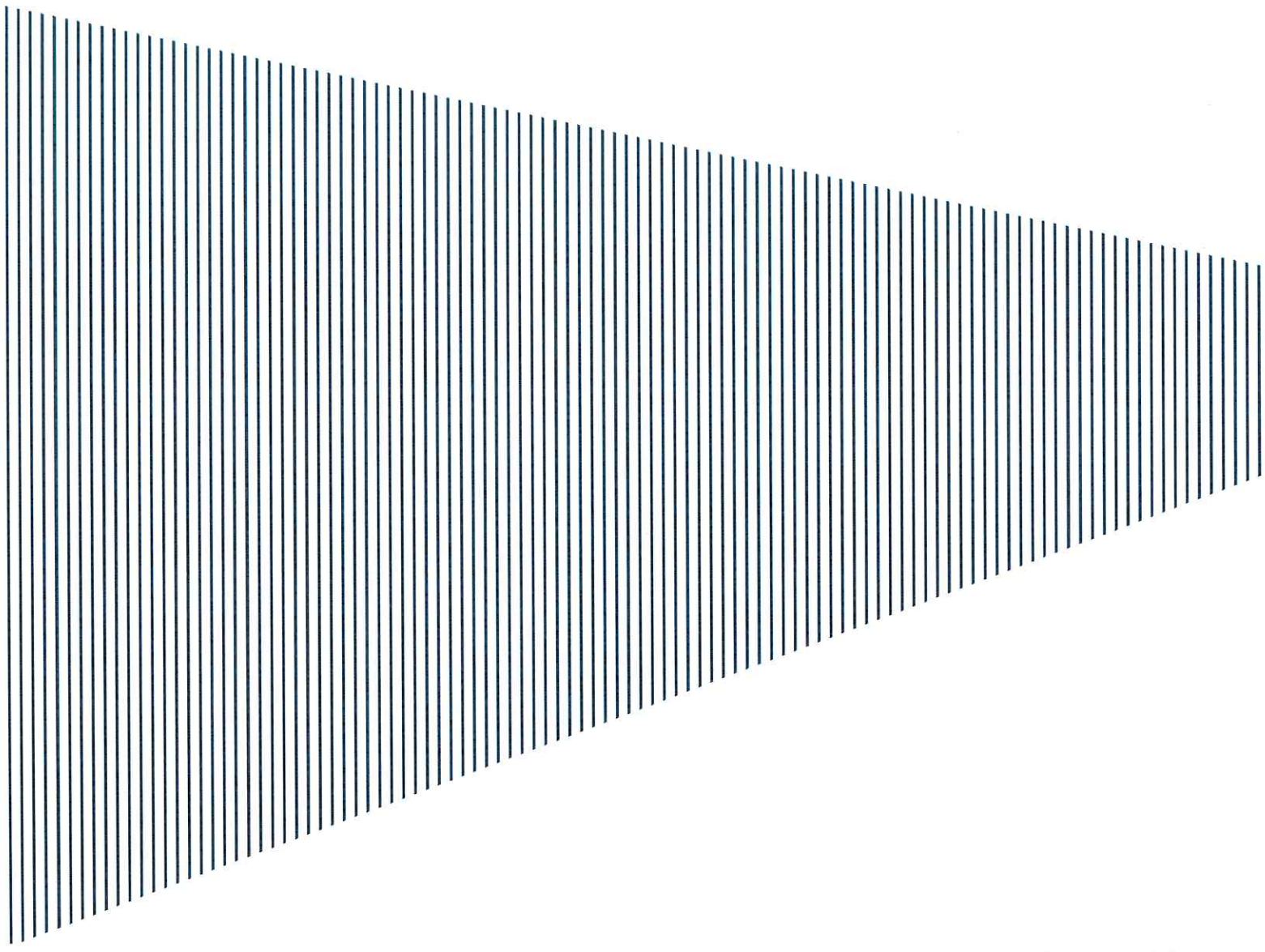
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Consolidated Financial Statements and Supplementary Information

Peninsula Regional Health System, Inc.
Years Ended June 30, 2016 and 2015
With Report of Independent Auditors

Ernst & Young LLP



Building a better working world

Peninsula Regional Health System, Inc.

Consolidated Financial Statements and Supplementary Information

Years Ended June 30, 2016 and 2015

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Report of Independent Auditors

The Board of Trustees
Peninsula Regional Health System, Inc.

We have audited the accompanying consolidated financial statements of Peninsula Regional Health System, Inc. and subsidiaries (the Health System), which comprise the consolidated balance sheets as of June 30, 2016 and 2015, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We did not audit the financial statements of certain subsidiaries and joint ventures of both Peninsula Health Ventures, Inc. (Health Ventures) and Peninsula Regional Medical Center (the Hospital), both of which are wholly owned subsidiaries of the Heath System. Two of the entities, Delmarva Peninsula Insurance Company (DPIC) and Delmarva Surgery Center, LLC, (Delmarva), reflect total assets constituting 2.9% in 2016 and 4.8% in 2015 and total revenues constituting 1.2% in 2016 and 1.1% in 2015 of the related consolidated totals. Those statements were audited by other auditors whose reports have been furnished to us, and our opinion, insofar as it relates to the amounts included for DPIC and Delmarva, is based solely on the reports of the other auditors. Additionally, we did not audit the financial statements of Peninsula Imaging, LLC (Imaging), in which the Health System has a 50% interest. In the consolidated financial statements, the Health System's investment in Imaging is stated at $2.1 million and $2.8 million as of June 30, 2016 and 2015, respectively, and the Health System's equity in the excess of unrestricted revenue and other support over expenses of Imaging is stated at $1.1 million and $1.1 million for the years ended June 30, 2016 and 2015, respectively. Those statements were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Imaging, is based solely on the report of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

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An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Health System's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audits and the reports of other auditors, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Peninsula Regional Health System, Inc. and subsidiaries at June 30, 2016 and 2015, and the consolidated results of their operations and changes in net assets and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating supplementary information is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Ernst & Young LLP

September 23, 2016

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Peninsula Regional Health System, Inc.

Consolidated Balance Sheets
(In Thousands)

	June 30	
	2016	**2015**
Assets		
Current assets:		
Cash and cash equivalents	**$ 36,755**	$ 52,976
Short-term investments	**6,760**	6,477
Accounts receivable, less allowance for uncollectible accounts (2016 – $8,278; 2015 – $7,927)	**42,234**	39,306
Inventories and other	**10,226**	10,561
Prepaids	**6,327**	4,922
Total current assets	**102,302**	114,242
Long-term investments	**226,353**	226,306
Board-designated investments	**23,584**	23,963
Assets limited as to use:		
Construction fund	**10,228**	18,863
Donor-restricted fund	**33,217**	31,922
Self-insurance fund	**19,713**	19,293
	63,158	70,078
Property and equipment, net	**224,843**	206,171
Unamortized financing costs, net of accumulated amortization	**1,349**	1,402
Other assets	**19,663**	19,405
Total assets	**$ 661,252**	$ 661,567

	June 30	
	2016	**2015**
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	**$ 2,068**	$ 2,005
Current portion of accrued self-insured liabilities	**2,495**	2,495
Accounts payable	**18,088**	17,941
Accrued liabilities	**14,936**	18,765
Advances from third-party payors	**11,401**	9,846
Total current liabilities	**48,988**	51,052
Long-term debt, net	**143,319**	146,494
Other liabilities	**38,537**	17,141
Total liabilities	**230,844**	214,687
Net assets:		
Unrestricted	**395,287**	413,327
Temporarily restricted	**25,058**	23,520
Permanently restricted	**8,245**	8,246
Peninsula Regional Health System, Inc. net assets	**428,590**	445,093
Minority interest	**1,818**	1,787
Total net assets	**430,408**	446,880
Total liabilities and net assets	**$ 661,252**	$ 661,567

See accompanying notes.

Peninsula Regional Health System, Inc.

Consolidated Statements of Operations and Changes in Net Assets
(In Thousands)

	Year Ended June 30	
	2016	**2015**
Unrestricted revenue and other support:		
Net patient service revenue	**$ 418,423**	$ 405,009
Provision for bad debts	**(11,477)**	(10,785)
Net patient service revenue less provision for bad debts	**406,946**	394,224
Other operating revenue	**2,749**	3,711
Total unrestricted revenue and other support	**409,695**	397,935
Operating expenses:		
Salaries and wages	**165,766**	155,405
Supplies and other expenses	**184,578**	167,655
Employee benefits	**34,429**	32,187
Depreciation	**22,804**	22,571
Interest	**5,052**	6,186
Total operating expenses	**412,629**	384,004
(Loss) income from operations	**(2,934)**	13,931
Nonoperating income (expense):		
Investment income	**10,690**	18,945
Loss on extinguishment of debt	**–**	(7,309)
Total nonoperating income	**10,690**	11,636
Excess of unrestricted revenue and other support over expenses	**7,756**	25,567
Minority interest in earnings of controlled subsidiaries	**(31)**	279
Excess of unrestricted revenue and other support over expenses attributable to Peninsula Regional Health System, Inc.	**7,725**	25,846

(continued on next page)

Peninsula Regional Health System, Inc.

Consolidated Statements of Operations and Changes in Net Assets (continued)
(In Thousands)

	Year Ended June 30	
	2016	**2015**
Unrestricted net assets:		
Excess of unrestricted revenue and other support over expenses attributable to Peninsula Regional Health System, Inc.	**$ 7,725**	$ 25,846
Unrealized (losses) gains on investments	**(9,251)**	828
Pension adjustment	**(16,514)**	(2,717)
(Decrease) increase in unrestricted net assets	**(18,040)**	23,957
Temporarily restricted net assets:		
Donations	**1,673**	1,313
Net realized gains on investments	**1,266**	1,690
Unrealized (losses) gains on investments	**(1,130)**	491
Net assets released from restrictions	**(271)**	(335)
Increase in temporarily restricted net assets	**1,538**	3,159
Permanently restricted net assets:		
Net realized gains on investments	**2**	152
Unrealized (losses) gains on investments	**(3)**	1
(Decrease) increase in permanently restricted net assets	**(1)**	153
(Decrease) increase in net assets	**(16,503)**	27,269
Net assets at beginning of year	**445,093**	417,824
Net assets at end of year	**$ 428,590**	$ 445,093

See accompanying notes.

Peninsula Regional Health System, Inc.

Consolidated Statements of Cash Flows
(In Thousands)

	Year Ended June 30	
	2016	**2015**
Operating activities		
Change in net assets	**$ (16,503)**	$ 27,269
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation of property and equipment	**22,804**	22,571
Loss on advance refunding of debt	**–**	7,309
Amortization of original issue premium	**(1,105)**	(166)
Amortization of financing costs	**46**	78
Losses (gains) on sale of property and equipment	**–**	(12)
Net unrealized losses on investments	**7,358**	372
Net realized gains on investments	**(7,251)**	(15,155)
Proceeds from restricted contributions and realized gains on restricted investments	**(2,939)**	(3,003)
Minority interest in earnings of controlled subsidiaries	**31**	(279)
Changes in operating assets and liabilities:		
Accounts receivable	**(2,587)**	(95)
Inventories and other assets	**(1,205)**	1,441
Accounts payable and accrued liabilities	**(4,981)**	5,259
Other liabilities	**18,568**	2,493
Advances from third-party payors	**1,555**	625
Net cash provided by operating activities	**13,791**	48,707
Investing activities		
Purchase of investments	**(154,630)**	(167,972)
Proceeds from sales of investments	**162,126**	146,946
Purchases of property and equipment	**(37,283)**	(21,576)
Proceeds from disposal of assets	**–**	14
Change in assets limited to use	**(1,160)**	(4,395)
Net cash used in investing activities	**(30,947)**	(46,983)
Financing activities		
Proceeds from restricted contributions and realized losses on restricted investments	**2,939**	3,003
Proceeds from Bond Issuance	**–**	147,435
Deferred financing costs	**–**	(1,375)
Repayments of long-term debt	**(2,004)**	(130,404)
Net cash provided by financing activities	**935**	18,659
Net (decrease) increase in cash and cash equivalents	**(16,221)**	20,383
Cash and cash equivalents at beginning of year	**52,976**	32,593
Cash and cash equivalents at end of year	**$ 36,755**	$ 52,976

See accompanying notes.

Peninsula Regional Health System, Inc.

Notes to Consolidated Financial Statements
(Dollar Amounts in Thousands)

June 30, 2016

1. Organization and Mission

Peninsula Regional Health System, Inc. (the Health System) serves as the parent company to Peninsula Regional Medical Center (the Hospital); Peninsula Regional Medical Center Foundation, Inc. (the Foundation); Peninsula Health Ventures, Inc. (Health Ventures); Peninsula Women's Surgery Center, LLC; and Peninsula Regional Clinically Integrated Network, LLC. The Health System is a not-for-profit Maryland membership corporation established to manage the integrated delivery of health care services to the community. The Health System is the sole corporate member of the Hospital and the Foundation. In its capacity as sole corporate member, the Health System will appoint trustees, approve major expenditures, and approve long-term borrowings.

The Hospital is a not-for-profit, nonstock corporation founded in 1897 to serve the health care needs of its region. Primary service areas include the Maryland counties of Wicomico, Somerset, and Worcester; southern Delaware; and the northern Eastern Shore of Virginia. The Hospital's mission is to improve the health care of the community by providing exceptional quality primary, secondary, and selected tertiary health care services to patients in a competent and compassionate manner, designed to elicit a high degree of customer satisfaction. The Hospital provides services regardless of race, creed, sex, national origin, handicap, or age. In May 2013, Delmarva Peninsula Insurance Company (DPIC) was incorporated as a wholly owned subsidiary of the Hospital. DPIC was formed as captive insurer to provide professional and general liability (GL) insurance.

The Foundation is a not-for-profit, nonstock corporation organized to raise contributions exclusively for the benefit of charitable, educational, medical, and scientific purposes for the Hospital.

Health Ventures is a for-profit corporation organized for the purpose of owning, developing, operating, and investing in health care enterprises on the Delmarva Peninsula. The Health System owns all of the outstanding shares of common stock of Health Ventures.

2. Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements include the accounts of the Health System and all wholly owned subsidiaries, principally the Hospital, the Foundation, and Health Ventures. Additionally, the Health System has consolidated a 55%-owned affiliate, Delmarva Surgery Center, LLC, and recorded minority interest equal to the remaining ownership interest.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual amounts could differ from those estimates.

Fair Value of Financial Instruments

The carrying amounts of financial instruments, including cash and cash equivalents, accounts receivable, accounts payable, and advances from third-party payors, approximate fair value given the short-term nature of these financial instruments.

Cash and Cash Equivalents

Cash and cash equivalents include surplus operating funds invested in money market funds and highly liquid corporate, U.S. government, and agency obligations, all with maturities of less than three months when purchased.

Investments and Investment Income

Investments are carried at fair value. All such investments are considered available for sale and are classified as current or noncurrent assets based on management’s intention as to use. Short-term investments represent investments with contractual maturities within one year and current investments in money market funds that have been designated for investment purposes. Assets limited as to use by donor restriction are recorded at fair value at the date of donation, and changes in fair value are recognized in the period in which the change occurs. Investment income

2. Significant Accounting Policies (continued)

from all unrestricted investments is reported as nonoperating income. Investment income on investments of restricted assets is added to or deducted from the appropriate restricted net assets when restricted as to use by the donor.

The value of securities sold is based on the specific identification method.

The Health System periodically evaluates whether any declines in the fair value of investments are other than temporary. This evaluation consists of a review of several factors, including, but not limited to, length of time and extent that a security has been in an unrealized loss position, the existence of an event that would impair the issuer's future earnings potential, the near-term prospects for recovery of the market value of a security, and the intent and ability of the Health System to hold the security until the market value recovers. Realized gains or losses are included in nonoperating income (expense) on the accompanying consolidated statements of operations and changes in net assets. Declines in fair value below cost that are deemed to be other than temporary would be recorded as realized losses within nonoperating income (expense). Based on its evaluation, the Health System has recorded no other-than-temporary impairments for the years ended June 30, 2016 or 2015.

Accounts Receivable and Contractual Allowances

The Health System, through its member companies, provides services to patients in the Eastern Shore area of Maryland, Delaware, and Virginia, the majority of whom are covered by third-party health insurance. The Health System bills the insurer directly for services provided.

Insurance coverage and financial information is obtained from patients upon admission when available. The Health System's policy is to perform in-house collection procedures for approximately 85 days. A determination is made at that time as to which additional collection efforts to pursue. A provision for uncollectible accounts is recorded for amounts not yet written off, which are expected to become uncollectible.

Discounts ranging from 2% to 6% of charges are given to Medicare, Medicaid, and certain approved commercial health insurance and health maintenance organization programs for regulated services. Discounts in varying percentages are given for certain unregulated services. These major payors routinely review patient billings and deny payment for certain charges as medically unnecessary or as performed without appropriate preauthorization. Discounts and

2. Significant Accounting Policies (continued)

denials are recorded as reductions of net patient service revenue. Revenue and accounts receivable from these third-party payors have been adjusted to reflect the difference between charges and the estimated reimbursable amounts.

Approximately 35% and 38% of accounts receivable were due from the Medicare program as of June 30, 2016 and 2015, respectively.

The Medicare and Medicaid reimbursement programs represent a substantial portion of the Health System's revenues. The Health System's operations are subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services and Medicare, and Medicaid fraud and abuse.

Over the past several years, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs, together with the imposition of fines and penalties, as well as repayments for patient services previously billed. Compliance with fraud and abuse standards and other government regulations can be subject to future government review and interpretation. Also, future changes in federal and state reimbursement funding mechanisms and related government budgeting constraints could have an adverse effect on the Health System.

Inventories and Other

Inventories and other primarily include inventories of supplies and prepaid expenses. Inventories of supplies are carried at the lower of cost or market, using the first-in, first-out method.

Other Assets

Other assets primarily include a 50% non-controlling interest in each of the following entities, which are accounted for as equity method investments: Peninsula Imaging, LLC; AHP Delmarva, LLP; Genesis Healthcare; Peninsula-NRH Regional Rehabilitation, LLC; and Peninsula Home Care, LLC. The Hospital also has a 33.3% non-controlling interest in Peninsula Home Care at Nanticoke, which is accounted for as an equity method investment. Additionally, other assets include a reinsurance receivable asset in 2016 and 2015 and a prepaid pension asset in 2015.

2. Significant Accounting Policies (continued)

Assets Limited as to Use

Assets limited as to use primarily include assets held by trustees under indenture agreements; assets held by trustees under irrevocable self-insurance trust agreements; and assets, including pledges receivable, whose use has been limited by the donor of the underlying funds. Amounts required to meet current liabilities have been classified on the consolidated balance sheets as current assets.

Board-Designated Investments

Board-designated investments include assets set aside by the Board of Trustees for future capital improvements and expansion. The Board of Trustees retains control of these assets and may, at its discretion, subsequently use them for other purposes.

Property and Equipment

Property and equipment consists of furniture, fixtures, equipment, and capitalized internal use software and acquired software development costs. Property acquired and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Software development costs that are incurred in the preliminary project stage for internal use software are expensed as incurred. During the development stage, direct consulting costs and payroll and payroll-related costs for employees that are directly associated with each project are capitalized and amortized over the estimated useful life of the software once the software is ready for its intended use. Capitalized software is amortized using the straight-line method over its estimated useful life, which is generally seven years. Replacements and upgrades and enhancements to existing systems that result in added functionality are capitalized, while maintenance and repairs are charged to expense as incurred.

Gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted donations. Absent explicit donor stipulations about how long those assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

2. Significant Accounting Policies (continued)

Construction Fund

The Construction Fund was created as a result the proceeds of the 2015 Maryland Health and Higher Educational Facilities Authority (MHHEFA) Revenue Bond Offering, net of the advance refunding of the 2006 MHHEFA bond offering. The net proceeds are required to be spent on capital improvements, and used for the acquisition, renovation, or equipping of certain facilities of the Hospital.

Unamortized Financing Costs

Financing costs incurred in issuing the Maryland Health and Higher Educational Facilities Authority Project and Refunding Revenue Bonds have been capitalized and are being amortized using the straight-line method over the life of the bonds, which approximates the effective interest method. The amount amortized is recorded as an operating expense.

Estimated Self-Insurance Liabilities and Workers' Compensation

The provision for estimated professional liability claims, general liability claims, and workers' compensation claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

Pension Benefits

Pension benefits are recorded in accordance with Accounting Standards Codification Topic (ASC) 715, *Compensation – Retirement Benefits*, which requires the recognition of the funded status of pension plans within the accompanying consolidated balance sheets. As of June 30, 2016 and 2015, the funded status of the pension plan has been recorded within other long-term liabilities and other assets, respectively.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Health System has been limited by donors to a specific time period or purpose. Temporarily restricted net assets are to be used for capital purposes and other health care services.

2. Significant Accounting Policies (continued)

Permanently restricted net assets have been restricted by donors to be maintained by the Health System in perpetuity.

Net Patient Service Revenue

Net patient service revenue is reported at the estimated realizable amounts from patients, third-party payors, and others for services rendered. During 2016 and 2015, approximately 49% and 48%, respectively, of net patient service revenue was received under the Medicare program, 12% from CareFirst Blue Cross Blue Shield, 33% and 34%, respectively, from contracts with other third parties, and 6% from other sources.

The following table sets forth the detail of net patient service revenue:

	Year Ended June 30	
	2016	**2015**
Gross patient service revenue	**$ 522,069**	$ 506,851
Revenue deductions:		
Charity care	**8,670**	9,408
Contractual and other allowances	**94,976**	92,434
Patient revenue, net of deductions	**418,423**	405,009
Less provision for bad debts	**11,477**	10,785
Net patient service revenue less bad debts	**$ 406,946**	$ 394,224

The Health System employs physicians in several hospital-based specialties. The Health System bills for the services provided by these physicians. Net physician revenue is recognized when the services are provided and recorded at the estimated net realizable amount based on the contractual arrangements with third-party payors and the expected payments from the third-party payors and the patients. The difference between the billed charges and the estimated net realizable amounts is recorded as a reduction in physician revenue when the services are provided. For the years ended June 30, 2016 and 2015, the Health System recorded $33,388 and $29,460 of net physician revenue, respectively.

2. Significant Accounting Policies (continued)

Patient accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Health System analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payer sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Health System analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary. For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Health System records a provision for bad debts in the period of service on the basis of its past experience. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts. The Health System has not changed its charity care or uninsured discount policies during fiscal years 2016 or 2015.

Other Operating Revenue

The American Recovery and Reinvestment Act of 2009 provides for Medicare and Medicaid incentive payments for eligible hospitals and professionals that implement and achieve meaningful use of certified electronic health record (EHR) technology. For Medicare and Medicaid EHR incentive payments, the Hospital uses a gain contingency accounting method to recognize the revenues. Under this accounting policy, EHR incentive payments are recognized as revenue upon the completion of the meaningful use period and completion of the related 12-month cost report. Accordingly, the Hospital recognized approximately $790 and $1,974 of EHR revenues for the years ended June 30, 2016 and 2015, respectively. This is based on cost report data that is subject to audit by the Centers for Medicare & Medicaid Services (CMS) or its intermediaries, and the amounts recognized are subject to change.

These amounts are included in other operating revenue on the consolidated statements of operations. The Hospital’s attestation of compliance with the meaningful use criteria is subject to audit by the federal government or its designee. The recognition of revenues is based on management’s best estimate. Any subsequent changes in the recognition of revenue will impact the results of operations in the period in which they occur.

2. Significant Accounting Policies (continued)

Charity Care

The Health System provided care to patients who met certain criteria under its charity care policy, without charge or at amounts less than its approved rates. Because the Health System did not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The amounts written off as charity care for 2016 and 2015 were $7,113 and $7,402, respectively. These amounts represent direct and indirect charity care costs, which are calculated using the Health System's cost to charge ratio. The state of Maryland rate system includes components within the rates to partially compensate health systems for uncompensated care.

Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Health System are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted donations if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or the purpose of the restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported on the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying consolidated financial statements.

Investment Income

Investment income primarily includes income from short-term and long-term investments, board-designated investments, and investments within assets limited as to use. In addition, investment income is also recorded for certain equity method investments that are included within other assets.

2. Significant Accounting Policies (continued)

The components of investment income are as follows:

	Year Ended June 30	
	2016	**2015**
Interest and dividend income	**$ 5,587**	$ 4,300
Realized gains, net	**1,837**	11,373
Income earned on equity method investments	**3,168**	3,155
Other	**98**	117
Total	**$ 10,690**	$ 18,945

Income Taxes

The Health System is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code.

Performance Indicator

The performance indicator for the Health System is excess of unrestricted revenue and other support over expenses, which includes all changes in unrestricted net assets except for changes in unrealized gains and losses on investments; pension adjustments in accordance with ASC 958-715, *Not-for-Profit Entities – Compensation – Retirement Benefits*; and net assets released from restrictions for property acquisitions.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued ASC 2014-09, *Revenue from Contracts with Customers (Topic 606).* This guidance is intended to improve and converge with international standards the financial reporting requirements for revenue from contracts with customers. It will be effective for fiscal year 2019, and early adoption is permitted beginning in fiscal year 2018. The Health System has not yet determined the impact from adoption of this new accounting pronouncement on its consolidated financial statements.

2. Significant Accounting Policies (continued)

In August 2014, the FASB issued ASU 2014-15, *Presentation of Financial Statements – Going Concern (Subtopic 205-40)*, which provides guidance in GAAP about management's responsibility to evaluate whether there is substantial doubt about an entity's ability to continue as a going concern and to provide related footnote disclosures. This amendment should reduce diversity in the timing and content of footnote disclosures. This ASU is effective for fiscal year 2017. The guidance is not expected to materially impact the Health System's consolidated results of operations, net assets, or cash flows.

In April 2015, the FASB issued ASU 2015-03, *Interest – Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs*. The amendments in this ASU require that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts. This guidance is effective for fiscal year 2017. The guidance is not expected to materially impact the Health System's consolidated results of operations, net assets, or cash flows.

In April 2015, the FASB issued ASU 2015-05, *Intangibles – Goodwill and Other – Internal – Use Software (Subtopic 350-40): Customer's Accounting for Fees Paid in a Cloud Computing Arrangement*, which provides guidance to clarify the customer's accounting for fees paid in a cloud computing arrangement and also eliminates today's requirement that customers analogize to the leases standard when determining the asset acquired in a software licensing arrangement. This guidance is effective for fiscal year 2017. The guidance is not expected to materially impact the Health System's consolidated results of operations, net assets, or cash flows.

In February 2016, the FASB issued ASU 2016-02, *Leases*. This ASU amends the existing accounting standards for lease accounting, including requiring lessees to recognize most leases on their balance sheets. This guidance is effective for fiscal year 2020. The Health System is currently assessing the potential impact this ASU will have on the Health System's consolidated results of operations, financial position and cash flows.

3. Property and Equipment

A summary of property and equipment follows:

	Estimated Useful Lives (in Years)	June 30 2016	2015
Land	–	**$ 11,385**	$ 11,385
Land improvements	20	**11,711**	13,997
Buildings and improvements	15–40	**233,272**	220,063
Fixed equipment	20	**33,822**	34,115
Movable equipment	7–10	**209,822**	201,143
		500,012	480,703
Less accumulated depreciation		**(301,092)**	(290,123)
		198,920	190,580
Acquired and internally developed software		**17,482**	–
Construction-in-progress		**8,441**	15,591
Property and equipment, net		**$ 224,843**	$ 206,171

As of June 30, 2016, the Hospital was committed to building and equipment purchases totaling approximately $5,628.

4. Other Liabilities

The components of other liabilities are as follows:

	June 30 2016	2015
Self-insurance obligations	**$ 17,898**	$ 15,847
Long-term pension benefit obligation	**16,306**	–
Other	**4,333**	1,294
Total	**$ 38,537**	$ 17,141

5. Long-Term Debt

Long-term debt consists of the following:

	June 30, 2016
Maryland Health and Higher Educational Facilities Authority Revenue Bonds Series 2015:	
Series 2015 serial bonds with interest rates ranging from 3.00% to 5.00% and effective rates ranging from 2.57% to 3.01% due in various annual amounts on July 1 of each year from 2016 through 2034	**$ 55,964**
Series 2015 5.00% term bonds with effective rate of 3.99% due July 1, 2039	**26,444**
Series 2015 5.00% term bonds with effective rate of 4.13% due July 1, 2045	**41,550**
Building and equipment collateral loans:	
4.40% fixed rate due monthly from 2012 to 2022	**1,774**
	125,732
Less current portion of Maryland Health and Higher Educational Facilities Authority Series 2015 serial bonds	**1,990**
Less current portion of building and equipment collateral loans	**78**
	123,664
Original issue premium	**19,655**
Long-term debt, less current portion	**$ 143,319**

5. Long-Term Debt (continued)

	June 30, 2015
Maryland Health and Higher Educational Facilities Authority Revenue Bonds Series 2015:	
Series 2015 serial bonds with interest rates ranging from 3.00% to 5.00% and effective rates ranging from 2.57% to 3.01% due in various annual amounts on July 1 of each year from 2015 through 2034	$ 57,895
Series 2015 5.00% term bonds with effective rate of 3.99% due July 1, 2039	26,445
Series 2015 5.00% term bonds with effective rate of 4.13% due July 1, 2045	41,550
Building and equipment collateral loans:	
4.40% fixed rate due monthly from 2012 to 2022	1,849
	127,739
Less current portion of Maryland Health and Higher Educational Facilities Authority Series 2015 serial bonds	1,930
Less current portion of building and equipment collateral loans	75
	125,734
Original issue premium	20,760
Long-term debt, less current portion	$ 146,494

Series 2015 Revenue Bonds

On February 5, 2015, MHHEFA authorized the issuance of $126,665 aggregate principal amount of Revenue Bonds (Series 2006 Revenue Bonds) at a premium of $20,770. The proceeds of the issue, after payment of financing costs, were used primarily (i) to advance refund outstanding 2006 bonds and (ii) to finance $25,000 of capital purchases.

5. Long-Term Debt (continued)

The Hospital is required to make semiannual payments to the trustee sufficient to meet the annual debt service requirements of the refunding bond issue for the succeeding year. Annual sinking fund installments for the term bonds range from $3,322 on July 1, 2015, to $8,189 on July 1, 2020. The premium on the Series 2015 Bonds is being amortized over the life of the bonds using the effective interest method.

As security for the debt service requirements of the Series 2015 Bonds, MHHEFA has a first lien and claim on all receipts of the Hospital. The terms of the indenture agreement restrict the Hospital's ability to create additional indebtedness and its use of the facilities, and require the Hospital to maintain stipulated insurance coverage and a rate structure in each year sufficient to meet certain rate covenant requirements.

Series 2006 Revenue Bonds

On February 9, 2006, MHHEFA authorized the issuance of $142,910 aggregate principal amount of Series 2006 Revenue Bonds at a premium of $5,333. The proceeds of the issue, after payment of financing costs, were used primarily (i) to finance and refinance a portion of the costs of construction, renovation, acquisition and equipping of the 2006 Project; (ii) to refund outstanding 1993 bonds; (iii) to pay a portion of the interest accruing on the Series 2006 Revenue Bonds for a period to extend to January 1, 2009; and (iv) to pay the Counterparty a termination payment of $1,575 in connection with a forward starting interest rate exchange agreement entered into on August 9, 2005, and unwound on January 24, 2006.

The Series 2006 Revenue Bonds were refunded in February 2015 upon the issuance of the Series 2015 Revenue Bonds. The Health System incurred a $7,300 loss on advance refunding of Series 2006 Revenue Bonds, which relates to advance refunding amounts in excess of principal payments and the write-off of unamortized financing costs, partially offset by the write-off of the unamortized bond premium.

Delmarva Surgery Center, LLC Building Loan

On June 1, 2012, Delmarva Surgery Center, LLC, a 55%-owned subsidiary of Health Ventures, entered into a fixed rate loan agreement with BB&T Bank in the amount of $2,059 ($1,774 outstanding at June 30, 2016), with fixed monthly payments through June 1, 2022.

5. Long-Term Debt (continued)

Scheduled principal repayments on long-term debt for the years ending June 30 are as follows:

2017	$ 2,068
2018	2,173
2019	2,282
2020	2,396
2021	2,515
2022 and thereafter	114,298
	$ 125,732

Fair values of long-term debt are estimated using discounted cash flow analyses, based on current incremental borrowing rates for similar types of borrowing arrangements.

The fair value of the Health System's long-term debt outstanding as of June 30, 2016 and 2015, was approximately $148,928 and $139,628, respectively.

Total interest paid for fiscal years 2016 and 2015 was $4,999 and $6,133, respectively.

6. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes:

	June 30	
	2016	**2015**
Health care services:		
Capital purposes	**$ 17,390**	$ 17,208
Patient services	**6,569**	5,185
Educational purposes	**1,099**	1,127
	$ 25,058	$ 23,520

6. Temporarily and Permanently Restricted Net Assets (continued)

Permanently restricted net assets are restricted as follows:

	June 30	
	2016	**2015**
Investments to be held in perpetuity, the income from which is expendable to support health care services	**$ 8,245**	$ 8,246

The Foundation initiated a major fundraising campaign for capital funds during fiscal year 2005 to support the Hospital's capital plans that include expansion and modernization of facilities. The Foundation has raised approximately $14,629 as of June 30, 2016, which includes net pledges receivable presently valued at approximately $584. The Foundation expects to receive payment on the majority of the pledges by 2020 and all payments by 2025. Additionally, during 2011, the Foundation launched a fundraising campaign to support the operating room expansion. This campaign has raised $2,894 as of June 30, 2016, which includes net pledges receivable presently valued at $123. Additionally during 2015, the Foundation initiated a behavioral health campaign that has raised $1,511 as of June 30, 2016, and includes net pledges receivable presently valued at $558. Pledges receivable are included in assets limited as to use in the accompanying balance sheets.

Scheduled payments on pledges receivable for the years ending June 30 are as follows:

2017	$ 445
2018–2021	739
2022 and thereafter	355
	1,539
Less:	
Impact of discounting of pledges receivable to net present value	112
Allowance for uncollectible pledges	163
Net pledges receivable, capital campaign	$ 1,264

7. Functional Expenses

The Health System considers health care services and management and general to be its primary functional categories for purposes of expense classification. Depreciation and interest costs are included in health care services. The Health System's operating expenses by functional classification are as follows:

	Year Ended June 30	
	2016	**2015**
Health care services	**$ 353,874**	$ 345,559
Management and general	**58,755**	38,445
	$ 412,629	$ 384,004

8. Malpractice Insurance Costs, Self-Insured Professional Liability, and Workers' Compensation

Effective July 1, 2013, Delmarva Peninsula Insurance Captive (DPIC) was formed as a captive insurer to provide professional liability insurance. DPIC is a wholly owned subsidiary of the Hospital. The primary layer of professional and GL insurance coverage is self-insured through DPIC, and the secondary layer is fully insured through a commercial carrier.

Effective July 1, 2013, under a loss portfolio transfer agreement, DPIC assumed the medical professional liability (MPL) and GL coverage previously included under PRMC's self-insurance plan for incidents occurring between March 1, 1986 and June 30, 2013, for MPL and for occurrences between March 1, 2004 and June 30, 2013, for GL that were reported to the Hospital prior to June 30, 2013. The policy provides MPL coverage limits varying from $1,000 to $2,000 for each and every medical incident, with policy aggregates varying from $3,000 to $8,000. The policy provides GL coverage limits of $1,000 per occurrence and $3,000 policy aggregates. This policy is retrospectively rated.

DPIC is fully insured by commercial carriers in excess of the coverage limits discussed above up to $25,000 per claim and in the aggregate. As of June 30, 2016 and 2015, the accrued self-insured professional liability losses have been undiscounted for both years. As of June 30, 2016 and 2015, $16,646 and $14,146, respectively, has been reserved for professional liability loss contingencies, including excess coverage. A related reinsurance receivable of $5,100 and $4,010 has been recorded in other assets as of June 30, 2016 and 2015, respectively.

8. Malpractice Insurance Costs, Self-Insured Professional Liability, and Workers' Compensation (continued)

Effective July 1, 2013, DPIC provides excess umbrella liability coverage on a mature claims-made basis with a retroactive date of March 1, 2005. The excess MPL tower follows the form of the underlying primary MPL coverage providing a total of $25,000 limits of liability. The umbrella liability coverage provides $25,000 limits of liability excess of scheduled underlying coverages including the primary GL coverage. The excess umbrella liability coverage is 100% reinsured with Darwin for the first $10,000 limit and OneBeacon for the second $15,000 limit.

The Hospital is also self-insured for workers' compensation up to an annual limit of $500 per occurrence. The Hospital carries an excess liability insurance policy for workers' compensation claims above this limit. As of June 30, 2016 and 2015, $3,701 and $4,200, respectively, has been reserved for workers' compensation loss contingencies.

9. Investments

The following methods and assumptions were used by the Health System in estimating the fair value of its financial instruments:

Fair values of all investments, including short-term investments, long-term investments, board-designated investments, and assets limited as to use are based on quoted market prices and/or prices obtained from a third party using other market data for the same or comparable instruments and transactions in establishing the prices. Certain long-term pledges receivable have been discounted.

9. Investments (continued)

Fair value of investments and certain assets limited as to use held by the Health System is summarized as follows:

	June 30	
	2016	**2015**
Investments:		
Cash and cash equivalents	**$ 22,692**	$ 19,149
U.S. Treasury securities	**16,592**	12,789
Corporate bonds	**58,267**	54,843
Mortgage-backed securities	**25,879**	39,909
Equity securities	**194,893**	198,168
Other (including pledges receivable held at the Foundation)	**1,533**	1,966
Total	**$ 319,856**	$ 326,824

ASC 320, *Investments – Debt and Equity Securities*, provides guidance on the recognition and presentation of other-than-temporary impairments. If a debt security is in an unrealized loss position and the Health System has the intent to sell the debt security, or it is more likely than not that the Health System will have to sell the debt security before recovery of its amortized cost basis, the decline in value is deemed to be other than temporary and is recorded to other-than-temporary impairment losses recognized in the performance indicator on the consolidated statements of operations and changes in net assets. For impaired debt securities that the Health System does not intend to sell or it is more likely than not that the Health System will not have to sell such securities, but the Health System expects that it will not fully recover the amortized cost basis, the credit component of the other-than-temporary impairment is recognized in other-than-temporary impairment losses recognized in income on the consolidated statements of operations and changes in net assets and the non-credit component of the other-than-temporary impairment is recognized as a change in unrestricted net assets.

The credit component of other-than-temporary impairment is determined by comparing the net present value of projected future cash flows with the amortized cost basis of the debt security. The net present value is calculated by discounting the best estimate of projected future cash flows at the effective interest rate implicit in the debt security at the date of acquisition. Cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings, and estimates regarding timing and amount of recoveries associated with a default.

9. Investments (continued)

Furthermore, unrealized losses entirely caused by non-credit-related factors related to debt securities for which the Health System expects to fully recover the amortized cost basis continue to be recognized as an unrealized loss on investments within the changes in unrestricted net assets.

The following table shows the gross unrealized losses and fair value of the Health System's investments with unrealized losses that are not deemed to be other than temporarily impaired, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position:

	Fair Value < 1 Year	Unrealized Losses < 1 Year	Fair Value > 1 Year	Unrealized Losses > 1 Year	Total Unrealized Losses
June 30, 2016					
U.S. Treasury	**$ –**	**$ –**	**$ 3,255**	**$ 213**	**$ 213**
Mortgage-backed securities	**542**	**23**	**1,486**	**55**	**78**
Corporate bonds	**5,154**	**65**	**8,041**	**488**	**553**
Equity securities	**37,776**	**3,215**	**2,664**	**206**	**3,421**
Total investments	**$ 43,472**	**$ 3,303**	**$ 15,446**	**$ 962**	**$ 4,265**
June 30, 2015					
U.S. Treasury	$ 4,334	$ 63	$ 3,869	$ 218	$ 281
Mortgage-backed securities	2,690	25	4,869	235	260
Corporate bonds	20,204	299	7,000	408	707
Equity securities	33,149	1,910	204	19	1,929
Total investments	$ 60,377	$ 2,297	$ 15,942	$ 880	$ 3,177

10. Fair Value Measurements

ASC 820, *Fair Value Measurement*, establishes a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under ASC 820 are described below.

- Level 1 – Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Health System has the ability to access.

- Level 2 – Inputs to the valuation methodology include:

  – Quoted prices for similar assets or liabilities in active markets

  – Quoted prices for identical or similar assets or liabilities in inactive markets

  – Inputs other than quoted prices that are observable for the asset or liability

  – Inputs that are derived principally from or corroborated by observable market data by correlation or other means

- Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

10. Fair Value Measurements (continued)

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Health System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following table presents the Health System's assets and liabilities measured at fair value, aggregated by level in the fair value hierarchy within which those measurements fall:

	Assets at Fair Value as of June 30, 2016			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Cash and cash equivalents	**$ 22,692**	**$ –**	**$ –**	**$ 22,692**
U.S. government securities	**16,592**	**–**	**–**	**16,592**
Corporate bonds	**–**	**58,267**	**–**	**58,267**
Government-sponsored mortgage-backed securities	**–**	**25,879**	**–**	**25,879**
Equity securities	**194,893**	**–**	**–**	**194,893**
Other	**269**	**–**	**1,264**	**1,533**
Total assets	**$ 234,447**	**$ 84,146**	**$ 1,264**	**$ 319,856**

	Assets at Fair Value as of June 30, 2015			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Cash and cash equivalents	$ 19,149	$ –	$ –	$ 19,149
U.S. government securities	12,789	–	–	12,789
Corporate bonds	–	54,843	–	54,843
Government-sponsored mortgage-backed securities	–	39,909	–	39,909
Equity securities	198,168	–	–	198,168
Other	853	–	1,113	1,966
Total assets	$ 230,959	$ 94,752	$ 1,113	$ 326,824

10. Fair Value Measurements (continued)

The fair values of securities are determined by third-party service providers utilizing various methods dependent upon the specific type of investment. Where quoted prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. Where significant inputs, including benchmark yields, broker-dealer quotes, issuer spreads, bids, offers, the London Interbank Offered Rate curve, and measures of volatility, are used by these third-party dealers or independent pricing services to determine fair values, the securities are classified within Level 2.

Long-term pledges receivable, which are measured at fair value on a nonrecurring basis, are discounted to net present value upon receipt using an appropriate risk-free discount rate based on the term of the receivable. Pledges receivable are recorded net of an allowance for uncollectible pledges. The following table provides a reconciliation of the beginning and ending balances of pledges receivable at fair value that used significant unobservable inputs (Level 3):

	Year Ended June 30	
	2016	**2015**
Pledges receivable		
Balance at July 1	**$ 1,113**	$ 1,503
New pledges	**725**	257
Collections on pledges	**(601)**	(726)
Write-off of pledges	**–**	(1)
Changes in reserves	**27**	80
Balance at June 30	**$ 1,264**	$ 1,113

11. Pension Plan

The Health System has a cash balance-type defined benefit pension plan covering substantially all of its employees. Plan benefits are based on years of service and the employees' compensation during the last five years of covered employment. The Health System's funding policy is to make sufficient contributions to the plan to comply with the minimum funding provisions of the Employee Retirement Income Security Act of 1974. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future.

11. Pension Plan (continued)

The Peninsula Regional Medical Center Pension Plus Plan (the Plan) provides annual allocations to a participant's hypothetical account. When a participant retires, the participant has the choice to receive a lump-sum distribution equal to the value of the hypothetical account or to receive an annuity based on the value of the hypothetical account.

Prior to January 1, 2009, the Plan provided three different allocations: (i) a service-related allocation, (ii) an age-related allocation, and (iii) a matching allocation. Both the service-related allocation and the age-related allocation were determined by multiplying a participant's annual compensation by a certain percentage. The matching allocation operated to provide an annual allocation in the Plan based on the participant's contribution to the Health System's 403(b) plan.

The Internal Revenue Service issued new regulations that were effective as of January 1, 2009. The new regulations prohibited a pension plan from providing a matching allocation based on a participant's contributions to a different plan. The Plan provided a matching allocation based on a participant's contribution to a 403(b) plan. In order to comply with the new tax law requirements, the Plan was amended effective as of December 31, 2008, to eliminate future matching allocations in the Plan. At the same time, the Health System adopted a 403(b) plan effective as of January 1, 2009, and provided a replacement matching contribution in the 403(b) plan.

11. Pension Plan (continued)

The following provides a reconciliation of the changes in fair value of the Plan's assets and projected benefit obligations, and the Plan's funded status:

	June 30	
	2016	**2015**
Accumulated benefit obligation	**$ 121,840**	$ 108,280
Projected benefit obligation, beginning of year	**$ 117,330**	$ 106,976
Service cost	**5,825**	5,126
Interest cost	**4,584**	3,587
Actuarial loss	**9,819**	6,318
Benefits paid	**(3,127)**	(4,677)
Projected benefit obligation, end of year	**134,431**	117,330
Fair value of plan assets, beginning of year	**119,411**	113,002
Actual gain on plan assets	**(1,159)**	8,086
Employer contributions	**3,000**	3,000
Benefits paid	**(3,127)**	(4,677)
Fair value of plan assets, end of year	**118,125**	119,411
Fair value of plan assets (less) greater than the projected benefit obligation	**$ (16,306)**	$ 2,081
(Pension liability) prepaid pension cost recorded on the consolidated balance sheet	**$ (16,306)**	$ 2,081

11. Pension Plan (continued)

Components of net periodic benefit cost are as follows:

	Year Ended June 30	
	2016	**2015**
Service cost	**$ 5,825**	$ 5,126
Interest cost	**4,584**	3,587
Expected return on plan assets	**(7,725)**	(7,088)
Amortization of prior service credit	**(126)**	(126)
Recognized net actuarial loss	**2,314**	2,729
Net periodic benefit cost	**$ 4,872**	$ 4,228

Net amounts recognized in unrestricted net assets that have not been recognized in net periodic benefit cost are as follows:

	2016	**2015**
Net actuarial loss	**$ 45,808**	$ 29,420
Prior service credit	**(63)**	(189)
Total recognized in unrestricted net assets	**$ 45,745**	$ 29,231

The estimated net actuarial loss and prior service credit for the Plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are $2,796 and $(63), respectively.

11. Pension Plan (continued)

Weighted average assumptions used to determine projected benefit obligations and net periodic benefit costs at June 30 were as follows:

	2016	2015
Projected benefit obligation		
Discount rate	**3.15%**	4.00%
Rates of increase in compensation levels:		
Service:		
<11	**8.00**	8.00
11<21	**5.00**	5.00
21=<	**3.00**	3.00
Net periodic benefit cost		
Discount rate	**4.00**	3.50
Expected long-term return on plan assets	**7.00%**	7.00%
Rate of increase in compensation levels:		
Service:		
<11	**8.00**	8.00
11<21	**5.00**	5.00
21=<	**3.00**	3.00

The defined benefit pension plan asset allocation as of the measurement date and the target asset allocation, presented as a percentage of total plan assets, were as follows:

	2016	2015	Target Allocation
Debt securities	**27%**	27%	25%–40%
Equity securities	**70**	70	45%–75%
Cash and cash equivalents	**3**	3	1%–10%
Total	**100%**	100%	

11. Pension Plan (continued)

The Health System's defined benefit plan invests in a diversified mix of traditional asset classes. Investments in U.S. equity securities and fixed income securities are made to maximize long-term results while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. Risk tolerance of unexpected investment and actuarial outcomes is continually evaluated by understanding the pension plan's liability characteristics. This is performed through forecasting and assessing ranges of investment outcomes over short-term and long-term horizons, and by assessing the Health System's financial condition and its future potential obligations from both the pension and general operational requirements. Complementary investment styles, such as growth and value equity investing techniques, are utilized by the Health System's investment advisors to further improve portfolio and operational risk characteristics. Equity investments, both actively and passively managed, are used primarily to increase overall plan returns. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

Asset allocations and investment performance are formally reviewed at regularly scheduled meetings of the Health System's Financial Resources Committee.

The overall rate of expected return on assets assumption was based on historical returns, with adjustments made to reflect expectations of future returns. The extent to which the future expectations were recognized included the target rates of return for the future, which have not historically changed.

11. Pension Plan (continued)

The fair values of the Health System's pension plan assets as of June 30, by asset category (see Note 10, *Fair Value Measurements*, for a description of the asset categories), are as follows:

	2016			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Investments at fair value:				
Cash and cash equivalents	**$ 3,621**	**$ –**	**$ –**	**$ 3,621**
U.S. Treasuries	**7,021**	**–**	**–**	**7,021**
Government-sponsored mortgage-backed securities	**–**	**8,875**	**–**	**8,875**
Corporate debt securities	**–**	**16,419**	**–**	**16,419**
Publicly traded equity securities	**81,870**	**–**	**–**	**81,870**
Other	**319**	**–**	**–**	**319**
Total investments	**$ 92,831**	**$ 25,294**	**$ –**	**$ 118,125**

	2015			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Investments at fair value:				
Cash and cash equivalents	$ 4,057	$ –	$ –	$ 4,057
U.S. Treasuries	6,746	–	–	6,746
Government-sponsored mortgage-backed securities	–	9,253	–	9,253
Corporate debt securities	–	15,523	–	15,523
Publicly traded equity securities	83,491	–	–	83,491
Other	341	–	–	341
Total investments	$ 94,635	$ 24,776	$ –	$ 119,411

11. Pension Plan (continued)

The following methods and assumptions were used to estimate fair value of each class of financial instrument:

U.S. Treasuries: The fair value is determined by an active price for an identical security in an observable market.

Corporate debt securities and government-sponsored mortgage-backed securities: The fair value is estimated using quoted prices for similar assets in active markets or quoted prices for identical or similar assets in non-active markets (few transactions, limited information, noncurrent prices, and high variability over time).

Money market funds: The carrying value of these money market funds approximates fair value as the maturities are less than three months.

Publicly traded equity securities: The fair value is determined by market quotes for an identical security in an observable market.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Health System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

Cash Flows

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid as follows for the years ending June 30:

2017	$ 6,701
2018	8,032
2019	8,044
2020	8,254
2021	9,179
2022–2026	48,868

11. Pension Plan (continued)

The Health System intends to make voluntary contributions to the defined benefit pension plan of $3,000 for the year ending June 30, 2017. This funding level exceeds any regulatory requirements for 2017.

12. Commitments and Contingencies

Agreement With the Office of Inspector General

The Health System received several subpoenas from the Office of Inspector General of the U.S. Department of Health and Human Services (OIG), requiring the production of certain documents related to claims for physician health care services provided by a former medical staff member. These subpoenas were issued in connection with a civil investigation being conducted by the U.S. Attorney's Office for the District of Maryland. In January 2011, the Health System reached a tentative agreement in principle, which was ultimately approved by the U.S. Department of Justice, the OIG, the Office of Personnel Management, and the state of Maryland in August 2011, to resolve all remaining potential civil claims arising out of the Health System's medical services to patients of the physician. The Health System reached this agreement without admitting liability in order to avoid the expense and uncertainty of litigation and to allow the Health System to move forward. In this regard and consistent with the settlement, an amount of $1,800 was paid in June 2011. The settlement also includes a five-year Corporate Integrity Agreement that will require the Health System to establish and/or enhance various compliance processes and also have several independent peer review reports completed on an annual basis.

Other

The Health System has been named as a defendant in various lawsuits arising from the performance of its normal activities. In the opinion of the Health System's management, after discussion with legal counsel, the amount, if any, of the Health System's ultimate liability under these lawsuits will not have a material adverse effect on the consolidated financial position of the Health System.

A portion of the Health System's revenues is received from health maintenance organizations and other managed care payors. Managed care payors generally use case management activities to control utilization. These payors also have the ability to select providers offering the most cost-effective care. Management does not believe that the organization has undue exposure to any one managed care payor.

12. Commitments and Contingencies (continued)

The Health System's revenues may be subject to adjustment as a result of examination by government agencies or contractors based upon differing interpretation of government regulations, medical diagnosis, charge coding, medical necessity, or other contract terms. The resolution of these matters, if any, often is not finalized until subsequent to the period during which the services were rendered. Section 302 of the Tax Relief and Health Care Act of 2006 authorized a permanent program involving the use of third-party recovery audit contractors (RACs) to identify Medicare overpayments and underpayments made to providers. The Health System has established protocols to respond to RAC requests and payment denials. Payment recoveries resulting from RAC reviews are appealable through administrative and judicial processes, and the Health System intends to pursue the reversal of adverse determinations where appropriate. In addition to overpayments that are not reversed on appeal, the Health System will incur additional costs to respond to requests for records and pursue the reversal of payment denials. As of June 30, 2016 and 2015, the Health System has recorded an estimated reserve regarding the Medicare overpayments. In the opinion of the Health System's management, the ultimate settlement of this matter will not have a material adverse effect on the consolidated financial position of the Health System.

As part of a national investigation, the Health System has been working with the Department of Justice (DOJ) regarding the Medicare programs' coverage guidelines for the implantation of implantable cardioverter defibrillators. On June 15, 2015, the Health System executed a settlement agreement with the DOJ for $2,910. Upon settlement, the Health System accrued the settlement balance as accrued liabilities. Payment was made in July 2015.

On June 22, 2012, the Health System filed a self-disclosure to CMS, reporting technical violations of the self-referral regulations (referred to as Stark). As of June 30, 2016, the Health System does not believe the settlement of this issue will have a material adverse effect on its consolidated financial statements.

Operating Leases

The Health System leases certain of its operating facilities and equipment. These leases, which expire through 2028, generally require the Health System to pay all maintenance, property tax, and insurance costs.

12. Commitments and Contingencies (continued)

At June 30, 2016, aggregate amounts of future minimum payments under operating leases were as follows:

2017	$	2,219
2018		2,041
2019		1,705
2020		1,333
2021 and thereafter		7,567

Rent expense is recognized on a straight-line basis over the terms of the leases. Rent expense was $2,695 and $2,400 for the years ended June 30, 2016 and 2015, respectively.

13. Maryland Health Services Cost Review Commission

Certain hospital charges are subject to review and approval by the Maryland Health Services Cost Review Commission (the Commission). Hospital management has filed the required forms with the Commission and believes the Hospital to be in compliance with Commission requirements.

The current rate of reimbursement for principally all inpatient services and certain other services to patients under the Medicare and Medicaid programs is based on an agreement between CMS and the Commission. This agreement is based upon a waiver from Medicare prospective payment system reimbursement principles granted to the state of Maryland under Section 1814(b) of the Social Security Act. As of January 2014, the CMS approved a modernized waiver that will be in place as long as Maryland hospitals commit to achieving significant quality improvements, limits on all-payer capita hospital growth, and limits on annual Medicare per capita hospital cost growth to a rate lower than the national annual per capita growth rate. This model is projected to save Medicare at least $330,000 over the next five years.

Beginning in fiscal year 2014, the Hospital entered into an agreement with the Commission to participate in the Global Budgeted Revenue (GBR) program. GBR methodology encourages hospitals to focus on population health strategies by establishing a fixed annual revenue cap for each GBR hospital. The agreement is evergreen in nature and covers both regulated inpatient and outpatient revenues.

13. Maryland Health Services Cost Review Commission (continued)

Under GBR, hospital revenue is known at the beginning of each fiscal year. Annual revenue is calculated from a base year and is adjusted annually for inflation, infrastructure requirements, population changes, performance in quality-based programs, and changes in levels of uncompensated care. Revenue may also be adjusted annually for market levels and shifts of services to unregulated services.

The Commission's rate-setting methodology for hospital service centers that provide both inpatient and outpatient services or only outpatient services consists of establishing an acceptable unit rate for defined inpatient and outpatient service centers within a hospital. The actual average unit charge for each service center is compared to the approved rate monthly and annually. Overcharges and undercharges due to either patient volume or price variances, adjusted for penalties where applicable, are applied to decrease (in the case of overcharges) or increase (in the case of undercharges) future approved rates on an annual basis. The Hospital undercharged by $122 as of June 30, 2016, which is within the allowable corridor as specified in the GBR Agreement.

The timing of the Commission's rate adjustments for the Hospital could result in an increase or reduction in rates due to the variances and penalties described above in a year subsequent to the year in which such items occur, and there is at least a possibility that the amounts may be material. The Hospital's policy is to record revenue based on actual charges for services to patients in the year in which the services are performed. The Hospital recognizes unbilled revenue for in-house patient services.

14. Subsequent Events

The Health System has evaluated subsequent events through September 23, 2016, the date the accompanying consolidated financial statements were issued.

Supplementary Information

Peninsula Regional Health System, Inc.

Consolidating Balance Sheet
(In Thousands)

June 30, 2016

	Peninsula Regional Medical Center	Peninsula Regional Medical Center Foundation, Inc.	Peninsula Health Ventures, Inc.	Peninsula Regional Clinically Integrated Network	Peninsula Surgery Center	Peninsula Regional Health System, Inc.	Eliminations	Consolidated
Assets								
Current assets:								
Cash and cash equivalents	$ 29,256	$ 1,166	$ 6,316	$ 1	$ 1	$ 15	$ –	$ 36,755
Short-term investments	6,760	–	–	–	–	–	–	6,760
Intercompany receivables	341	–	–	–	–	–	(341)	–
Accounts receivable, less allowance for uncollectible accounts	41,520	–	714	–	–	–	–	42,234
Inventories and other	9,888	–	338	–	–	–	–	10,226
Prepaids	6,276	–	51	–	–	–	–	6,327
Total current assets	94,041	1,166	7,419	1	1	15	(341)	102,302
Long-term investments	226,353	–	–	–	–	–	–	226,353
Investment in subsidiaries	–	–	–	–	–	435,743	(435,743)	–
Board-designated investments	23,584	–	–	–	–	–	–	23,584
Assets limited as to use:								
Construction fund	10,228	–	–	–	–	–	–	10,228
Donor-restricted fund	33,217	7,000	–	–	–	–	(7,000)	33,217
Self-insurance fund	19,713	–	–	–	–	–	–	19,713
Total assets limited as to use	63,158	7,000	–	–	–	–	(7,000)	63,158
Property and equipment, net	220,671	–	3,708	–	464	–	–	224,843
Unamortized financing costs, net of accumulated amortization	1,310	–	39	–	–	–	–	1,349
Other assets	10,145	–	9,414	–	–	104	–	19,663
Total assets	$ 639,262	$ 8,166	$ 20,580	$ 1	$ 465	$ 435,862	$ (443,084)	$ 661,252

Peninsula Regional Health System, Inc.

Consolidating Balance Sheet (continued)
(In Thousands)

June 30, 2016

	Peninsula Regional Medical Center	Peninsula Regional Medical Center Foundation, Inc.	Peninsula Health Ventures, Inc.	Peninsula Regional Clinically Integrated Network	Peninsula Surgery Center	Peninsula Regional Health System, Inc.	Eliminations	Consolidated
Liabilities and net assets								
Current liabilities:								
Current portion of long-term debt	$ 1,990	$ –	$ 78	$ –	$ –	$ –	$ –	$ 2,068
Current portion of accrued self-insured liabilities	2,495	–	–	–	–	–	–	2,495
Intercompany payables	–	–	9	39	20	273	(341)	–
Accounts payable	17,724	–	364	–	–	–	–	18,088
Accrued liabilities	14,936	–	–	–	–	–	–	14,936
Advances from third-party payors	11,401	–	–	–	–	–	–	11,401
Total current liabilities	48,546	–	451	39	20	273	(341)	48,988
Long-term debt, net	141,624	–	1,695	–	–	–	–	143,319
Other liabilities	38,537	–	–	–	–	–	–	38,537
Total liabilities	228,707	–	2,146	39	20	273	(341)	230,844
Net assets:								
Unrestricted	377,252	1,166	16,616	(38)	445	395,285	(395,439)	395,287
Temporarily restricted	25,058	7,000	–	–	–	32,059	(39,059)	25,058
Permanently restricted	8,245	–	–	–	–	8,245	(8,245)	8,245
Peninsula Regional Health System, Inc. net assets	410,555	8,166	16,616	(38)	445	435,589	(442,743)	428,590
Minority interest	–	–	1,818	–	–	–	–	1,818
Total net assets	410,555	8,166	18,434	(38)	445	435,589	(442,743)	430,408
Total liabilities and net assets	$ 639,262	$ 8,166	$ 20,580	$ 1	$ 465	$ 435,862	$ (443,084)	$ 661,252

Peninsula Regional Health System, Inc.

Consolidating Statement of Operations
(In Thousands)

Year Ended June 30, 2016

	Peninsula Regional Medical Center	Peninsula Regional Medical Center Foundation, Inc.	Peninsula Health Ventures, Inc.	Peninsula Regional Clinically Integrated Network	Peninsula Surgery Center	Peninsula Regional Health System, Inc.	Eliminations	Consolidated
Unrestricted revenue and other support:								
Net patient service revenue	$ 413,532	$ –	$ 4,891	$ –	$ –	$ –	$ –	$ 418,423
Provision for bad debts	(11,449)	–	(28)	–	–	–	–	(11,477)
Net patient service revenue less provision for bad debts	402,083	–	4,863	–	–	–	–	406,946
Other operating revenue	2,739	–	10	–	–	–	–	2,749
Net assets released from restrictions	–	271	–	–	–	–	(271)	–
Total unrestricted revenue and other support	404,822	271	4,873	–	–	–	(271)	409,695
Operating expenses:								
Salaries and wages	165,766	–	–	–	–	–	–	165,766
Supplies and other expenses	177,927	4	5,909	451	287	–	–	184,578
Employee benefits	34,429	–	–	–	–	–	–	34,429
Depreciation	22,554	–	250	–	–	–	–	22,804
Interest	4,964	–	88	–	–	–	–	5,052
Contributions to Hospital	–	271	–	–	–	–	(271)	–
Total operating expenses	405,640	275	6,247	451	287	–	(271)	412,629
Loss from operations	(818)	(4)	(1,374)	(451)	(287)	–	–	(2,934)
Nonoperating income (expense):								
Investment income	7,655	3	3,201	–	–	(169)	–	10,690
Loss on extinguishment of debt	–	–	–	–	–	–	–	–
Total nonoperating income	7,655	3	3,201	–	–	(169)	–	10,690
Excess (deficit) of unrestricted revenue and other support over expenses	6,837	(1)	1,827	(451)	(287)	(169)	–	7,756
Minority interest in earnings of controlled subsidiaries	–	–	(31)	–	–	–	–	(31)
Excess (deficit) of unrestricted revenue and other support over expenses attributable to PRHS	$ 6,837	$ (1)	$ 1,796	$ (451)	$ (287)	$ (169)	$ –	$ 7,725

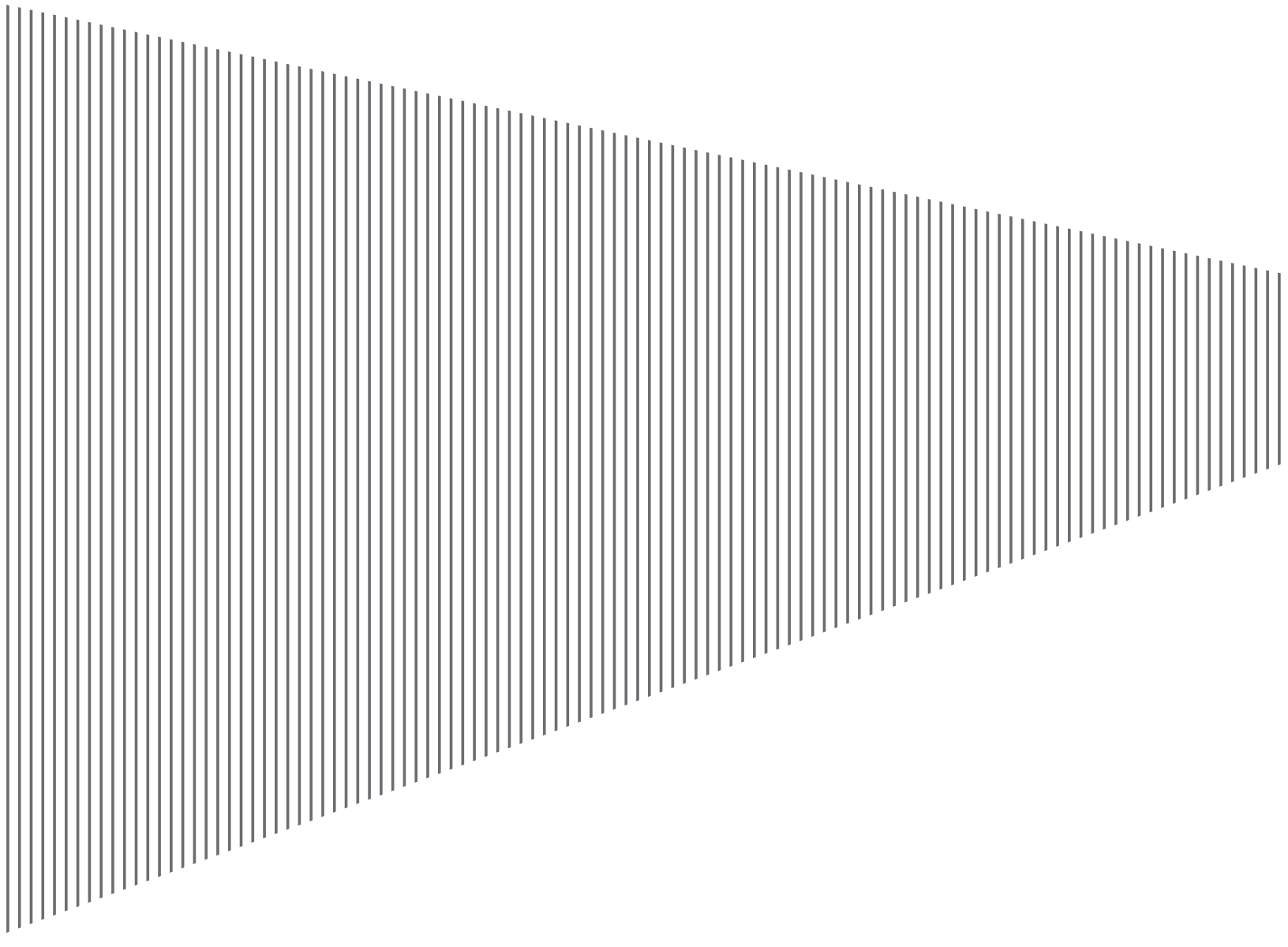
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Peninsula Regional Medical Center
COMMISSION DECISIONS AND PROJECTS WITHDRAWN

Docket No.	*Project Name*	*Project Description*	*Project Costs*	*Decision*	*Decision Date*
89-22-1559	Peninsula Regional Medical Center *Wicomico Co.*	New construction to the South Wing, renovations to the West Wing and the East Wing, and establishment of acute psychiatric services	$9,014,000	New Certification	6/12/1990
88-22-1434	Peninsula Regional Medical Center *Wicomico Co.*	Development of a 17 bed acute psychiatric unit for adults	$1,163,000	Modification	6/12/1990
95-22-1789	Peninsula Regional Medical Center *Wicomico Co.*	Establish a 20-bed sub-acute care unit at the hospital	$95,896	Denied	11/14/1995
96-22-1890	Peninsula Regional Medical Center *Wicomico Co.*	The purchase of 30 comprehensive care beds from Wicomico Nursing Home (pursuant to modification) and the establishment of a 30 bed sub-acute care unit at the hospital	$975,000	New Certification	7/31/1996
95-22-1801	Peninsula Regional Medical Center *Wicomico Co.*	Establish a 20-bed comprehensive care unit at the hospital located at 100 East Carroll Street, Salisbury, Maryland	$500,000	Denied	7/8/1997

MHCC - Certificate of Need Status Report

Peninsula Regional Medical Center
COMMISSION DECISIONS AND PROJECTS WITHDRAWN

Docket No.	*Project Name*	*Project Description*	*Project Costs*	*Decision*	*Decision Date*
93-22-1730	Peninsula Regional Medical Center *Wicomico Co.*	Initiate a 30-bed comprehensive care unit at the hospital	$0	Withdrawn	8/27/1997
99-22-2055	Peninsula Regional Medical Center *Wicomico Co.*	Relocation of 4 existing OR from Peninsula Regional Medical Center to a new free-standing ambulatory surgery center to also include 2 minor procedures rooms to be located at Salisbury Boulevard and Roland Street, Salisbury Modification - Change in the ownership structure to include physicians and the Delmarva Surgery Center, LLC not , PRMC would own the land and building, change in the financing of the project	$6,567,935	Modification	6/21/2001
02-22-2109	Peninsula Regional Medical Center *Wicomico Co.*	Renovation of the hospital emergency department and expansion of the authorized surgical capacity by four operating rooms	$2,350,000	New Certification	5/16/2003

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Peninsula Regional Medical Center
COMMISSION DECISIONS AND PROJECTS WITHDRAWN

Docket No.	*Project Name*	*Project Description*	*Project Costs*	*Decision*	*Decision Date*
05-22-2158	Peninsula Regional Medical Center *Wicomico Co.*	Construction of 1) a 5-level addition on the south end of the hospital, 2) a 3-story addition on the east side of the hospital, and 3) a 2-story addition on the north side of the hospital, and renovations to several areas of the hospital for the development of an Outpatient Center, development of expanded perinatal services, expansion of post surgical recovery space and develop a	$111,584,948	New Certification	12/15/2005
06-22-2183	Peninsula Regional Medical Center *Wicomico Co.*	Establish a Level IIIa perinatal program including a Level IIIa Neonatal Intensive Care Unit at the hospital	$10,000	New Certification	3/15/2007
10-22-2313	Peninsula Regional Medical Center *Wicomico Co.*	Renovation and expansion of the existing operating rooms at the hospital	$17,955,000	New Certification	1/20/2011

(A)

PENINSULA REGIONAL MEDICAL CENTER
Part of Peninsula Regional Health System

ADMINISTRATIVE POLICY MANUAL

Subject: Emergency Psychiatric Center

Effective Date:	September 1982
Approved by:	Executive Vice President/COO
Responsible Parties:	Vice President, Patient Care Services/CNO
Revised Date:	12/86, 3/91, 7/94; 7/15/09; 7/1/12
Reviewed Date:	8/84, 5/88, 6/92, 5/95, 7/96, 7/97, 8/98, 9/01, 2/04, 1/06; 5/20/16
Keywords:	emergency psychiatric

DESIGNATION

Peninsula Regional Medical Center has been designated by the Maryland Department of Health and Mental Hygiene (DHMH) as a psychiatric emergency facility.

INTENT

The intent of the legislature, which authorizes DHMH to designate these facilities, is that individuals who are evaluated on the basis of an emergency petition be medically screened to determine if their disturbed behavior results from a medical or psychiatric condition.

STANDARDS

1. Be available twenty-four (24) hours a day, seven days a week, to individuals of all ages.
2. Provide face-to-face contact by personnel competent to evaluate and treat disturbed individuals.
3. Provide supervision and case review by a physician prior to a final disposition.
4. Provide medical back up through the Emergency Department or through the Medical Center.
5. Patient evaluation by a physician within six hours and disposition by thirty hours when system allows in relation to bed availability.
6. Have access to an evaluation bed pending disposition, (a bed stretcher or litter in the Emergency Department or the Medical Center itself while examination and disposition are concluded).
7. Have available two persons qualified under law to certify patients when an involuntary admission is indicated.
8. Transport, or arrange to transport, any patients requiring involuntary admission.
9. Provide appropriate continuity of care through referrals to other hospitals or community based programs. The program to which the individual is referred may be under public or private auspices.

Reference SB 896
Executive Office File: "Maryland, State of: Re Peninsula regional Designated as Psychiatric Facility"

_____
Cindy Lunsford, Executive Vice President/COO

PENINSULA REGIONAL MEDICAL CENTER
Part of Peninsula Regional Health System

(B)

ADMINISTRATIVE POLICY MANUAL

Subject: Restraints/Seclusion/Alternative to Restraints

Effective Date: November 2006
Approved by: Executive Vice President/COO; President, Medical Staff
Responsible Parties: Clinical Practice and Standards Policy and Procedure Committee
Revised Date: 01/01, 9/01, 3/03, 5/03, 9/04, 9/05, 1/07, 8/07, 11/07; 11/10; 07/12; 5/13/2013; 5/30/13; 5/16/16; 3/7/17
Reviewed Date:
Key Words: Restraints, Seclusion, Alternatives

APPENDICES:

- **A.** Staff Training & Competency
- **B.** Restraint Alternatives
- **C.** Code Purple Process
- **D.** Restraint vs. Non-Restraint Interventions
- **E.** Face-to-Face Evaluation
- **F.** Daily Provider Progress Notes for Non-Violent/Non-Self-Destructive Behavior

PHILOSOPHY

Peninsula Regional Medical Center is committed to creating a culture that supports a patient's right to be free from restraint or seclusion. The Medical Center promotes alternative interventions and provides staff training to ensure the preservation of patients' safety and dignity. Restraint or seclusion may only be utilized to ensure the immediate physical safety of the patient, staff member(s), or others and shall be discontinued at the earliest possible time. Staff's decision to use a restraint or seclusion is not driven by diagnosis, but by a comprehensive individualized patient assessment. The Medical Center supports the use of restraint or seclusion in circumstances when the use of less restrictive measures poses a greater risk than the risk of using a restraint or seclusion.

PATIENT RIGHTS

The basic rights of human dignity and respect shall be maintained.

1. Patients have the right to be free from physical or mental abuse, and corporal punishment.
2. Patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.
3. Patients and, as appropriate, their families should be provided with information regarding restraint or seclusion. Staff should explain the need for the use of restraint devices to increase their understanding and decrease their fears regarding the use of restraints. Whenever possible, they should be informed about alternatives tried, the reason for restraints, and be included in the decision process.
4. Patients' basic needs for nourishment, personal care, and exercise shall be met during use of restraints.
5. Patients have the right to safe implementation of restraint or seclusion by trained staff.
6. Patients have the right to be included in the treatment plan and informed of behavioral expectations that shall discontinue the need for restraints.

POLICY

1. Restraint alternatives are attempted prior to application of restraints ordered by a Licensed Independent Practitioner (LIP) and utilized only when clinically indicated and when the use of restraints is necessary, the least restrictive method shall be used to ensure patient safety.

2. Restraints shall only be initiated by a LIP or RN and applied/removed by Medical Center staff with demonstrated competence in the application and removal of the type of restraint in question.

3. Medical Center staff shall receive training on the restraint policy and application of restraints at new employee orientation and annually. Additional training shall be given to physicians, LIPs and RNs that initiate behavioral restraints and seclusion. See Appendix A- "Staff Training and Competency."

4. The use of handcuffs, weapons, shackles, or other restrictive devices are not to be considered safe, appropriate health care restraint interventions and are considered law enforcement restraint devices. The law enforcement officers who maintain custody and direct supervision of their prisoner (the patient) are responsible for the use, application, and monitoring of these restrictive devices in accordance with Federal and State law.

DEFINITIONS

1. **Alternatives to Restraint/Seclusion:** Strategies implemented to encourage appropriate behaviors and prevent utilization of restraint/seclusion. Examples may include: safety interventions or precautions, supervision, assistive devices or activities. See Appendix B for "Restraint Alternatives."

2. **Comprehensive Assessment:** Performed by the LIP and/or registered nurse, a comprehensive patient assessment is used to determine if there are any underlying medical problems contributing to the patient's behavior, and that the risks associated with the use of the restraint or seclusion is outweighed by the risk of not using the restraint or seclusion. Less restrictive interventions do not always need to be tried, but less restrictive interventions shall be determined by staff to be ineffective to protect the patient or others from harm prior to the introduction of more restrictive measures.

3. **Face-to-face Evaluation**: The Physician or LIP, or in the Mental Health Unit, a specially trained RN, evaluates the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition, and the need to continue or terminate the restraint or seclusion. The evaluation includes a comprehensive review to consider if other factors are contributing to the behavior, such as hypoxia, sepsis, or medication interactions.

4. **Licensed Independent Practitioner (LIP):** An individual independently authorized by the State of Maryland and Medical Center policy as having the prescriptive authority to order restraints and seclusion. (i.e. Physician, Nurse Practitioner, Physician Assistant)

5. **Medication as Restraint:** A medication that is not being used as a standard treatment for the patient's medical or psychiatric condition, and that results in restricting the patient's freedom of movement or reduces his ability to interact with the world around him.

6. **Non-Violent and Non-Self Destructive Behavior:** Behavior in which the patient is displaying actions that interfere with necessary medical treatment. These behaviors may be due to conditions such as dementia and confusion rendering the patient cognitively unable to comply. Restraint may be necessary for the patient to receive effective treatment, when less restrictive interventions have been determined to be ineffective and are used in accordance with the patient's plan of care.

7. **Restraint**: Any manual method, physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he/she cannot easily remove, that restricts a person's freedom of movement, or normal access to his/her bodies in order to prevent intentional harm to self or others. This also includes medication given to restrict a patient's freedom of movement. Restraints are grouped into two categories, Category I (more restrictive) and Category II (less restrictive).

a. **Category I (more restrictive) Restraint**: a device that limits a patient's mobility to the extent that the patient would not be able to independently reposition his/herself or would be rendered helpless in an emergency.

b. **Category II (less restrictive) Restraint**: any device not considered by the facility as a Category I restraint.

Medical center Category I Restraints For Violent/Self-Destructive Behavior	**Medical Center Category II Restraints For Non-Violent/Non-Self Destructive Behavior**	
	Category II Least Restrictive	Category II More Restrictive
• Seclusion with restraints • Limb restraints x 4	• Freedom splints • Four side rails • Hand mitts	• Roll belt (patient is unable to release) • Geri-chair with locking tray • Soft limb restraint(s)

8. **Restraint Episode**: The use of physical restraints which begins when the patient is first restrained and ends when the restraints are removed because the behavior has ceased. Removing the restraint for bathing and feeding is still the same episode if the behavior continues and the restraints are reapplied.

9. **Seclusion:** The involuntary confinement of a person alone in a room or an area where the person is prevented from leaving. If a patient is restricted to a room and staff are physically intervening or threatening physical interventions to keep the patient in the room, the room is considered locked (whether locked or not) and is considered a restraint. Seclusion does not include confinement on a locked unit or ward where the patient is with others.

    a. **Seclusion** may only be used for the management of violent or self-destructive behavior and may only occur in the **Emergency Department** or the **Mental Health Unit**.

    b. **Time out/quiet time** is a therapeutic intervention in which the patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving and **not considered a restraint**.

10. **Treatment Team:** A multidisciplinary team consisting of a nurse, social worker/care coordinator and psychiatrist/LIP, who together, examine the use of restraint/seclusion for a patient with violent/self destruction behavior.

11. **Violent and Self Destructive Behavior****: A situation in which a patient's behavior poses a serious and imminent danger to self or others, the physical environment, or behavior of such a grave or protracted nature that significantly interferes with the emotional well-being of other patients or with their treatment.

****EXCEPTION – REPETITIVE SELF-MUTILATING BEHAVIOR**

If a patient is diagnosed with a chronic medical or psychiatric condition, such as Lesch-Nyhan Syndrome, and the patient enegages in repetitive self-mutilating behavior, a standing or PRN order for restraint to be applied in accordance with specific parameters established in the treatment plan would be permitted. Since the use of restraints to prevent self-injury is needed for these types of rare, severe, medical and psychiatric conditions, the specific requirements (1-hour face-to-face, time-limited orders, and evaluation every 24 hours before renewal of the order) for the management of violent or self-destructive behavior do not apply.

For patients determined to have met this exception for LIP – the LIP must document the parameters of the treatment plan and the patient will be monitored per our non-violent restraint standard.

ASSESSMENT FOR RESTRAINT/SECLUSION NEED

Prior to implementing restraint or seclusion the following criteria should be met:

1. The **LIP** shall conduct a comprehensive assessment. The **comprehensive assessment** should include a physical assessment to identify medical problems (i.e., temperature elevation, hypoxia, hypoglycemia, electrolyte imbalance, drug interactions, and drug side effects) that may cause confusion, agitation, combative behaviors. Addressing these medical issues may eliminate or minimize the need for the use of restraints or seclusion.

   Note: *In the absence of a LIP, a* ***registered nurse*** *shall conduct the comprehensive individualized patient assessment and report findings utilizing SBARR to a LIP.*

2. The physician or registered nurse shall assess and document whether less restrictive **alternative approaches** are appropriate and, if so, whether and what approaches have been attempted.

3. A **request from a patient or a family member** for the application of a restraint, which they would consider beneficial (such as raising all four side rails) is **not** a sufficient basis for the use of a restraint intervention.

4. If patient is determined by the LIP to meet the exclusion definition of Repetitive Self-Mutilating Behiavior, the LIP must review and identify the location of the treatment plan which outlines the specific parameters of treatment.

UTILIZATION OF RESTRAINT OR SECLUSION

When behavior is escalating, staff shall determine whether patient behavior is violent/self-destructive or non-violent/non-self-destructive and follow the process outlined below. Note—if patient has been determined to meet the definition of Repetitive Self-Mutilating Behavior follow non-violent/non-self-destructive guidelines in conjunction with treatment plan.

Action	Violent/Self-Destructive	Non-Violent/Non-Self-Destructive
Attempt Alternatives	• Attempt alternatives, as appropriate • Utilize **Appendix B** – "Restraint Alternatives". NOTE: Consider population/age appropriate alternatives • Document alternatives to restraints used	• Attempt alternatives to restraints. • Utilize **Appendix B** – "Restraint Alternatives". NOTE: Consider population/age appropriate alternatives. • Document alternatives to restraints used.
Assess Patient Behavior	An RN or LIP recognizes violent or self-destructive behavior and immediately activates ***Code Purple*** by dialing "11" See **Appendix C,** "Code Purple Process".	An RN or LIP recognizes non-violent or non-self-destructive behavior that is a safety concern and calls for a ***Code Restraint*** by dialing "11". This will activate the Clinical Response Team to respond.

Perform Comprehensive Assessment	**When an LIP is immediately available:** • The LIP shall be responsible for determining a patient's need for a restraint and make the decision whether to restrain based on a comprehensive individualized patient assessment. **If an LIP is not immediately available:** The **RN** shall determine a patient's need for restraint based on a comprehensive individualized patient assessment and may initiate/direct the use of restraints.	**When an LIP is immediately available:** • The LIP shall be responsible for determining a patient's need for a restraint and make the decision whether to restrain based on a comprehensive individualized patient assessment. **If an LIP is not immediately available:** • The **RN** shall determine a patient's need for restraint based on a comprehensive individualized patient assessment and may initiate/direct the use of restraints. • The Clinical Response Team will assess if restraints are appropriate.
Action	**Violent/Self-Destructive**	**Non-Violent/Non-Self-Destructive**
Perform Comprehensive Assessment, continued	**A Comprehensive Assessment is done to identify possible medical causes of behavior. The assessment includes:** • Physical assessment of patient • Labs • Vital signs • Review of home and current medications Based on the Comprehensive Assessment, the LIP, if available, or RN will collaborate with the Code Purple team as to if/what restraint(s) is/are appropriate.	**A Comprehensive Assessment is done to identify possible medical causes of behavior. The assessment includes:** • Physical assessment of patient • Labs • Vital signs • Review of home and current medications Based on the Comprehensive Assessment, the LIP, if available, or RN will collaborate with the Clinical Response Team as to if/what restraint(s) is/are appropriate.
Obtain Restraint or Seclusion Order	If restraint/seclusion deemed necessary, the LIP should be notified immediately for an order. *NOTE: If the attending physician did not order the restraint/seclusion, the **LIP should notify the attending** as soon as possible.* All orders should include: a. Date and time of order b. Type of restraint	If restraint deemed necessary, the LIP should be notified immediately for an order. *NOTE: If the attending physician did not order the restraint, the **LIP should notify the attending** as soon as possible.* All orders should include: a. Date and time of order b. Type of restraint c. Reason for the restraint (medical

	c. Reason for the restraint/ seclusion (medical necessity) d. Length of time for restraint/ seclusion, as defined below: • 4 hours for adults (18 years or older) • 2 hours or children and adolescents (9-17 years) • 1 hour for children (under 9 years) e. Signature of the physician. All telephone orders shall be:	necessity) d. Length of time restraint to be applied, up to 24 hours e. Signature of the physician All telephone orders shall be: a. Obtained by an RN b. Dated, timed and countersigned by the physician within 24 hours **NOTE:** Verbal orders are **not acceptable.**

Action	Violent/Self-Destructive	Non-Violent/Non-Self-Destructive
Obtain Restraint or Seclusion Order, continued	a. Obtained by an RN b. Dated, timed and countersigned by the physician within 24 hours **NOTE:** Verbal orders are **not acceptable.**	
Selection of Restraint	The type or technique of restraint or seclusion used shall be the **least restrictive intervention** that will be effective to protect the patient, a staff member or others from harm. See **Appendix D**, "Restraint vs. Non-Restraint Interventions" **NOTE:** Four point restraints are ***never*** appropriate for children (less than 12 years of age).	The type or technique of restraint or seclusion used shall be the **least restrictive intervention** that will be effective to protect the patient, a staff member or others from harm. See **Appendix D**, "Restraint vs. Non-Restraint Interventions" **NOTE:** Seclusion is ***never*** appropriate for non-violent or non-self-destructive behaviors.
Staffing Adjustment	For a patient with violent/self-destructive behavior who is restrained **1:1 staffing** is required, contact the Nursing Supervisor. An **RN** shall be assigned the care of the patient in restraint or seclusion for violent or self-destructive behaviors.	Either an **RN** or **LPN** may be assigned the care of the patient in restraints for non-violent or non-self-destructive behaviors.

ASSESSMENT & MONITORING OF PATIENT IN RESTRAINT OR SECLUSION

Action	Violent/Self-Destructive	Non-Violent/Non-Self-Destructive
While patient is in restraint or seclusion the clinical staff shall . . .	1. Keep patient in full view at all times. 2. Provide a safe environment and protect the patient from harm. 3. Perform vital signs per unit standard or more frequently as clinically indicated. 4. **RN** – Initiate or modify	1. Provide a safe environment and protect the patient from harm. 2. Perform vital signs per unit standard or more frequently as clinically indicated. **3. RN** – Initiate or modify appropriate restraint care plan according to type of restraint used.

Action	Violent/Self-Destructive	Non-Violent/Non-Self-Destructive
While patient is in restraint or seclusion the clinical staff shall . . . continued	appropriate restraint care plan according to type of restraint used. **NOTE:** If ***medication*** has been utilized as a restraint, effectiveness should be reassessed as clinically indicated.	**NOTE:** If ***medication*** has been utilized as a restraint, effectiveness should be reassessed as clinically indicated.
Q 15 Minute Observations	**Clinical Staff** – Closely observe every 15 minutes or as clinically indicated and document each observation.	If clinically indicated
1 Hour Face-to-Face Assessment	A face-to-face assessment shall be completed in person* by a **LIP within one hour** of restraint/ seclusion initiation, **regardless if the behavior has resolved** and restraint or seclusion has been discontinued. **Telemedicine/E-care methodology is not permitted for the 1 hour face-to-face; this must be an "in person" encounter with the patient.* Utilize **Appendix E** – "Provider Progress Note for Violent or Self-Destructive Behavior *Face-to-Face Evaluation*" to evaluate: a. The patient's immediate situation b. The patient's reaction to the intervention c. The patient's medical and behavioral condition d. The need to continue or terminate the restrain or seclusion. **NOTE:** In the Mental Health Unit a specially trained RN may	A 1 hour face-to-face assessment is not required.

Action	Violent/Self-Destructive	Non-Violent/Non-Self-Destructive
1 Hour Face-to-Face Assessment, continued	perform the 1 hour face-to-face assessment when an LIP is not available.	
Q 1 Hour Personal Contact	**Clinical Staff** – Offer/provide and document the following at least every 1 hour*or as clinically indicated: a. Determine special needs b. Check circulation c. Adjust restraint d. Realign the body or massage the extremities restrained * Unless contraindicated by circumstances as assessed and documented by LIP or RN. **NOTE:** • After the first hour a patient in seclusion without physical restraint may be continuously monitored using simultaneous video and audio equipment. • Whenever releasing restraints for violent behavior at least 2 staff members should be present.	If clinically indicated
Q 2 Hour Personal Contact	**RN or LIP** – At least every 2 hours or as clinically indicated, assess the appropriateness of continuing the restraint and document the indication for the continued need. **Clinical Staff** – Offer/provide and document the following at least every 2 hours* or as clinically indicated. a. Perform full range motion of restrained extremity b. Assist with toileting c. Provide fluids	**RN or LIP** – At least every 2 hours or as clinically indicated, assess the appropriateness of continuing the restraint and document the indication for the continued need. **Clinical Staff** – Offer/provide and document the following at least every 2 hours* or as clinically indicated. a. Perform full range motion of restrained extremity b. Assist with toileting c. Provide fluids d. Determine special needs e. Check circulation

Action	Violent/Self-Destructive	Non-Violent/Non-Self-Destructive
Q 2 Hour Personal Contact, continued	*Unless contraindicated by circumstances as assessed and documented by LIP or RN.	f. Adjust restraint g. Realign the body or massage the extremities restrained *Unless contraindicated by circumstances as assessed and documented by LIP or RN.
Q Meals	**Clinical Staff** – Offer/provide meals during regularly scheduled hours and under supervision of nursing personnel.	**Clinical Staff** – Offer/provide meals during regularly scheduled hours and under supervision of nursing personnel.
Q 24 Hour Hygiene	**Clinical Staff** – Offer/provide bathing and oral hygiene at least once every 24 hour period.	**Clinical Staff** – Offer/provide bathing and oral hygiene at least once every 24 hour period.
Q Day Notification	Episodes of restraint/seclusion are automatically reported to Nursing Supervisors, Administration and Clinical Managers. Clinical Managers should investigate unusual or possible unwarranted patterns of restraint/seclusion use.	Episodes of restraint/seclusion are automatically reported to Nursing Supervisors, Administration and Clinical Managers. Clinical Managers should investigate unusual or possible unwarranted patterns of restraint/seclusion use.
Huddle Within 7 Days	**Treatment Team** – Clinical Managers should identify a treatment team within 7 days and meet to examine the use of restraint/seclusion for the patient. Regardless of whether the patient remains in restraint or seclusion, anyone who has been restrained/ secluded for violent behavior must have the restraint/seclusion episode reviewed by the Treatment Team. The Treatment Team should: a. Review the appropriateness of the restraint/seclusion use. b. Establish and implement a plan calculated to eliminate the	

Action	Violent/Self-Destructive	Non-Violent/Non-Self-Destructive
	need for further restraint. c. Identify a team member who should explain to the patient the potential risks and benefits of continuous restraint, if applicable.	

RENEWAL PROCESS OF LIP ORDERS

	Violent/Self-Destructive	Non-Violent/Non-Self-Destructive
Time Limits for Renewal	Prior to the order expiring, an **RN should contact the LIP** and request for the order to be renewed using the following limits: a. 4 hours for adults (18 years or older) b. 2 hours for children and adolescents (9-17 years) c. 1 hour for children (under 9 years) At the end of the time frame, if restraint or seclusion is still deemed necessary another order is required. ***Note:*** *An onsite assessment is necessary prior to renewing the restraint order at the discretion of the LIP in conjunction with a discussion with the RN who is over-seeing the care of the patient.* The **original restraint/seclusion order** may only be **renewed** within the required time limits for up to a **total of 24 hours**.	Orders are renewed daily.
Order Renewal Assessment	The LIP may only renew an order for restraint following a 24 hour **face-to-face assessment** for continued need of restraint.	A LIP may renew an order for restraint following a daily **face-to-face assessment** for continued need of restraint. The face-to-face assessment is to be documented on the "Daily Provider Progress Note for Non-Violent/Non-self-Destructive Behavior" form, **See Appendix F.**

Continuous Utilization of Restraint	The renewal process should be **repeated every 24 hours** as indicated. If a patient requires restraints or seclusion **greater than a continuous 48 hours,** authorization is required by the Chief of Psychiatry or the physician designee (neither of whom may be the treating physician). Following a face-to-face evaluation the Chief of Psychiatry may: • Recommend an order as indicated for continuation of restraint/seclusion for up to 48 hours and should; • Incorporate into treatment plan proposed strategies to accomplish discontinuance of the restraint. ***Note:*** *Each time the restraint is authorized by the Chief of Psychiatry he/she shall countersign the physician's order for continued restraint.*	
Discontinuation	Restraint/seclusion shall be **discontinued at the earliest possible time,** regardless of the length identified in the order. A **LIP or RN** may clinically determine that the release of the patient is appropriate and document the assessment. ***Note:*** *Each new restraint episode requires a new order.*	Restraint shall be **discontinued at the earliest possible time,** regardless of the length identified in the order. A **LIP or RN** may clinically determine that the release of the patient is appropriate and document the assessment. ***Note:*** *Each new restraint episode requires a new order.*

FAMILY NOTIFICATION

Cases in which the patient has consented to have **family kept informed** of his/her care, treatment, and services and the family has agreed to be notified, staff should attempt to contact the family promptly to notify them of the restraint/seclusion use, alternatives attempted, and the goal of early termination and document the conversation in the medical record.

NURSING DOCUMENTATION

Documentation should include:

- The patient's specific behaviors
- Alternatives attempted
- Comprehensive Assessment findings
- Appropriate response team notification
- Restraints, if any, initiated
- Patient/Family education pertaining to restraints (expected behavior needed by patient to have restraints discontinued)
- Discontinuation of restraints

UTILIZATION OF MEDICATION AS A RESTRAINT

Administration of a medication to temporarily manage an individual's behavior, in a way that reduces his/her ability to interact with the therapeutic environment, **is a restraint**. The medication is not being used as a standard treatment for the patient's medical or psychiatric condition, and that results in restricting the patient's freedom of movement. Such treatment is only used after less restrictive measures have been determined to be ineffective or cannot be employed without jeopardizing patient safety or care and all other options have been explored.

Note:

- *This does not apply to clinical treatment of patients who are suffering from serious mental illness and who need therapeutic doses of medication to improve their level of function*
- *This also does not apply to doses of sleeping medications prescribed for patients with insomnia, anti-anxiety medications prescribed to calm a patient who is anxious or analgesics prescribed for pain management or standard practices in which sedation is utilized for diagnostic or therapeutic procedures.*

PERFORMANCE IMPROVEMENT

Data collection shall occur with each episode of restraint or seclusion. Data elements shall include:

1. Staff/Unit who initiated the process
2. Date and time each episode was initiated
3. The type of restraint used
4. If reported injuries sustained by patient/staff

The analyst should receive the data on a monthly basis, correlate and present the data to the restraint team, who should then analyze the data and report the findings at least every 6 months or more frequently if warranted, to both the Nursing PI committee and the Medical Center PI committee. Opportunities for decreasing restraint and seclusion usage and process improvement to reduce associate risks should be identified.

DEATH REPORTING REQUIREMENTS

The Medical Center should report the following information to CMS:

1. Each death that occurs while a patient is in restraint or seclusion.
2. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
3. Each death known to the Medical Center that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death.

***Note**: This is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.*

Each death referenced in this paragraph shall be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.*

The **nursing supervisor** should document in the patient's medical record the date and time the death was reported to CMS.

Patient death in **soft wrist restraints is recorded in the **Patient Restraint Death Log** maintained by nursing supervisors and does **not** have to be reported as outlined above.*

David Kerrigan
President, Medical Staff

Cindy Lunsford
Executive Vice President/COO

APPENDIX A- Staff Training & Competency

TRAINING FOR DIRECT CARE STAFF
All direct care staff must demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion as appropriate. These competencies shall be demonstrated initially as part of orientation and subsequently on at least an annual basis.

The content and frequency of training shall be targeted to the specific needs of the patient populations being served (i.e. children, elderly), and the competency level of the staff.

Components of this training include:

1. The use of nonphysical intervention skills to help the patient maintain self-control and avert escalation.
2. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
3. The safe application and use of all types of restraint or seclusion used in assigned clinical area(s), including training in how to recognize and respond to signs of physical and psychological distress. Including:
    a. Understanding that any history of sexual or physical abuse may place the patient at greater psychological risk during restraint or seclusion.
4. Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
5. Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements associated with the 1-hour face-face evaluation.
6. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification, as applicable.

Staff providing the education/training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors for the patient populations being served. Trainers should demonstrate a high level of knowledge regarding all the requirements of these regulations as well as the hospital's policies and procedures that address these requirements.

Skills and knowledge assessments will be performed with initial and all subsequent training. As results of skills and knowledge assessments, acquisition of new equipment, or results of QAPI data indicate a need the hospital will initiate targeted training, more frequent, and/or revised training as appropriate.

TRAINING FOR 1-HOUR FACE-TO-FACE EVALUATIONS
Training for a LIP to conduct the 1-hour face-to-face evaluation must include the above requirements as well as content to evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition, and the need to continue or terminate the restraint or seclusion.

Components of this training include:

- Complete review of systems assessment
- Behavioral assessment
- Assessment of the patient's history
- Medication review
- Review of diagnostic studies (most recent lab results, etc.)

Competence must be demonstrated in evaluating the patient's condition and determining if other factors are contributing the patient's violent or self-destructive behavior.

TRAINING FOR PROTECTION SERVICES AND OTHER NON-HEALTHCARE STAFF

Non-healthcare staff **may assist** direct care staff in the application of restraint or seclusion. Protection Services receives CPI (Crises Prevention Intervention) training during orientation and updated annually.

TRAINING FOR PHYSICIANS AND OTHER LIPS

All LIPs authorized to order restraint or seclusion must have a working knowledge of the Medical Center's policy regarding the use of restraint and seclusion, including the comprehensive assessment, required documentation, order renewal process, and components of the required face-to-face 1 hour evaluation.

DOCUMENTATION OF TRAINING

The Medical Center requires documentation in the staff personnel records that the training and demonstration of competency were successfully completed.

APPENDIX B- Restraint Alternatives

Many restraint alternatives are possible for each patient. We have listed some ideas below that you may find helpful. This is by no means a comprehensive list. Each patient should be assessed for the appropriateness of the alternative. Likewise, alternatives may be used in combination to best meet the needs of the patient.

VERBAL DE-ESCALATION STRATEGIES

- ☐ Use simple, concrete positive statements
- ☐ Use soothing voice & eye contact (i.e. appropriate tone & volume)
- ☐ Speak slowly and calmly with self assurance, smile as appropriate
- ☐ Listen attentively
- ☐ Offer verbal support, reassurance and encouragement
- ☐ Speak in a slow non-threatening manner
- ☐ Explain procedure/treatments to reduce fear/anxiety
- ☐ Use relaxation techniques

MODIFICATION OF PATIENT ENVIRONMENT STRATEGIES

- ☐ Ensure safe surrounding
- ☐ Place call bell within patient's reach
- ☐ Reposition patient
- ☐ Place patient belongings within easy reach (i.e. water, urinal, glasses, BSC)
- ☐ Place tubes/catheters/IV lines out of site (i.e. skin sleeve)
- ☐ Place near nurse's station or relocate work station to be closer to patient
- ☐ Assess readiness for tubes/catheters/IV lines to be discontinued and discuss with LIP
- ☐ Utilize bed/chair alarm
- ☐ Provide assistive devices (i.e. walker, cane, glasses, hearing aid)
- ☐ Offer nourishment
- ☐ Provide necessities for patient comfort (i.e. pillows, blankets)

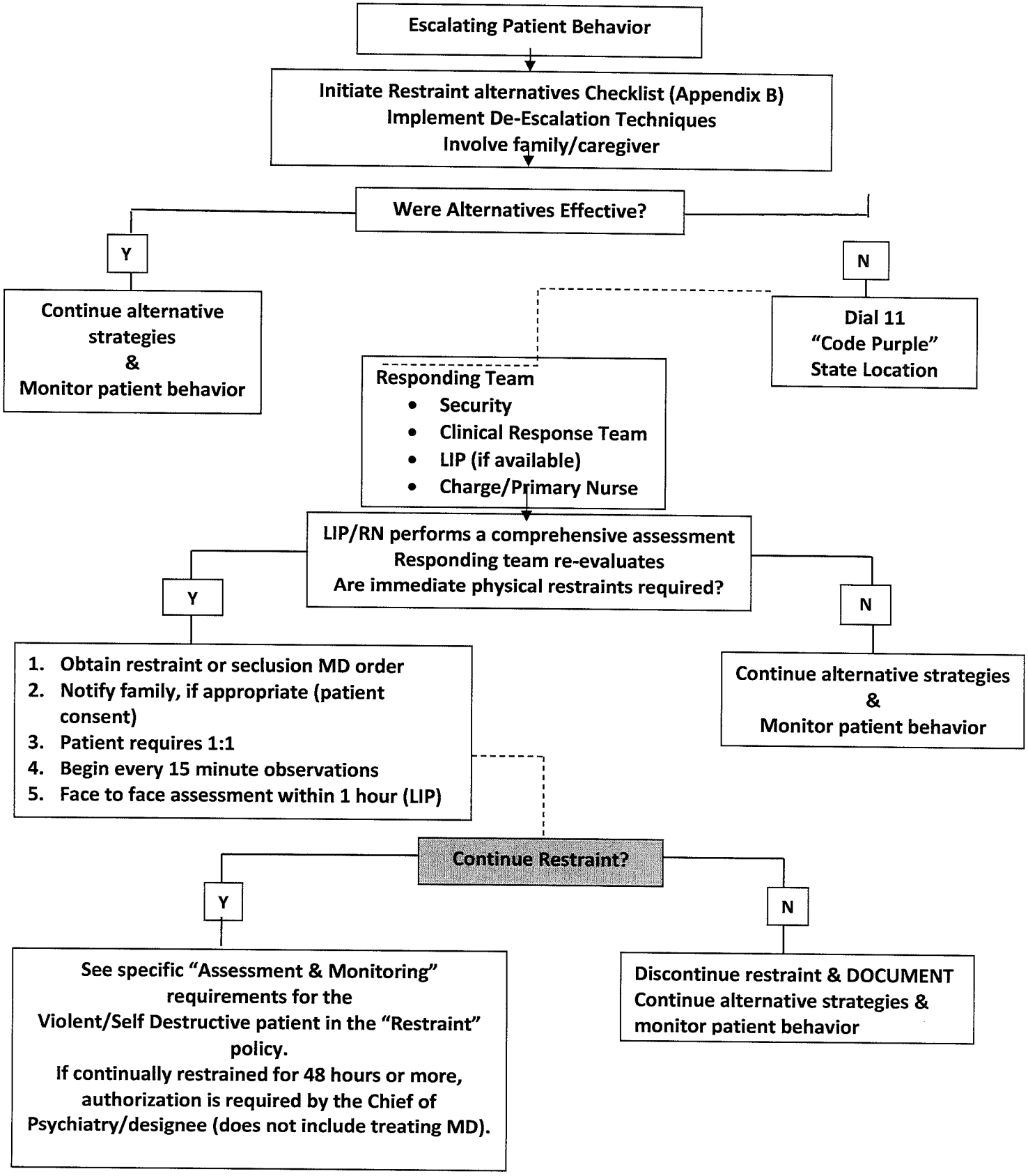
FAMILY/SIGNIFICANT OTHER INVOLVEMENT STRATEGIES

- ☐ Contact family/significant other
- ☐ Encourage family/significant other visits
- ☐ Encourage family/significant other to stay with patient
- ☐ Encourage family/significant other to offer reassurance (i.e. holding a hand, speaking calmly, listening)

DIVERSIONAL/PHYSICAL ACTIVITY STRATEGIES

- ☐ Diversion activities (i.e. TV, videos, music, folding linens)
- ☐ Allow patient to choose activities
- ☐ Exercise/ambulate

APPENDIX C CODE PURPLE PROCESS



APPENDIX D- Restraint vs. Non-Restraint Interventions

Note: *Always consider the specific comprehensive assessment of the individual patient.*

1. **Devices which are NOT considered a restraint:**

   a. **Medical/Protective devices**: orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations/tests or for the purpose of preventing unintentional harm to self or others or which are used for promoting or maintaining normative body functions. (This does not include a physical escort.)

   b. **Age or developmentally appropriate protective safety interventions** (such as stroller, swing safety belts, high chair lap belts, raised crib rails, and crib covers): that a safety-conscious child care provider outside a health care setting would utilize to protect an infant, toddler, or preschool-aged child would not be considered restraint or seclusion. A staff member picking up, redirecting, or holding an infant, toddler, or preschool-aged child to comfort the patient is not considered restraint.

   Note: *Because the definition of physical restraint does not name each device and situation that can be used to immobilize or reduce the ability of the patient to move his or her arms, legs, body or head freely, it promotes looking at each patient situation on a case-by-case basis.*

2. **Situations in which interventions may or may not be considered a restraint:**

	Restraint	Non-Restraint
Medications or Drugs	If the overall effect of a drug or medication, or combination of drugs or medications, is to reduce the patient's ability to effectively or appropriately interact with the world around the patient, then the drug or medication is not being used as a standard treatment or dosage for the patient's condition and is considered a restraint.	Administered as part of the plan of care and medication allows patient to better interact with the world. Follows the expectation that the standard use of a drug or medication to treat the patient's condition enables the patient to more effectively or appropriately function in the world around him/herself than would be possible without the use of the drug or medication.
Physical/ Therapeutic holding	The application of force to physically hold a patient, in order to administer a medication or intervention against the patient's wishes. Tucking blankets or arranging bed so that patient has limited movement is also considered a restraint.	A patient may agree to an injection or procedure, but may not be able to hold still for the procedure, staff may hold the patient at the patient's request and is not considered a restraint.
Side rails	The use of side rails to prevent the patient from exiting the bed. It is not necessary to obtain a new order each time the patient is returned to bed after being out of bed.	Raising the side rails when a patient is on a stretcher, recovering from anesthesia, sedated, or experiencing involuntary movements. If a patient is not physically able to get out of bed regardless of whether the side rails

	Restraint	Non-Restraint
	Consider use of side rail protectors when patient is in a roll belt.	are raised or not, raising all four side rails for this patient would not be considered restraint because the side rails have no impact on the patient's freedom of movement. Raising less than 4 side rails allows patient to get in and out of bed without restraint.
IV Arm Board	If the arm board is tied down (or otherwise attached to the bed), or the entire limb is immobilized such that the patient cannot access his or her body, the use of the arm board would be considered a restraint.	Short arm board used to stabilize an IV line/A-line.
Geri Chair/ Recliner	If a patient is unable to safely get up from the chair on his/her own, this also includes recliners with table tray placed in front – this is a restraint.	If patient is able to get up from the recliner on their own.
Physical Escort	If the grasp is strong enough that the patient is unable to release his/herself if desired.	A light grasp that the patient can easily remove or escape from, is used to escort the patient to a desired location.
Post-Anesthesia Care	If restraints are maintained after the patient has recovered from the effects of the anesthesia.	When the patient is in a critical care or post-anesthesia care unit recovering from the effects of anesthesia, interventions or devices are considered part of the surgical procedure.

APPENDIX E – PROVIDER PROGRESS NOTE FOR VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR FACE TO FACE EVALUATION

Peninsula Regional Medical Center

Provider Progress Note for Violent or Self-Destructive Behavior
Face to Face Evaluation

Restraint/seclusion (including medication) used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others, requires the patient to be seen *face-to face* within 1 hour after the initiation of the intervention. The purpose of the *face-to-face* is for the physician, LIP, or in the Mental Health Unit, the specially trained RN, to complete a comprehensive review of the patient's physical and behavioral condition to determine if factors such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the violent or self-destructive behavior.

... This document can not be considered an order for restraints ...

☐ Restraints initiated face-to-face examination within 1 hour of the initiation of restraints?

☐ Restraints continued face to face examination which must be completed every 24 hours for continuous restraint episode?

Behavioral Assessment ***(describe in detail the patient's violent or self destructive behavior)*:**

_____

_____

_____

Physical Assessment ***(complete review of systems)*:**
___ No change from last documented physical assessment
___ Assessment Findings _____

Current Medication/Laboratory Assessment (possibly contributing to behavior):
___ Non-contributory
___ Assessment Findings _____

Patient's Immediate Situation:

_____

_____

Patient's reaction/response to restraint intervention thus far:

_____

_____

Based upon the above evaluation, continued restraint/seclusion for violent or self destructive behavior continues to be required (circle one) **YES NO**

If continued restraint is necessary the restraints will only be employed while the violent or self-destructive behavior continues and once the unsafe situation ends, the restraint/seclusion must be discontinued. Nursing staff will continue to monitor and assess to ensure that restraint/seclusion is discontinued at the earliest possible time.

If the violent or self-destructive behavior continues to exist for up to 4 hours, the nurse will update me with the most recent assessment & a decision will be made at that time if this restraint/seclusion episode should continue for up to an additional 4 hours or until such time as the violent or self-destructive behavior ends.



Date & Time:_____ **Provider Signature:**_____

NUR-801 (1/13)

APPENDIX F – DAILY PROVIDER PROGRESS NOTE FOR NON-VIOLENT/NON SELF-DESTRUCTIVE BEHAVIOR (NUR-802)

Peninsula Regional Medical Center

Daily Provider Progress Note for Non-Violent/Non Self-Destructive Behavior

Restraints (including medication) used for the management of Non-Violent/Non Self-Destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others, requires the patient to be evaluated daily .

This document can not be considered an order for restraints

Physical Assessment *(complete review of systems)*:
___ No change from last documented physical assessment
___ Assessment Findings _____

Current Medication/Laboratory Assessment *(possibly contributing to behavior)*:
___ Non-contributory
___ Assessment Findings _____

Patient's Current Situation:

_____

_____

Patient's reaction/response to the restraint intervention thus far:

_____

_____

Based upon the above evaluation, continued restraint for Non- Violent/Non Self Destructive behavior continues to be required ***(circle one)*** **YES** **NO**

If continued restraint is necessary the restraints will only be employed while the Non-Violent/Non- Self-Destructive behavior continues. When the unsafe situation ends, the restraint must be discontinued.

Nursing staff will continue to monitor and assess to ensure that restraint is discontinued at the earliest possible time.

Date & Time:_____ **Provider Signature:**_____

500

NUR-802 (7/12)

WILLIAM H. CERRATO, D.O.

8658 Camac St Easton, MD 21601 | 304-546-4776 | wcerrato@adventisthealthcare.com

EDUCATION

University of Maryland/Sheppard & Enoch Pratt Hospital, Baltimore, MD
Child & Adolescent Psychiatry Fellowship-Chief Fellow **7/1/11-6/30/13**
Experience in evaluation and treatment of children and adolescents in inpatient, partial day, outpatient, special school programs, standard public school and community settings as well as eating disorder and substance abuse programs

Virginia Commonwealth University Health System, Richmond, VA
Internship and General Psychiatry Residency **7/1/08-6/30/11**

West Virginia School Of Osteopathic Medicine, Lewisburg, WV
Medical School, Doctor of Osteopathy **8/2004-5/2008**

Rutgers, The State University Of New Jersey, Piscataway, NJ
Post Baccalaureate Pre-Medicine Program **2001-2003**

American University, Washington, DC
Undergraduate, BS Accountancy **1995-1999**

TEACHING EXPERIENCE

*Responsible for Teaching Medical Students and Residents 2008-2013

RELATED EXPERIENCE

*Medical Director Rebecca and Leighton Moore Child and Adolescent Behavioral Unit at PRMC **3/2017-present**
*Marshy Hope Family Services, LLC Staff Psychiatrist **2/2017-present**
*ESPS Staff Psychiatrist **12/2016-3/2017**
*Medical Director Adventist Behavioral Health & Wellness Services-Cambridge **11/2014-11/2016**
*Psychiatrist; Catholic Charities of Baltimore **9/2013-11/2014**
*Psychiatrist; Oasis, The Center for Mental Health; Annapolis, MD **3/2013-9/2013**
*Psychiatrist; Crisis Walk-In Clinic at Sheppard&Enoch Pratt Hospital, Towson, MD **9/2012-6/2013**
*Psychiatrist; University of Maryland Medical Center Acute Inpatient Child Psychiatric Unit **6/2012-2/2013**
*Psychiatrist; Baltimore City Detention Center, Baltimore, MD **11/2011-8/2012**
*Jr. Commodities Trader/ Accountant; Engelhard Corporation, Iselin, NJ **1999-2001**

PUBLICATIONS AND PAPERS

*Investigation into acute psychiatry unit adverse events in a university hospital setting: PI Dr. Pandurangi **9/2010**
Poster presentation Psychiatric Society of Virginia Fall Meeting
*Meta Analysis to assess outcomes of multi-systemic therapy as it relates to re-incarceration when compared to traditional services for juvenile offenders **7/2012-4/2013**

MEMBERSHIPS

*American Psychiatric Association
*American Academy of Child And Adolescent Psychiatry
*Maryland Psychiatric Society

LICENSSURE/CERTIFICATION

*American Board of Psychiatry and Neurology-Board Certified
*American Board of Psychiatry and Neurology-Child & Adolescent-Board Certified
*State of Maryland Medical License Certification #H0072194; Exp 9.30.18

REFERENCES

*Available on Request

JOHNNY MAUTZ
Legislative District 37B
Caroline, Dorchester, Talbot,
and Wicomico Counties

Economic Matters Committee



The Maryland House of Delegates
6 Bladen Street, Room 323
Annapolis, Maryland 21401
410-841-3429 · 301-858-3429
800-492-7122 *Ext.* 3429
Fax 410-841-3523 · 301-858-3523
Johnny.Mautz@house.state.md.us

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

January 16, 2018

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

Dear Mr. Steffen,

We are writing to express our support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides many services to the adult population in our community. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, we fully support this project and trust that you will consider their Certificate of Need application.

Sincerely,

JOHNNY MAUTZ
Member – Economic Matters Committee

The INSURANCE MARKET

Est. 1900

1.23.2018

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

Dear Mr. Steffen,

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Jim W. Hartstein

www.insurancechoices.com

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February 19, 2018

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

Dear Mr. Steffen,

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Dena Hall, LCSW-C
Program Coordinator

Eastern Shore Psychological Services, LLC
A Behavioral Wellness Company
29520 Canvasback Dr
Easton, Maryland 21601
Phone: 410-822-5007 Fax: 410-822-5569

2/23/2018

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

Dear Mr. Steffen,

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Barbara C Glenn, LCPC, NCC, CPRP
Assistant Regional Director

WYFCS

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124 N. Main Street,
Suite C
Berlin, MD 21811

Phone
410-641-4598
FAX
410-641-4696
Website
www.gowoyo.org

United Way of the Lower Eastern Shore

January 24, 2018

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

Dear Mr. Steffen,

Please accept my support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services on the Eastern Shore, including critical inpatient and outpatient mental health services.

The lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services causing these vulnerable patients to frequently wait for available beds and delay in care. The inpatient child and adolescent unit at PRMC will create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve access of mental healthcare throughout the community.

PRMC continues to demonstrate commitment to health and wellness in our community. Services are currently provided to the adult population include: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Steven Taylor
Executive Director

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201 Hall Highway
Crisfield, MD 21817
410.968.1200
mccreadyhealth.org

January 24, 2018

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

Dear Mr. Steffen,

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Tiffany Travers, LCSW-C
Director of Behavioral Health

THE PERSONAL
WELLNESS
CENTER
mind • body • spirit

January 25, 2018

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

Dear Mr. Steffen,

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Venessa Bowers, MSW, LCSW-C, CCTP, MA
Trauma Therapist

410.742.6016 • www.The PersonalWellnessCenter.com
6508 Deer Pointe Dr. • Suite 4C • Salisbury, MD 21804

01/18/2018

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

Dear Mr. Steffen:

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on. The community has needed a unit like this for years!

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those badly in need of this level of care, alleviating the stress and burden of being transferred to Delaware (or further away) which delays treatment and compounds the problem.

PRMC currently provides services to the adult population including inpatient and intensive outpatient services, a partial hospitalization program, and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. It is the children who suffer due to lack of available services and accommodation when they are in extremis.

Given its excellent reputation and the area's critical need for these inpatient services for children, I consider this Certificate of Need to be of vital importance and trust that you will give every consideration to expediting PRMC's application.

Very truly yours,



Connie G. Polovina, LCSW-C
Mental Health Therapist
1813 Sweetbay Drive #7
Salisbury, MD 21801-1663
410-845-1645

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Salisbury, MD 21804
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Baltimore, MD 21201
Office (443) 449-7713
Fax (443) 451-8268

29509 Canvasback Dr., #207
Easton, MD 21601
Office (410) 690-4805
Fax (410) 690-4806

January 31, 2018

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

Dear Mr. Steffen:

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Currently, there is no inpatient child and adolescent unit on the lower Eastern Shore of Maryland. These individuals in need of emotional supports and services frequently are forced to wait for available beds, causing a delay in care, or travel a long distance from their home to Delaware or other parts of Maryland or the District of Columbia. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Due to our area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Chalarra A. Sessoms, LCSW-C, MSW
Clinical Director
410-219-5070 ext. 104
csessoms@wraparoundmd.com

Wicomico County Health Department
108 East Main Street • Salisbury, Maryland 21801
Lori Brewster, MS, APRN/BC, LCADC • Health Officer

January 29, 2018

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

Dear Mr. Steffen,

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Tammy L. Griffin, MCHES
Director, Wicomico Behavioral Health Authority
Wicomico County Health Department
108 East Main Street
Salisbury, MD 21801
410-219-7480

Dorchester County
Department of Health

"Working for Healthier People"

3 Cedar Street
Cambridge MD 21613

410-228-3223
FAX: 410-228-9319

Roger L. Harrell, M.H.A.
Health Officer

January 30, 2018

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

Dear Mr. Steffen,

I would like to share my support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including inpatient and outpatient mental health services.

The lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental health care available in this area.

PRMC has shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's lack of access to these types of inpatient services, I give my full support to this project. Thank you for your consideration of PRMC's CON application.

Sincerely,

Roger L. Harrell

Roger L. Harrell, MHA
Health Officer

Pediatric and Adolescent Medicine

January 31, 2018

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

Dear Mr. Steffen,

I would like offer my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC continues to be vitally important to providing high-quality healthcare services to the citizens of the Eastern Shore, including critical inpatient and outpatient mental health services that our community relies on.

Unfortunately, the lower Eastern Shore of Maryland continues to be adversely impacted by the critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. Families who are fortunate enough, drive to neighboring states in search of more immediate solutions, are often disappointed. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve both quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room. However, there remains a missing and vital link, that of a local inpatient mental health unit.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to Peninsula Regional Medical Center's CON application.

Sincerely,

Sharon A. McFayden-Eyo, MD, MBA, FAAP

1205 PEMBERTON DRIVE ✦ SUITE 102 ✦ SALISBURY, MARYLAND 21801 ✦ PHONE (410) 749-8300 ✦ FAX (410) 860-9007

The First Judicial Circuit of Maryland

TRUANCY REDUCTION PROGRAM

101 N. DIVISION STREET
P.O. BOX 806
SALISBURY, MARYLAND 21803
(410) 548-7107

DORCHESTER COUNTY
SOMERSET COUNTY
WICOMICO COUNTY
WORCESTER COUNTY

February 6, 2018

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

Dear Mr. Steffen,

On behalf of Maryland First Judicial Circuit Truancy Reduction Program (Dorchester, Wicomico, Worcester, and Somerset Counties) I would like to share our strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Kendall E. Timmons
Program Coordinator

EASTERN SHORE PSYCHOLOGICAL SERVICES, LLC
A Behavioral Health Company

January 26, 2018

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

Dear Mr. Steffen,

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Laura Harrison, LCSW-C
Programs Director

Chesapeake Pediatrics & Adolescent Associates, P.A.
106 Milford St., Suite 201
Salisbury, Md. 21804
410-543-1616. fax 410-543-8497
www.chesapeakepeds.com

01/19/2018

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

Dear Mr. Steffen,

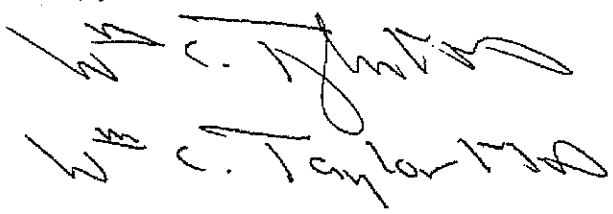
I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,



Chesapeake Pediatrics & Adolescent Associates, P.A.
106 Milford St., Suite 201
Salisbury, Md. 21804
410-543-1616. fax 410-543-8497
www.chesapeakepeds.com

01/19/2018

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

Dear Mr. Steffen,

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

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Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Nicole Hewitt DO

Chesapeake Pediatrics & Adolescent Associates, P.A.
106 Milford St., Suite 201
Salisbury, Md. 21804
410-543-1616. fax 410-543-8497
www.chesapeakepeds.com

01/19/2018

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

Dear Mr. Steffen,

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Laymon CRNP

Laymon CRNP

Chesapeake Pediatrics & Adolescent Associates, P.A.
106 Milford St., Suite 201
Salisbury, Md. 21804
410-543-1616. fax 410-543-8497
www.chesapeakepeds.com

01/19/2018

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

Dear Mr. Steffen,

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

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Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Dr. Mithila Jegathesan
Pediatrics

CHESAPEAKE PEDIATRIC & ADOLESCENT
ASSOCIATES, P.A.
106 MILFORD STREET
SUITE 201
SALISBURY, MD 21804

Chesapeake Pediatrics & Adolescent Associates, P.A.
106 Milford St., Suite 201
Salisbury, Md. 21804
410-543-1616. fax 410-543-8497
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01/19/2018

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

Dear Mr. Steffen,

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

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Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Carrie Davis CPNP

Chesapeake Pediatrics & Adolescent Associates, P.A.
106 Milford St., Suite 201
Salisbury, Md. 21804
410-543-1616. fax 410-543-8497
www.chesapeakepeds.com

01/19/2018

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

Dear Mr. Steffen,

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

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106 Milford St., Suite 201
Salisbury, Md. 21804
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www.chesapeakepeds.com

01/19/2018

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

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Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

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Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

10776 Grays Corner Rd.
Suite 2
Berlin, MD 21811
410.213.7875
410.213.7877 FAX
seasidecounseling@gmail.com

SEASIDE COUNSELING & Wellness Center

February 15, 2018

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

Dear Mr. Steffen,

We would like to share our strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

The lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. Families are also faced with the financial burden of having a loved one placed hours away from their home, creating a loss in income and travel expenses. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, we give our full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Debra Dotson, MSW, LCSW-C
Co-Owner/Therapist

Amy P. Ginnavan, MSW, LCSW-C, LCADC
Co-Owner/Therapist

Jose F. Alvarado, MD and Associates

1208 Pemberton Drive
Salisbury, Maryland 21801
Phone 410-742-7660
Fax 410-742-5309

February 16, 2018

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

Dear Mr. Steffen,

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Maria Sofia Avendano-Welch, M.D.

Maria S. Avendano-Welch, M.D

Jose F. Alvarado, MD and Associates

1208 Pemberton Drive
Salisbury, Maryland 21801
Phone 410-742-7660
Fax 410-742-5309

February 16, 2018

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

Dear Mr. Steffen,

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Jose E. Alvarado, M.D

MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Behavioral Health Administration
55 Wade Avenue - Dix Building SGHC - Catonsville, MD 21228
Barbara J. Bazron, Ph.D., Deputy Secretary / Executive Director

February 23, 2018

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

Dear Mr. Steffen:

I would like to share my support for the Certificate of Need (CON) application submitted by the Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. The PRMC is vitally important to providing high-quality healthcare services to the communities of the Eastern Shore, including critical inpatient and outpatient mental health services upon which the community relies.

The lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. Vulnerable youth are frequently forced to wait for available beds, causing a delay in their care. An inpatient child and adolescent unit at the PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred. In addition, it will avoid unnecessary delays in their treatment due to having to wait for bed availability at another facility. This would improve access and enhance the quality of mental healthcare available throughout the community.

The PRMC has clearly shown its dedication to promoting the health and wellness of Maryland's residents. The PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, the PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project, and hope that you will give every consideration to the PRMC's CON application.

Sincerely,

Barbara J. Bazron, Ph.D.
Deputy Secretary for Behavioral Health

cc: Roger Harrell, MHA, Health Officer, Dorchester County Health Department
Diane Hyde, Business Development Community Liaison, Peninsula Regional Medical Center
Thomas Merrick, Acting Director, Child, Adolescent and Young Adult Services,
Behavioral Health Administration

January 28, 2018

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

Dear Mr. Steffen,

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. As a local psychologist I am forced to send children and teens to the ED who then wait for days for available beds, causing a horrible delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,
Samantha J. Scott, Ph.D.
Samantha Scott
The Child & Family Center
Psychologist #05307

CARL ANDERTON, JR.
Legislative District 38B
Wicomico County

Environment and Transportation Committee

Subcommittees

Environment

Motor Vehicle and Transportation

Joint Committee on the Chesapeake and Atlantic Coastal Bays Critical Area



THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

The Maryland House of Delegates
6 Bladen Street, Room 317
Annapolis, Maryland 21401
410-841-3431 · 301-858-3431
800-492-7122 *Ext.* 3431
Carl.Anderton@house.state.md.us

Date: 1/15/2018
Mr. Ben Steffen,
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Steffen,

I would like to share my strong support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I give my full support to this project and trust that you will give every appropriate consideration to PRMC's CON application.

Sincerely,

Delegate Carl Anderton
District 38B-Wicomico County Delegation Chair

JAMES N. MATHIAS, JR.
Legislative District 38
Somerset, Wicomico,
and Worcester Counties

Finance Committee

Executive Nominations Committee

Joint Committee on Administrative,
Executive, and Legislative Review

Joint Subcommittee on Program
Open Space/Agricultural Land Preservation

Chair, Eastern Shore Senate Delegation

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

Annapolis Office
James Senate Office Building
11 Bladen Street, Room 216
Annapolis, Maryland 21401
410-841-3645 · 301-858-3645
800-492-7122 *Ext.* 3645
Fax 410-841-3006 · 301-858-3006
James.Mathias@senate.state.md.us

District Office
410-352-3096
Fax 410-352-3087

February 9, 2018

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

Dear Mr. Steffen:

As Maryland State Senator from District 38 on the Lower Eastern Shore, I fully support the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vitally important to the District I represent, providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Because of the shortage of inpatient child and adolescent services, these vulnerable patients frequently must wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. The facility currently provides services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC offers the following services for the child and adolescent population: outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I respectfully request your favorable action on PRMC's CON application. Please feel free to contact me at any time if I can be of further assistance.

Sincerely,

James N. Mathias Jr.

Senator James N. Mathias, Jr.

Public Health
Prevent. Promote. Protect.
Wicomico County Health Department

Wicomico County Health Department
108 East Main Street • Salisbury, Maryland 21801
Lori Brewster, MS, APRN/BC, LCADC • Health Officer

Accredited Health Department • PHAB Advancing public health performance • Public Health Accreditation Board

February 7, 2018

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

Dear Mr. Steffen,

On behalf of the Wicomico County Health Department and the Behavioral Health program, I would like to share our support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. PRMC is vital to providing high-quality healthcare to the people of the Eastern Shore, including critical inpatient and outpatient mental health services the community relies on.

The lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients are frequently forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they await availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

PRMC has clearly shown its dedication to promoting the health and wellness of our residents. PRMC currently provides inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room for the adult population. In addition, PRMC offers outpatient services and a dedicated 24/7 behavioral assessment unit in the emergency room for the child and adolescent population.

Given its excellent reputation and the area's critical lack of access to these types of inpatient services, I fully support this project and trust that you will appropriately consider PRMC's CON application. Please do not hesitate to contact me at (410) 543-6930 if you have questions regarding the local health department's support of this application.

Sincerely,

Lori Brewster, MS, APRN/BC, LCADC
Health Officer

Christopher T. Adams
Legislative District 37B
Caroline, Dorchester, Talbot,
and Wicomico Counties

Economic Matters Committee



The Maryland House of Delegates
6 Bladen Street, Room 326
Annapolis, Maryland 21401
410-841-3343 · 301-858-3343
800-492-7122 *Ext.* 3343
Fax 410-841-3299 · 301-858-3299
Christopher.Adams@house.state.md.us

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

January 16, 2018

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

Dear Mr. Steffen:

Please accept this letter of support for the Certificate of Need (CON) application submitted by Peninsula Regional Medical Center (PRMC) to establish an inpatient child and adolescent mental health unit. Peninsula Regional Medical Center is vitally important to providing high-quality healthcare services to the people of the Eastern Shore, including critical inpatient and outpatient mental health services that the community relies on.

Unfortunately, the lower Eastern Shore of Maryland has a critical shortage of inpatient child and adolescent services. These vulnerable patients frequently are forced to wait for available beds, causing a delay in care. An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

Peninsula Regional Medical Center has clearly shown its commitment to promoting the health and wellness of our residents. They currently provide services to the adult population including: inpatient, intensive outpatient, partial hospitalization program services and a fully staffed and secured 24/7 behavioral assessment unit in the emergency room. In addition, PRMC's emergency room offers outpatient services and a dedicated 24/7 behavioral assessment unit offering services for the child and adolescent population.

I fully support this project and trust that you will give every appropriate consideration to PRMC's Certificate of Need application. Should you have any questions, please do not hesitate to contact me.

Sincerely,

Christopher T. Adams