Exhibit 1: Atlantic General 2020 Vision

ATLANTIC GENERAL HOSPITAL

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ATLANTIC GENERAL

2020 VISION

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Atlantic General Hospital/Health System "2020 Vision"

- *Reviewed at Planning Committee meeting 18September2014*
- *Reviewed at Medical Executive Committee meeting 15October2014*
- *Presented and reviewed at AGH Annual Corporation Meeting 16October2014*
- *Final approval AGH Board of Trustees 06November2014*

I. Executive Summary

Continuing to build upon our Mission "To create a coordinated care delivery system that will provide access to quality care," the AGH 2020 Vision will drive strategic decisions toward integration beyond the acute care facility. These decisions will build upon the current investments in developing community-based care delivery systems that incorporate primary care, specialty care, and care management of chronic conditions through our PCMH. Accomplishing our Vision will require disciplined investment of time and resources in the "Right" principles:

Right Care - Patient/Family Centric, Error Free, Primary Care Provider-Driven, Timely Delivery, Best Practice Protocols;

Right People – Needs-Based Provider Recruitment, Service Orientation, Right Training, Continuous Learning;

Right Place – Appropriate Distribution of Primary Care, Availability of Specialists, Telemedicine, Community-Based vs. Hospital Based;

Right Partners – Advanced Acute Care Referral Relationships, Rehabilitation Care, Long-Term Care, Home Health Care, Supportive Care/Hospice, Mental Health Care, Accountable Care;

Right Hospital – The Right Leader for Coordinated Quality Care in our Community.

Our "2020 Vision" will build upon our distinctive competencies to create a new system of health. Investment in technology-based solutions will facilitate care being distributed more evenly throughout our region, creating equity in access to all. Building upon our health literacy initiatives and our relationship with the Worcester County Health

Department, AGH will be a leader in addressing the individual factors that affect health promotion and prevention of disease. Continuing to promote health care interventions driven by patient-centered values to improve individual function and well-being will result in improved quality of life for those who choose to live in our community.

II. Mission/Vision/Current State

Mission: To create a coordinated care delivery system that will provide access to quality care, personalized service and education to improve individual and community health.

Vision: To be the leader in caring for people and advancing health for the residents of and visitors to our community.

- ***CURRENT STATE***

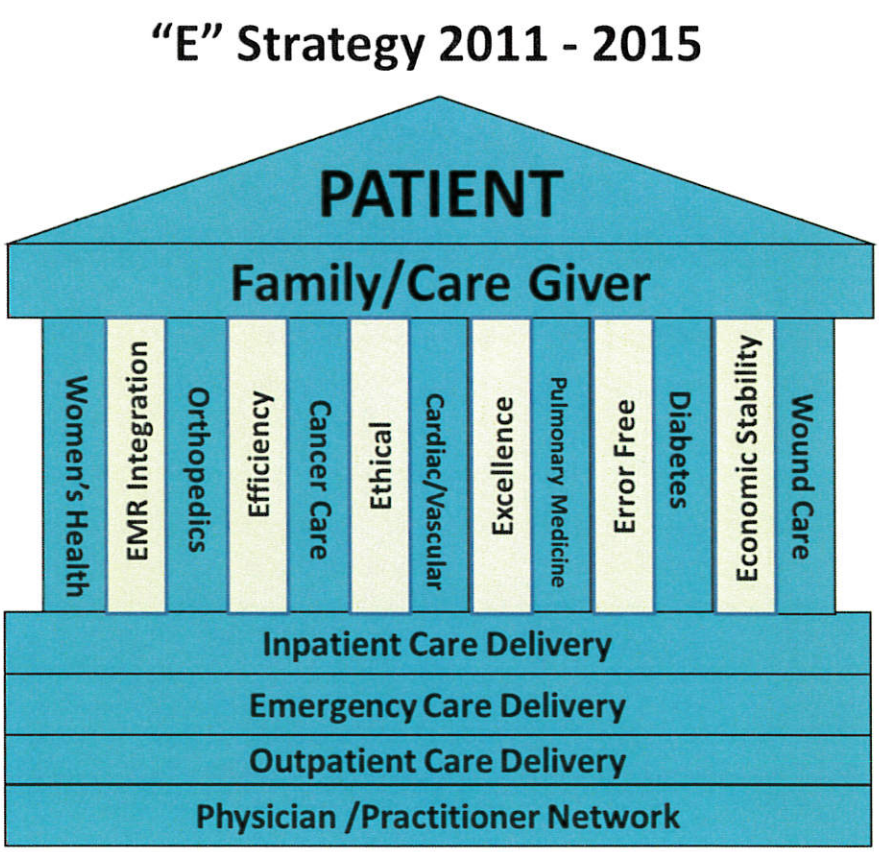
Atlantic General Hospital/Health System (AGH/HS) is a not-for-profit community hospital organized under the Internal Revenue Service (IRS) code 501(c)(3), and it fully incorporates related entities such the Atlantic ImmediCare (AIC). The Atlantic General Hospital Foundation (Foundation), the Atlantic General Hospital Health System (AGHS), and the Atlantic General Hospital Auxiliary (Auxiliary) are all part of the Atlantic General Hospital Corporation (AGH).

Through the AGHS entity, AGH/HS employs over 50 physicians and providers in the hospital and throughout the region at 14 different locations. As a separate corporation, AIC provides walk-in primary care services 7 days per week in partnership with Rite Aid pharmacies in Ocean Pines and Millsboro, DE, and in Ocean City between Memorial Day and Labor Day. AGH/HS has recently purchased property in West Ocean City to provide capacity for expanding primary and specialty services to that growing segment of the community.

The Foundation and the Auxiliary provide significant non-operating benefits to AGH/HS. In 2014, the Foundation raised over $1 million to support programs and operations of AGH/HS, and AGH/HS continues to have the second largest, single hospital Auxiliary in the state of Maryland. The benefits of the Auxiliary result from tens of thousands of volunteer hours, and over $110,000 annually in donated income from programs such as our AGH Thrift Shop.

AGH/HS serves a geographic region that extends from the Indian River Bay in southeastern Sussex County, DE, to the northernmost part of Accomack County, VA. The service area is very sensitive to the seasonal influx of resort vacationers between Memorial Day and Labor Day each year, where the regional population expands from

approximately 100,000 to approximately 500,000. This seasonal flux creates unique challenges for the healthcare services in the region, and significantly influences the labor industry[1].



The hotel, restaurant and tourism industries provide a significant income and tax base for the region. From a wider perspective, the predominant industries are related to agriculture, poultry, and the seafood/waterman industries. The service industry impacts the economy in the region through education/schools, healthcare, and local/regional government. With a population mix of nearly 25% 65 years of age and older, there are workforce and skilled labor challenges and a disproportionate tendency toward service industry employment versus manufacturing or technology. The overall influence of this regional mix is a lower than average educational status, even though income averages are relatively higher. This regional economic mix creates unique challenges for the health and healthcare in the community[2].

During the past five years, AGH/HS has been deploying our "E" Strategy – developing the operational environment and principles that will support AGH/HS meeting the needs of our community. The "E" Strategy supported the investment in EMR Integration, Efficiency, Ethical choices and care delivery models, Excellence in service delivery and

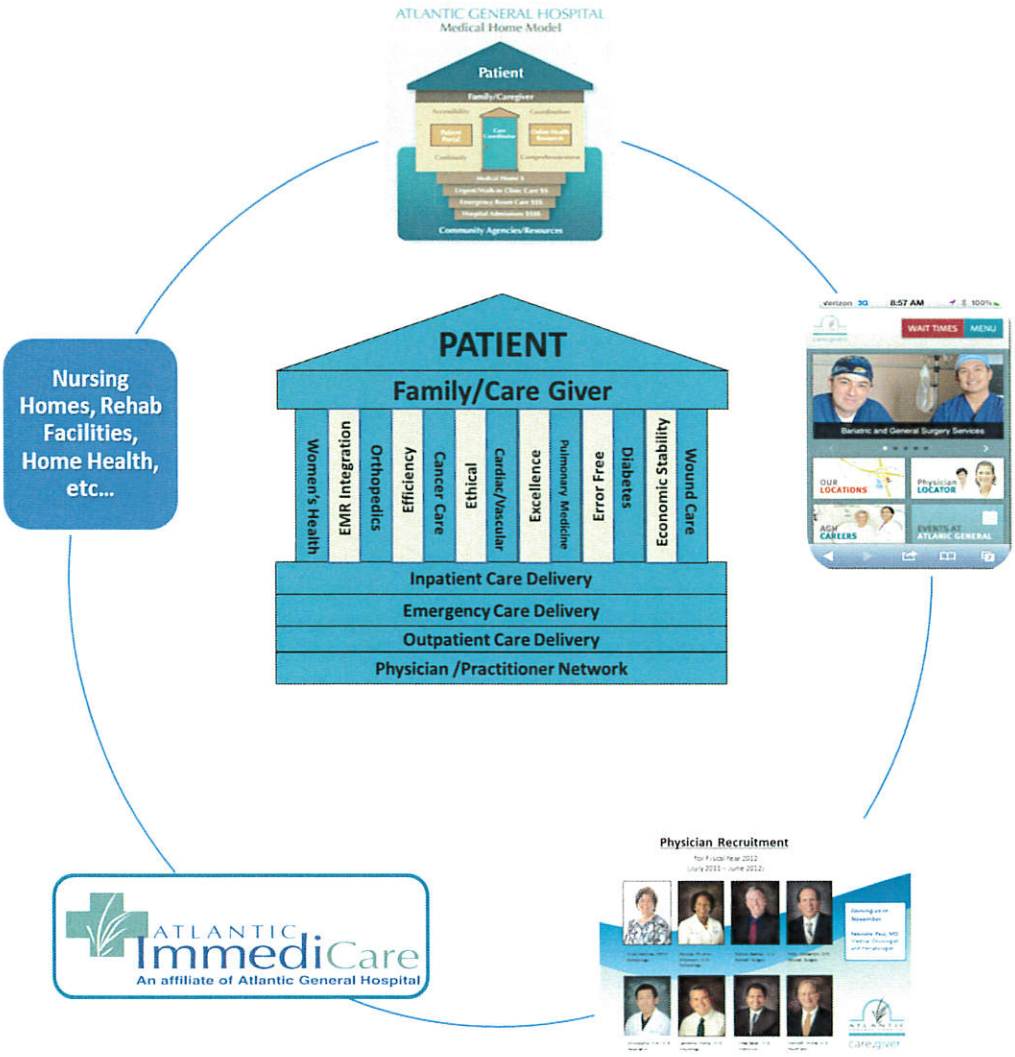
[1] U.S. Census Bureau. (2013). State and County Quick Facts. Washington, D.C.: U.S. Department of Commerce.

[2] Goeller, D. R. (2012). *Community Health Improvement Plan (CHIP) 2012-2017.* Snow Hill, MD: Worcester County Health Department.

operational performance, Error Free in care delivery to our patients, and Economic Stability of our organization to be here in the future for our community.

These principles supported the hospital/health system structure that we had been creating since 2005, and were principles founded in the health care environment of the time.

Up until 2014, the system of care in Maryland and throughout the U.S. was a hospital-centric model of care delivery. In our community and in Maryland, AGH/HS was often a leader in advancing this model of care design, incorporating advanced supportive structures to channel patients to our hospital services. Our design of this community



model was successful for the era, and afforded us the resources to continue to advance the care delivery in the region.

2014 has ushered in a new era for healthcare delivery. Maryland has adopted the most progressive plan for changing the healthcare financing model, with an attempt at designing a value-based versus volume-based hospital payment system that results in achievement of the "Triple Aim" in healthcare – improve the health of the population, enhance the patient care experience, and reduce the cost of care.[3] This radical redirection in healthcare delivery in Maryland, and the overall impetus for moving toward a future in healthcare that is unmapped – Patient Protection and Affordable Care Act of 2010 [4] (PPACA) - present a new challenge for AGH/HS to redistribute healthcare resources toward a different care delivery system for the future.

To begin the process of visioning the new "future", AGH/HS completed a *Community Health Needs Assessment* (CHNA) in 2013, in accordance with the new federal regulations. The results of the CHNA have been reviewed with members of the community through our Board of Trustees' Planning Committee to identify priorities to be addressed. In addition, AGH/HS has engaged the medical staff leadership, the Board of Trustees, and the executive leadership team to assess the current state by evaluating the following 10 strategic questions:

A. What are the primary community health needs?

Based upon the prioritized CHNA, there are significant health and healthcare improvement needs around the following:

- Obesity
- Diabetes
- Access to Care
- Cancer
- Cardiovascular Disease
- Mental Health

The Board Planning Committee has identified the need to develop community-focused measures associated with these health improvement needs. The goal is

[3] Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, Health, And Cost. *Health Affairs, 27*(3), 759-769.

[4] U.S. Congress. (2010). Patient Protection and Affordable Care Act. Washington, D.C.

to develop indicators that can measure community improvements in the following:

- Type II Diabetes
- Obesity Rate
- Acute Care Hospital Admission Rate
- Tobacco Use Rate
- Incidence of Heart Disease
- Self-Reported "Well-Being"
- Suicide Rate
- Screening Rate for Key Conditions (Mammography, Colonoscopy, etc…)
- Patient Portal Use

In addition to healthcare needs for the community, an independent study of the presence of key medical staff and specialties in the region was performed by AmeriMed Consulting in September, 2013, and was augmented with medical staff interviews. With the changes in healthcare delivery – essentially, ensuring the availability of care in non-hospital settings as well as hospital-based care – hospitals have become the *de facto* leaders alongside the county health departments in assuring the redesign of care in the community. This includes having a medical staff development plan that presents the physician/provider needs for the community, and that invests in the infrastructure to address those needs. Below are the identified physician shortages in our community in alphabetical order:

- Allergy/Immunology
- Anesthesiology
- Cardiology
- Dermatology
- Endocrinology
- Family Medicine
- Gastroenterology
- General Surgery
- Geriatric Care
- Gynecology
- Hematology/Oncology
- Infectious Disease
- Internal Medicine
- Neurology

- Otolaryngology (ENT)
- Pain Management
- Pediatrics
- Plastic Surgery
- Psychiatry
- Radiology
- Rheumatology
- Urology

AGH/HS will develop an annual "Medical Staff Development Plan" in conjunction with the Medical Staff Leadership to address the recruitment and retention of physicians to the community. In addressing the above shortages in physicians in our community, the "Medical Staff Development Plan" evaluates current delays in patients obtaining appointments to see primary and specialty care physicians/providers. AGH/HS also evaluates the effects of physician/provider shortages on the quality of health and healthcare outcomes in the community.

Complicating AGH/HS's ability to address these needs is the community's infrastructure:

- 75% of the population growth in the region predicted to be 65 years of age and older, creating workforce challenges to continue meeting the geriatric health and healthcare needs of this population.
- Advanced information systems technology that can potentially increase the efficiency of healthcare delivery systems are very difficult to operate in this region, due to the lack of sufficient information technology (IT) infrastructure.
- The rural/remote nature of the population distribution around the region, outside of the Berlin/Ocean Pines/Ocean City area. This mix of population characteristics has been shown to increase the variation in health and healthcare in a regional population, and to have an adverse impact on health-related measures[5].

[5] Herrin, J., St. Andre, J., Kenward, K., Joshi, M. S., Audet, A.-M. J., & Hines, S. C. (2014). Community Factors and Hospital Readmission rates. *Health Services Research*, 1-20.

B. What are the long-term financial and clinical goals?

The future of community health and healthcare delivery must include an alignment of clinical and financial goals to ensure the achievement of the "Triple Aim" of high quality (improving the health of communities and the outcomes of healthcare services), low cost (reducing the overall cost of healthcare in the community), and a good patient experience (satisfaction with care delivery, convenience, etc.).[6]

The introduction of the Affordable Care Act (ACA), signed into law in March 2010, was intended to bring quality and affordability to healthcare services for all Americans. This created an opportunity and a need to redefine our care delivery model by moving services to a more ambulatory and more affordable setting. The resulting response to the ACA and the move of services to an ambulatory venue created more volume in the outpatient environment. As a result, Maryland's Health Services Cost Review Commission (HSCRC) responded by negotiating a new "Medicare Waiver" formula to include both inpatient and outpatient activity. This new waiver is part of a five year experiment or pilot program with the Centers for Medicare and Medicaid Services (CMS) and became effective January 1, 2014. As a result, the HSCRC expects Hospitals to reduce hospital volumes and the resulting costs through better management of population health. In response to this new mandate, the HSCRC has developed new "global" revenue models to constrain hospital charges/costs while encouraging and rewarding hospitals to keep patients well and reduce unnecessary hospital inpatient admissions and outpatient services/tests.

AGH has negotiated with the HSCRC to enter a Global Budget Revenue (GBR) model. Under a GBR agreement, the hospital's revenue is fixed for a given period of time (i.e. an upcoming rate year), based not on explicit links to a specific population, but on its previously approved budget and revenue history trended forward. AGH's fiscal year 2013 will be used as the base year for the GBR agreement. To ensure financial success under a fixed revenue model, AGH/HS must embrace strategic initiatives that support the achievement of the Triple Aim.

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[6] Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, Health, And Cost. *Health Affairs, 27*(3), 759-769.

C. Would the organization be included in a narrow/preferred network by a health insurer based on cost and quality outcomes?

AGH has historically maintained a "top 5" position in cost per case-mix adjusted equivalent inpatient admission (EIPA), relative to all other Maryland Hospitals. Additionally, AGH has achieved the top spot on the Maryland Hospital Acquired Conditions (MHAC) for 65 potentially preventable complications that occur in hospitals. AGH/HS has developed an advanced Patient Centered Medical Home (PCMH) that is an attractive component of our care delivery system. AGH/HS employs a network of primary and key specialty physicians throughout the region, and this integration between hospital and physicians is attractive to insurers.

On the other hand, AGH/HS is located in a relatively rural region, with a low concentration of population and healthcare services. AGH is the only hospital in Worcester County. AGH does not offer all of the services necessary for a completely closed network – especially obstetrics, cardiac interventional capabilities, etc… For a narrow network with insurance companies or self-insured employers, AGH/HS would be a strong choice for inclusion with another tertiary center. Given the current environment and the current distribution of providers in this region, it is unlikely that this will be a pervasive insurance strategy here.

The southeastern portion of Sussex County, DE is a more unique situation. While it is encompassed in our primary and secondary service areas, the state boundary has created a barrier for AGH to participate in state governmental plans (i.e. Medicaid HMOs). AGH has attempted to present a compelling case to the Medicaid administrators in Delaware, but the Maryland "all-payer" regulatory structure has created a barrier to negotiating rates. This presents a referral risk for hospital inpatient and outpatient care.

D. Is there a healthy physician-hospital organization?

Generally, AGH/HS enjoys a strong positive relationship with physicians in the community, based upon physician responses to interviews and responses to surveys[7,8,9]. AGH/HS has established varying formal structures related to

[7] NDNQI . (2013). *Nursing Satisfaction Survey.* NDNQI.

[8] Press Ganey. (2013). *Physician Partnership Survey.* Press Ganey.

physician relationships, ranging from employment of primary care physicians throughout the region, employment of key specialties to stabilize the acute care environment (hospitalists, intensivists, anesthesiologists), and other key specialties in the community (gynecology, general surgery, neurology, dermatology, pulmonology and urology). In addition to the employment model, AGH/HS has established other relationship models that have engaged independent community physicians in collaboration with AGH.

As demonstrated in our Physician Partnership Survey conducted by Press Ganey in November, 2013, and as demonstrated in the facilitated discussions of the results of this survey at the annual Board of Trustees/Medical Staff Leadership Retreat in February, 2014, significant opportunity for AGH/HS alignment with physicians lies in enhancing the infrastructure around electronic medical records (EMR). This opportunity exists in all areas – employed community-based physicians, hospital-based physicians, and independent physicians. The current EMR environment, and the necessary "feeder" systems to support the electronic environment, stands out as the largest detractor from a healthier physician-hospital organization.

Other opportunities to enhance the physician-hospital relationship, as demonstrated in the surveys and in the structured discussions, are through strengthening of the primary care network in our community (e.g. more primary care capacity) and enhancing the specialty care support in the community. Physicians are frustrated at times with the lack of available appointment times for primary care visits for referrals, or with patients seeking care in the emergency room due to the inability to see their physician in a timely fashion. These examples of inefficiencies in the healthcare system in the community related to lack of access in key areas increases the frustration level of physicians working in our community.

E. How much financial risk is the organization willing or able to take?

The hospital payment system in Maryland has undertaken a statewide demonstration project with the federal government, designed to create a predictable cost structure for healthcare in the state. Currently, hospital revenue has been "capped" on an annual basis through the GBR system, which pre-establishes the total hospital revenue that can be charged by a Maryland

[9] RKM Research & Communications. (2013). *Community Perceptions Survey.* RKM Research & Communications.

hospital for a given fiscal year. Under the GBR payment system, hospitals will be incentivized to reduce potentially avoidable utilization (PAU) in efforts to improve community health.

This new environment incentivizes and encourages investment in the transitions of care into non-hospital, non-rate-regulated environments of care. These could be existing hospital-based programs, or they could be new programs for meeting the needs of the community. Under the existing system, the hospital subsidizes a significant portion of the non-rate-regulated care delivered through our health system. Investment in care systems outside of the hospital must be self-sustaining in the future, and must help defray the costs of care that are currently subsidized by the hospital.

AGH currently enjoys a financial balance sheet that is relatively healthy, with primary ratio indicators being equal to or better than the average Maryland hospital. Cash reserves at the end of FY 2014 were 71 days cash on hand, a cash flow margin of 7.4%, and earnings before interest, taxes, depreciation and amortization (EBITDA) of 8.4%. With the revenue constraints of the GBR system, AGH/HS will need to make operational changes to continue being successful.

Given this economic outlook, AGH will need to be thoughtful and deliberate in assuming risk with future investments. Rather than investments leading to growth in hospital-based services, capital investments will need to be focused on system improvements/efficiency, relocation of services to a non-hospital environment, or new non-acute-care hospital services that generate returns to contribute to the overall support of services in the region. Resources will also need to be channeled toward changing, enhancing or adding services in the community that reduce PAUs and reduce demand for the acute-care hospital services, thus providing margin capacity under the GBR system.

While AGH has debt capacity due to the reduction in long-term debt service related to the 2010 bond placement, this capacity must be managed judiciously with the unpredictability of future revenue under the GBR system. Master facility plans may require collaboration with the AGH Foundation and the community, to formulate philanthropic support of these high capital cost initiatives. AGH has not conducted a major gift campaign in over a decade, so this may be a timely opportunity for financing these programs.

Finally, successful financing of the future healthcare system under the new payment structure may require collaboration and partnerships with other acute

care or non-acute care organizations to mitigate financial risk associated with investment in new services. Creating a community model for improving population health will require investment in enhanced services in the community. AGH/HS may not have the core competencies necessary for successful operation of such services, and investment in these programs without necessary competencies will increase risk associated with successful performance. Financial risk mitigation for service expansion in the community may necessitate establishing relationships with other entities to ensure success.

The new healthcare financing system in Maryland changes the future landscape for risk tolerance of Maryland hospitals. Constrained revenue throughout the hospital enterprise will require investments in programs and services that result in the reduction of demand for hospital services. Constrained hospital revenue also fosters investment in non-acute care hospital service offerings that provide additional sources of revenue. Under the GBR system, investment in non-growth oriented capital that improves operational efficiencies may prove to provide a greater return on investment than new hospital-based programs. The new environment creates less tolerance for risk, and greater demand for seeking alternative sources of revenue to support investment in new programs to serve the community.

F. What sustainable factors differentiate the organization from current and future competitors?

- Key Differentiators
  - Location
  - Small Size (an advantage - this has been mentioned repeatedly lately from physicians and others as a benefit)
  - "High touch" atmosphere
  - Personal relationships in the community
  - Attractive and clean facilities
  - Consistent messaging in the community – reinforcement of market share and advantages
  - Convenience/Efficiency (e.g. "30 Minute Promise")
  - Prevention programs (e.g. Bariatrics)
  - Adaptability
  - Patient satisfaction
  - Quality of certain services (potential for "halo effect")
  - Not overextended in rate-regulated space (Hospital "right sized")