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May 4, 2018

Via Email and Overnight Delivery
Ben Steffen, Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Re: **Adventist HealthCare Shady Grove Medical Center**
Adventist HealthCare Behavioral Health & Wellness – Rockville
Request for Determination of Exemption from Certificate of Need Review

Dear Mr. Steffen:

On behalf of Adventist HealthCare, Inc. d/b/a Adventist Healthcare Shady Grove Medical Center ("SGMC") and Adventist HealthCare, Inc. d/b/a Adventist Behavioral Health and Wellness ("ABH") (collectively "AHC"), and pursuant to COMAR 10.24.01.04 regarding "Exemption From Certificate of Need Review," we request a determination of exemption from CON review (the "Request") for the consolidation of the psychiatric beds at ABHs Rockville campus to a single location under SGMC, an acute general hospital within the AHC merged asset system. The consolidated behavioral health beds would include 117 ABH special hospital-psychiatric beds already located in Rockville. This would bring all of AHC's inpatient psychiatric beds in Rockville under one AHC acute care hospital. This represents a combination of services. For ease of reference, the proposed merger, consolidation and relocation addressed in this Request will be referred to as the "Consolidation." This letter updates and replaces a March 2 filing that had initially included the consolidation of behavioral health beds from other locations besides the special hospital psychiatric beds at ABH in Rockville.

Sustaining a Vital Health Care Service

AHC is undertaking this initiative to strengthen and ensure the continued viability of its behavioral health services, a vital part of the region's health care infrastructure. AHC, through its affiliate ABH and other sites, is the largest provider of behavioral health in Montgomery County and one of the largest providers of behavioral health services in the State of Maryland. Consolidation of this service at the main behavioral health campus in Rockville, regulated by the

Health Services Cost Review Commission ("HSCRC") as an acute hospital service, is designed to provide clinical, operational and financial stability for this regional health care service and is supported by Maryland Department of Health's Medical Assistance Program, as noted in the enclosed letter from Ms. Tricia Roddy (see Exhibit 1).

Merged Asset System

AHC is, as noted, a merged asset system. SGMC and ABH are unincorporated divisions of one legal entity, i.e. AHC. Thus, the Consolidation will not result in any acquisition of a health care facility under COMAR 10.24.01.03A. We do note that ABH will be combined into SGMC with all inpatient psychiatric services at one location under one acute general hospital license.

The Maryland Health Care Commission ("Commission") statute and regulations require CON approval for changes in bed capacity, or the relocation of a health care facility to another site. COMAR 10.24.01.02A(2), (3). However, certain exceptions to these CON requirements are permissible "as provided in Regulations .03 and .04 of this Chapter." §.02A. Section .04 of the above-cited Commission regulations permits an exemption from CON review for a "health care facility or merged asset system comprised of two or more health care facilities" in the following circumstances:

> (1) Merger or consolidation of two or more hospitals or other health care facilities, if the facilities or an organization that operates the facilities give the Commission 45 days written notice of their intent to merge or consolidate;
>
> (2) Relocation of an existing health care facility owned or controlled by a merged asset system, if:
>
> > (a) The relocation is to a site outside the primary service area of the health care facility to be relocated but within the primary service area of the merged asset system; and
> >
> > (b) The relocation of the existing health care facility does not:
> >
> > > (i) Change the type or scope of health care services offered; and

(ii) Does not require a capital expenditure for its construction that exceeds the capital review threshold, adjusted for inflation, except as provided by Regulation .03I of this chapter;

AHC is a "merged asset system" and eligible to seek a CON exemption under these regulations. This Consolidation of AHC's inpatient behavioral health services fits squarely under this SHP definition.

Elements of the Consolidation

SGMC, located in Rockville, Maryland, is an acute general hospital, which currently has no acute care beds licensed as acute psychiatric beds. Following the Consolidation, all of the Rockville campus buildings in which inpatient and outpatient psychiatric services are provided will become part of SGMC, and ABH will no longer function as a separate licensee and provider and its services will be operated under SGMC.

ABH is located in Rockville, Maryland on the same campus as SGMC and the interconnected buildings that comprise ABH are adjacent to SGMC. As such, it is within the primary service area ("PSA") of SGMC. ABH is currently licensed as a special hospital-psychiatric with 117 beds used to treat adult, adolescent and child patients. Of these 117 beds, 30 are allocated to children and adolescents and 87 are allocated to adults. It also provides outpatient behavioral health services. SGMC has a current licensed bed count, prior to the consolidation of the behavioral health services, of 266. The total capital cost of any renovations at this location is estimated to be approximately $100,000 which is related to information technology changes as part of the integration into SGMC.

As a freestanding special hospital with more than 15 beds, Medicaid reimbursement to ABH in Rockville is hampered by the federal regulations limiting reimbursement from the Centers for Medicare and Medicaid Services ("CMS") governing the Federal Medical Assistance Percentage ("FMAP") to "Institutions for Mental Diseases" (an "IMD"). A former CMS waiver enabling Maryland's Medicaid program to receive FMAP for IMD services in facilities with more than 15 beds is no longer in effect.

Thus, consolidating these beds into SGMC on the Rockville campus will ensure coordinated, efficient and effective services and new construction will not be needed to accomplish this. Moreover, under the HSCRC total cost of care demonstration approved by the federal Centers for Medicare and Medicaid Services ("CMS"), there is a financial benefit for the

State of Maryland for ABH's psychiatric services to be covered under the AHC Global Budget Revenue ("GBR") agreement. As noted above, the Maryland Department of Health's Medical Assistance Program has written a letter supporting this consolidation of behavioral health beds (Exhibit 1).

Financial Overview

The financial performance for the ABH division of AHC has been challenged recently. ABH is a free standing psychiatric facility and has been operating at a significant loss over the past few years. As a result, AHC continues to evaluate the service line so that it can provide a much needed service to the community in a financially viable way. As a result of this evaluation, in November 2016, AHC closed its Eastern Shore facility and in April 2017 AHC closed the remaining residential treatment beds at its Rockville campus. At this time, AHC also began evaluating with the HSCRC and stakeholders at the State, the option of consolidating the licensure of ABH under SGMC. The change in licensure while also placing the service under a GBR will result in improved financial viability of the service for three primary reasons. First, combining the ABH license into SGMC's license will mitigate any risk associated with the State of Maryland not having sufficient budgetary funds in the future to fund the loss of the IMD waiver. Second, when licensed as an acute general hospital, the hospital rates for all payers, including Medicare, will be set by the HSCRC and the hospital will be reimbursed under those rates rather than the federal CMS Inpatient Psychiatric Facilities Prospective Payment System (IPF-PPS). Lastly, with the service under GBR set by the HSCRC, the hospital's revenue will be stable and predictable allowing the facility to focus on reducing unnecessary utilization which will free up capacity to serve additional demand in both inpatient and outpatient services. AHC worked with the HSCRC to establish a GBR amount for behavioral health of $46,958,839 to be added to SGMC's GBR on July 1, 2018.

ABH has experienced significant growth in admissions over the past years, while also successfully reducing length of stay as shown below. Continued focus on reduction in length of stay will allow ABH to create capacity to serve additional patients within its GBR. Additionally, reductions in unnecessary utilization under a GBR will allow ABH to shift resources as appropriate to outpatient community mental health services where reimbursement is not sufficient to cover costs without a negative impact to its revenue base.

Adventist Behavioral Health & Wellness
Summary of Volume Statistics and Average Charges
Regulated Hospital Only - Does not include RTC

	Discharges	Days	I/P Revenue	ALOS
CY 2013	2,705	29,785	33,188.5	11.01
CY 2014	2,949	29,922	33,796.6	10.15
CY 2015	2,627	26,090	30,441.4	9.93
CY 2016	3,151	29,104	34,473.9	9.24
CY 2017	3,750	32,155	39,255.3	8.57
Total 4 Year Growth	38.6%	8.0%	18.3%	-22.1%
Average Annual Growth	8.51%	1.93%	4.29%	-6.06%

Source: CY 2013 - CY 2016 Annual Filings, CY 2017 YTD Experience Report

A three year historical income statement for ABH is shown below. In CY 2017, AHC updated the structure of its financial statements to include specialty physician practices in their respective hospital entity. AHC employs psychiatrists and midlevel providers within the behavioral health service line. The revenues for these physicians are now included in the consolidated ABH entity. CY 2015 and CY 2016 have been revised to match the CY 2017 audited format.

	Historical		
	CY 2015	CY 2016	CY 2017
Inpatient Revenue	$ 42,380,437	$ 44,687,017	$ 37,664,193
Outpatient Revenue	3,862,125	4,711,318	5,272,196
Physician Revenue	5,509,476	8,700,679	9,984,045
Gross Patient Revenue	$ 51,752,038	$ 58,099,014	$ 52,920,434
HSCRC Assessments/Pass-thrus	$ -	$ -	$ 55,284
Contractual Allowances	8,291,135	9,799,587	9,605,254
Charity Care	1,863,598	1,567,671	1,387,441
Deductions from Revenue	$ 10,154,733	$ 11,367,258	$ 11,047,979
Net Patient Revenue before Bad Debt	$ 41,597,305	$ 46,731,756	$ 41,872,455
Bad Debt	2,358,284	1,972,640	1,620,476
Net Patient Revenue	**$ 39,239,021**	**$ 44,759,116**	**$ 40,251,979**
		14.07%	*-10.07%*
Other Operating Revenue	7,313,987	7,674,154	6,313,441
Total Operating Revenue	**$ 46,553,008**	**$ 52,433,270**	**$ 46,565,420**
		12.63%	*-11.19%*
Salaries and Wages	$ 23,066,573	$ 26,932,370	$ 21,899,004
Employee Benefits	5,418,669	5,653,270	4,628,007
Supplies	1,766,719	1,647,484	1,360,406
Contract Labor	695,815	731,056	1,075,084
General & Administrative	4,058,187	4,579,609	3,789,845
Professional Fees	5,402,165	7,748,804	6,527,160
Building and Maintenance	3,345,254	3,489,436	2,408,546
Insurance	350,472	454,832	344,492
Depreciation and Amortization	1,118,057	1,834,438	1,289,470
IT Depreciation	681,334	721,318	742,097
IT Services	1,536,200	1,387,999	1,903,545
Interest Expense	245,907	274,690	259,762
Other - Overhead Allocation	1,410,861	1,525,447	3,333,962
Total Operating Expenses	**$ 49,096,213**	**$ 56,980,753**	**$ 49,561,380**
		16.06%	*-13.02%*
Income (loss) from operations	**$ (2,543,205)**	**$ (4,547,483)**	**$ (2,995,960)**
	-5.5%	*-8.7%*	*-6.4%*

Tables J & K (Exhibit 2) attached to this submission show that the financial performance of ABH under SGMC's licensure and GBR agreement is significantly improved from current state under the same growth assumptions and expense structure ($2.1 million loss in 2021 in current state versus a $160,000 profit under GBR in the same year).

Merger and Consolidation Parameters

The general CON regulations do not define the terms "merger" or "consolidation." In looking at the State Health Plan chapter addressing psychiatric services found at COMAR 10.24.07, there are no definitions of those terms. However, in COMAR 10.24.10, the State Health Plan for Facilities and Services: Acute Hospital Services (the "Acute Hospital Chapter"), definitions of these terms may be found. We believe these definitions may be appropriately referenced by analogy to ABH in this context.

The Acute Hospital Chapter is instructive to review for its definitions of "merger" and "consolidation," as they are the only regulatory definitions the Commission has published that might be relied upon in interpreting the general CON regulations addressing exemptions from CON review for hospitals and other health care facilities. Further, we are aware that traditionally the Commission has viewed acute psychiatric services in freestanding psychiatric hospitals licensed as special hospitals (such as ABH) to be equivalent, in evaluating bed need, to acute psychiatric services provided in acute general hospitals, supporting the appropriateness of applying the merger/consolidation definitions of the Acute Hospital Chapter (pages 47, 50) to consideration of ABH as part of the Merger/Consolidation.

> (8) "Consolidation" means a merger such that one or more acute inpatient services are eliminated or centralized at one or more of the hospitals of the merged organization.
>
> * * *
>
> (20) "Merger" means the combining of two or more independent hospitals under a permanent, legally binding arrangement or reorganization so as to result in a reduction in hospital capacity in the State or the reapportionment and reconfiguration of beds or services among the health care facilities of a merged or consolidated organization that operates more than one health care facility. It also refers to a merged or consolidated organization that operates one or more health care facility and holds a Certificate of Need to construct a health care facility, so as to result in a reduction in capacity in one or more hospitals in the State.

The definition of "consolidation" includes a situation in which "acute inpatient services are eliminated or centralized" at hospitals of the merged organization. The Consolidation will result in the services being "centralized" at the ABH-Rockville facility in Montgomery County under SGMC's license. The proposed consolidation of ABH beds into SGMC will be a "merger" as part of a reapportionment and reconfiguration of AHC psychiatric beds and services such that the special hospital psychiatric inpatient beds previously operated as ABH would now be provided under SGMC's license.

In addition, the re-licensure of the ABH beds would neither change the type nor scope of health care services offered since the beds will continue to be used as acute psychiatric beds for adults, children and adolescents.

COMAR 10.24.01.04B requires that a complete notice of intent to seek exemption from Certificate of Need review shall be filed with the Commission at least 45 days before the intended action. Information required to be provided by this regulation includes:

(1) The name or names of each affected health care facility

a. Adventist HealthCare Shady Grove Medical Center
b. Adventist HealthCare Behavioral Health and Wellness

(2) The location of each health care facility

a. 9901 Medical Center Drive, Rockville, MD 20850
b. 14901 Broschart Road, Rockville, MD 20850

(3) A general description of the proposed project including, in the case of mergers and consolidations, any proposed:

(a) Conversion, expansion, relocation, or reduction of one or more health care services

See above.

(b) Renovation of existing facilities

Renovation of former ABH space will be needed.

(c) New construction

None is required.

(d) Relocation or reconfiguration of existing medical services

SGMC will continue to operate 117 inpatient psychiatric beds. The physical capacity at ABH is 164.

Unit	Service Type	Room Count	Bed Count	Current Licensed Beds
Chesapeake	Adolescent General Psych (13 to 18)	12	24	22
Shenandoah	Child General Psych (7 to 13)	6	12	8
Potomac	Adult SPMI	12	24	22
Seneca	Adult General Psych/Co-occurring	14	28	24
Montgomery	Adult Mood	7	14	12
Magnolia	Seniors (Geri-psych)	10	14	13
Azalea	Adult General Psych/Co-occurring	8	16	16
Cypress	(Future Adult Psych Beds)	16	32	0
Total		**85**	**164**	**117**

(e) Change in bed capacity at each affected facility.

None.

(4) The scheduled date of the project's completion.

The ABH beds will move under the SGMC license July 1, 2018.

(5) Identification of any outstanding public body obligation

AHC operates as a consolidated group and as such there are no obligations for specific entities.

(6) Information demonstrating that the project:

(a) Is consistent with the State Health Plan

The proposed relocation meets the standards in the State Health Plan chapters on Acute Psychiatric Services. Detailed analyses are attached at Exhibit 3. Additionally, Exhibits 9-17 pertain to the public disclosure of charges, Licenses Joint Commission Quality Reports, drawings of the Facility, and Audited Financial Statement for 2017.

(b) Will result in more efficient and effective delivery of health care services

The consolidation of ABH into SGMC provides a number of important benefits which enhance the delivery of health care services for behavioral health patients, behavioral patients with accompanying medical conditions and general medical patients in the acute care setting:

- First, the consolidation will help improve throughput of psychiatric patients from the emergency department at SGMC to admission for a behavioral health condition or discharge from the emergency department to the most appropriate level of care. Currently, SGMC and ABH are separate entities with different admissions processes, something that will be unified and streamlined once the behavioral health beds at ABH are a unit of SGMC. The medical staffs from both hospitals are currently separate but will be combined which will allow psychiatric clinicians from ABH to more easily and more quickly assess patients in the SGMC emergency department, helping to avoid unnecessary admissions and move patients through for admission more efficiently.

- Second, with combined medical staffs psychiatrists from ABH will be able to more easily consult medical patients admitted to SGMC, providing an enhanced level of behavioral health care for acute medical inpatients. The combined medical staff also facilitates shared learning and education among psychiatrists and other medical specialties as the hospitals will have one medical executive committee, combined grand rounds and singular semi-annual medical staff meetings.

- Third, patients at ABH who have a medical condition often have to be transferred to the emergency department at SGMC for care. ABH has its own internal medicine service for patients but it is limited and plans are to expand the inpatient hospitalist service at SGMC to include patients on the behavioral health unit. This will provide more seamless care for patients at the bedside and may help reduce unnecessary transfers from ABH to the SGMC emergency room.

- Fourth, with the consolidation ABH will have access to the more extensive support services that are part of SGMC as everything

from housekeeping to maintenance to human resources to medical records will be combined.

Finally, and importantly, the effective delivery of health care services is further enhanced with improved financial stability. As discussed elsewhere in this filing, the transition of the behavioral health service into the acute care GBR model provides a more stable financial foundation for this service and ensures the behavioral health program, and the specialty services that are part of ABH, remain viable and available for the community. As noted in the financial overview of this filing, "with the service under GBR set by the HSCRC, the hospital's revenue will be stable and predictable allowing the facility to focus on reducing unnecessary utilization which will free up capacity to serve additional demand in both inpatient and outpatient services."

(c) Is in the public interest

The public has an interest in the continued availability of quality, efficient and effective behavioral health services in Montgomery County and the region. The Project will ensure the availability of inpatient and outpatient behavioral health services, including both voluntary and involuntary admissions. The reimbursement for this service will be regulated by the HSCRC under the SGMC GBR. SGMC is already a major provider of pediatric services and this will be integrated with child and adolescent behavioral health services. An acute care hospital with integrated quality improvement, medical and nursing staff and related functions will oversee this service on one campus, helping to ensure the sustainability of this important service for the community.

Thank you for attention to this matter. If you have any questions or require any additional material, please don't hesitate to contact me.

Sincerely,

Howard L. Sollins

HLS/tjr
Enclosures
cc: Travis Gayles, MD, Health Officer
Montgomery County
Ms. Ruby Potter
Health Facilities Coordination Officer
Robert E. Jepson, Vice President/Business Development
Washington Adventist Hospital
John J. Eller, Esquire

EXHIBITS

1. Letter from Maryland Department of Health
2. Financial Tables
3. Acute Psychiatric Services State Health Plan Standards COMAR 10.24.07
4. SGMC Patient Care Standards Manual Behavioral Health Assessment and Management Policy #101-01-010
5. Department of Health and Mental Hygiene Behavioral Health Administration Designated Psychiatric Emergency Facilities Calendar Year 2017
6. AHC Financial Assistance Policy AHC 3.19
7. AHC Asistencia Financiera AHC 3.19.B
8. Adventist Behavioral Health & Wellness Services Discharge Policy PC-14
9. Policy 3.19.2 Public Disclosure of Charges
10. 2017 Public Notice Washington Post
11. 2017 Affidavit of Performance El Tiempo Latino
12. Adventist Behavioral Health State License # 15-039
13. Adventist HealthCare Shady Grove Medical Center State License #15-023
14. The Joint Commission Quality Report Adventist Behavioral Health
15. The Joint Commission Quality Report Shady Grove Medical Center
16. Drawings
17. Adventist HealthCare 2017 Audited Financial Statement
18. Affirmations

EXHIBIT 1

MARYLAND
Department of Health
Larry Hogan, Governor · Boyd Rutherford, Lt. Governor · Dennis Schrader, Secretary

December 20, 2017

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

Dear Mr. Steffen,

I am writing to express my support for Adventist HealthCare's request to the Maryland Health Care Commission to combine both Adventist Behavioral Health & Wellness's (ABH) psychiatric services in Rockville and the Washington Adventist Hospital (WAH) psychiatric beds from Takoma Park into Shady Grove Medical Center (SGMC), an acute general hospital.

Investing in behavioral health services is a top priority for the Maryland Department of Health. Federal rules prohibit Medicaid from receiving a federal match for services rendered in institutions for mental disease (IMDs) for adults between the ages of 21 and 64. Maryland Medicaid requested a waiver to this rule in 2015, which CMS denied for psychiatric IMDs. By combining the ABH and WAH psychiatric beds into SGMC, Adventist HealthCare creates an opportunity for Medicaid to receive the federal match for these psychiatric admissions. It is estimated that savings to the State General Fund could total more than $4.5 million from the ABH conversion and avoid an increase in funding requirements of an additional $2 million by maintaining the federal match for the WAH beds. In turn, these savings would allow the Maryland Medicaid program to serve more individuals in need of behavioral health services.

Adventist HealthCare's identified pathway will both improve access to care for individuals with behavioral health needs as well as create efficiencies in the manner that the All-Payer Model was designed to produce. If you have any questions, please feel free to contact me via phone at 410-767-5809 or via email at tricia.roddy@maryland.gov.

Sincerely,

Tricia Roddy

Tricia Roddy
Director, Planning Administration
Office of Health Care Financing

Exhibit 2

Financial Tables

BHWS under IMD license -UNINFLATED

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	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018 Budget**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**
1. REVENUE							
a. Inpatient Services	$ 42,380,437	$ 44,687,017	$ 37,664,193	$ 37,995,638	$ 38,330,000	$ 38,665,104	$ 39,007,846
b. Outpatient Services	$ 9,371,601	$ 13,411,997	$ 15,256,241	$ 15,278,848	$ 15,622,916	$ 15,977,902	$ 16,345,787
Gross Patient Service Revenues	***$ 51,752,038***	***$ 58,099,014***	***$ 52,920,434***	***$ 53,274,485***	***$ 53,952,916***	***$ 54,643,005***	***$ 55,353,634***
c. Allowance For Bad Debt	$ 2,358,284	$ 1,972,640	$ 1,620,476	$ 1,626,417	$ 1,647,129	$ 1,668,197	$ 1,689,892
d. Contractual Allowance	$ 8,291,135	$ 9,799,587	$ 9,660,538	$ 9,610,323	$ 9,732,707	$ 9,857,194	$ 9,985,386
e. Charity Care	$ 1,863,598	$ 1,567,671	$ 1,387,441	$ 1,399,156	$ 1,416,973	$ 1,435,097	$ 1,453,761
Net Patient Services Revenue	***$ 39,239,021***	***$ 44,759,116***	***$ 40,251,979***	***$ 40,638,589***	***$ 41,156,106***	***$ 41,682,517***	***$ 42,224,595***
f. Other Operating Revenues (Specify)	$ 7,313,987	$ 7,674,154	$ 6,313,441	$ 6,313,441	$ 6,313,441	$ 6,313,441	$ 6,313,441
NET OPERATING REVENUE	***$ 46,553,008***	***$ 52,433,270***	***$ 46,565,420***	***$ 46,952,030***	***$ 47,469,547***	***$ 47,995,958***	***$ 48,538,036***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 28,485,242	$ 32,585,640	$ 26,527,011	$ 26,050,744	$ 26,340,111	$ 26,634,210	$ 26,937,327
b. Contractual Services	$ 695,815	$ 731,056	$ 1,075,084	$ 1,054,810	$ 1,068,242	$ 1,081,906	$ 1,095,976
c. Interest on Current Debt	$ 245,907	$ 274,690	$ 259,762	$ 259,762	$ 259,762	$ 259,762	$ 259,762
d. Interest on Project Debt							
e. Current Depreciation	$ 1,799,391	$ 2,555,756	$ 2,031,567	$ 2,031,567	$ 2,031,567	$ 2,031,567	$ 2,031,567
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,766,719	$ 1,647,484	$ 1,360,406	$ 1,334,751	$ 1,351,749	$ 1,369,038	$ 1,386,843
j. IT Services	$ 1,536,200	$ 1,387,999	$ 1,903,545	$ 1,903,545	$ 1,903,545	$ 1,903,545	$ 1,903,545
k. Professional Fees	$ 5,402,165	$ 7,748,804	$ 6,527,160	$ 6,404,069	$ 6,485,623	$ 6,568,578	$ 6,654,002
l. Building & Maintenance	$ 3,345,254	$ 3,489,436	$ 2,408,546	$ 2,408,546	$ 2,408,546	$ 2,408,546	$ 2,408,546
m. Insurance	$ 350,472	$ 454,832	$ 344,492	$ 344,492	$ 344,492	$ 344,492	$ 344,492
m. G&A	$ 5,469,048	$ 6,105,056	$ 7,123,807	$ 7,123,807	$ 7,123,807	$ 7,123,807	$ 7,123,807
TOTAL OPERATING EXPENSES	**$ 49,096,213**	**$ 56,980,753**	**$ 49,561,380**	**$ 48,916,093**	**$ 49,317,444**	**$ 49,725,450**	**$ 50,145,867**
3. INCOME							
a. Income From Operation	**$ (2,543,205)**	**$ (4,547,483)**	**$ (2,995,960)**	**$ (1,964,063)**	**$ (1,847,896)**	**$ (1,729,492)**	**$ (1,607,830)**
b. Non-Operating Income							
SUBTOTAL	***$ (2,543,205)***	***$ (4,547,483)***	***$ (2,995,960)***	***$ (1,964,063)***	***$ (1,847,896)***	***$ (1,729,492)***	***$ (1,607,830)***

BHWS under IMD license -UNINFLATED

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

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	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	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018 Budget**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**
c. Income Taxes							
NET INCOME (LOSS)	***$ (2,543,205)***	***$ (4,547,483)***	***$ (2,995,960)***	***$ (1,964,063)***	***$ (1,847,896)***	***$ (1,729,492)***	***$ (1,607,830)***

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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	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018 Budget**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	21.7%	21.9%	25.7%	25.7%	25.7%	25.7%	25.7%
2) Medicaid	40.1%	43.1%	39.1%	39.1%	39.1%	39.1%	39.1%
3) Blue Cross	10.6%	11.7%	3.9%	3.9%	3.9%	3.9%	3.9%
4) Commercial Insurance	7.5%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%
5) HMO	15.9%	11.9%	20.0%	20.0%	20.0%	20.0%	20.0%
6) Self-pay	2.5%	3.1%	2.7%	2.7%	2.7%	2.7%	2.7%
7) Other	1.9%	1.9%	2.3%	2.3%	2.3%	2.3%	2.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	23.3%	22.1%	24.1%	24.1%	24.1%	24.1%	24.1%
2) Medicaid	38.7%	42.6%	38.7%	38.7%	38.7%	38.7%	38.7%
3) Blue Cross	10.5%	11.7%	4.1%	4.1%	4.1%	4.1%	4.1%
4) Commercial Insurance	6.9%	6.3%	6.7%	6.7%	6.7%	6.7%	6.7%
5) HMO	16.5%	12.6%	21.3%	21.3%	21.3%	21.3%	21.3%
6) Self-pay	2.5%	2.9%	2.8%	2.8%	2.8%	2.8%	2.8%
7) Other	1.7%	1.8%	2.3%	2.3%	2.3%	2.3%	2.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Assumptions & Drivers

Current State - NO Inflation (Table J1)

	Historical			Budget	Projection		
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
IP Hospital Revenue	42,380,437	44,687,017	37,664,193	37,995,638	38,330,000	38,665,104	39,007,846
OP Hospital Revenue	3,862,125	4,711,318	5,272,196	5,483,084	5,702,407	5,930,503	6,167,724
Adjustment for RTC Closure			(761,416)				
Physician Revenue	5,509,476	8,700,679	9,984,045	9,795,764	9,920,509	10,047,398	10,178,064
EIPA Factor ("Equivalent IP Admission")	1.0911	1.1054	1.1400	1.1443	1.1488	1.1534	1.1581
Regulated Deductions:							
HSCRC Pass Thrus/Assessments	0%	0%	0.13%	0.13%	0.13%	0.13%	0.13%
Contractual Allowances	10.38%	9.60%	9.59%	9.59%	9.59%	9.59%	9.59%
Charity	4.03%	3.16%	3.20%	3.20%	3.20%	3.20%	3.20%
Bad Debt	4.44%	3.20%	3.20%	3.20%	3.20%	3.20%	3.20%
Pro Fee Deductions:							
Contractual Allowances	63.40%	58.10%	54.97%	54.97%	54.97%	54.97%	54.97%
Charity	0.02%	0.06%	0.08%	0.08%	0.08%	0.08%	0.08%
Bad Debt	5.56%	4.49%	2.40%	2.40%	2.40%	2.40%	2.40%
IP Revenue per Admission	$ 16,133	$ 14,182	$ 10,044	$ 10,044	$ 10,044	$ 10,044	$ 10,044
OP Revenue per EIPD ("Equivalent IP Day")	187	271	929	1,171	1,171	1,171	1,171
Physician Revenue per EIPD	118	187	264	264	264	264	264
Other Operating Revenue Growth				*0.00%*	*0.00%*	*0.00%*	*0.00%*
Revenue Inflation Update				*0.00%*	*0.00%*	*0.00%*	*0.00%*
Acute Growth		*19.95%*	*19.01%*	*4.00%*	*4.00%*	*4.00%*	*4.00%*
Acute Admissions	2,627	3,151	3,750	3,900	4,056	4,218	4,387
RTC Admissions	344	288	-	-	-	-	-
Acute Days	26,090	29,104	32,155	32,438	32,723	33,010	33,302
RTC Days	16,744	12,945	1,032	-	-	-	-
Acute ALOS	9.93	9.24	8.57	8.32	8.07	7.83	7.59
Length of Stay Reduction		*-7.0%*	*-7.2%*	*-3.00%*	*-3.00%*	*-3.00%*	*-3.00%*
EIPA	3,242	3,802	4,275	4,463	4,659	4,865	5,081
EIPD	46,737	46,482	37,832	37,119	37,592	38,073	38,568
AOB	128.0	127.3	103.7	101.7	103.0	104.3	105.7
Acute Licensed Beds	107	107	117	117	117	117	117
Acute Occupancy Rate	66.8%	74.5%	75.3%	86.9%	88.0%	89.2%	90.3%
Non-pro fee FTEs	490.4	546.4	350.96	344.61	348.40	352.24	356.20
FTEs per AOB	3.83	4.29	3.39	3.38	3.37	3.37	3.36
Salary per FTE	47,036	49,291	62,397	62,406	62,414	62,422	62,430
Salary Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*
Benefit %	23.5%	21.0%	21.1%	21.1%	21.1%	21.1%	21.1%
Supply per EIPD	$ 37.80	$ 35.44	$ 35.96	$ 35.96	$ 35.96	$ 35.96	$ 35.96
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*
Contract Labor per EIPD	$ 14.89	$ 15.73	$ 28.42	$ 28.42	$ 28.42	$ 28.42	$ 28.42
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*
General & Administrative	$ 4,058,187	$ 4,579,609	$ 3,789,845	$ 3,789,845	$ 3,789,845	$ 3,789,845	$ 3,789,845
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*
Professional Fees per EIPD	$ 115.59	$ 166.70	$ 172.53	$ 172.53	$ 172.53	$ 172.53	$ 172.53
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*
Building and Maintenance	$ 3,345,254	$ 3,489,436	$ 2,408,546	$ 2,408,546	$ 2,408,546	$ 2,408,546	$ 2,408,546
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*
Insurance	$ 350,472	$ 454,832	$ 344,492	$ 344,492	$ 344,492	$ 344,492	$ 344,492
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*
Depreciation and Amortization	$ 1,118,057	$ 1,834,438	$ 1,289,470	$ 1,289,470	$ 1,289,470	$ 1,289,470	$ 1,289,470
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*
IT Depreciation	$ 681,334	$ 721,318	$ 742,097	$ 742,097	$ 742,097	$ 742,097	$ 742,097
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*
IT Services	$ 1,536,200	$ 1,387,999	$ 1,903,545	$ 1,903,545	$ 1,903,545	$ 1,903,545	$ 1,903,545
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*
Interest Expense	$ 245,907	$ 274,690	$ 259,762	$ 259,762	$ 259,762	$ 259,762	$ 259,762
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*
Other - Overhead Allocation	$ 1,410,861	$ 1,525,447	$ 3,333,962	$ 3,333,962	$ 3,333,962	$ 3,333,962	$ 3,333,962
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*

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	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018 Budget**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**
1. REVENUE							
a. Inpatient Services	$ 42,380,437	$ 44,687,017	$ 37,664,193	$ 38,083,754	$ 39,302,526	$ 40,557,993	$ 41,858,618
b. Outpatient Services	$ 9,371,601	$ 13,411,997	$ 15,256,241	$ 15,656,336	$ 16,377,577	$ 17,135,443	$ 17,933,683
Gross Patient Service Revenues	***$ 51,752,038***	***$ 58,099,014***	***$ 52,920,434***	***$ 53,740,090***	***$ 55,680,103***	***$ 57,693,437***	***$ 59,792,301***
c. Allowance For Bad Debt	$ 2,358,284	$ 1,972,640	$ 1,620,476	$ 1,639,306	$ 1,698,485	$ 1,759,900	$ 1,823,924
d. Contractual Allowance	$ 8,291,135	$ 9,799,587	$ 9,660,538	$ 9,769,326	$ 10,121,997	$ 10,487,998	$ 10,869,547
e. Charity Care	$ 1,863,598	$ 1,567,671	$ 1,387,441	$ 1,406,212	$ 1,456,976	$ 1,509,659	$ 1,564,580
Net Patient Services Revenue	***$ 39,239,021***	***$ 44,759,116***	***$ 40,251,979***	***$ 40,925,247***	***$ 42,402,645***	***$ 43,935,880***	***$ 45,534,250***
f. Other Operating Revenues (Specify/add rows of needed)	$ 7,313,987	$ 7,674,154	$ 6,313,441	$ 6,408,143	$ 6,504,265	$ 6,601,829	$ 6,700,856
NET OPERATING REVENUE	***$ 46,553,008***	***$ 52,433,270***	***$ 46,565,420***	***$ 47,333,390***	***$ 48,906,909***	***$ 50,537,708***	***$ 52,235,106***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 28,485,242	$ 32,585,640	$ 26,527,011	$ 26,545,708	$ 27,350,544	$ 28,181,387	$ 29,043,653
b. Contractual Services	$ 695,815	$ 731,056	$ 1,075,084	$ 1,083,993	$ 1,125,321	$ 1,168,291	$ 1,213,160
c. Interest on Current Debt	$ 245,907	$ 274,690	$ 259,762	$ 259,762	$ 259,762	$ 259,762	$ 259,762
d. Interest on Project Debt							
e. Current Depreciation	$ 1,799,391	$ 2,555,756	$ 2,031,567	$ 2,031,567	$ 2,031,567	$ 2,031,567	$ 2,031,567
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,766,719	$ 1,647,484	$ 1,360,406	$ 1,371,680	$ 1,423,976	$ 1,478,350	$ 1,535,127
j. IT Services	$ 1,536,200	$ 1,387,999	$ 1,903,545	$ 1,951,134	$ 1,999,912	$ 2,049,910	$ 2,101,158
k. Professional Fees	$ 5,402,165	$ 7,748,804	$ 6,527,160	$ 6,581,251	$ 6,832,165	$ 7,093,049	$ 7,365,463
l. Building & Maintenance	$ 3,345,254	$ 3,489,436	$ 2,408,546	$ 2,468,760	$ 2,530,479	$ 2,593,741	$ 2,658,584
m. Insurance	$ 350,472	$ 454,832	$ 344,492	$ 353,104	$ 361,932	$ 370,980	$ 380,255
m. G&A	$ 5,469,048	$ 6,105,056	$ 7,123,807	$ 7,285,232	$ 7,450,360	$ 7,619,276	$ 7,792,067
TOTAL OPERATING EXPENSES	**$ 49,096,213**	**$ 56,980,753**	**$ 49,561,380**	**$ 49,932,191**	**$ 51,366,017**	**$ 52,846,312**	**$ 54,380,796**
3. INCOME							
a. Income From Operation	**$ (2,543,205)**	**$ (4,547,483)**	**$ (2,995,960)**	**$ (2,598,802)**	**$ (2,459,108)**	**$ (2,308,604)**	**$ (2,145,690)**
b. Non-Operating Income							
SUBTOTAL	***$ (2,543,205)***	***$ (4,547,483)***	***$ (2,995,960)***	***$ (2,598,802)***	***$ (2,459,108)***	***$ (2,308,604)***	***$ (2,145,690)***
c. Income Taxes							
NET INCOME (LOSS)	***$ (2,543,205)***	***$ (4,547,483)***	***$ (2,995,960)***	***$ (2,598,802)***	***$ (2,459,108)***	***$ (2,308,604)***	***$ (2,145,690)***

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	CY 2015	CY 2016	CY 2017	CY 2018 Budget	CY 2019 Proj	CY 2020 Proj	CY 2021 Proj

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	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018 Budget**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	21.7%	21.9%	25.7%	25.7%	25.7%	25.7%	25.7%
2) Medicaid	40.1%	43.1%	39.1%	39.1%	39.1%	39.1%	39.1%
3) Blue Cross	10.6%	11.7%	3.9%	3.9%	3.9%	3.9%	3.9%
4) Commercial Insurance	7.5%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%
5) HMO	15.9%	11.9%	20.0%	20.0%	20.0%	20.0%	20.0%
6) Self-pay	2.5%	3.1%	2.7%	2.7%	2.7%	2.7%	2.7%
7) Other	1.9%	1.9%	2.3%	2.3%	2.3%	2.3%	2.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days							
a. Percent of Total Revenue							
1) Medicare	23.3%	22.1%	24.1%	24.1%	24.1%	24.1%	24.1%
2) Medicaid	38.7%	42.6%	38.7%	38.7%	38.7%	38.7%	38.7%
3) Blue Cross	10.5%	11.7%	4.1%	4.1%	4.1%	4.1%	4.1%
4) Commercial Insurance	6.9%	6.3%	6.7%	6.7%	6.7%	6.7%	6.7%
5) HMO	16.5%	12.6%	21.3%	21.3%	21.3%	21.3%	21.3%
6) Self-pay	2.5%	2.9%	2.8%	2.8%	2.8%	2.8%	2.8%
7) Other	1.7%	1.8%	2.3%	2.3%	2.3%	2.3%	2.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Assumptions & Drivers

Current State - with Inflation (Table K1)

	Historical			Budget	Projection		
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
IP Hospital Revenue	42,380,437	44,687,017	37,664,193	38,083,754	39,302,526	40,557,993	41,858,618
OP Hospital Revenue	3,862,125	4,711,318	5,272,196	5,609,195	5,967,734	6,349,192	6,755,032
Adjustment for RTC Closure			(761,416)				
Physician Revenue	5,509,476	8,700,679	9,984,045	10,047,141	10,409,842	10,786,251	11,178,651
EIPA Factor ("Equivalent IP Admission")	1.0911	1.1054	1.1400	1.1473	1.1518	1.1565	1.1614
Regulated Deductions:							
HSCRC Pass Thrus/Assessments	0%	0%	0.13%	0.13%	0.13%	0.13%	0.13%
Contractual Allowances	10.38%	9.60%	9.59%	9.59%	9.59%	9.59%	9.59%
Charity	4.03%	3.16%	3.20%	3.20%	3.20%	3.20%	3.20%
Bad Debt	4.44%	3.20%	3.20%	3.20%	3.20%	3.20%	3.20%
Pro Fee Deductions:							
Contractual Allowances	63.40%	58.10%	54.97%	54.97%	54.97%	54.97%	54.97%
Charity	0.02%	0.06%	0.08%	0.08%	0.08%	0.08%	0.08%
Bad Debt	5.56%	4.49%	2.40%	2.40%	2.40%	2.40%	2.40%
IP Revenue per Admission	$ 16,133	$ 14,182	$ 10,044	$ 10,275	$ 10,511	$ 10,753	$ 11,000
OP Revenue per EIPD ("Equivalent IP Day")	989	1,063	1,135	1,174	1,201	1,229	1,257
Physician Revenue per EIPD	118	187	264	270	276	283	289
Other Operating Revenue Growth				*1.50%*	*1.50%*	*1.50%*	*1.50%*
Revenue Inflation Update				*2.30%*	*2.30%*	*2.30%*	*2.30%*
Acute Growth		*19.95%*	*19.01%*	*4.00%*	*4.00%*	*4.00%*	*4.00%*
Acute Admissions	2,627	3,151	3,750	3,900	4,056	4,218	4,387
RTC Admissions	344	288	-	-	-	-	-
Acute Days	26,090	29,104	32,155	32,438	32,723	33,010	33,302
RTC Days	16,744	12,945	1,032	-	-	-	-
Acute ALOS	9.93	9.24	8.57	8.32	8.07	7.83	7.59
Length of Stay Reduction		*-7.0%*	*-7.2%*	*-3.00%*	*-3.00%*	*-3.00%*	*-3.00%*
EIPA	3,242	3,802	4,275	4,474	4,672	4,878	5,095
EIPD	46,737	46,482	37,832	37,216	37,692	38,177	38,676
Adjusted Occupied Bed	128.0	127.3	103.7	102.0	103.3	104.6	106.0
Acute Licensed Beds	107	107	117	117	117	117	117
Acute Occupancy Rate	66.8%	74.5%	75.3%	76.0%	76.6%	77.3%	78.0%
Non-pro fee FTEs	490.4	546.4	350.96	344.61	348.40	352.24	356.20
FTEs per AOB	3.83	4.29	3.39	3.38	3.37	3.37	3.36
Salary per FTE	47,036	49,291	62,397	63,591	64,808	66,048	67,312
Salary Inflation				*1.90%*	*1.90%*	*1.90%*	*1.90%*
Benefit %	23.5%	21.0%	21.1%	21.1%	21.1%	21.1%	21.1%
Supply per EIPD	$ 38	$ 35	$ 36	$ 37	$ 38	$ 39	$ 40
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*
Contract Labor per EIPD	$ 15	$ 16	$ 28	$ 29	$ 30	$ 31	$ 31
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*
General & Administrative	$ 4,058,187	$ 4,579,609	$ 3,789,845	$ 3,884,591	$ 3,981,706	$ 4,081,249	$ 4,183,280
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*
Professional Fees per EIPD	$ 115.59	$ 166.70	$ 172.53	$ 177	$ 181	$ 186	$ 190
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*
Building and Maintenance	$ 3,345,254	$ 3,489,436	$ 2,408,546	$ 2,468,760	$ 2,530,479	$ 2,593,741	$ 2,658,584
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*
Insurance	$ 350,472	$ 454,832	$ 344,492	$ 353,104	$ 361,932	$ 370,980	$ 380,255
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*
Depreciation and Amortization	$ 1,118,057	$ 1,834,438	$ 1,289,470	$ 1,289,470	$ 1,289,470	$ 1,289,470	$ 1,289,470
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*
IT Depreciation	$ 681,334	$ 721,318	$ 742,097	$ 742,097	$ 742,097	$ 742,097	$ 742,097
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*
IT Services	$ 1,536,200	$ 1,387,999	$ 1,903,545	$ 1,951,134	$ 1,999,912	$ 2,049,910	$ 2,101,158
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*
Interest Expense	$ 245,907	$ 274,690	$ 259,762	$ 259,762	$ 259,762	$ 259,762	$ 259,762
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*
Other - Overhead Allocation	$ 1,410,861	$ 1,525,447	$ 3,333,962	$ 3,400,641	$ 3,468,654	$ 3,538,027	$ 3,608,788
Inflation				*2.00%*	*2.00%*	*2.00%*	*2.00%*

BHWS under SGMC license and GBR -UNINFLATED

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	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018 Budget**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**
1. REVENUE							
a. Inpatient Services	$ 42,380,437	$ 44,687,017	$ 37,664,193	$ 39,945,118	$ 40,599,544	$ 40,599,544	$ 40,599,544
b. Outpatient Services	$ 9,371,601	$ 13,411,997	$ 15,256,241	$ 15,350,181	$ 15,527,664	$ 15,613,731	$ 15,701,760
Gross Patient Service Revenues	***$ 51,752,038***	***$ 58,099,014***	***$ 52,920,434***	***$ 55,295,299***	***$ 56,127,207***	***$ 56,213,275***	***$ 56,301,304***
c. Allowance For Bad Debt	$ 2,358,284	$ 1,972,640	$ 1,620,476	$ 1,691,380	$ 1,717,314	$ 1,719,380	$ 1,721,492
d. Contractual Allowance	$ 8,291,135	$ 9,799,587	$ 9,660,538	$ 9,142,735	$ 8,697,632	$ 8,744,943	$ 8,793,333
e. Charity Care	$ 1,863,598	$ 1,567,671	$ 1,387,441	$ 1,464,978	$ 1,488,920	$ 1,488,989	$ 1,489,059
Net Patient Services Revenue	***$ 39,239,021***	***$ 44,759,116***	***$ 40,251,979***	***$ 42,996,206***	***$ 44,223,341***	***$ 44,259,963***	***$ 44,297,419***
f. Other Operating Revenues (Specify)	$ 7,313,987	$ 7,674,154	$ 6,313,441	$ 6,313,441	$ 6,313,441	$ 6,313,441	$ 6,313,441
NET OPERATING REVENUE	***$ 46,553,008***	***$ 52,433,270***	***$ 46,565,420***	***$ 49,309,647***	***$ 50,536,782***	***$ 50,573,404***	***$ 50,610,860***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 28,485,242	$ 32,585,640	$ 26,527,011	$ 26,050,744	$ 26,340,111	$ 26,634,210	$ 26,937,327
b. Contractual Services	$ 695,815	$ 731,056	$ 1,075,084	$ 1,050,819	$ 1,060,066	$ 1,069,334	$ 1,078,813
c. Interest on Current Debt	$ 245,907	$ 274,690	$ 259,762	$ 259,762	$ 259,762	$ 259,762	$ 259,762
d. Interest on Project Debt							
e. Current Depreciation	$ 1,799,391	$ 2,555,756	$ 2,031,567	$ 2,031,567	$ 2,031,567	$ 2,031,567	$ 2,031,567
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,766,719	$ 1,647,484	$ 1,360,406	$ 1,329,701	$ 1,341,403	$ 1,353,130	$ 1,365,125
j. IT Services	$ 1,536,200	$ 1,387,999	$ 1,903,545	$ 1,903,545	$ 1,903,545	$ 1,903,545	$ 1,903,545
k. Professional Fees	$ 5,402,165	$ 7,748,804	$ 6,527,160	$ 6,379,841	$ 6,435,984	$ 6,492,251	$ 6,549,801
l. Building & Maintenance	$ 3,345,254	$ 3,489,436	$ 2,408,546	$ 2,408,546	$ 2,408,546	$ 2,408,546	$ 2,408,546
m. Insurance	$ 350,472	$ 454,832	$ 344,492	$ 344,492	$ 344,492	$ 344,492	$ 344,492
m. G&A	$ 5,469,048	$ 6,105,056	$ 7,123,807	$ 7,123,807	$ 7,123,807	$ 7,123,807	$ 7,123,807
TOTAL OPERATING EXPENSES	**$ 49,096,213**	**$ 56,980,753**	**$ 49,561,380**	**$ 48,882,824**	**$ 49,249,282**	**$ 49,620,644**	**$ 50,002,785**
3. INCOME							
a. Income From Operation	**$ (2,543,205)**	**$ (4,547,483)**	**$ (2,995,960)**	**$ 426,822**	**$ 1,287,500**	**$ 952,760**	**$ 608,075**
b. Non-Operating Income							
SUBTOTAL	***$ (2,543,205)***	***$ (4,547,483)***	***$ (2,995,960)***	***$ 426,822***	***$ 1,287,500***	***$ 952,760***	***$ 608,075***
c. Income Taxes							
NET INCOME (LOSS)	***$ (2,543,205)***	***$ (4,547,483)***	***$ (2,995,960)***	***$ 426,822***	***$ 1,287,500***	***$ 952,760***	***$ 608,075***

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	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018 Budget**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	21.7%	21.9%	25.7%	25.7%	25.7%	25.7%	25.7%
2) Medicaid	40.1%	43.1%	39.1%	39.1%	39.1%	39.1%	39.1%
3) Blue Cross	10.6%	11.7%	3.9%	3.9%	3.9%	3.9%	3.9%
4) Commercial Insurance	7.5%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%
5) HMO	15.9%	11.9%	20.0%	20.0%	20.0%	20.0%	20.0%
6) Self-pay	2.5%	3.1%	2.7%	2.7%	2.7%	2.7%	2.7%
7) Other	1.9%	1.9%	2.3%	2.3%	2.3%	2.3%	2.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	23.3%	22.1%	24.1%	24.1%	24.1%	24.1%	24.1%
2) Medicaid	38.7%	42.6%	38.7%	38.7%	38.7%	38.7%	38.7%
3) Blue Cross	10.5%	11.7%	4.1%	4.1%	4.1%	4.1%	4.1%
4) Commercial Insurance	6.9%	6.3%	6.7%	6.7%	6.7%	6.7%	6.7%
5) HMO	16.5%	12.6%	21.3%	21.3%	21.3%	21.3%	21.3%
6) Self-pay	2.5%	2.9%	2.8%	2.8%	2.8%	2.8%	2.8%
7) Other	1.7%	1.8%	2.3%	2.3%	2.3%	2.3%	2.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Assumptions & Drivers

GBR - NO Inflation (Table J2)

	Historical			Budget	Projection		
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
IP Hospital Revenue	42,380,437	44,687,017	37,664,193	39,945,118	40,599,544	40,599,544	40,599,544
OP Hospital Revenue	3,862,125	4,711,318	5,272,196	5,591,478	5,683,083	5,683,083	5,683,083
Adjustment for RTC Closure			(761,416)				
Physician Revenue	5,509,476	8,700,679	9,984,045	9,758,703	9,844,580	9,930,647	10,018,676
EIPA Factor	1.0911	1.1054	1.1400	1.1400	1.1400	1.1400	1.1400
Regulated Deductions							
HSCRC Pass Thrus/Assessments	0%	0%	0.13%	1.25%	2.60%	2.60%	2.60%
Contractual Allowances	10.38%	9.60%	9.59%	7.05%	4.50%	4.50%	4.50%
Charity	4.03%	3.16%	3.20%	3.20%	3.20%	3.20%	3.20%
Bad Debt	4.44%	3.20%	3.20%	3.20%	3.20%	3.20%	3.20%
Pro Fee Deductions							
Contractual Allowances	63.40%	58.10%	54.97%	54.97%	54.97%	54.97%	54.97%
Charity	0.02%	0.06%	0.08%	0.08%	0.08%	0.08%	0.08%
Bad Debt	5.56%	4.49%	2.40%	2.40%	2.40%	2.40%	2.40%
IP Gross Revenue per Admission	$ 16,133	$ 14,182	$ 10,044	$ 10,242	$ 10,010	$ 9,625	$ 9,255
OP Gross Revenue per EIPD	187	271	929	1,231	1,241	1,230	1,219
Physician Gross Revenue per EIPD	118	187	264	264	264	264	264
Other Operating Revenue Growth				*0.00%*	*0.00%*	*0.00%*	*0.00%*
Regulated Rate update for GBR Agreeement				*6.06%*	*1.64%*	*0.00%*	*0.00%*
Physician Revenue Update				*0.00%*	*0.00%*	*0.00%*	*0.00%*
Acute Growth		*19.95%*	*19.01%*	*4.00%*	*4.00%*	*4.00%*	*4.00%*
Acute Admissions	2,627	3,151	3,750	3,900	4,056	4,218	4,387
RTC Admissions	344	288					
Acute Days	26,090	29,104	32,155	32,438	32,723	33,010	33,302
RTC Days	16,744	12,945	1,032	-	-	-	-
Acute ALOS	9.93	9.24	8.57	8.32	8.07	7.83	7.59
Length of Stay Reduction		*-7.0%*	*-7.2%*	*-3.00%*	*-3.00%*	*-3.00%*	*-3.00%*
EIPA	3,242	3,802	4,275	4,446	4,624	4,808	5,001
EIPD	46,737	46,482	37,832	36,979	37,304	37,630	37,964
AOB	128.0	127.3	103.7	101.3	102.2	103.1	104.0
Acute Licensed Beds	107	107	117	117	117	117	117
Acute Occupancy Rate	66.8%	74.5%	75.3%	86.6%	87.4%	88.1%	88.9%
Non-pro fee FTEs	490	546.4	350.96	344.61	348.40	352.24	356.20
FTEs per AOB		3.65	3.39	3.38	3.37	3.37	3.36
Salary per FTE			62,397	62,406	62,414	62,422	62,430
Salary Inflation				0.00%	0.00%	0.00%	0.00%
Benefit %			21.1%	21.1%	21.1%	21.1%	21.1%
Supply per EIPD			$ 36	$ 36	$ 36	$ 36	$ 36
Inflation				0.00%	0.00%	0.00%	0.00%
Contract Labor per EIPD			$ 28	$ 28	$ 28	$ 28	$ 28
Inflation				0.00%	0.00%	0.00%	0.00%
General & Administrative			$ 3,789,845	$ 3,789,845	$ 3,789,845	$ 3,789,845	$ 3,789,845
Inflation				0.00%	0.00%	0.00%	0.00%
Professional Fees per EIPD			$ 172.53	$ 173	$ 173	$ 173	$ 173
Inflation				0.00%	0.00%	0.00%	0.00%
Building and Maintenance			$ 2,408,546	$ 2,408,546	$ 2,408,546	$ 2,408,546	$ 2,408,546
Inflation				0.00%	0.00%	0.00%	0.00%
Insurance			$ 344,492	$ 344,492	$ 344,492	$ 344,492	$ 344,492
Inflation				0.00%	0.00%	0.00%	0.00%
Depreciation and Amortization			$ 1,289,470	$ 1,289,470	$ 1,289,470	$ 1,289,470	$ 1,289,470
Inflation				0.00%	0.00%	0.00%	0.00%
IT Depreciation			$ 742,097	$ 742,097	$ 742,097	$ 742,097	$ 742,097
Inflation				0.00%	0.00%	0.00%	0.00%
IT Services			$ 1,903,545	$ 1,903,545	$ 1,903,545	$ 1,903,545	$ 1,903,545
Inflation				0.00%	0.00%	0.00%	0.00%
Interest Expense			$ 259,762	$ 259,762	$ 259,762	$ 259,762	$ 259,762
Inflation				0.00%	0.00%	0.00%	0.00%
Other - Overhead Allocation			$ 3,333,962	$ 3,333,962	$ 3,333,962	$ 3,333,962	$ 3,333,962
Inflation				0.00%	0.00%	0.00%	0.00%

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	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018 Budget**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**
1. REVENUE							
a. Inpatient Services	$ 42,380,437	$ 44,687,017	$ 37,664,193	$ 39,986,355	$ 41,561,142	$ 42,517,049	$ 43,494,941
b. Outpatient Services	$ 9,371,601	$ 13,411,997	$ 15,256,241	$ 15,721,185	$ 16,266,464	$ 16,732,970	$ 17,214,484
Gross Patient Service Revenues	***$ 51,752,038***	***$ 58,099,014***	***$ 52,920,434***	***$ 55,707,539***	***$ 57,827,607***	***$ 59,250,019***	***$ 60,709,425***
c. Allowance For Bad Debt	$ 2,358,284	$ 1,972,640	$ 1,620,476	$ 1,702,574	$ 1,767,853	$ 1,810,731	$ 1,854,698
d. Contractual Allowance	$ 8,291,135	$ 9,799,587	$ 9,660,538	$ 9,291,467	$ 9,050,128	$ 9,309,061	$ 9,576,301
e. Charity Care	$ 1,863,598	$ 1,567,671	$ 1,387,441	$ 1,470,378	$ 1,528,227	$ 1,563,450	$ 1,599,486
Net Patient Services Revenue	***$ 39,239,021***	***$ 44,759,116***	***$ 40,251,979***	***$ 43,243,121***	***$ 45,481,398***	***$ 46,566,777***	***$ 47,678,940***
f. Other Operating Revenues (Specify/add rows of needed)	$ 7,313,987	$ 7,674,154	$ 6,313,441	$ 6,408,143	$ 6,504,265	$ 6,601,829	$ 6,700,856
NET OPERATING REVENUE	***$ 46,553,008***	***$ 52,433,270***	***$ 46,565,420***	***$ 49,651,264***	***$ 51,985,663***	***$ 53,168,606***	***$ 54,379,796***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 28,485,242	$ 32,585,640	$ 26,527,011	$ 26,545,708	$ 27,350,544	$ 28,181,387	$ 29,043,653
b. Contractual Services	$ 695,815	$ 731,056	$ 1,075,084	$ 1,079,819	$ 1,116,554	$ 1,154,473	$ 1,193,825
c. Interest on Current Debt	$ 245,907	$ 274,690	$ 259,762	$ 259,762	$ 259,762	$ 259,762	$ 259,762
d. Interest on Project Debt							
e. Current Depreciation	$ 1,799,391	$ 2,555,756	$ 2,031,567	$ 2,031,567	$ 2,031,567	$ 2,031,567	$ 2,031,567
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,766,719	$ 1,647,484	$ 1,360,406	$ 1,366,397	$ 1,412,882	$ 1,460,865	$ 1,510,660
j. IT Services	$ 1,536,200	$ 1,387,999	$ 1,903,545	$ 1,951,134	$ 1,999,912	$ 2,049,910	$ 2,101,158
k. Professional Fees	$ 5,402,165	$ 7,748,804	$ 6,527,160	$ 6,555,905	$ 6,778,937	$ 7,009,157	$ 7,248,071
l. Building & Maintenance	$ 3,345,254	$ 3,489,436	$ 2,408,546	$ 2,468,760	$ 2,530,479	$ 2,593,741	$ 2,658,584
m. Insurance	$ 350,472	$ 454,832	$ 344,492	$ 353,104	$ 361,932	$ 370,980	$ 380,255
m. G&A	$ 5,469,048	$ 6,105,056	$ 7,123,807	$ 7,285,232	$ 7,450,360	$ 7,619,276	$ 7,792,067
TOTAL OPERATING EXPENSES	***$ 49,096,213***	***$ 56,980,753***	***$ 49,561,380***	***$ 49,897,387***	***$ 51,292,928***	***$ 52,731,118***	***$ 54,219,602***
3. INCOME							
a. Income From Operation	**$ (2,543,205)**	**$ (4,547,483)**	**$ (2,995,960)**	**$ (246,124)**	**$ 692,735**	**$ 437,488**	**$ 160,194**
b. Non-Operating Income							
SUBTOTAL	***$ (2,543,205)***	***$ (4,547,483)***	***$ (2,995,960)***	***$ (246,124)***	***$ 692,735***	***$ 437,488***	***$ 160,194***
c. Income Taxes							
NET INCOME (LOSS)	***$ (2,543,205)***	***$ (4,547,483)***	***$ (2,995,960)***	***$ (246,124)***	***$ 692,735***	***$ 437,488***	***$ 160,194***

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	CY 2015	CY 2016	CY 2017	CY 2018 Budget	CY 2019 Proj	CY 2020 Proj	CY 2021 Proj

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	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018 Budget**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	21.7%	21.9%	25.7%	25.7%	25.7%	25.7%	25.7%
2) Medicaid	40.1%	43.1%	39.1%	39.1%	39.1%	39.1%	39.1%
3) Blue Cross	10.6%	11.7%	3.9%	3.9%	3.9%	3.9%	3.9%
4) Commercial Insurance	7.5%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%
5) HMO	15.9%	11.9%	20.0%	20.0%	20.0%	20.0%	20.0%
6) Self-pay	2.5%	3.1%	2.7%	2.7%	2.7%	2.7%	2.7%
7) Other	1.9%	1.9%	2.3%	2.3%	2.3%	2.3%	2.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days							
a. Percent of Total Revenue							
1) Medicare	23.3%	22.1%	24.1%	24.1%	24.1%	24.1%	24.1%
2) Medicaid	38.7%	42.6%	38.7%	38.7%	38.7%	38.7%	38.7%
3) Blue Cross	10.5%	11.7%	4.1%	4.1%	4.1%	4.1%	4.1%
4) Commercial Insurance	6.9%	6.3%	6.7%	6.7%	6.7%	6.7%	6.7%
5) HMO	16.5%	12.6%	21.3%	21.3%	21.3%	21.3%	21.3%
6) Self-pay	2.5%	2.9%	2.8%	2.8%	2.8%	2.8%	2.8%
7) Other	1.7%	1.8%	2.3%	2.3%	2.3%	2.3%	2.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Assumptions & Drivers

GBR - with Inflation (Table K2)

	Historical			Budget	Projection		
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
IP Hospital Revenue	42,380,437	44,687,017	37,664,193	39,986,355	41,561,142	42,517,049	43,494,941
OP Hospital Revenue	3,862,125	4,711,318	5,272,196	5,712,738	5,937,724	6,074,291	6,214,000
Adjustment for RTC Closure			(761,416)				
Physician Revenue	5,509,476	8,700,679	9,984,045	10,008,446	10,328,741	10,658,679	11,000,484
EIPA Factor	1.0911	1.1054	1.1400	1.1429	1.1429	1.1429	1.1429
Regulated Deductions							
HSCRC Pass Thrus/Assessments	0%	0%	0.13%	1.25%	2.60%	2.60%	2.60%
Contractual Allowances	10.38%	9.60%	9.59%	7.05%	4.50%	4.50%	4.50%
Charity	4.03%	3.16%	3.20%	3.20%	3.20%	3.20%	3.20%
Bad Debt	4.44%	3.20%	3.20%	3.20%	3.20%	3.20%	3.20%
Pro Fee Deductions							
Contractual Allowances	63.40%	58.10%	54.97%	54.97%	54.97%	54.97%	54.97%
Charity	0.02%	0.06%	0.08%	0.08%	0.08%	0.08%	0.08%
Bad Debt	5.56%	4.49%	2.40%	2.40%	2.40%	2.40%	2.40%
IP Gross Revenue per Admission	$ 16,133	$ 14,182	$ 10,044	$ 10,253	$ 10,247	$ 10,080	$ 9,915
OP Gross Revenue per EIPD	989	1,063	1,135	1,233	1,270	1,288	1,306
Physician Gross Revenue per EIPD	118	187	264	270	276	283	289
Other Operating Revenue Growth				*1.50%*	*1.50%*	*1.50%*	*1.50%*
Regulated Rate update for GBR Agreeement				*8.36%*	*3.94%*	*2.30%*	*2.30%*
Physician Revenue Update				*2.30%*	*2.30%*	*2.30%*	*2.30%*
Acute Growth		*19.95%*	*19.01%*	*4.00%*	*4.00%*	*4.00%*	*4.00%*
Acute Admissions	2,627	3,151	3,750	3,900	4,056	4,218	4,387
RTC Admissions	344	288	-	-	-	-	-
Acute Days	26,090	29,104	32,155	32,438	32,723	33,010	33,302
RTC Days	16,744	12,945	1,032	-	-	-	-
Acute ALOS	9.93	9.24	8.57	8.32	8.07	7.83	7.59
Length of Stay Reduction		*-7.0%*	*-7.2%*	*-3.00%*	*-3.00%*	*-3.00%*	*-3.00%*
EIPA	3,242	3,802	4,275	4,457	4,635	4,821	5,014
EIPD	46,737	46,482	37,832	37,072	37,399	37,725	38,060
AOB	128.0	127.3	103.7	101.6	102.5	103.4	104.3
Acute Licensed Beds	107	107	117	117	117	117	117
Acute Occupancy Rate	66.8%	74.5%	75.3%	86.8%	87.6%	88.3%	89.1%
Non-pro fee FTEs	490	546.4	350.96	344.61	348.40	352.24	356.20
FTEs per AOB	3.83	4.29	3.39	3.38	3.37	3.37	3.36
Salary per FTE	47,075	49,291	62,397	63,591	64,808	66,048	67,312
Salary Inflation				1.90%	1.90%	1.90%	1.90%
Benefit %			21.1%	21.1%	21.1%	21.1%	21.1%
Supply per EIPD			$ 36	$ 37	$ 38	$ 39	$ 40
Inflation				2.50%	2.50%	2.50%	2.50%
Contract Labor per EIPD			$ 28	$ 29	$ 30	$ 31	$ 31
Inflation				2.50%	2.50%	2.50%	2.50%
General & Administrative			$ 3,789,845	$ 3,884,591	$ 3,981,706	$ 4,081,249	$ 4,183,280
Inflation				2.50%	2.50%	2.50%	2.50%
Professional Fees per EIPD			$ 172.53	$ 177	$ 181	$ 186	$ 190
Inflation				2.50%	2.50%	2.50%	2.50%
Building and Maintenance			$ 2,408,546	$ 2,468,760	$ 2,530,479	$ 2,593,741	$ 2,658,584
Inflation				2.50%	2.50%	2.50%	2.50%
Insurance			$ 344,492	$ 353,104	$ 361,932	$ 370,980	$ 380,255
Inflation				2.50%	2.50%	2.50%	2.50%
Depreciation and Amortization			$ 1,289,470	$ 1,289,470	$ 1,289,470	$ 1,289,470	$ 1,289,470
Inflation				0.00%	0.00%	0.00%	0.00%
IT Depreciation			$ 742,097	$ 742,097	$ 742,097	$ 742,097	$ 742,097
Inflation				0.00%	0.00%	0.00%	0.00%
IT Services			$ 1,903,545	$ 1,951,134	$ 1,999,912	$ 2,049,910	$ 2,101,158
Inflation				2.50%	2.50%	2.50%	2.50%
Interest Expense			$ 259,762	$ 259,762	$ 259,762	$ 259,762	$ 259,762
Inflation				0.00%	0.00%	0.00%	0.00%
Other - Overhead Allocation			$ 3,333,962	$ 3,400,641	$ 3,468,654	$ 3,538,027	$ 3,608,788
Inflation				2.00%	2.00%	2.00%	2.00%

TABLE H. 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			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)*											
Admin/Finance/HR/Mgmt	28.0	$97,707	$2,737,751			$0			$0	28.0	$2,737,751
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration	28.0	$97,707	$2,737,751			$0			$0	28.0	$2,737,751
Direct Care Staff *(List general categories, add rows if needed)*											
Nursing	72.9	$87,429	$6,370,106			$0	1.6	$142,083	$142,083	74.5	$6,512,189
Therapist	86.1	$62,570	$5,387,931			$0	1.9	$120,176	$120,176	88.0	$5,508,107
Patient Care Tech	65.6	$42,781	$2,805,548			$0	1.5	$62,577	$62,577	67.0	$2,868,125
Pharmacist	1.9	$105,084	$201,762			$0	0.0	$4,500	$4,500	2.0	$206,262
Pastoral Care	2.5	$55,123	$136,153			$0	0.1	$3,037	$3,037	2.5	$139,190
Patient Advocates	5.0	$57,165	$285,251			$0	0.1	$6,362	$6,362	5.1	$291,613
Total Direct Care	233.9	$64,920	$15,186,751			$0	5.2	$338,735	$338,735	239.1	$15,525,486
Support Staff *(List general categories, add rows if needed)*											
Case Mgmt	9.2	$61,319	$565,365			$0	0.2	$12,610	$12,610	9.4	$577,975
Dietary	15.9	$34,079	$540,490			$0				15.9	$540,490
HIM/Coding	3.0	$60,715	$182,146			$0				3.0	$182,146
Housekeeping	13.0	$30,338	$393,791			$0				13.0	$393,791
Patient Access	7.6	$40,651	$307,728			$0				7.6	$307,728
Plant Ops	3.2	$54,262	$173,637			$0				3.2	$173,637

TABLE H. WORKFORCE INFORMATION

Quality/Risk Mgmt	1.8	$106,165	$192,111			$0				1.8	$192,111
Teacher	21.2	$50,944	$1,082,069			$0			$0	21.2	$1,082,069
Transport	4.6	$39,196	$179,342			$0			$0	4.6	$179,342
Unit Secretary	9.6	$37,484	$357,819			$0			$0	9.6	$357,819
Total Support	89.0	$44,652	$3,974,498			$0			$0	89.0	$3,974,498
REGULAR EMPLOYEES TOTAL	351.0	***$62,397***	$21,899,000	0.0		$0	5.2		$338,735	356.2	$22,237,735
2. Contractual Employees											
Administration *(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 Administration			$0			$0			$0	0.0	$0
Direct Care 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 Direct Care Staff			$0			$0			$0	0.0	$0
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 TOTAL			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below)* **:**											
TOTAL COST	***351.0***		***$21,899,000***	***0.0***		***$0***	***5.2***		***$338,735***		***$22,237,735***

Exhibit 3
Consistency with Acute Psychiatric Services
State Health Plan Standards
COMAR 10.24.07

Standard AP la. The projected maximum bed need for child, adolescent, and adult acute psychiatric bed is calculated using the Commission's statewide child, adolescent, and adult acute psychiatric bed need projection methodologies specified in this section of the State Health Plan. Applicants for Certificates of Need must state how many child, adolescent and adult acute psychiatric beds they are applying for in each of the following categories: net acute psychiatric bed need, and/or state hospital conversion bed need.

APPLICANT RESPONSE:

Currently there are 117 licensed specialty hospital psychiatric beds at Adventist Behavioral Health (ABH); 87 designated for adults and 30 for children and adolescents. This consolidation will not affect access or usage since all of the affected beds will remain in the same location.

Standard AP 2a. All acute general hospitals with psychiatric units must have written procedures for providing psychiatric emergency inpatient treatment 24 hours a day, 7 day a week with no special limitation for weekdays or late night shifts.

APPLICANT RESPONSE:

ABH is already located on the same Rockville campus as SGMC. It is located next to the existing acute general hospital's emergency department. ABH already accepts involuntary and emergency psychiatric emergency admissions on a 24/7 basis with no special limitation for weekdays or late night shifts. This will not change.

Procedures at SGMC for psychiatric emergency inpatient treatment are in place at SGMC and will not change following this consolidation (Exhibit 4).

Standard AP 2b. Any acute general hospital containing an identifiable psychiatric unit must be an emergency facility, designated by the Department of Health and Mental Hygiene to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition.

APPLICANT RESPONSE:

SGMC is already designated by the Maryland Department of Health's Behavioral Health Administration as a psychiatric emergency facility, designated to perform mental disorder evaluations of persons brought in on emergency petition. (See Exhibit 5)

Standard AP 2c. Acute general hospitals with psychiatric units must have emergency holding bed capabilities and a seclusion room.

APPLICANT RESPONSE:

SGMC has the largest emergency department in Montgomery County. It has capacity for 8 emergency holding beds of which 2 are seclusion rooms within the main emergency department. The ABH-R buildings have a seclusion room for each unit.

> **Standard AP 3a. Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include: chemotherapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.**

APPLICANT RESPONSE:

The psychiatric programs offered at ABH are tailored to each patient's needs. Chemotherapy, individual psychotherapy, group therapy, family therapy, social services and expressive therapies are available to patients in the programs. Programs are offered specifically for the child, adolescent, and adult units (which includes a geriatric unit) which are all separate from one another. The modalities listed and others that could be instituted at a future date are designed to assist patients in the development of interpersonal skills within a group setting, restoration of family functioning and provision of any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family. The programs and services will not change after the consolidation with SGMC.

> **Standard AP 3b. In addition to the services mandated in Standard 3a, inpatient child and adolescent acute psychiatric services must be provided by a multidisciplinary treatment team which provides services that address daily living skills, psycho educational and/or vocational development, opportunity to develop interpersonal skills within a group setting, restoration of family functioning and any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family. Applicants for a Certificate of Need for child and/or adolescent acute psychiatric beds must document that they will provide a separate physical environment consistent with the treatment needs of each age group.**

APPLICANT RESPONSE:

Inpatient psychiatric services for children and adolescents are provided at the ABH facility in units separate from one another and the adult and geriatric populations. These services are provided by a multidisciplinary team providing daily living skills and psycho-educational development. The team also makes every attempt to partner with the schools and/or parents to assist with school-based learning requirements to prevent patients from getting behind in their academics, group settings to learn and practice interpersonal skills, family programs and individualized diagnostic and treatment plans. These services will continue after the consolidation.

Standard AP 3c. All acute general hospitals must provide psychiatric consultation services either directly or through contractual arrangements.

APPLICANT RESPONSE:

SGMC and ABH have full-time and part-time psychiatrists on staff and available for consultation.

Standard AP 4a. A certificate of Need for child, adolescent or adult acute psychiatric beds shall be issued separately for each age category. Conversion of psychiatric beds from one of these services to another shall require a separate Certificate of Need.

APPLICANT RESPONSE:

AHC is requesting a consolidation of 117 beds currently licensed as 87 adult/geriatric beds and 30 child and adolescent beds from ABH, consolidated into SGMC. This is an exemption request from a Certificate of Need.

Standard AP 4b. Certificate of need applicants proposing to provide two or more age specific acute psychiatric services must provide that physical separations and clinical/programmatic distinctions are made between the patient groups.

APPLICANT RESPONSE:

The units at ABH, which will continue to be used as the physical space under the SGMC consolidation of psychiatric services, currently is configured to separately house children, adolescents, adults and geriatric patients in age-appropriate units.

Accessibility

Standard AP 5. Once a patient has requested admission to an acute psychiatric inpatient facility, the following services must be made available:

(i) intake screening and admission;

(ii) arrangements for transfer to a more appropriate facility for care if medically indicated;

(iii) necessary evaluation to define the patient's psychiatric problem and/or

(iv) emergency treatment.

APPLICANT RESPONSE:

SGMC Needs Assessment department clinical staff will provide the face-to-face evaluation to determine psychiatric criteria and the most appropriate level of care. A physician will evaluate and determine that the individual is medically stable to participate in psychiatric care. These services will be provided by SGMC staff on campus in Rockville. The Needs Assessment staff

will arrange for an appropriate transfer only if needed services and/or appropriate space are not available.

> **Standard AP 6. All hospitals providing care in designated psychiatric units must have separate written quality assurance programs, program evaluations and treatment protocols for special populations, including children, adolescents, patients with a secondary diagnosis of substance abuse, and geriatric patients, either through direct treatment or through referral.**

APPLICANT RESPONSE:

Quality assurance programs of ABH will be reviewed and integrated into SGMC as part of the merger/consolidation. Program evaluations and treatment protocols for special populations will remain in effect and become integrated into SGMC, while still assuring the appropriate level of focus on psychiatric components. Protocols and programming for co-occurring disorders such as substance abuse are in place.

> **Standard AP 7. An acute general or private psychiatric hospital applying for a Certificate of Need for new or expanded acute psychiatric services may not deny admission to a designated psychiatric unit solely on the basis of the patient's legal status rather than clinical criteria.**

APPLICANT RESPONSE:

Although AHC is not proposing new psychiatric services, no individual will be denied psychiatric services based on legal status. The SGMC facility will continue to accept adult involuntary admissions.

> **Standard AP 8. All acute general hospitals and private freestanding psychiatric hospitals must provide a percentage of uncompensated care for acute psychiatric patients which is equal to the average level of uncompensated care provided by all acute general hospitals located in the health service area where the hospital is located, based on data available from the HSCRC for the most recent 12-month period.**

APPLICANT RESPONSE:

In FY 2016 (the last publicly available data for all hospitals) SGMC provided 4.18% and ABH provided 7.49% compared to the Montgomery County straight average for all acute hospitals of 6.37%. ABH and SGMC are all governed by the AHC financial assistance policy (Exhibits 6, 7) and will continue to be governed by this policy upon merger of the psychiatric beds into the SGMC license.

> **Standard AP 9. If there are no child acute psychiatric beds available within a 45 minute travel time under normal road conditions, then an acute child psychiatric patient may be admitted, if appropriate, to a general pediatric bed. These hospitals**

must develop appropriate treatment protocols to ensure a therapeutically safe environment for those child psychiatric patients treated in general pediatric beds.

APPLICANT RESPONSE:

This standard is not applicable since SGMC will continue to have both child and adolescent psychiatric services currently offered by ABH.

Quality

Standard AP 12a. Acute inpatient psychiatric services must be under the clinical supervision of a qualified psychiatrist.

APPLICANT RESPONSE:

All psychiatric care at SGMC will be directed by a board-certified psychiatrist who is the head of a multidisciplinary team of mental health professionals. All staff psychiatrists will be evaluated by the SGMC Medical Director and the Chief of the Psychiatric Services.

Standard AP 12b. Staffing of acute psychiatric programs should include therapists for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment. Staffing should cover a seven-day per week treatment program.

APPLICANT RESPONSE:

Patients at SGMC will receive therapeutic programming which provides active treatment in compliance with standards of practice, 7 days per week. The patient's therapist is responsible for coordinating aftercare planning to promote continuity of care. In addition to making appointments and referrals to outpatient providers, the therapist ensures that an aftercare plan with recommendations is transmitted to the patient's next level of care provider.

Continuity

Standard AP 13: Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.

APPLICANT RESPONSE:

The SGMC staff will follow the current ABH discharge planning and referral policies (Exhibit 8) to ensure the patient's next level of care needs are met through a variety of services including inpatient, outpatient, partial hospitalization, aftercare treatment programs and other alternative treatment programs. These policies will be available for review by appropriate licensing and certifying bodies.

Care management staff is a part of the treatment team at SGMC and assist with arranging the needed services at discharge to enhance the successful treatment of the individual.

<u>Standard AP 14:</u> Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all the following:

(i) the local and state mental health advisory council(s);

(ii) the local community mental health center(s);

(iii) the Department of Health and Mental Hygiene; and

(iv) the city/county mental health department(s).

Letter from other consumer organizations are encouraged.

<u>APPLICANT RESPONSE:</u>

This standard is not applicable as AHC is not seeking to expand its psychiatric program.

EXHIBIT 4

Behavioral Health Assessment and Management Policy

Effective Date: 07/03 | Policy No: 101-01-010
Review Date: 6/98, 5/02, 11/05 | Authority: Emergency Department
Revision Date: 6/07, 06/10, 10/10, 2/18 | Page 1 of 5

PURPOSE	To outline behavioral health assessment and management of patients displaying behavioral sequelae including guidelines for protecting these patients from causing harm to themselves and/or others.
PEOPLE AFFECTED	Health Care Providers
SUPPORTIVE DATA	Restraint policy, #101-01-027 Care Companion policy # 25037 Triage policy # 101-04-034 Advanced Treatment Protocols, #101-04-003
DEFINITIONS	**Licensed Independent Practitioner (LIP)** – **Licensed Independent Practitioner (LIP):** Doctors of Osteopathy (DO) and Medical Doctors (MD); Physician Assistants (PA) and Nurse Practitioners (NP) who are by law and by the organization to provide care, treatment and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. **Behavioral Sequelae** – include but are not limited to: aggressive, anxious, abusive, violent, depressed, angry, sad, agitated gestures, or statements of attempted self-harm, suicidal ideation, and/or the presence or absence of a suicide plan. **Behavioral Patient –** patient displaying behavioral sequelae due not only to organic causes, but may also be due to psychiatric problems or drug or alcohol abuse. **Care Companion (CC)/Sitters -** an employee or agency personnel who has had training on job expectations, documentation, aggressive behavior management, maintenance of environmental safety, sensitivity training, and patient rights. **Suicide Precautions –** Constant (1:1) observation requiring a designated staff member to remain at a safe distance from the patient, but not more than a step away, at all times. The patient is deemed by the attending physician, in conjunction with the Registered Nurse, to be a danger to themselves or others. **Close Observation** – An intervention whereby a designated staff member is in constant visual view of the patient for the purpose of monitoring and observing behavior or maintaining patient safety.
CONTENT Determine Risk	**Determining Risk:** 1. During the initial contact with nursing personnel, patients presenting with known mental health behaviors, i.e. externally reported suicide attempts, suicidal or homicidal ideation, self injurious or self-mutilating, poor impulse control or violence, bizarre or unexplained behavior OR self reporting mental health concerns, should be promptly assessed and placed in a safe environment. The patient must be continually observed and /or placed in restrictive environment until he/she is determined to be safe. A risk assessment (see Addendum A) will be completed on these patients if they are able to cooperate, or may be based upon reported information if they are not able to participate. Findings should be documented in the nurse's notes. 2. Patients presenting without externally reported or self reported mental health issues, follow the Triage policy #101-04 034 and then may be determined to require mental health evaluation based upon the nurse's assessment of their appearance and body movements, ability to participate in the triage process, rate, tone, and fluency of their speech, general mood and affect, cognition and thought control, or insight and judgment. A risk assessment will be completed on these patients. 3.

Risk Scale

The SADS scale is used to help identify the patient's numeric risk level and can be quickly completed by asking the patient or the patient's family or friends the questions..

4. Behavioral patients assessed as moderate to high risk will be managed by the most appropriate means for ensuring the patient's and staff's safety.

Implement Precautions

Implementing Behavioral Management Precautions:

4. If the patient arrives involuntarily to the emergency department, he/she will receive a medical screening examination in the timeframe indicated by their severity of illness (triage classification). An emergency psychiatric evaluation must be completed within 6 hours. The patient should not be detained involuntarily for more than 30 hours (Health-General Article, sections 10-622 et seq.).

Psych Consult

5. Whether admitted or detained in the ED, the psychiatric consultation should be completed as soon as possible and preferably within 30 hours of the patient's admission to the hospital. (Exception: unconscious or nonresponsive patients, in which case the psychiatric evaluation should be performed within a reasonable time after the patient becomes able to participate in the assessment process.)

Restraints

6. If the patient's behavior warrants, the charge nurse, primary care nurse, or director may place the patient on behavioral management precautions (see providing safe environment section), which may necessitate restraints, and subsequently obtain a physician's written order. The LIP ordering the restraints should complete a face-to-face evaluation of the patient within 1 hour. If different from the physician ordering the precautions, the attending physician should be notified within 1 hour of the initial order for behavioral restraints. Orders for behavioral restraints should not exceed 4 hours for adults, 2 hours for patients aged 9 –17, and 1 hour for children (<9y) without review and reordering. (See Restraint policy, #101-01-027).
7. The RN caring for the patient is responsible for assuring the safe application, monitoring and removal of restraints. Qualified staff with documented training in the application of restraint may apply and remove restraints under the direction the of the RN.

Removal of Restraints/ Pre-Cautions

8. Behavioral management precautions may be continued and discontinued by physician order only. Physicians will ensure that the order is completed and includes the appropriate times, dates, and signatures.
9. If a psychiatrist records on the chart that the patient is not dangerous to self or others, the patient no longer needs to be on behavioral management precautions and restraints (if in place) should be removed. Case management should be notified so that they may address any outstanding certifications.

NOTE: If less restrictive methods are unsuccessful and restraints (including the use of a CC) have been implemented, the Restraint policy (#101-01-027) should be used as a guide. The nurse and/or designated CC (under the supervision of the nurse) will document their observation on the Restraint/Observation Flow Sheet. The primary RN and/or charge RN should also ensure that the assessment is completed according to policy and that both the physician's order form and flow sheet is completed with the appropriate times, dates, and signatures.

Providing a Safe Environment for the High Risk Patient:

Based upon the psychosocial risk assessment, if the patient is determined to be at high risk, behavioral management precautions will be implemented.

1. Room Preparation: A safe, calm environment will be provided by placing the patient in a

Provide Safe Environment

Behavioral management precautions

private room, in a hospital gown, separated from his/her belongings and potentially harmful objects. The room will be made safe by removing potentially harmful products and/or dismantling the headwall and/or removing items which may include but is not limited to:

- Razors
- Scissors
- Lighters
- Matches
- Plastic bags
- Bras
- Eating utensils
- Any other freestanding equipment not needed for care of patient.

· Sashes, belts
· Telephone
· Glass items
· Soda cans
· Cords
· Bed frames

· Shoestrings
· Tray tables
· Any alcohol based products
· Bathrobe
· IV poles
· Bed linens

2. Observation - A Care Companion may be assigned to observe patients displaying behavioral sequelae of the intent to harm themselves or others, or those who are restrained (see policy#25037).

a. The CC:

- will be able to visually observe the restrained patient at all times.
- **will alert the medical staff if the patient is attempting to leave or harm him/herself.**
- may observe more than 1 patient at a time,* if patient is not on suicide precautions.
- will complete the observation section of the Restraint/Observation Flow Sheet to document observation.

** A monitoring device (such as a security camera) may be used to allow the observation of more than 1 patient. If the CC needs to be outside of visual contact with a patient, the CC will notify a staff member who will visually observe the patient. Room and bed configuration also impacts ability to observe more than 1 patient at a time.*

b. Discontinuing CC Observation may occur with a physician's order if for at least 1 hour both:

- the CC observes the patient to be sleeping, quiet/calm or cooperative and this observation is confirmed by RN
- the patient's behavior has been assessed to be < 5 according to the risk assessment scale.

c. Continuation of Observation Duties: may occur with a physician's order. The Primary RN will reassess the patient's behavior every eight hours and risk status at least every 24 hours on the inpatient units and at every transfer of care in the ED.

3. Suicide precautions: One-to-one observation will be conducted on all patients at high risk (SAD PERSON scale of > 7) for suicidal behavior.

4. Other Safety Measures:

a. Medication Checks: Following the administration of oral medications the nurse will implement mouth checks to ensure that the patient is not hoarding the medication.

b. Smoking: If high risk, a nicotine patch may be offered after consultation/order of the physician.

Completing Documentation for Behavioral Management Precautions:

1. If the patient exemplifies any high-risk behaviors, documentation should include:
   a. Time of initial observation
   b. If he/she is cooperative or uncooperative
   c. Risk assessment score (see Addendum A)
   d. The behavioral sequelae such as but not limited to: aggressive, anxious, abusive, violent, depressed, angry, sadness, agitation, gestures, or statements of attempted self-harm, suicidal or homicidal ideation, and/or the presence or absence of a suicide plan.
   e. Type of behavioral management initiated
   f. Time that behavioral management precautions were implemented (includes private room, restraints, CCs, or chemical treatment)
   g. Notification and explanation of precautions to family and/or significant others

Detaining Suspected/Diagnosed Behavioral Patients Against Their Will:
When a behavioral patient is attempting to leave the hospital against medical advice and is demonstrating the potential for causing immediate personal harm to himself/herself or others, a Code Gray (elopement) should be initiated (dial 4444) to detain the patient in an attempt to protect all involved. Any licensed physician can complete an Emergency petition (available in ED) to hold the patient for psychiatric evaluation.

1. If the patient is communicating the desire to leave, the nurse has the following responsibility:
   h. Immediately implement constant observation.
   i. Initiate notification of the:
      - Charge Nurse
      - Director/Administrative Supervisor
      - House Physician, as appropriate
      - Security
      - Attending Physician /Emergency Department Physician

2. If the attending physician is of the medical opinion that the patient presents a danger to himself or others unless detained, the attending physician and another physician should prepare the requisite certifications to allow the patient to be admitted to an appropriate facility involuntarily/against his/her will.

3. The following should be documented on the patient's chart:
   j. Time and date the patient first expressed a desire to leave the Hospital
   k. Behavior exhibited
   l. Security measures taken
   m. Persons notified
   n. Risk assessment (use Addendum A)

Determining the Plan of Care in the Emergency Department

1. A Needs Assessment Clinician (NAC) may be contacted for further assessment to

ED Plan of Care	recommend the appropriate level of care to address psychiatric problems and/or substance abuse. Family members or significant others will be included in the assessment phase of the care as necessary. 2. The plan of care will be guided by the patient's condition and established by the emergency department physician in consultation with the mental health evaluator. It will include discharge with written outpatient referrals (for example, Crisis Center number, suicide hotline, substance abuse center, mental health providers), transfer to acute care hospitals for medical or psychiatric treatment, freestanding psychiatric hospitals or admission to Shady Grove Adventist Hospital. Admission/transfer may be voluntary or involuntary and appropriate procedures will be followed.
Pediatric Patients In Peds/ PICU	**Care of Pediatric Patients with High Risk Behavior** All of the above should apply as well as the following considerations: 1. Family members are strongly encouraged to stay with the pediatric patient if it is deemed that their presence will not exacerbate the patient's condition. 2. If the patient's parent or guardian is not present, the staff will use diligence in efforts to contact him/her. 3. In the absence of relatives or friends (>18y of age) at the patient's bedside, a CC will continue observation. 4. Patients < 16 will be placed in the Pediatric Emergency Department for medical clearance and then transferred to the EPTU for psychiatric evaluation. 5. In the PICU & Pediatric Unit: Behavioral and risk assessments will be performed at least every 8 hours using age-appropriate language during questioning of the pediatric patient. 6. In the Pediatric ED: Behavioral assessments will be performed hourly until discontinued by physician order using appropriate language during questioning of the pediatric patient. a. Patients 12 and under should not be placed in the EPTU unless their behavior is seriously disruptive or inappropriate to be witnessed by other pediatric patients.
Transfer to Adventist Behavioral Health	**Transferring/Transporting Behavioral Health Patients to Adventist Behavioral Health** Once accepted by Adventist Behavioral Health, to expedite the patient's safe transfer, the patient may be transported by wheelchair or stretcher and will be accompanied by a security officer and either an RN or tech. The method of transportation depends on the patient's behavior, the level of assessed risk, and the prevailing weather conditions.
REFERENCE(S)	Maryland Health-General Article, sections 10-622 et seq. Newberry, L. MS,RN,CEN, and Criddle, Laura M., RN, CNNS, CEN,CRRN,CNRN editor, Sheehy's Manual of Emergency Care, Sixth Edition, Mosby Elsevier, 2005 Patterson, W, Dohn, H , Bird, J, Patterson, G. Psychsomatics, 1983, 24, 343349 Juhnke, G.E. "SAD PERSONS scale review." Measurement & Evaluation in Counseling & Development, 1994, 27, 325328 Juhnke, G.E. ("The adapted SAD PERSONS: As assessment scale designed for use with children" Elementary School Guidance & Counseling, 1996, 252258.
APPROVAL	CNE and MEC signature on file
DISTRIBUTION	All nursing units

EXHIBIT 5

Department of Health and Mental Hygiene
Behavioral Health Administration
Designated Psychiatric Emergency Facilities
Calendar Year 2017

Allegany County

Western Maryland Regional
Medical Center
12500 Willowbrook Rd.
Cumberland, MD 21502
(240) 964-1399

Anne Arundel County

Anne Arundel Medical Center
2001 Medical Parkway
Annapolis, MD 21401
(443) 481-1000

UMD Baltimore Washington Medical Center
301 Hospital Drive
Glen Burnie, MD 21061
(410) 787-4565

Baltimore City

Bon Secours Hospital
2000 W. Baltimore Street
Baltimore, MD 21223
(410) 362-3075

Johns Hopkins Hospital & Health System
600 N. Wolfe Street
Baltimore, MD 21287
(410) 955-5964

Johns Hopkins Bayview Medical Center
4940 Eastern Avenue
Baltimore, MD 21224
(410) 550-0350

MedStar Harbor Hospital
3001 S. Hanover Street
Baltimore, MD 21225
(410) 350-3510

MedStar Union Memorial Hospital
201 E. University Parkway
Baltimore, MD 21218
(410) 554-2000

Sinai Hospital of Baltimore *(Lifebridge Health)*
2401 W. Belvedere Avenue
Baltimore, MD 21215
(410) 601-9000

University of Maryland Medical Center
22 S. Greene Street
Baltimore, MD 21201
(410) 328-8667

UMD Medical Center Midtown Campus
827 Linden Avenue
Baltimore, MD 21201
(410) 225-8100

Department of Health and Mental Hygiene
Behavioral Health Administration
Designated Psychiatric Emergency Facilities
Calendar Year 2017

Baltimore County

MedStar Franklin Square Medical Center
(MedStar Health)
9000 Franklin Square Drive
Baltimore, MD 21237
(443) 777-7046

Northwest Hospital
5401 Old Court Road
Randallstown, MD 21133
(410) 521-5950

UMD St. Joseph Medical Center
7601 Osler Drive
Towson, MD 21204
(410) 337-1226

Calvert County

Calvert Memorial Hospital
100 Hospital Rd.
Prince Frederick, MD 20678
(410) 535-8344

Caroline County

UMD Shore Medical Center at Easton
219 S. Washington Street
Easton, MD 21601
(410) 822-1000

UMD Shore Medical Center at Chestertown
100 Brown Street
Chestertown, MD 21620
(410) 778-3300

UMD Shore Medical Center at Dorchester
300 Byrn Street
Cambridge, MD 21613
(410) 228-5511

Carroll County

Carroll Hospital Center
200 Memorial Avenue
Westminster, MD 21157
(410) 848-3000

Department of Health and Mental Hygiene
Behavioral Health Administration
Designated Psychiatric Emergency Facilities
Calendar Year 2017

Cecil County

Union Hospital
106 Bow Street
Elkton, MD 21921
(410) 398-4000

Charles County

UMD Charles Regional Medical Center 5
Garrett Avenue
La Plata, MD 20646
(301) 609-4000

Dorchester County

UMD Shore Medical Center at Dorchester
(Shore Health System)
300 Byrn Street
Cambridge, MD 21613
(410) 228-5511

Frederick County

Frederick Memorial
Healthcare System
400 W. Seventh Street
Frederick, MD 21701
(240) 566-3300

Garrett County

Garrett Regional Medical Center
251 N. Fourth Street
Oakland, MD 21550
(301) 533-4000

Department of Health and Mental Hygiene
Behavioral Health Administration
Designated Psychiatric Emergency Facilities
Calendar Year 2017

Harford County

UMD Upper Chesapeake Medical Center 500 Upper Chesapeake Drive Bel Air, MD 21014 (443) 643-2000	UMD Harford Memorial Hospital 501 S. Union Avenue Havre de Grace, MD 21078 (443) 843-5500

Howard County

Howard County General Hospital
(Johns Hopkins Health System)
5755 Cedar Lane
Columbia, MD 21044
(410) 740-7777

Kent County

UMD Shore Medical Center at Chestertown 100 Brown Street Chestertown, MD 21620 (410) 778-3300	UMD Shore Medical Center at Dorchester 300 Byrn Street Cambridge, MD 21613 (410) 228-5511

Montgomery County

Holy Cross Health 1500 Forest Glen Road Silver Spring, MD 20910 (301) 754-7500	MedStar Montgomery Medical Center 18101 Prince Philip Drive Olney, MD 20832 (301) 774-8900
Shady Grove Medical Center *(Adventist Health Care)* 9901 Medical Center Drive Rockville, MD 20850 (301) 279-6053	Suburban Hospital Health Care System 8600 Old Georgetown Road Bethesda, MD 20814 (301) 896-3880

Adventist HealthCare
Washington Adventist Hospital
7600 Carroll Ave.
Takoma Park, MD 20912
(301) 891-7600

Department of Health and Mental Hygiene
Behavioral Health Administration
Designated Psychiatric Emergency Facilities
Calendar Year 2017

Prince George's County

Laurel Regional Hospital
7300 Van Dusen Road
Laurel, MD 20707
(301) 725-4300

Prince George's Hospital Center
3001 Hospital Drive
Cheverly, MD 20785
(301) 618-3162

Medstar Southern Maryland Hospital Center
7503 Surratts Road
Clinton, MD 20735
(301) 877-4500

Queen Anne's County

UMD Shore Medical Center at Easton
219 S. Washington Street
Easton, MD 21601
(410) 822-1000

UMD Shore Medical Center at Chestertown
100 Brown Street
Chestertown, MD 21620
(410) 778-3300

UMD Shore Medical Center at Dorchester
300 Byrn Street
Cambridge, MD 21613
(410) 228-5511

St. Mary's County

Medstar St. Mary's Hospital
25500 Point Lookout Road
Leonardtown, MD 20650
(301) 475-6110

Somerset County

Peninsula Regional Health System
100 E. Carroll Street
Salisbury, MD 21801
(410) 543-7101

Department of Health and Mental Hygiene
Behavioral Health Administration
Designated Psychiatric Emergency Facilities
Calendar Year 2017

Talbot County

UMD Shore Medical Center at Easton
219 S. Washington Street
Easton, MD 21601
(410) 822-1000

Washington County

Meritus Medical Center
11116 Medical Campus Road
Hagerstown, MD 21742
(301) 790-8300

Wicomico County

Peninsula Regional Health System
100 E. Carroll Street
Salisbury, MD 21801
(410) 543-7101

Worcester County

Peninsula Regional Health System
100 E. Carroll Street
Salisbury, MD 21801
(410) 543-7101

*10 Beds total for all three counties

EXHIBIT 6

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance

(Formerly "Charity Care")

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Effective Date	01/08	Policy No:	AHC 3.19
Cross Referenced:	Previously: Financial Assistance Policy (see AHC 3.19.1 for Decision Rules / Application)	Origin:	PFS / FC
Reviewed:	02/09, 9/19/13, 10/10/17	Authority:	EC
Revised:	05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13, 2/01/16, 11/09/17	Page: 1 of 14	

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FINANCIAL ASSISTANCE POLICY SUMMARY

SCOPE:

This policy applies to the following Adventist HealthCare facilities: Shady Grove Adventist Hospital, Germantown Emergency Center, Washington Adventist Hospital, Adventist Behavioral Health, and Adventist Rehabilitation Hospital of Maryland, collectively referred to as AHC.

PURPOSE:

In keeping with AHC's mission to demonstrate God's care by improving the health of people and communities Adventist HealthCare provides financial assistance to low to mid income patients in need of our services. AHC's Financial Assistance Plan provides a systematic and equitable way to ensure that patients who are uninsured, underinsured, have experienced a catastrophic event, and/or and lack adequate resources to pay for services can access the medical care they need.

Adventist HealthCare provides emergency and other non-elective medically necessary care to individual patients without discrimination regardless of their ability to pay, ability to qualify for financial assistance, or the availability of third-party coverage. In the event that third-party coverage is not available, a determination of potential eligibility for Financial Assistance will be initiated prior to, or at the time of admission. This policy identifies those circumstances when AHC may provide care without charge or at a discount based on the financial need of the individual.

Printed public notification regarding the program will be made annually in Montgomery County, Maryland and Prince George's County, Maryland newspapers and will be posted in the Emergency Departments, the Business Offices and Registration areas of the above named facilities.

This policy has been adopted by the governing body of AHC in accordance with the regulations and requirements of the State of Maryland and with the regulations under Section 501(r) of the Internal Revenue Code.

This financial assistance policy provides guidelines for:

- Financial assistance to self-pay individual patients receiving emergency and other non-elective medically necessary services based on medical necessity and financial need.
- prompt-pay discounts (%) that may be charged to self-pay patients who receive medically necessary services that are not considered emergent or non-elective.
- special consideration, where appropriate, for those individuals who might gain special consideration due to catastrophic care.

BENEFITS:

Enhance community service by providing quality medical services regardless of a patient's (or their guarantors') ability to pay. Decrease the unnecessary or inappropriate placement of accounts with collection agencies when a charity care designation is more appropriate.

DEFINITIONS:

- **Medically Necessary:** health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine
- **Emergency Medical Services**: treatment of individuals in crisis health situations that may be life threatening with or without treatment
- **Non-elective services:** a medical condition that without immediate attention:
    - Places the health of the individual in serious jeopardy
    - Causes serious impairment to bodily functions or serious dysfunction to a bodily organ.
    - And may include, but are not limited to:
        - Emergency Department Outpatients
        - Emergency Department Admissions
        - IP/OP follow-up related to previous Emergency visit
- **Catastrophic Care**: a severe illness requiring prolonged hospitalization or recovery. Examples would include coma, cancer, leukemia, heart attack or stroke. These illnesses usually involve high costs for hospitals, doctors and medicines and may incapacitate the person from working, creating a financial hardship
- **Prompt Pay Discount**: The state of Maryland allows a 1% prompt-pay discount for those patients who pay for medical services at the time the service is rendered.
- **FPL** (Federal Poverty Level): is the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the

United States, this level is determined by the Department of Health and Human Services.

- **Uninsured Patient**: Person not enrolled in a healthcare service coverage insurance plan. May or may not be eligible for charitable care.
- **Self-pay Patient**: an Uninsured Patient who does not qualify for AHC Financial Assistance due to income falling above the covered FPL income guidelines

POLICY

1. General Eligibility

1.1. All patients, regardless of race, creed, gender, age, sexual orientation, national origin or financial status, may apply for Financial Assistance.

1.2. It is part of Adventist HealthCare's mission to provide necessary medical care to those who are unable to pay for that care. The Financial Assistance program provides for care to be either free or rendered at a reduced charge to:

1.2.1. those most in need based upon the current Federal Poverty Level (FPL) assessment, (i.e., individuals who have income that is less than or equal to 200% of the federal poverty level (See Attachment A for current FPL).

1.2.2. those in some need based upon the current FPL, (i.e., individuals who have income that is between 201% and 600% of the current FPL guidelines

1.2.3. patients experiencing a financial hardship (medical debt incurred over the course of the previous 12 months that constitutes more than 25% of the family's income), and/or

1.2.4. absence of other available financial resources to pay for urgent or emergent medical care

1.3. This policy requires that a patient or their guarantor to cooperate with, and avail themselves of all available programs (including those offered by AHC, Medicaid, workers compensation, and other state and local programs) which might provide coverage for services, prior to final approval of Adventist HealthCare Financial Assistance.

1.4. **Eligibility for Emergency Medical Care:** Patients may be eligible for financial assistance for Emergency Medical Care under this Policy if:

1.4.1. They are uninsured, have exhausted, or will exhaust all available insurance benefits; and

1.4.2. Their annual family income does not exceed 200% of the current Federal Poverty Guidelines to qualify for full financial assistance or 600% of the current Federal Poverty Guidelines for partial financial assistance; and

1.4.3. They apply for financial assistance within the Financial Assistance Application Period (i.e. within the period ending on the 240th day after the first post-discharge billing statement is provided to a patient).

1.5. **Eligibility for non-emergency Medically Necessary Care:** Patients may be eligible for financial assistance for non-emergency Medically Necessary Care under this Policy if:

1.5.1. They are uninsured, have exhausted, or will exhaust all available insurance benefits; and

1.5.2. Their annual family income does not exceed 200% of the current Federal Poverty Guidelines to qualify for full financial assistance or 600% of the current Federal Poverty Guidelines for partial financial assistance; and

1.5.3. They apply for financial assistance within the Financial Assistance Application Period (i.e. within the period ending on the 240th day after the first post-discharge billing statement is provided to a patient) and

1.5.4. The treatment plan was developed and provided by an AHC care team

1.6. **Considerations:**

1.6.1. Insured Patients who incur high out of pocket expenses (deductibles, co-insurance, etc.) may be eligible for financial assistant applied to the patient payment liability portion of their medically necessary services

1.6.2. Pre-approved financial assistance for medical services scheduled past the 2nd midnight post an ER admission are reviewed by the

appropriate staff based on medical necessity criteria established in this policy, and may or may not be approved for financial assistance.

1.7. **Exclusions:** Patients are INELIGIBLE for financial assistance for Emergency Medical Care or other non-emergency Medically Necessary Care under this policy if:

1.7.1. Purposely providing false or misleading information by the patient or responsible party; or

1.7.2. Providing information gained through fraudulent methods in order to qualify for financial assistance (EXAMPLE: using misappropriated identification and/or financial information, etc.)

1.7.3. The patient or responsible party refuses to cooperate with any of the terms of this Policy; or

1.7.4. The patient or responsible party refuses to apply for government insurance programs after it is determined that the patient or responsible party is likely to be eligible for those programs; or

1.7.5. The patient or responsible party refuses to adhere to their primary insurance requirements where applicable.

1.8. **Special Considerations (Presumptive Eligibility)**: Adventist Healthcare make available financial assistance to patients based upon their "assumed eligibility" if they meet on of the following criteria:

1.8.1. Patients, *unless otherwise eligible for Medicaid or CHI*P, who are beneficiaries of the means-tested social services programs listed below are eligible for free care, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below:

1.8.1.1. Households with children in the free or reduced lunch program;

1.8.1.2. Supplemental Nutritional Assistance Program (SNAP);

1.8.1.3. Low-income-household energy assistance program;

1.8.1.4. Women, Infants and Children (WIC)

1.8.2. Patients who are beneficiaries of the Montgomery County programs listed below are eligible for financial assistance after meeting the copay requirements mandated by the program, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below:

1.8.2.1. Montgomery Cares;

1.8.2.2. Project Access;

1.8.2.3. Care for Kids

1.8.3. Additionally, patients who fit one or more of the following criteria may be eligible for financial assistance for emergency or non-emergency Medically Necessary Care under this policy with or without a completed application, and regardless of financial ability. IF the patient is:

1.8.3.1. categorized as homeless or indigent

1.8.3.2. unable to provide the necessary financial assistance eligibility information due to mental status or capacity

1.8.3.3. unresponsive during care and is discharged due to expiration

1.8.3.4. individual is eligible by the State to receive assistance under the Violent Crimes Victims Compensation Act or the Sexual Assault Victims Compensation Act;

1.8.3.5. a victim of a crime or abuse (other requirements will apply)

1.8.3.6. Elderly and a victim of abuse

1.8.3.7. an unaccompanied minor

1.8.3.8. is currently eligible for Medicaid, but was not at the date of service

For any individual presumed to be eligible for financial assistance in accordance with this policy, all actions described in the "Eligibility" Section

and throughout this policy would apply as if the individual had submitted a completed Financial Assistance Application form.

1.9. **Amount Generally Billed:** An individual who is eligible for assistance under this policy for emergency or other medically necessary care will never be charged more than the amounts generally billed (AGB) to an individual who is not eligible for assistance. The charges to which a discount will apply are set by the State of Maryland's rate regulation agency (HSCRC) and are the same for all payers (i.e. commercial insurers, Medicare, Medicaid or self-pay) with the exception of Adventist Rehabilitation Hospital of Maryland which charges for patients eligible for assistance under this policy will be set at the most recent Maryland Medicaid interim rate at the time of service as set by the Department of Health and Mental Hygiene.

2. **Policy Transparency:** Financial Assistance Policies are transparent and available to the individuals served at any point in the care continuum in the primary languages that are appropriate for the Adventist HealthCare service area.

2.1. As a standard process, Adventist HealthCare will provide Plain Language Summaries of the Financial Assistance Policy

2.1.1. During ED registration

2.1.2. During financial counseling sessions

2.1.3. Upon request

2.2. Adventist HealthCare facilities will prominently and conspicuously post complete and current versions of the Plain Language Summary of the Financial Assistance policy

2.2.1. At all registrations sites

2.2.2. In specialty area waiting rooms

2.2.3. In specialty area patient rooms

2.3. Adventist HealthCare facilities will prominently and conspicuously post complete and current versions of the following on their respective websites in English and in the primary languages that are appropriate for the Adventist HealthCare service area:

2.3.1. Financial Assistance Policy (FAP)

2.3.2. Financial Assistance Application Form (FAA Form)

2.3.3. Plain Language Summary of the Financial Assistance Policy (PLS)

3. Policy Application and Determination Period

3.1. The Financial Assistance Policy applies to charges for medically necessary patient services that are rendered by one of the referenced Adventist HealthCare facilities. A patient (or guarantor) may apply for Financial Assistance at any time within **240 days after the date it is determined that the patient owes a balance.**

3.2. Probable eligibility will be communicated to the patient within 2 business days of the submission of an application.

3.3. Each application for Financial Assistance will be reviewed, and a determination made based upon an assessment of the patient's (or guarantor's) ability to pay. This could include, without limitations the needs of the patient and/or guarantor, available income and/or other financial resources. Final Financial Assistance decisions and awards will be communicated to the patient within 10 business days of the submission of a completed application for Financial Assistance.

3.4. Pre-approved financial assistance for scheduled medical services is approved by the appropriate staff based on criteria established in this policy

3.5. **Policy Eligibility Period:** If a patient is approved for financial assistance under this Policy, their financial assistance under this policy **shall not exceed past 12 months from the date of the eligibility award letter**. Patients requiring financial assistance past this time must reapply and complete the application process in total.

4. **POLICY EXCLUSIONS:** Services not covered by the AHC Financial Assistance Policy include, but are not limited to:

4.1. Services deemed not medically necessary by AHC clinical team

4.2. Services not charged and billed by an Adventist HealthCare facility listed within this policy are not covered by this policy. Examples include, but at are

not limited to; charges from physicians, anesthesiologists, emergency department physicians, radiologists, cardiologists, pathologists, and consulting physicians requested by the admitting and attending physicians.

4.3. Cosmetic, other elective procedures, convenience and/or other Adventist HealthCare facility services which are not medically necessary, are excluded from consideration as a free or discounted service.

4.4. Patients or their guarantors who are eligible for County, State, Federal or other assistance programs will not be eligible for Financial Assistance for services covered under those programs.

4.5. Services Rendered by Physicians who provide services at one of the AHC locations are NOT covered under this policy.

4.5.1. Physician charges are billed **separately** from hospital charges.

Roles and Responsibilities

4.6. **Adventist HealthCare responsibilities**

4.6.1. AHC has a financial assistance policy to evaluate and determine an individual's eligibility for financial assistance.

4.6.2. AHC has a means of communicating the availability of financial assistance to all individuals in a manner that promotes full participation by the individual.

4.6.3. AHC workforce members in Patient Financial Services and Registration areas understand the AHC financial assistance policy and are able to direct questions regarding the policy to the proper hospital representatives.

4.6.4. AHC requires all contracts with third party agents who collect bills on behalf of AHC to include provisions that these agents will follow AHC financial assistance policies.

4.6.5. The AHC Revenue Cycle Function provides organizational oversight for the provision of financial assistance and the policies/processes that govern the financial assistance process.

4.6.6. After receiving the individual's request for financial assistance, AHC notifies the individual of the eligibility determination within a reasonable period of time.

4.6.7. AHC provides options for payment arrangements.

4.6.8. AHC upholds and honors individuals' right to appeal decisions and seek reconsideration.

4.6.9. AHC maintains (and requires billing contractors to maintain) documentation that supports the offer, application for, and provision of financial assistance for a minimum period of seven years.

4.6.10. AHC will periodically review and incorporate federal poverty guidelines for updates published by the United States Department of Health and Human Services.

4.7. **Individual Patient's Responsibilities**

4.7.1. To be considered for a discount under the financial assistance policy, the individual must cooperate with AHC to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for healthcare, such as Medicare, Medicaid, third-party liability, etc.

4.7.2. To be considered for a discount under the financial assistance policy, the individual must provide AHC with financial and other information needed to determine eligibility (this includes completing the required application forms and cooperating fully with the information gathering and assessment process).

4.7.3. An individual who qualifies for a partial discount must cooperate with the hospital to establish a reasonable payment plan.

4.7.4. An individual who qualifies for partial discounts must make good faith efforts to honor the payment plans for their discounted hospital bills. The individual is responsible to promptly notify AHC of any change in financial situation so that the impact of this change may be evaluated against financial assistance policies governing the provision of financial assistance.

5. Identification Of Potentially Eligible Individuals

5.1. Identification through socialization and outreach

5.1.1. Registration and pre-registration processes promote identification of individuals in need of financial assistance.

5.1.2. Financial counselors will make best efforts to contact all self-pay inpatients during the course of their stay or within 4 days of discharge.

5.1.3. The AHC hospital facility's PLS will be distributed along with the FAA Form to every individual before discharge from the hospital facility.

5.1.4. Information on how to obtain a copy of the PLS will be included with billing statements that are sent to the individuals

5.1.5. An individual will be informed about the AHC hospital facility's FAP in oral communications regarding the amount due for his or her care.

5.1.6. The individual will be provided with at least one written notice (notice of actions that may be taken) that informs the individual that the hospital may take action to report adverse information about the individual to consumer credit reporting agencies/credit bureaus if the individual does not submit a FAA Form or pay the amount due by a specified deadline. This deadline cannot be earlier than 120 days after the first billing statement is sent to the individual. The notice must be provided to the individual at least 30 days before the deadline specified in the notice.

5.2. **Requests for Financial Assistance**: Requests for financial assistance may be received from multiple sources (including the patient, a family member, a community organization, a church, a collection agency, caregiver, Administration, etc.).

5.2.1. Requests received from third parties will be directed to a financial counselor.

5.2.2. The financial counselor will work with the third party to provide resources available to assist the individual in the application process.

5.2.3. If available, an estimated charges letter will be provided to individuals who request it.

5.2.4. **AUTOMATED CHARITY PROCESS** for Accounts sent to outsourced agencies: Adventist HealthCare recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional financial assistance application process. If the required information is not provided by the patient, Adventist HealthCare may employ an automated, predictive scoring tool to qualify patients for financial assistance. The Payment Predictability Score (PPS) predicts the likelihood of a patient to qualify for Financial Assistance based on publicly available data sources. PPS provides an estimate of the patient's likely socio-economic standing, as well as, the patient's household income size. Approval used with PPS applies only to accounts being reviewed by Patient Financial Services. All other dates of services for the same patient or guarantor will follow the standard Adventist HealthCare collection process.

6. **Executive Approval Board:** Financial assistance award considerations that fall outside the scope of this policy must be reviewed and approved by AHC CFO of facility rendering services, AHC Vice President of Revenue Management, and AHC VP of Patient Safety/Quality.

7. **POLICY REVIEW AND MAINTAINENCE:**

7.1. This policy will be reviewed on a bi-annual basis

7.2. The review team includes Adventist Health entity CFOs and VP of Revenue Management for Adventist Health

7.3. Updates, edits, and/or additions to this policy must be reviewed and agreed upon, by the review team and then by the governing committee designated by the Board prior to adoption by AHC.

7.4. Updated policies will be communicated and posted as outlined in section 2- Policy Transparency of this document.

CONTACT INFORMATION AND ADDITIONAL RESOURCES

Adventist HealthCare Patient Financial Services Department
820 W Diamond Ave, Suite 500
Gaithersburg, MD 20878
(301) 315-3660

The following information can be found at Adventist HealthCare's Public Notice of Financial Assistance & Charity Care:

Document Title
AHC Financial Assistance Plain Language Summary - English
AHC Financial Assistance Plain Language Summary - Spanish
AHC Federal Poverty Guidelines
AHC Financial Assistant Application - English
AHC Financial Assistant Application - Spanish
List of Providers not covered under AHC's Financial Assistance Policy

Document Information

Document Title

AHC 3.19 Financial Assistance

Document Description

N/A

Approval Information

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EXHIBIT 7

ADVENTIST HEALTH CARE, INC.

Manual de política corporativa

Asistencia financiera

(Anteriormente "Atención de beneficencia")

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Referencia: Anteriormente: Política de asistencia financiera		Origen:	PFS
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RESUMEN DE LA POLÍTICA DE ASISTENCIA FINANCIERA

ALCANCE:

Esta política rige para los siguientes centros de Adventist HealthCare: Shady Grove Adventist Hospital, Germantown Emergency Center, Washington Adventist Hospital, Adventist Behavioral Health, y Adventist Rehabilitation Hospital of Maryland, a los que conjuntamente se los denomina AHC.

PROPÓSITO:

En concordancia con la misión de AHC de demostrar los cuidados de Dios mejorando la salud de las personas y las comunidades, Adventist HealthCare brinda asistencia financiera a los pacientes de bajos y medianos ingresos que necesitan nuestros servicios. El Plan de asistencia financiera de AHC constituye una manera sistemática y equitativa de garantizar que los pacientes sin seguro, que tengan un seguro insuficiente, que hayan sufrido un evento catastrófico o no cuenten con los recursos adecuados para pagar los servicios puedan acceder a la atención médica que necesitan.

Adventist HealthCare brinda atención médica de emergencia y cuidados no electivos médicamente necesarios a pacientes individuales sin discriminación, independientemente de su capacidad de pagar, su capacidad de calificar para recibir asistencia financiera o la disponibilidad de cobertura de terceros. En el caso de que la cobertura de terceros no estuviera disponible, se iniciará una determinación de posible elegibilidad para recibir Asistencia financiera antes o al momento de la internación. Esta política identifica las circunstancias para las cuales AHC podría proporcionar atención sin cargo o con descuento en base a la necesidad financiera de la persona.

Se realizará una notificación pública impresa sobre el programa anualmente en periódicos del Condado de Montgomery, Maryland y el Condado de Prince George, Maryland y se publicará en los Departamentos de Emergencias, las Oficinas Comerciales y las áreas de Registro de los centros mencionados anteriormente.

Esta política ha sido adoptada por el órgano rector de AHC de conformidad con las regulaciones y requisitos del Estado de Maryland y con las regulaciones de la Sección 501(r) del Código de Rentas Internas.

Esta política de asistencia financiera proporciona pautas para:

- Asistencia financiera a pacientes individuales que pagan por su cuenta que reciben servicios de emergencia u otros servicios no electivos médicamente necesarios en base a necesidad médica y financiera.
- Descuentos por pago puntual (%) que podrían ser cobrados a pacientes que pagan por su cuenta que reciben servicios médicamente necesarios que no se consideran de emergencia o no electivos.
- Consideración especial, cuando sea adecuado, para aquellas personas que reciban una consideración especial debido a cuidados intensivos.

BENEFICIOS:

Mejorar el servicio a la comunidad ofreciendo servicios médicos de calidad independientemente de la capacidad de pago del paciente (o del garante). Reducir la colocación innecesaria o inadecuada de cuentas con agencias de recaudación cuando una designación de atención de caridad es más adecuada.

DEFINICIONES:

- **Médicamente necesario:** servicios o suministros de atención médica necesarios para prevenir, diagnosticar o tratar una enfermedad, lesión, afección, o sus síntomas y que cumplen con las normas aceptadas de medicina.
- **Servicios médicos de emergencia:** tratamiento de personas en situaciones médicas de crisis que podrían ser mortales con o sin tratamiento.
- **Servicios no electivos:** una afección médica que sin atención inmediata:
    - Pone la salud de la persona en grave peligro.
    - Causa un trastorno grave de la función corporal o un deterioro grave a un órgano del cuerpo.
    - Y pueden incluir, entre otros:
        - Pacientes externos del Departamento de Emergencias
        - Internaciones del Departamento de Emergencias
        - Tratamiento de seguimiento para pacientes internos o externos relacionado con una visita previa al Departamento de Emergencias
- **Cuidados intensivos**: una enfermedad grave que requiere una hospitalización o recuperación prolongadas. Algunos ejemplos incluyen el coma, cáncer, leucemia, ataque cardíaco o accidente cerebrovascular. Por lo general, estas enfermedades implican un gran costo en hospitales, médicos y medicamentos y podrían hacer que una persona sea incapaz de trabajar, y por lo tanto, causarle problemas económicos.

- **Descuento por pago puntual**: El estado de Maryland permite un descuento por pago puntual del 1 % para los pacientes que pagan los servicios médicos al momento de recibirlos.
- **FPL** (Nivel federal de pobreza): es el monto mínimo de ingresos brutos que una familia necesita para comida, ropa, transporte, vivienda y otras necesidades. En los Estados Unidos, el Departamento de Salud y Servicios Humanos determina este nivel.
- **Paciente sin seguro**: Una persona que no está inscripta en un plan de seguro de cobertura médica. Puede o no ser elegible para recibir atención de beneficencia.
- **Paciente que paga por su cuenta**: Un paciente sin seguro que no califica para recibir Asistencia financiera de AHC debido a que sus ingresos superan lo establecido por las pautas de ingresos del Nivel federal de pobreza (FPL).

POLÍTICA

1. Elegibilidad general

1.1. Todos los pacientes, independientemente de su raza, credo, sexo, edad, orientación sexual, nacionalidad o situación financiera, pueden solicitar Asistencia financiera.

1.2. Brindar atención médica necesaria a aquellos que no pueden pagarla es parte de la misión de Adventist HealthCare. El programa de Asistencia financiera establece que la atención será gratuita o a un precio reducido para:

1.2.1. Quienes más lo necesitan de conformidad con la evaluación actual del Nivel federal de pobreza (FPL), es decir, aquellas personas que tienen ingresos inferiores o iguales al 200 % del Nivel federal de pobreza (Consultar Anexo A para ver el FPL actual).

1.2.2. Quienes lo necesitan de conformidad con el Nivel federal de pobreza actual (es decir, personas que tienen ingresos entre 201 % y 600 % de las pautas actuales del FPL).

1.2.3. Pacientes que sufren dificultades económicas (deuda médica incurrida durante los últimos 12 meses que constituye más del 25 % de los ingresos familiares), y/o

1.2.4. La ausencia de otros recursos financieros para pagar por atención médica urgente o de emergencia

1.3. Esta política exige que un paciente o su garante coopere y aproveche todos los programas disponibles (incluso aquellos ofrecidos por AHC, Medicaid, seguro de los trabajadores y otros programas estatales y locales) que podrían ofrecer cobertura para los servicios, antes de la aprobación final de Asistencia financiera de Adventist HealthCare.

1.4. **Elegibilidad para Atención médica de emergencia:** Los pacientes podrían ser elegibles para recibir asistencia financiera para Atención médica de emergencia de conformidad con esta Política si:

1.4.1. No tienen seguro, han agotado, o agotarán todos los beneficios de seguro disponibles; y

1.4.2. Sus ingresos familiares anuales no superan el 200 % de las Pautas federales de pobreza para calificar para asistencia financiera completa o el 600 % de las Pautas federales de pobreza para calificar para asistencia financiera parcial; y

1.4.3. Solicitan asistencia financiera dentro del Periodo de solicitud de asistencia financiera (es decir, en el periodo que termina el día 240 luego de que el paciente reciba el primer estado de cuenta posterior al alta).

1.5. **Elegibilidad para Atención médicamente necesaria que no sea de emergencia:** Los pacientes podrían ser elegibles para recibir asistencia financiera para Atención médicamente necesaria que no sea de emergencia de conformidad con esta Política si:

1.5.1. No tienen seguro, han agotado, o agotarán todos los beneficios de seguro disponibles; y

1.5.2. Sus ingresos familiares anuales no superan el 200 % de las Pautas federales de pobreza para calificar para asistencia financiera completa o el 600 % de las Pautas federales de pobreza para calificar para asistencia financiera parcial; y

1.5.3. Solicitan asistencia financiera dentro del Periodo de solicitud de asistencia financiera (es decir, en el periodo que termina el día 240 luego de que el paciente reciba el primer estado de cuenta posterior al alta); y

1.5.4. El plan de tratamiento fue desarrollado y brindado por un equipo de atención de AHC.

1.6. **Consideraciones:**

1.6.1. Los pacientes asegurados que incurran gastos de bolsillo altos (deducibles, coseguro, etc.) podrían ser elegibles para recibir asistencia financiera aplicada a la parte de responsabilidad a pagar por el paciente de sus servicios médicamente necesarios.

1.6.2. El personal apropiado analizará la asistencia financiera preaprobada para servicios médicos programados pasada la 2da noche luego de una admisión al Departamento de Emergencias en función de los criterios de necesidad médica establecidos en esta política, y la asistencia financiera podría ser aprobada o no.

1.7. **Exclusiones:** De conformidad con esta política, los pacientes son INELEGIBLES para recibir asistencia financiera para Atención médica de emergencia u otra Atención médicamente necesaria que no sea de emergencia si:

1.7.1. El paciente o responsable proporciona información falsa o engañosa intencionalmente; o

1.7.2. Se proporciona información obtenida a través de métodos fraudulentos para calificar para la asistencia financiera (EJEMPLO: utilizar una identificación o información financiera adquiridas indebidamente, etc.)

1.7.3. El paciente o responsable se niega a cooperar con cualquiera de los términos de esta Política; o

1.7.4. El paciente o responsable se niega a enviar su solicitud para programas de seguros del gobierno luego de haberse determinado que es probable que el paciente o responsable sea elegible para dichos programas; o

1.7.5. El paciente o responsable se niega a cumplir los requisitos de su seguro primario cuando corresponda.

1.8. **Consideraciones especiales (Presunta elegibilidad)**: Adventist HealthCare pone asistencia financiera a disposición de los pacientes en función de su «supuesta elegibilidad» si cumplen con los siguientes criterios:

1.8.1. Los pacientes, *a menos que de otro modo sean elegibles para Medicaid o CHIP*, que son beneficiarios de los programas de servicios sociales en los que se verifican los ingresos son elegibles para recibir atención gratuita, siempre y cuando el paciente presente un comprobante de inscripción dentro de 30 días, a menos que se solicite una extensión de 30 días. La Asistencia continuará en vigencia mientras el paciente siga siendo un beneficiario activo de uno de los siguientes programas:

1.8.1.1. Familias con hijos en el Programa de almuerzo gratuito o a precio reducido;

1.8.1.2. Programa de Asistencia Nutricional Suplementaria (SNAP);

1.8.1.3. Programa de asistencia energética para hogares de bajos ingresos;

1.8.1.4. Mujeres, infantes y niños (WIC)

1.8.2. Los pacientes que son beneficiarios de los siguientes programas del condado de Montgomery son elegibles para recibir asistencia financiera luego de cumplir con los requisitos de copagos exigidos por el programa, siempre y cuando el paciente presente un comprobante de inscripción dentro de 30 días, a menos que se solicite una extensión de 30 días. La Asistencia continuará en vigencia mientras el paciente siga siendo un beneficiario activo de uno de los siguientes programas:

1.8.2.1. Montgomery Cares;

1.8.2.2. Project Access;

1.8.2.3. Care for Kids

1.8.3. Además, es posible que los pacientes que cumplan con uno o más de los siguientes criterios sean elegibles para recibir asistencia financiera para Atención de emergencia o atención médicamente necesaria que no sea de emergencia de conformidad con esta política con o sin una

solicitud completa, e independientemente de la capacidad financiera. SI el paciente:

1.8.3.1. está categorizado como una persona sin hogar o indigente

1.8.3.2. no puede proporcionar la información necesaria de elegibilidad para asistencia financiera debido a su estado o capacidad mental

1.8.3.3. no responde durante la atención y es dado de alta debido al vencimiento

1.8.3.4. según el Estado, es elegible para recibir asistencia bajo la Ley de indemnización para víctimas de crímenes violentos o la Ley de indemnización para víctimas de agresión sexual;

1.8.3.5. es una víctima de un crimen o abuso (regirán otros requisitos)

1.8.3.6. es anciano y víctima de un abuso

1.8.3.7. es un menor no acompañado

1.8.3.8. es actualmente elegible para Medicaid, pero no lo era al momento del servicio

Para cualquier persona que se presuma que es elegible para recibir asistencia financiera de conformidad con esta política, regirán todas las acciones descritas en la sección «Elegibilidad» y en otras partes de esta política de la misma manera que si la persona hubiese presentado un formulario completo de solicitud de Asistencia financiera.

1.9. **Monto generalmente facturado:** Nunca se le cobrará a una persona que es elegible para recibir asistencia bajo esta política para atención de emergencia u otro tipo de atención médicamente necesaria más que los montos que se cobran generalmente (AGB) a una persona que no sea elegible para recibir asistencia. La agencia de reglamentación de tarifas del estado de Maryland (HSCRC) establece los cargos a los que se aplicará un descuento y son iguales para todos los pagadores (es decir, compañía de seguros comerciales, Medicare, Medicaid o pacientes que pagan por su cuenta) con la excepción de Adventist Rehabilitation Hospital of Maryland, cuyos cargos a pacientes elegibles para recibir asistencia bajo esta política se establecerán a la tasa provisional actual

de Medicaid de Maryland al momento del servicio, según lo determinado por el Departamento de Salud y Salud Mental.

2. **Transparencia de la política:** Las Políticas de Asistencia financiera son transparentes y están disponibles para las personas atendidas en cualquier momento durante la atención en los idiomas primarios adecuados para el área de servicio de Adventist HealthCare.

   2.1. Como parte de un proceso estándar, Adventist HealthCare proporcionará Resúmenes en lenguaje sencillo de la Política de Asistencia financiera.

      2.1.1. Durante el registro en el Departamento de Emergencias

      2.1.2. Durante sesiones de asesoramiento financiero

      2.1.3. A petición

   2.2. Los centros de Adventist HealthCare publicarán de manera visible versiones completas y actuales del Resumen en lenguaje sencillo de la política de Asistencia financiera.

      2.2.1. En todos las oficinas de registro

      2.2.2. En las salas de espera de áreas de especialidad

      2.2.3. En las habitaciones de pacientes de áreas de especialidad

   2.3. Los centros de Adventist HealthCare publicarán de manera visible versiones completas y actuales de lo siguiente en sus respectivos sitios web en inglés y en los idiomas primarios que son adecuados para el área de servicio de Adventist HealthCare:

      2.3.1. Política de Asistencia financiera:

      2.3.2. Formulario de solicitud de Asistencia financiera

      2.3.3. Resumen en lenguaje sencillo de la Política de asistencia financiera:

3. Periodo de solicitud y determinación de la Política

   3.1. La Política de Asistencia financiera rige para cargos por servicios médicamente necesarios para pacientes que son prestados por uno de los centros de Adventist HealthCare mencionados. Un paciente (o garante) puede enviar una

solicitud para recibir Asistencia financiera en cualquier momento dentro de **240 días desde que se determina que el paciente tiene un saldo deudor.**

3.2. Se comunicará la elegibilidad probable al paciente dentro de 2 días laborales desde la presentación de la solicitud.

3.3. Se analizarán todas las solicitudes de Asistencia financiera y se llegará a una determinación en función de la evaluación de la capacidad de pagar del paciente (o garante). Esto podría incluir, sin limitaciones, las necesidades del paciente o garante, los ingresos disponibles u otros recursos financieros. Las decisiones y adjudicaciones finales sobre Asistencia financiera se comunicarán al paciente dentro de 10 días laborales de la presentación de una solicitud completa para Asistencia financiera.

3.4. La asistencia financiera preaprobada para servicios médicos programados es aprobada por el personal adecuado en base a los criterios establecidos en esta política

3.5. **Periodo de elegibilidad de la política:** Si se aprueba la asistencia financiera de un paciente bajo esta Política, su asistencia financiera de conformidad con esta política no deberá exceder los 12 meses **desde la fecha de la carta de adjudicación**. Los pacientes que requieran asistencia financiera pasado este tiempo deberán volver a enviar la solicitud y completar el proceso de solicitud nuevamente.

4. **EXCLUSIONES DE LA POLÍTICA:** Los siguientes son algunos de los servicios no cubiertos por la Política de Asistencia financiera de AHC:

4.1. Servicios que el equipo clínico de AHC determine que no son médicamente necesarios

4.2. Los servicios no cobrados y facturados por un centro de Adventist HealthCare enumerado en esta política no están cubiertos bajo esta política. Los siguientes son algunos de los ejemplos: cargos de médicos, anestesiólogos, médicos del departamento de emergencias, radiólogos, cardiólogos, patólogos y médicos de consulta solicitados por el médico que realiza el ingreso del paciente y el médico adjunto.

4.3. Los servicios cosméticos, otros procedimientos electivos, de conveniencia u otros servicios de centros de Adventist HealthCare que no sean médicamente

necesarios están excluidos de ser considerados para un servicio gratuito o con descuento.

4.4. Los pacientes o sus garantes que son elegibles para programas de asistencia del condado, estatales, federales o de otras fuentes no serán elegibles para recibir Asistencia financiera por servicios cubiertos por esos programas.

4.5. Los servicios prestados por médicos que ofrecen servicios en uno de los centros de AHC NO están cubiertos bajo esta política.

4.5.1. Los cargos de los médicos se facturan de manera **separada** a los cargos del hospital.

Funciones y responsabilidades

4.6. **Responsabilidades de Adventist HealthCare**

4.6.1. AHC tiene una política de asistencia financiera para evaluar y determinar la elegibilidad de una persona para recibir asistencia financiera.

4.6.2. AHC tiene una manera de comunicar la disponibilidad de asistencia financiera a todas las personas para fomentar una participación absoluta de la persona.

4.6.3. Los miembros del personal de Servicios Financieros para Pacientes y las áreas de Registro conocen la política de asistencia financiera de AHC y pueden dirigir preguntas sobre la política a los representantes adecuados del hospital.

4.6.4. AHC exige que todos los contratos con agentes externos que cobran facturas en nombre de AHC incluyan disposiciones que establezcan que dichos agentes cumplirán las políticas de asistencia financiera de AHC.

4.6.5. La Función del ciclo de ingresos de AHC posibilita una supervisión institucional para la prestación de asistencia financiera y las políticas/procesos que rigen el proceso de asistencia financiera.

4.6.6. Luego de recibir la solicitud de asistencia financiera de la persona, AHC le notifica sobre la determinación de elegibilidad dentro de un periodo razonable de tiempo.

4.6.7. AHC brinda opciones para planes de pago.

4.6.8. AHC respeta y honra el derecho de las personas a apelar las decisiones y solicitar que se reconsideren.

4.6.9. AHC mantiene (y requiere que los contratistas de facturación mantengan) documentación que respalda la oferta, la solicitud y la prestación de asistencia financiera por un periodo mínimo de siete años.

4.6.10. AHC analizará e incorporará periódicamente actualizaciones de las pautas federales de pobreza publicadas por el Departamento de Salud y Servicios Humanos de los Estados Unidos

4.7. **Responsabilidades individuales de los pacientes**

4.7.1. Para que se le considere para recibir un descuento bajo la política de asistencia financiera, la persona debe cooperar con AHC para proporcionar la información y documentación necesarias para solicitar otros recursos financieros existentes que podrían estar disponibles para pagar la atención médica, como Medicare, Medicaid, responsabilidad de terceros, etc.

4.7.2. Para que se le considere para recibir un descuento bajo la política de asistencia financiera, la persona debe brindarle a AHC información financiera y de otros tipos necesaria para determinar su elegibilidad (esto incluye completar los formularios de solicitud requeridos y cooperar completamente con el proceso de recopilación de información y evaluación).

4.7.3. La persona que califique para recibir un descuento parcial debe cooperar con el hospital para establecer un plan de pago razonable.

4.7.4. La persona que califique para recibir descuentos parciales debe esforzarse de buena fe para honrar el plan de pago de sus facturas de hospital con descuento. La persona es responsable de notificar oportunamente a AHC de cualquier cambio en su situación financiera

para que el impacto de este cambio pueda ser evaluado en función de las políticas de asistencia financiera que rigen para la prestación de asistencia financiera.

5. Identificación de personas potencialmente elegibles

5.1. Identificación a través de socialización y divulgación

5.1.1. Los procesos de inscripción y preinscripción fomentan la identificación de personas que necesitan asistencia financiera.

5.1.2. Los asesores financieros se esforzarán por contactar a todos los pacientes internos que paguen sus propias cuentas durante el curso de su internación o dentro de 4 días de haber recibido el alta.

5.1.3. Se distribuirá el Resumen en lenguaje sencillo con el Formulario de solicitud de asistencia financiera de AHC a todos los pacientes antes de recibir el alta del centro hospitalario.

5.1.4. Se incluirá información sobre cómo obtener una copia de la Política de asistencia financiera con los estados de cuenta que se envían a las personas

5.1.5. Se informará a la persona de la Política de asistencia financiera del centro hospitalario de AHC en las comunicaciones orales sobre el monto adeudado por su atención.

5.1.6. Se le dará a la persona por lo menos un aviso por escrito (aviso de las medidas que podrían tomarse) que le informa que el hospital podría tomar medidas para denunciar información adversa sobre la persona a agencias de informes crediticios del consumidor/agencias de crédito si la persona no presenta un Formulario de solicitud de asistencia financiera o paga el monto adeudado antes de una fecha límite especificada. La fecha límite no puede ser anterior a 120 días luego de que se envíe el primer estado de cuenta a la persona. Se debe enviar el aviso a la persona por lo menos 30 días antes de la fecha límite especificada en el aviso.

5.2. **Pedidos de Asistencia financiera**: Se pueden recibir pedidos de asistencia financiera de varias fuentes (como el paciente, un familiar, una organización

comunitaria, una iglesia, una agencia de cobros, un cuidador, la Administración, etc.)

5.2.1. Los pedidos recibidos de terceros se dirigirán a un asesor financiero.

5.2.2. El asesor financiero trabajará junto con este tercero para proporcionar los recursos disponibles para asistir a la persona en el proceso de solicitud.

5.2.3. Si está disponible, se le dará una carta que contenga los cargos estimados a la persona que la solicite.

5.2.4. **PROCESO AUTOMATIZADO DE BENEFICENCIA** para Cuentas enviadas a agencias contratadas: Adventist HealthCare reconoce que una parte de la población sin seguro o que tenga un seguro insuficiente podría no involucrarse en el proceso tradicional de solicitud de asistencia financiera. Si la información requerida no es suministrada por el paciente, Adventist HealthCare podría utilizar una herramienta de puntuación predictiva automatizada para clasificar a los pacientes para asistencia financiera. El Puntaje de Previsibilidad de Pago (PPS) predice la probabilidad de que un paciente califique para recibir Asistencia financiera en base a fuentes públicas de información. El PPS ofrece una estimación de la posible situación socioeconómica de un paciente, como el tamaño del ingreso del hogar del paciente. La aprobación mediante PPS rige solo para cuentas que estén siendo analizadas por Servicios Financieros para Pacientes. Todas las otras fechas de servicios del mismo paciente o garante seguirán el proceso estándar de cobro de Adventist HealthCare.

6. **Junta ejecutiva de aprobación:** Las consideraciones de otorgamiento de asistencia financiera que no estén abarcadas por esta política deberán ser analizadas y aprobadas por el Director Financiero (CFO) del centro de AHC que presta los servicios, el Vicepresidente de Gestión de Ingresos de AHC, y el Vicepresidente de Seguridad del Paciente y Calidad de AHC.

7. **REVISIÓN Y MANTENIMIENTO DE LA POLÍTICA:**

7.1. Esta política se revisará bianualmente.

7.2. El equipo de revisión incluye a los Directores Financieros (CFO) de las entidades de Adventist HealthCare y al Vicepresidente de Gestión de Ingresos de Adventist Health

7.3. Las actualizaciones, modificaciones o adiciones a esta política deberán ser revisadas y acordadas por el equipo de revisión y luego por el comité rector designado por la Junta antes de que AHC la adopte.

7.4. Las actualizaciones se comunicarán y publicarán como se establece en la sección 2 - Transparencia de la política, de este documento.

INFORMACIÓN DE CONTACTO Y RECURSOS ADICIONALES

Adventist HealthCare Patient Financial Services Department
820 W Diamond Ave, Suite 500
Gaithersburg, MD 20878
(301) 315-3660

Se puede encontrar la siguiente información en Aviso público de Adventist HealthCare sobre Asistencia financiera y Atención de beneficencia:

Títulos de los documentos
Resumen en lenguaje sencillo de la Asistencia financiera de AHC - inglés
Resumen en lenguaje sencillo de la Asistencia financiera de AHC - español
Pautas federales de pobreza de AHC
Solicitud de Asistencia financiera de AHC - inglés
Solicitud de Asistencia financiera de AHC - español
Lista de proveedores que no están cubiertos bajo la Política de Asistencia financiera de AHC

EXHIBIT 8

Adventist HealthCare
Behavioral Health & Wellness Services

Adventist Behavioral Health & Wellness Services
POLICY MANUAL
DISCHARGE POLICY

Effective Date: July 2014	Policy: PC 14
COMAR:	Cross Referenced:
Reviewed: January 2016	Authority:
Revised:	Page: 1 of 3

SCOPE:
ABHWS

PURPOSE:

In order to ensure that discharges occur between **11 a.m. and 1 p.m.; 24 hours of notice** from physicians is required, indicating that a patient is ready for discharge.
Prepare to discharge orders from the Physician will be placed in the patient's chart by **2 p.m. the day before** the intended day of discharge.

In order for this occur, critical steps need to take place;

- Rounds must occur **by 10 a.m.**
- Physicians should come in early to evaluate patients and place discharge orders in the charts.
- Patients should be asked to remain on the unit to facilitate the discharge process.
- Patient belongings should be located and collected the night before discharge.

If they prepare to discharge orders are not in by **2 p.m.** the day before, the patient may not be discharged the following day.

POLICY:
24 hours before discharge

Physician Duties:

- Prepare discharge instructions and med reconciliation
- Ensure medical issues addressed
- Indicate if patient can take home medications
- Complete HBIPS paperwork
- Ensure all follow up appointments are specified (i.e. medical tests)
- Communicate with social worker to ensure discharge location is secured
- Write prescriptions

Social Work:

- Communicate with physician which appointments need to be made and then make them
- By 4pm complete the continuing care plan
- Check HBIPS and notify physician if there is any follow up required the next day
- Arrange transportation
- Discuss discharge plan with family
- Provide satisfaction survey (to be collected at discharge)
- Ensure resources available for medications
- Call Care Management to prepare for discharge and if any changes occur prior to discharge
- Work with patient on completing safety plan

Nursing:

- Complete medication reconciliation
- Pack patient belongings
- Ensure patient reviews and completes Medicare Important Message as needed

Care Management:

- Ensure authorization for next level of care (depending on patient insurance)
- Verify authorization for medication

Day of Discharge

Physician:

- Final patient visit
- Complete discharge note
- Complete Suicide Risk Assessment
- Complete any outstanding HBIPS

Social Work:

- Final patient visit
- Complete Suicide Risk Assessment
- Collect Satisfaction Survey
- Sign Discharge
- Provide patient with a copy of the safety plan and make a copy for the chart

Nursing:

- Provide medications from home to patient if applicable, with a physician's order
- Complete medication reconciliation instructions
- Retrieve and provide patient belongings
- Ensure patient is dressed appropriately for the weather
- Double check Medicare Important Message
- Complete discharge note
- Provide patient with all discharge instructions
- Make copies of forms as needed
- Call discharge to Needs Assessment and inform them of disposition

Care Management:
- Authorize for the next level of care (depending on patient insurance)

Needs Assessment:
- Discharge patient out of electronic system

Day After Discharge

Physician:
- Review dictation discharge note and complete any outstanding paperwork

Social Work:
- Fax discharge and medication reconciliation

Care Management:
- Save HBIPS information on shared drive

HIMS:
- Pick up medical record from unit

Document Information

Document Title

PC 14 Discharge Policy

Document Description

N/A

Approval Information

Approved On: 01/01/2016

Approved By: PIC, MEC

Approval Expires: 01/01/2019

Approval Type: Manual Entry

Document Location: / Behavioral Health & Wellness Services / Clinical

Keywords: N/A

Printed By: Guest User

Standard References: N/A

Note: This copy will expire in 24 hours

EXHIBIT 9

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Public Disclosure of Charges

Effective Date	03/11/11	Policy No:	AHC 3.19.2
Cross Referenced:	Charity Care AHC 3.19	Origin:	PFS
Reviewed:	10.15.13	Authority:	EC
Revised:	11.01.13	Page:	1 of 2

SCOPE:

This policy applies to Adventist HealthCare acute care hospitals located in the State of Maryland; Shady Grove Adventist Hospital and Washington Adventist Hospital.

PURPOSE:

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

BENEFITS:

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

POLICY:

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

PROCEDURE

A. For the provision of information to the public concerning charges for services, a representative list of services and charges will be available to the public in written form at the hospital and also via the AHC web site. The information will be updated quarterly and average actual charges will be consistent with hospital rates as approved by the Maryland Health Services Cost Review Commission (HSCRC). The Financial Planning and Reimbursement Department shall be responsible for ensuring the information's accuracy and updating it on a quarterly basis. The Patient Access Department(s) shall be responsible for ensuring that the written information is available to the public at the Hospital(s). The Marketing Department will ensure that the information is available to the public on the AHC web site.

Effective Date	03/11/11	Policy No:	AHC 3.19.2
Cross Referenced:	Charity Care AHC 3.19	Origin:	PFS
Reviewed:	10.15.13	Authority:	EC
Revised:	11.01.13	Page:	2 of 2

B. Individuals or their payor representative may make a request for an estimate of charges for any scheduled or non-scheduled diagnostic test or service. Requests for an estimate of charges are handled by the Financial Counselors and/or Schedulers in the Patient Access Department at each Hospital.

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

Document Information

Document Title

AHC 3.19.2 Public disclosure of charges policy

Document Description

N/A

Approval Information

Approved On: 10/02/2013

Approved By: Executive Council

Approval Expires: 10/02/2018

Approval Type: Manual Entry

Document Location: / Adventist HealthCare / AHC Corporate Policies / Finance

Keywords: N/A

Printed By: Guest User

Standard References: N/A

Note: This copy will expire in 24 hours

EXHIBIT 10

Ad # 12113987 Name ATTN: CHERYL MCKY ADVENTIST HEALTHCARE I Size 33 Lines T0003
Class 820 PO# Authorized by Account 2010239567

PROOF OF PUBLICATION

District of Columbia, ss., Personally appeared before me, a Notary Public in and for the said District, Travona James well known to me to be BILLING SUPERVISOR of The Washington Post, a daily newspaper published in the City of Washington, District of Columbia, and making oath in due form of law that an advertisement containing the language annexed hereto was published in said newspaper on the dates mentioned in the certificate herein.

I Hereby Certify that the attached advertisement was published in The Washington Post, a daily newspaper, upon the following date(s) at a cost of $128.62 and was circulated in the Washington metropolitan area.

Published 1 time(s). Date(s):06 of July 2017

Account 2010239567

Witness my hand and official seal this 6th day of July 2017

MICHELLE SINCLAIR NOTARY PUBLIC MY COMMISSION EXPIRES 1/01/2020 DISTRICT OF COLUMBIA

My commission expires _____

PUBLIC NOTICE Adventist HealthCare, Inc., and its entities provide access to all persons requiring care regardless of their ability to pay. Patients unable to pay for any portion of their bill may quality for financial assistance even if they are employed and/or insured. An application for financial assistance can be completed by any patient. The amount of assistance will be based on current Federal Income Poverty Guidelines. Applications are available throughout the Hospital or by calling (301) 315-3660. Further, no persons shall, on the grounds of race, color, religion, age, sex, national origin, ancestry, sexual orientation, or disability, be excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination in the provision of any care, service or employment.

Alexandria - Fairfax County
BIG COMMUNITY YARD SALE
7137 Beulah Street, Alexandria, VA. 07/08/2017, 7am-1pm, 607-279-3077

358 Moving Sale

Gaithersburg—Sale 8316 Plum Creek Dr Gaithersburg, MD, 07/08/2017, 8am-3pm
Furniture, art, china, crystal, silver

360 Estate Sales

1438 Highwood Dr McLean, VA
TM SALES Thur - Sun, 9-4
Steinway Upright Piano Thorens, Marantz & McIntosh stereo equipment Full house of Mid-Century furn, many signed Model ships, Antique & Coffee table books for more info see **www.estatesales.net**

Clifton Fri & Sat, 10-4, Sun 1-4
WELLS ESTATE SALES
is proud to present a fabulous primative Americano sale! Incl. loveseat, chests, banquet DR table & chairs, antique beds incl 4 poster, amazing oil paintings, Hinkle Harris secretary, towles (Old Master), wingback chairs, old toys, books, clothes, linens, lamps & whole housewares. **Outdoor Statuary** worth the drive. Tools. Craftsman lawn cart. Colt Rd to 6505 Stallion Rd. #'s 9:30 Friday see website estatesales.net. **703-536-7816**

Clifton, VA - 6608 Lady Slipper Ln
Fri-Sun, 10-3 Full house sale.
www.caringtransitionsnova.com
for pics and details.

Springfield Fri & Sat, 10-4, Sun 1-4
WELLS ESTATE SALES
presents a beautiful sale with quality items incl Gorham (Rhondo) Sterling, & silver plate Wegewood china (Queensware) Baccarat Crystal, Hummels & Lladro, sofas, chairs, 2 beautiful leather sectional sofas, LR, DR & office furn., kitchen table & chairs, oriental rugs Pool table & accessories. Men's clothes, chairlifts, housewares,tools, patio furn. **2000 Cadillac Seville STS**, much more! 8501 Shadeway Pl #'s 9:30 Friday see website estatesales.net. **703-536-7816**

610 Dogs for Sale

Bernedoodle—Puppies! 8 weeks old. **540-908-5372 mrsshank24@gmail.com**

BOUVIER DES FLANDRES—AKC PUPS 1 MALE/1 FEMALE, 4 Months Old. 301-274-9232. Vet Checked. Up To Date On All Shots. 301-274-9232

Jack Russell Yorkies On Sale — 304-904-6289. Many breeds avail. Some 10% off w/cash pay. CC, cash, easy financing on our web. wvpuppy.com

Labrador—$750, 9 weeks old, 434-409-0077. Husky Yellow Male. 1 Black Female and 1 Black Male. Registerable. Vet-checked, up to date on all vaccinations and dewormers. No shipping available.

Labrador Retriever Yellow puppies, AKC, 8 weeks old, wormed, 1st shots, 40 miles west of Frederick Md. $400 Call 301-678-5814

LABRADOR RETRIEVER English-style, AKC, black lab pups with champion bloodlines. Raised in home with sire, dam & caring family. $800. Avail 7/8. Pics plus at akc.com (21738 zip). **443-280-8280**

OLD ENGLISH BULLDOG PUPS - 4 Males & 6 Female. Avail 07/31. Accepting deposit $50. Shots, IOEBA registered. $800. Call 703-987-7084

Rottweiler, AKC —3 M & 1 F. Born 6/17, Ready 8/12. OFA Hip/Elbows/Heart. Multiple World Champs in Line. $1500,703-853-2074

Shiba Inu pups- ACA Registered. 11 weeks, red/cream, great personality, 1st shots and vet checked, $400. **Call 540-879-2228.**

Standard Poodle Puppies - AKC. Born 5/22, ready 7/18. Health guarantee. $950. **Call 540-207-1394 or email LChicco55@gmail.com**

Weimaraner, AKC—Puppies, 8 wks, 5 silver boys, 1 silver female & 1 blue female. AKC Limited Registration, $1300. Call/text 540-383-1778

WHEATEN TERRIER & Wheatini blending" Soft/No shed/allergy crt/ppr trnd soc lap dg. see parents 8 wks /12 mo M/F. **Fursonality.com 540-286-0633**

CLERK, Circuit Court
Montgomery County, Maryland

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF MERIAM MOSSAD MICHEAL MOSSAD FOR CHANGE OF NAME TO: MERIAM HELAL FAMILY LAW 145975FL

PUBLICATION NOTICE

The above Petitioner has filed a Petition for change of Name in which he/she seeks to change his/her name from Meriam Mossad Micheal Mossad to Meriam Helal. The petitioner is seeking a name change because I want to take my step-father's name.
Any person may file an objection to the Petition on or before the 21st day of July, 2017. The objection must be supported by an affidavit and served upon the Petitioner in accordance with Maryland Rule 1-321. failure to file an objection or affidavit within the time allowed my result in a judgement by default or the grant of the relief sought.
This Notice is to be published the the Washington Post newspaper of general circulation in Montgomery County, Maryland, one successive week on or before the 6th day of July, 2017.

/s/ Barbara H. Meiklejohn
CLERK, Circuit Court
Montgomery County, Maryland

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF WINSTON HAO-NINING YEUNG FOR CHANGE OF NAME TO: WINSTON AN YEUNG FAMILY LAW 145972FL Shwu-Ling Yeung Petitioner

PUBLICATION NOTICE

The above Petitioner has filed a Petition for change of Name of a Minor in which he/she seeks to change his/her name from Winston Hao-Nining Yeung to Winston An Yeung. The petitioner is seeking a name change because Better meaning and easy to remember.
Any person may file an objection to the Petition on or before the 21st day of July, 2017. The objection must be supported by an affidavit and served upon the Petitioner in accordance with Maryland Rule 1-321. failure to file an objection or affidavit within the time allowed my result in a judgement by default or the grant of the relief sought.
This Notice is to be published the the Washington Post newspaper of general circulation in Montgomery County, Maryland, one successive week on or before the 6th day of July, 2017.

/s/ Barbara H. Meiklejohn
CLERK, Circuit Court
Montgomery County, Maryland

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF ELIZABETH A. BECKERT-KIND FOR CHANGE OF NAME TO: ELIZABETH ANNE KIND FAMILY LAW 145855FL

PUBLICATION NOTICE

The above Petitioner has filed a Petition for change of Name in which he/she seeks to change his/her name from Elizabeth A. Beckert-Kind to Elizabeth Anne Kind. The petitioner is seeking a name change because I no longer want my maiden name to be part of my last name.
Any person may file an objection to the Petition on or before the 21st day of July, 2017. The objection must be supported by an affidavit and served upon the Petitioner in accordance with Maryland Rule 1-321. failure to file an objection or affidavit within the time allowed my result in a judgement by default or the grant of the relief sought.
This Notice is to be published the the Washington Post newspaper of general circulation in Montgomery County, Maryland, one successive week on or before the 6th day of July, 2017.

/s/ Barbara H. Meiklejohn
CLERK, Circuit Court
Montgomery County, Maryland

JN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF PHILLIP JAMES KENDALL-KUPPE FOR CHANGE OF NAME TO: PHILLIP JAMES KENDALL FAMILY LAW: 145827FL

PUBLICATION NOTICE

The above Petitioner has filed a Petition for change of Name in which he/she seeks to change his/her name from Phillip James Kendall-Kuppe to Phillip James Kendall. The petitioner is seeking a name change because want to simplify last name for self, wife and

as follows
1. Breach of Contract, and
2. Attorney Fees.
You are required to make defense to such pleading no later than forty days from the date of this publication, and upon your failure to do so the party seeking service against will apply to the court for the relief sought.
This the 29th day of June, 2017.
SHARP GRAHAM BAKER & VARNELL, LLP
By: Starkey Sharp
Attorney for the Plaintiff
Post Office Drawer 1027
Kitty Hawk, NC 27949
Tel. No (252) 261-2126
NCSB No. 8020

STATE OF CONNECTICUT
Superior Court/Juvenile Matters
ORDER OF NOTICE

NOTICE TO UNIDENTIFIED PERSON

of parts unknown

A petition/motion has been filed seeking termination of the above unidentified person's parental rights in the male minor child born on **8/17/2015** in Washington DC to **Alba Z**

The petition, whereby the court's decision can impact your parental rights, if any, regarding the minor child will be heard on 7/20/2017 at 12:00 PM at Superior Court Juvenile Matters 123 Hoyt Street Stamford CT 06905

It is therefore, ORDERED, that notice of the hearing of this petition/motion be given by publishing this Order of Notice once, immediately upon receipt, in the WashingtonPost a newspaper having a circulation in the town/city of: **Baltimore MD**

Name of Judge
Randolph J.

Date: 6/14/2017

Right to Counsel: Upon proof of inability to pay for a lawyer, the court will provide one for you at court expense. Any such request should be made immediately at the court office where your hearing is held.

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA PROBATE DIVISION WASHINGTON, D.C. 20001-2131 2017 ADM 414

CECELIA E. JONES PRO SE

NOTICE OF STANDARD PROBATE

Notice is hereby given that a petition has been filed in this Court by Joseph H. Green, Jr. for standard probate, including the appointment of one or more personal representatives. Unless a responsive pleading in the form of a complaint or an objection in accordance with Superior Court Probate Division Rule 407 is filed in this Court within 30 days from the date of first publication of this notice, the Court may take the action hereinafter set forth.
Order any interested person to show cause why the provisions of the lost or destroyed will dated March 22, 2011 should not be admitted to probate as expressed in the petition.

Joseph H. Green, Jr.
7400 14th St. NW,
Washington DC 20012
(202) 487-7750
PETITIONER
Anne Meister
REGISTER OF WILLS

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA PROBATE DIVISION WASHINGTON, D.C. 20001-2131 2017 ADM 712

UKBAB TSEGA PRO SE

NOTICE OF APPOINTMENT, NOTICE TO CREDITORS AND NOTICE TO UNKNOWN HEIRS

Samuel Beraki, whose address is 3403 16th Street NW Apt 105 Washington DC 20010, was appointed personal representative of the estate of Ukbab Tsega, who died on November 1, 2015 without a will and will serve without Court supervision. All unknown heirs and heirs whose whereabouts are unknown shall enter their appearance in this proceeding. Objections to such appointment shall be filed with the Register of Wills, D.C., 515 5th Street, NW, Building A, 3rd Floor, Washington DC 20001, on or before January 6, 2018. Claims against the decedent shall be presented to the undersigned with a copy to the Register of Wills or filed with the Register of Wills with a copy to the undersigned, on or before January 6, 2018, or be forever barred. Persons believed to be heirs or legatees of the decedent who do not receive a copy of this notice by mail within 25 days of its first publication shall so inform the Register of Wills, including name, address and rela-

16, 2017. Service of process may be made upon Deborah Jackson, 3409 Wheeler Rd. SE, Washington, DC 20032 whose designation as District of Columbia agent has been filed with the Register of Wills, D.C.
The decedent owned the following District of Columbia real property:
The decedent owned District of Columbia personal property. Claims against the decedent may be presented to the undersigned and filed with the Register of Wills for the District of Columbia, Building A, 515 5th, NW, 3rd Floor, Washington DC 20001 within 6 months from the date of first publication of this notice.

Debra A. Carroll
Personal Representative
Anne Meister
Register of Wills

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA PROBATE DIVISION WASHINGTON, D.C. 20001-2131 2017 ADM 760

JONATHAN LEROY DAWSON PRO SE

NOTICE OF STANDARD PROBATE

Notice is hereby given that a petition has been filed in this Court by Gina Gould on behalf of Branch Banking and Trust Company for standard probate, including the appointment of one or more personal representatives. Unless a responsive pleading in the form of a complaint or an objection in accordance with Superior Court Probate Division Rule 407 is filed in this Court within 30 days from the date of first publication of this notice, the Court may take the action hereinafter set forth.
In the absence of a will or proof satisfactory to the Court of due execution, enter an order determining that the decedent died intestate appoint a supervised representative.

Tracy Buck (DC Bar #1021540)
8601 Westwood Center Drive,
Suite 255, Vienna, VA 22182
(301) 907-8000
PETITIONER
Anne Meister
REGISTER OF WILLS

820 Official Notices

ABC LICENSE: AVR Crystal City Hotel I LLC and AVR Crystal City Hotel II LLC trading as The Westin Crystal City 1800 Jefferson Davis Highway Arlington (Arlington County) Virginia 22202-3506. The above establishment is applying to the VIRGINIA DEPARTMENT OF ALCOHOLIC BEVERAGE CONTROL (ABC) for a Mixed Beverage Restaurant, Wine and Beer On-and Off- Premises. Allan V. Rose, President. **NOTE: Objections to the issuance of this license must be submitted to ABC no later than 30 days from the publishing date of the first of two required newspaper legal notices. Objections should be registered at www.abc.virginia.gov or 800-552-3200.**

PUBLIC NOTICE
Adventist HealthCare, Inc., and its entities provide access to all persons requiring care regardless of their ability to pay. Patients unable to pay for any portion of their bill may quality for financial assistance even if they are employed and/or insured. An application for financial assistance can be completed by any patient. The amount of assistance will be based on current Federal Income Poverty Guidelines. Applications are available throughout the Hospital or by calling (301) 315-3660.
Further, no persons shall, on the grounds of race, color, religion, age, sex, national origin, ancestry, sexual orientation, or disability, be excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination in the provision of any care, service or employment.

The National Fallen Firefighters Foundation (NFFF), a 501(c)(3) nonprofit organization headquartered in the state of Maryland, publishes contract opportunities and open positions for employment on the Foundation website at **www.firehero.org/about-us/opportunities/ (firehero.org)**. All opportunities are posted for fourteen days, prior to opening of submissions. The Foundation provides equal employment opportunities for all applicants and does not discriminate based on race, color, religion, sex, national origin, ancestry, age, disability, veteran status, marital status, or sexual orientation. The Foundation also makes accommodations for qualified individuals with disabilities in accordance with applicable law.

allows for the permit to s
if they are unaltered follo
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specified at 40 CFR 423.13(
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restrictions on PCBs, biocid
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Industrial Activities (12-SW)
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can be scheduled. The
**Maryland Department of
agement Administration,
more, Maryland 21230-17
Chief, Industrial and Gen**
include the name, address
and work) of the person
any other party whom the
represent, and the name o
Failure to request a hearing
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determination for this perm
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will be considered in the pr
if submitted to the Departm
Richardson at the above a
2017. Any hearing-impaire
may request an interprete
Mr. Richardson at (410) 53
written request to the abo
days prior to the scheduled
Information supporting the
ing the draft permit and f
contacting Mr. Richardson
to make an appointment
Richardson at the above ad
be obtained at a cost of $0.3

851 Prince Georges County

IN THE CIRCUIT COURT FOR PRINCE GEORGE'S COUNTY, MARYLAND

ROBERT E. FRAZIER, et al
Substitute Trustees
Plaintiffs,
V.
JOANNE P. POWELL,
Defendant(s)

CASE NO. CAEF14-05776

NOTICE

Notice is hereby issued this **21st day of June, 2017**, that the sale of the property in this case, **13602 Royal Court, Laurel, Maryland 20708**, reported by Robert E. Frazier, Gene Jung, Laura D. Harris, Thomas W. Hodge, Thomas J. Gartner, Robert M. Oliveri, David M. Williamson and Keith M. Yacko, Substitute Trustees, be ratified and confirmed, unless cause to the contrary be shown on or before the **21st day of July, 2017** provided a copy of this Notice be inserted in The Washington Post, a newspaper published in Prince George's County, Maryland, once in each of three (3) successive weeks on or before the **21st day of July, 2017**.

The report states the amount of sale to be **$451,500.00**.

Sydney J. Harrison (#619)
Clerk of the Circuit Court
for Prince Georges County, MD

BROCK & SCOTT, PLLC
474 Viking Drive
Suite 203
Virginia Beach, VA 23452
(757) 213-2959
July 6, 13, 20, 2017 12115633

EXHIBIT 11

El Tiempo Latino

WASHINGTON D.C. METRO AREA'S NEWSPAPER IN SPANISH

1440 G STREET NW, 9TH FLOOR • WASHINGTON DC 20005

WWW.ELTIEMPOLATINO.COM

Affidavit of Performance

To: Ms. Cheryl McKy
Public Relations & Marketing
Adventist Healthcare Inc.
820 W. Diamond Ave, Ste 600
Gaithersburg, MD 20878

From: Zulema Tijero, El Tiempo Latino
VP of Advertising
1440 G St NW #8192
Washington DC 20005

Date: July 21, 2017

Dear Ms. McKy:

This is the Affidavit of Performance for Insertion Order #1756, 2c x 5 B/W Notificacion Publica that ran in El Tiempo Latino 7/07/17, on page B6.

Should you have any questions about the performance of this order please contact me at zulema@eltiempolatino.com .

Sincerely,

Zulema Tijero, VP of Advertising
El Tiempo Latino

El Tiempo Latino

WASHINGTON D.C. METRO AREA'S NEWSPAPER IN SPANISH

1440 G STREET NW, 9TH FLOOR • WASHINGTON DC 20005

WWW.ELTIEMPOLATINO.COM

July 21, 2017

El Tiempo Latino certifies that it is the publisher of El Tiempo Latino newspaper, that it is a newspaper of general circulation, published weekly in the Virginia, Maryland and District of Columbia area, and that El Tiempo Latino has been published continuously for more than one year prior to the date of first publication of the notice mentioned in the letter attached.

This certifies that the person signing below, Wendy L. Hawa is the duly authorized agent of El Tiempo Latino newspaper and Zulema Tijero, VP of Sales and Advertising at El Tiempo Latino newspaper.

Wendy Hawa Wendy Hawa, Asst. to Zulema Tijero

Witness my hand and official seal this 21 day of July, 2017.

My commission expires 8/14/2021.


CLASIFICADOS

VDOT

SOLICITUD DE PROPUESTAS

NOTIFICACIÓN PÚBLICA

DISTRICT OF COLUMBIA: SS
SUBSCRIBED AND SWORN TO BEFORE ME
THIS 21 DAY OF July, 17.

NOTARY PUBLIC
My Commission Expires 8/14/21

My Commission Expires
August 14, 2021

Anuncio Público

VDOT
Virginia Department of Transportation

SOLICITUD DE PROPUESTAS
del ID del Contrato: C00109486DB99
PR15 - 076 - 236, P101, R201, C501
Estacionamiento "Park and Ride" en la I-66 con la Ruta 15

El Departamento de Transporte de Virginia (The Virginia Department of Transportation (VDOT)) está solicitando propuestas de firmas calificadas y con experiencia en diseño y construcción de autopistas e instalaciones complementarias, para el proyecto de Diseño-Construcción de un Estacionamiento con Conexión al Transporte Público Colectivo (Park and Ride) en la intersección de la I-66 con la Ruta 15. El proyecto está ubicado en el cuadrante noreste de la Intersección de la I-66 y la Ruta 15 en la Ciudad de Haymarket y el Condado de Prince William, Virginia. El propósito de este proyecto es proporcionar un espacio de estacionamiento para los pasajeros en vehículos de uso compartido (carpoolers) que usan los carriles (HOV) de la I-66 y servicios futuros de tránsito en el área, lo cual ahorrará tiempo y aliviará la congestión en la I-66. El proyecto consiste en la construcción de un nuevo Estacionamiento de "Park and Ride" de 230 plazas, con acceso desde el Heathcote Boulevard, e incluirá un área para recoger y dejar pasajeros (kiss-and-ride), bahías y áreas de giro para autobuses, casetas para pasajeros, estacionamiento y casilleros para ciclistas, un sistema de manejo del estacionamiento, una carretera de acceso / entrada, aceras, drenaje, instalaciones para manejo de aguas pluviales e iluminación. El tráfico que utiliza el estacionamiento de Park and Ride para trabajadores viajeros estará compuesto por vehículos de pasajeros, autobuses, peatones, y ciclistas.

NOTIFICACIÓN PÚBLICA

Adventist HealthCare, Inc. y sus entidades proporcionan acceso a todas las personas que necesiten atención sin importar su capacidad de pago. Los pacientes que no puedan pagar por cualquier porción de su factura podrían calificar para recibir asistencia financiera incluso si están empleados y/o cuentan con seguro. Cualquier paciente puede presentar una solicitud de asistencia financiera. El monto de la asistencia se basará en las pautas federales de pobreza según el ingreso. Las solicitudes están a disposición del público por todo el hospital o al llamar al **(301) 315-3660.**

Adicionalmente, ninguna persona será excluida de participar, o rechazada para recibir beneficios, ni de otra manera se verá sujeta a discriminación para la prestación de cualquier atención, servicio o empleo sobre la base de su raza, color, religión, edad sexo, origen nacional, ascendencia, orientación sexual o discapacidad.

MONTGOMERY COUNTY DEPARTMENT OF TRANSPORTATION
100 Edison Park Drive, 4th Floor, Gaithersburg, Maryland

Manager III, Transportation Systems Engineering Team Leader
$74,445 - $136,069

Closing Date: July 19, 2017

The Department of Transportation provides project planning, engineering design, construction management, and subsequent operation and maintenance of the County's transportation infrastructure.

Employee will be responsible for leading, managing and directing the planning, implementation and day-to-day functions of the Traffic Systems Engineering Team within the Transportation Systems Management Section. This five-person team is responsible for the design, construction and maintenance of Traffic signal systems and the County FiberNet program. Duties include leading, supervising and managing a team of County professional and paraprofessional staff, engineering technicians, consultants, and contractors who are responsible for planning, designing, operating and maintaining the County's signal system and FiberNet; developing and maintaining signal timing and phasing; developing and monitoring budgets; establishing and maintaining effective contacts with officials of local, state, and federal government in support of the aforementioned programs, meeting and corresponding with citizens, community associations, and elected officials to address complex issues regarding Traffic signal technologies to improve operational efficiency; manage the preparation of studies and evaluations regarding signalized locations; provide for confirmation of deployment and maintenance

EXHIBIT 12

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. 15-039

Issued to:

Adventist Healthcare Behavioral Health & Wellness
14901 Broschart Road
Rockville, MD 20850

Type of Facility: Special Hospital - Psychiatric

Number of beds: 117

Date Issued: January 1, 2017

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: March 5, 2018

Patricia Tomko May M.D.

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

EXHIBIT 13

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. 15-023

Issued to:

Adventist Healthcare Shady Grove Medical Center
9901 Medical Center Drive
Rockville, MD 20850

Type of Facility: Acute General Hospital

Date Issued: November 12, 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: February 12, 2020

Patricia Tomko May MD

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

EXHIBIT 14

Quality Check®

Organizations that have achieved
The Gold Seal of Approval® from
The Joint Commission®

Quality Report

The Joint Commission®

Adventist Health Care, Inc.

DBA: Adventist Behavioral Health and Wellness Services
HCO ID: 642
14901 Broschart Road
Rockville, MD, 20850
(301) 251-4500
www.adventistbehavioralhealth.com

Summary of Quality Information

Accreditation Programs

View Accreditation History

	Accreditation Decision	Effective Date	Last Full Survey Date	Last On-Site Survey Date
Behavioral Health Care	Accredited	10/18/2017	10/17/2017	10/17/2017
Hospital	Accredited	10/21/2017	10/20/2017	12/1/2017

Sites

Adventist HealthCare
DBA: Adventist Behavioral Health & Wellness Services Rockville
14901, 14907 and 14915 Broschart Road
Rockville, MD, 20850

Available Services

- Addiction Care
- Addiction Care
- Addiction Care (Non-detox - Adult)
- Behavioral Health (Day Programs - Adult)
- Behavioral Health (Day Programs - Child/Youth)
- Behavioral Health (Non 24 Hour Care - Adult)
- Behavioral Health (Non 24 Hour Care - Child/Youth)
- Behavioral Health (24-hour Acute Care/Crisis Stabilization - Adult)
- Behavioral Health (24-hour Acute Care/Crisis Stabilization - Child/Youth)
- Behavioral Health (Partial - Adult)
- Behavioral Health (Partial - Child/Youth)
- Chemical Dependency (Day Programs - Adult)
- Chemical Dependency (Day Programs - Child/Youth)
- Chemical Dependency (Partial - Adult)
- Chemical Dependency (Partial - Child/Youth)
- Chemical Dependency (Non-detox - Adult)
- Community Integration (Non 24 Hour Care)

Other Clinics/Practices Located at This Site:

- Outpatient Wellness Clinic

Adventist HealthCare
DBA: Adventist Behavioral Health Cottage at North Potomac
14713 Latakia Place
North Potomac, MD, 20878

Available Services

- Behavioral Health (Group Home(s) - Child/Youth)
- Community Integration (Non 24 Hour Care)

Adventist HealthCare
DBA: Adventist Behavioral Health Cottage at Rockville
16412 Kipling Road
Derwood, MD, 20855

Available Services

- Behavioral Health (Group Home(s) - Child/Youth)
- Community Integration (Non 24 Hour Care)

Adventist Healthcare Inc.
DBA: Lourie Center for Childrens Social & Emotional Wellness-OMHC
12301 Academy Way, Rockville, MD 20852
Rockville, MD, 20852

Available Services

- Behavioral Health (Non 24 Hour Care - Child/Youth)
- Developmental Disabilities - Programs / Services (Non 24 Hour Care - Child/Youth)
- Family Support (Non 24 Hour Care)
- Peer Support (Non 24 Hour Care)

Adventist Healthcare, Inc
DBA: Adventist Behavioral Health Manor
8301 Barron Street
Silver Spring, MD, 20912-7363

Available Services

- Behavioral Health (Group Home(s) - Adult)
- Community Integration (Non 24 Hour Care)

National Patient Safety Goals and National Quality Improvement Goals

Symbol Key

- This organization achieved the best possible results
- This organization's performance is above the target range/value
- This organization's performance is similar to the target range/value

- This organization's performance is below the target range/value
- N/A This measure is not applicable for this organization
- N/D Not displayed

Measures Footnote Key

1. The measure or measure set was not reported.
2. The measure set does not have an overall result.
3. The number is not enough for comparison purposes.
4. The measure meets the Privacy Disclosure Threshold rule.
5. The organization scored above 90% but was below most other organizations.
6. The measure results are not statistically valid.
7. The measure results are based on a sample of patients.
8. The number of months with measure data is below the reporting requirement.
9. The measure results are temporarily suppressed pending resubmission of updated data.
10. Test Measure: a measure being evaluated for reliability of the individual data elements or awaiting National Quality Forum Endorsement.
11. There were no eligible patients that met the denominator criteria.

The Joint Commission only reports measures endorsed by the **National Quality Forum**.
* This information can also be viewed at **Hospital Compare**.

** Indicates per 1000 hours of patient care.
*** The measure was not in effect for this quarter.
---- Null value or data not displayed.

Hospital	**2017 National Patient Safety Goals**	**Nationwide Comparison:** ✓	**Statewide Comparison:** N/A
Behavioral Health Care	**2017 National Patient Safety Goals**	**Nationwide Comparison:** ✓	**Statewide Comparison:** N/A
	Reporting Period: April 2016 - March 2017 **National Quality Improvement Goals:**		
	Hospital-Based Inpatient Psychiatric Services	**National Comparison:** N/D [2]	**Statewide Comparison:** N/D [2]

New Changes to Quarterly Measure

Download Quarterly Measure Results

The Joint Commission only reports measures endorsed by the **National Quality Forum**.
* State results are not calculated for the National Patient Safety Goals.

EXHIBIT 15

Quality Check®

Organizations that have achieved
The Gold Seal of Approval® from
The Joint Commission®

Quality Report

The Joint Commission®

Adventist HealthCare Shady Grove Medical Center

HCO ID: 6297
9901 Medical Center Drive
Rockville, MD, 20850
(240) 826-6000
http://www.adventisthealthcare.com/locations/

Summary of Quality Information

Accreditation Programs

View Accreditation History

	Accreditation Decision	Effective Date	Last Full Survey Date	Last On-Site Survey Date
Hospital	Accredited	11/12/2016	11/11/2016	11/11/2016

Core Certification Programs

View Certification History

Joint Replacement - Hip

Certification Decision
Certification
Effective Date
10/12/2016
Last Full Survey Date
10/11/2016
Last On-Site Survey Date
10/11/2016

Joint Replacement - Knee

Certification Decision
Certification
Effective Date
10/12/2016
Last Full Survey Date
10/11/2016
Last On-Site Survey Date
10/11/2016

Sites

Adventist HealthCare Germantown Emergency Center

19735 Germantown Road
Rockville, MD, 20850

Available Services

- Administration of Blood Product (Outpatient)
- Administration of High Risk Medications (Outpatient)
- Anesthesia (Outpatient)
- Perform Invasive Procedure (Outpatient)

Adventist HealthCare Shady Grove Medical Center

9901 Medical Center Drive
Rockville, MD, 20850

Available Services

- Brachytherapy (Imaging/Diagnostic Services)
- Cardiac Catheterization Lab (Surgical Services)
- Coronary Care Unit (Inpatient)
- CT Scanner (Imaging/Diagnostic Services)

- Dialysis Unit (Inpatient)
- Ear/Nose/Throat Surgery (Surgical Services)
- EEG/EKG/EMG Lab (Imaging/Diagnostic Services)
- Gastroenterology (Surgical Services)
- GI or Endoscopy Lab (Imaging/Diagnostic Services)
- Gynecological Surgery (Surgical Services)
- Gynecology (Inpatient)
- Hematology/Oncology Unit (Inpatient)
- Inpatient Unit (Inpatient)
- Interventional Radiology (Inpatient)
- Interventional Radiology (Outpatient)
- Interventional Radiology (Imaging/Diagnostic Services)
- Labor & Delivery (Inpatient)
- Magnetic Resonance Imaging (Imaging/Diagnostic Services)
- Medical /Surgical Unit (Inpatient)
- Medical ICU (Intensive Care Unit)
- Neurosurgery (Surgical Services)
- Normal Newborn Nursery (Inpatient)
- Nuclear Medicine (Imaging/Diagnostic Services)
- Ophthalmology (Surgical Services)
- Orthopedic Surgery (Surgical Services)
- Orthopedic/Spine Unit (Inpatient)
- Pediatric Cardiology (Inpatient - Child/Youth)
- Pediatric Dentistry (Inpatient - Child/Youth)
- Pediatric Dermatology (Inpatient - Child/Youth)
- Pediatric Emergency Medicine (Inpatient - Child/Youth)
- Pediatric Endocrinology (Inpatient - Child/Youth)
- Pediatric Gastroenterology (Inpatient - Child/Youth)
- Pediatric Gastroenterology (Outpatient - Child/Youth)
- Pediatric General Surgery (Inpatient - Child/Youth)
- Pediatric Nephrology (Inpatient - Child/Youth)
- Pediatric Neurosurgery (Inpatient - Child/Youth)
- Pediatric Ophthalmology (Inpatient - Child/Youth)
- Pediatric Oral/Maxofacial Surgery (Inpatient - Child/Youth)
- Pediatric Otolaryngology (Inpatient - Child/Youth)
- Pediatric Unit (Inpatient)
- Pediatric Urology (Inpatient - Child/Youth)
- Plastic Surgery (Surgical Services)
- Positron Emission Tomography (PET) (Imaging/Diagnostic Services)
- Post Anesthesia Care Unit (PACU) (Inpatient)
- Radiation Oncology (Imaging/Diagnostic Services)
- Sleep Laboratory (Sleep Laboratory)
- Surgical Unit (Inpatient)
- Teleradiology (Imaging/Diagnostic Services)
- Thoracic Surgery (Surgical Services)
- Ultrasound (Imaging/Diagnostic Services)
- Urology (Surgical Services)
- Vascular Surgery (Surgical Services)

Certification Programs

- Joint Replacement - Hip
- Joint Replacement - Knee

Aquilino Cancer Center

9905 Medical Center Drive,
Rockville, MD, 20850

Available Services

- Outpatient Clinics (Outpatient)

Other Clinics/Practices Located at This Site:

- Lymphedema Clinic
- Radiation Oncology

Shady Grove Adventist Hospital Maternity Center

19735 Germantown Rd. # 270
Germantown, MD, 20874

Available Services

- Outpatient Clinics (Outpatient)
- Perform Invasive Procedure (Outpatient)

Special Quality Awards

Due to our commitment to accurate data reporting, The Joint Commission is suspending the practice of updating Special Quality Awards until further notice

- **2015** Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program
- **2013** Gold Plus Get With The Guidelines - Stroke

Cooperative Agreements

Hospital - Accredited by American College of Surgeons-Commission on Cancer (ACoS-COC)

National Patient Safety Goals and National Quality Improvement Goals

Symbol Key

- This organization achieved the best possible results
- This organization's performance is above the target range/value
- This organization's performance is similar to the target range/value
- This organization's performance is below the target range/value
- N/A This measure is not applicable for this organization
- N/D Not displayed

Measures Footnote Key

1. The measure or measure set was not reported.
2. The measure set does not have an overall result.
3. The number is not enough for comparison purposes.
4. The measure meets the Privacy Disclosure Threshold rule.
5. The organization scored above 90% but was below most other organizations.
6. The measure results are not statistically valid.
7. The measure results are based on a sample of patients.
8. The number of months with measure data is below the reporting requirement.
9. The measure results are temporarily suppressed pending resubmission of updated data.
10. Test Measure: a measure being evaluated for reliability of the individual data elements or awaiting National Quality Forum Endorsement.
11. There were no eligible patients that met the denominator criteria.

The Joint Commission only reports measures endorsed by the **National Quality Forum**.
* This information can also be viewed at **Hospital Compare**.

** Indicates per 1000 hours of patient care.
*** The measure was not in effect for this quarter.
---- Null value or data not displayed.

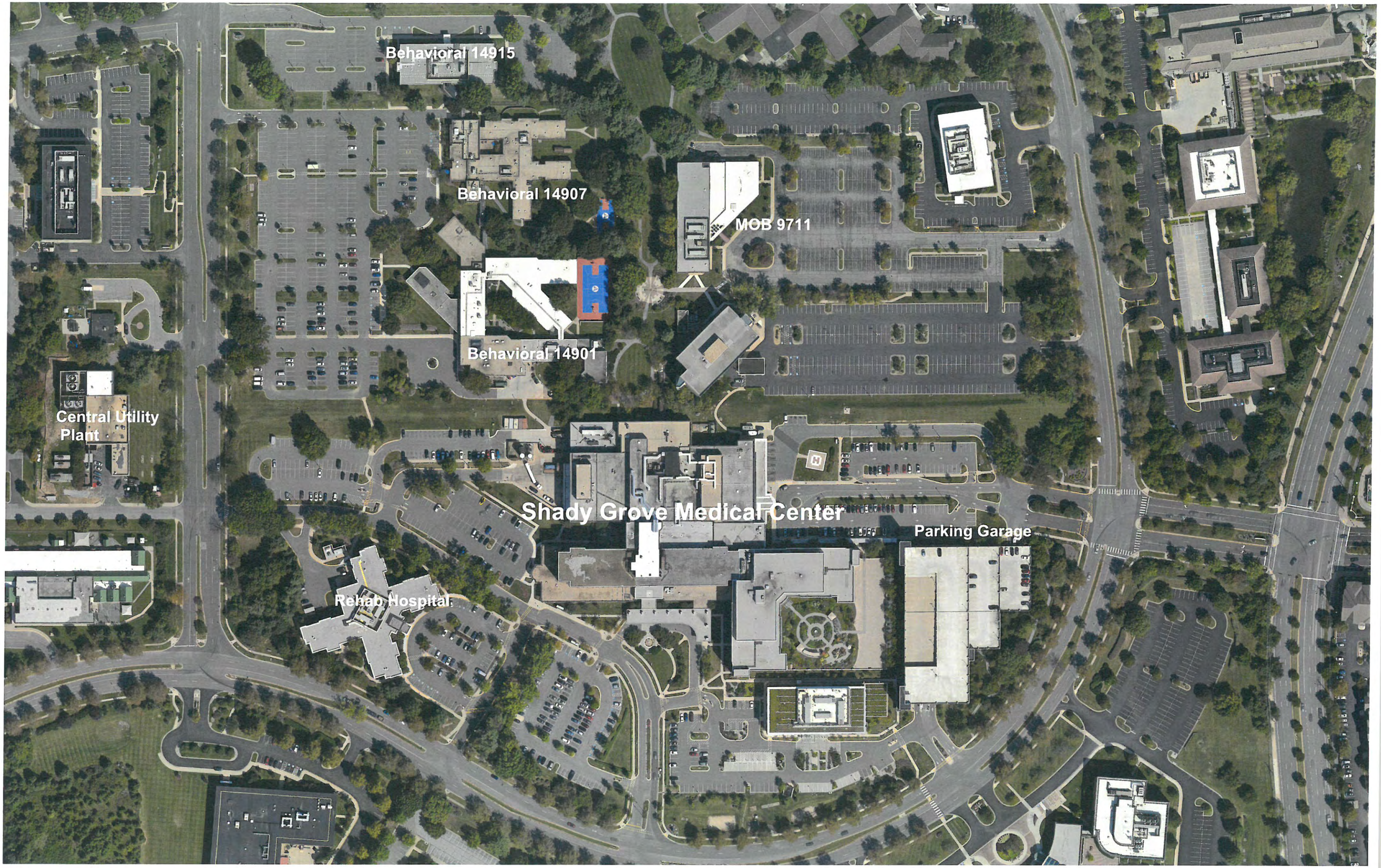
Hospital	2016 National Patient Safety Goals	Nationwide Comparison:	Statewide Comparison:
		✓	N/A
	Reporting Period: April 2016 - March 2017		
	National Quality Improvement Goals:		
	Emergency Department	National Comparison: N/D 2	Statewide Comparison: N/D 2
	Immunization	National Comparison: N/D 2	Statewide Comparison: N/D 2
	Perinatal Care	National Comparison: N/D 2	Statewide Comparison: N/D 2

New Changes to Quarterly Measure

Download Quarterly Measure Results

The Joint Commission only reports measures endorsed by the **National Quality Forum**.
* State results are not calculated for the National Patient Safety Goals.

EXHIBIT 16


Behavioral 14915
Behavioral 14907
MOB 9711
Behavioral 14901
Central Utility Plant
Shady Grove Medical Center
Parking Garage
Rehab Hospital

EXISTING HEALTH CARE WALL AND DOOR REQUIREMENTS PER 2012 EDITION OF *THE LIFE SAFETY CODE®*

Smoke-Resistive Construction

Wall
Smoke Resistive (No Hourly Rating) [19.3.6.2 & 8.4]

- Non-Sprinklered Protected: Extend to the Slab.
  - Seal penetrations with material capable of resisting smoke - No expanding foam. [8.4.4]
  - Seal center of conduits with material capable of resisting smoke – No expanding foam. [8.4.4]
- Sprinkler Protected: Terminate wall at the ceiling if ceiling is smoke resistive
- Building Code may require wall to slab even if sprinkler protected.

Doors
Smoke resistive (No Hourly Rating or Label) [19.3.6.3]

- Must positive latch [19.3.6.3.5 & CMS Rule]
- 1-inch clearance or less between bottom of door and floor [19.3.6.3.4]
- 1/8-inch gap between meeting edges of double doors
- Hold-open devices that permit closure when pushed or pulled are permitted [19.3.6.3.10]
- There is no limit on glazing and rated glazing is not required.

1/2-Hour Fire Barrier (Corridors in non-sprinkler protected compartments)

Wall
1/2-hour fire resistance rated and extend to the slab above [19.3.6.2.1]

- Seal penetrations, including center of conduits, with a listed fire stop material. No expanding foam [8.4.4]
- Fire and smoke dampers are NOT required in ductwork.
- Transfer grills are not permitted in these walls.
- Building Code may require fire dampers
- Glazing in the wall must be fire resistance rated and equal to the rating of the wall or wired glass [8.3.3]

Doors
Construction that resists fire for a minimum of 20-minutes or a 1 3/4-inch thick, solid-bonded wood core [19.3.6.3.1]

- Must positive latch [19.3.6.3.5 & CMS Rule]
- 1-inch clearance or less between bottom of door and floor [19.3.6.3.4]
- 1/8-inch gap between meeting edges of double doors.
- Hold-open devices that permit closure when pushed or pulled are permitted [19.3.6.3.10]
- If door is rated the glazing must be 20 minute rated and limited to 1296 square inches or the maximum area approved under the label.

Smoke Barrier

Line on drawing looks like:

Wall
Must extend to slab above [8.5.2]

- Seal penetrations, including center of conduits, with a listed fire stop material. No expanding foam [8.5.6]
- Smoke dampers may not be required in ductwork depending sprinkler protection but must be maintained if present. Dampers must be within 2 ft of the wall.
- Transfer grills must have smoke dampers. [8.5.5.7.3]
  - Building Code may require smoke or fire damper.
- Glazing in the wall must be fire resistance rated and equal to the rating of the wall or wired glass [8.5.4.5]

Doors
Equivalent construction to a 20-minute rated fire door or a 1-3/4-inch thick, solid-bonded wood core. Building Code may require labeled fire door [19.3.7.6]

- Must self close but are not required to positive latch [19.3.7.8]
  - Building Code may require positive latch.
- 3/4-inch clearance or less between bottom of door and floor [8.5.4.1]
- 1/8-inch gap between meeting edges of double doors or listed meeting edge protection.
  - New double doors must have an astragal or other form of meeting edge protection regardless of measurement of gap. [18.18.3.7.8]
- Doors on magnetic hold open must have smoke detection per NFPA 72 [8.5.4.4 & 7.2.1.8]
- Rated glazing must be 20-minute fire rated and limited to 1296 square inches or the maximum area approved under the label [8.5.4.5].

1-Hour Fire Barrier

Line on drawing looks like:

Wall
1-hour fire resistance rated and extend to the slab above [8.3.1.1]

- Seal penetrations, including center of conduits, with a listed fire stop material. No expanding foam [8.3.5]
- Fire dampers NOT required in ductwork if sprinkler protected but if present must be maintained
- Transfer grills must have fire dampers [8.3.5.7]
- Building Code may require fire dampers
- Glazing in the wall must be fire resistance rated and equal to the rating of the wall or wired glass [8.3.3]

Doors
3/4-hour fire rated [8.3.4.2]

- Must self close and positive latch [8.3.4.2]
- 3/4-inch clearance or less between bottom of door and floor [8.3.3.1]
- 1/8-inch gap between meeting edges of double doors [8.3.3.1]
- Fire Exit Hardware is required. [8.3.3.1]
- Doors on magnetic hold open must have smoke detection per NFPA 72 [8.3.3.1]
- Rated glazing must be 45-minute fire rated and limited to 1296 square inches or the maximum area approved under the label.

2-Hour Fire Barrier

Line on drawing looks like:

Wall
2-hour fire resistance rated and extend to the slab above [8.3.1.1]

- Seal penetrations, including center of conduits, with a listed fire stop material. No expanding foam [8.3.5]
- Fire dampers required in the wall [8.3.5.7]
- Glazing in the wall must be fire resistance rated and equal to the rating of the wall or wired glass [8.3.3]

Doors
1 ½-hour fire rated [8.3.4.2]

- Must self close and positive latch [8.3.4.2]
- 3/4-inch clearance or less between bottom of door and floor [8.3.3.1]
- 1/8-inch gap between meeting edges of double doors [8.3.3.1]
- Fire Exit Hardware is required. [8.3.3.1]
- Doors on magnetic hold open must have smoke detection per NFPA 72 [8.3.3.1]
- Rated glazing must be 90-minute fire rated and limited to 1296 square inches or the maximum area approved under the label.

Building Separation (Minimum of 2-hour Fire Rating)

Line on drawing looks like:

Wall
At least 2-hour fire resistance rated but possibly 3-hour or 4-hour and extend to the slab above [8.3.3.1]

- Seal penetrations, including center of conduits, with a listed fire stop material. No expanding foam [8.3.5]
- Fire dampers required in the wall [8.3.5.7]
- Glazing in the wall must be fire resistance rated and equal to the rating of the wall or wired glass [8.3.3]

Doors
At least 1 ½-hour fire rated or equivalent to the rating of the wall [8.3.4.2]

- Must self close and positive latch [8.3.3.1]
- 3/4-inch clearance or less between bottom of door and floor [8.3.3.1]
- 1/8 inch gap between meeting edges of double doors [8.3.3.1]
- Fire Exit Hardware is require. [8.3.3.1]
- Doors on magnetic hold open must have smoke detection per NFPA 72 [8.3.3.1]
- Rated glazing must be at least 90 minute fire rated or equivalent to the rating of the door and limited to 1296 square inches or the maximum area approved under the label.

REVISIONS

NO	DATE	DESCRIPTION
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-

LIFE SAFETY SYMBOLS

- BUILDING SEPARATION
- 3 HOUR FIRE BARRIER
- 2 HOUR FIRE BARRIER
- 1 HOUR FIRE BARRIER
- 1/2 HOUR FIRE BARRIER
- SMOKE BARRIER
- HORIZONTAL EXIT
- EXIT
- EXIT STAIRWELL
- BUSINESS SMOKE ZONE
- HAZARDOUS AREA
- SLEEPING SUITE
- NON-SLEEPING SUITE
- NON-PATIENT SUITE
- 2 HOUR FLOOR CEILING
- 1 HOUR FLOOR CEILING
- HORIZONTAL SMOKE BARRIER TRANSFER
- LINEN/TRASH CHUTE
- FP — FIRE PUMP
- XXXXX-XXXX / XXXXXXXXXXXXXXXX — DEFICIENCY NUMBER

ZONE ID

EQUIVALENCY INFORMATION:

EQUIVALENCY/ WAIVER NO.	EQUIVALENCY / WAIVER
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ABBREVIATIONS

T	COMPLETE SPRINKLER PROTECTION	STR	STORAGE
PT	PARTIAL SPRINKLER PROTECTION	ASM	ASSEMBLY
NT	NO SPRINKLER PROTECTION	INS	INSTITUTIONAL
EHC	EXISTING HEALTH CARE	EDU	EDUCATION
NHC	NEW HEALTH CARE	FAM	FAMILY DWELLING
AHC	AMBULATORY HEALTH CARE	APT	APARTMENT BUILDING
BUS	BUSINESS AND OTHER USES	APT	APARTMENT BUILDING
HAD	HOTEL AND DORMITORY	BCA	BORD AND CARE
LOR	LODGING OR ROOMING	MER	MERCANTILE
DAY	DAYCARE	IND	INDUSTRIAL

ADVENTIST HEALTH CARE
SHADY GROVE HOSPITAL
ROCKVILLE, MD
PROJECT TITLE

LIFE SAFETY PLAN COVER SHEET

SHEET TITLE

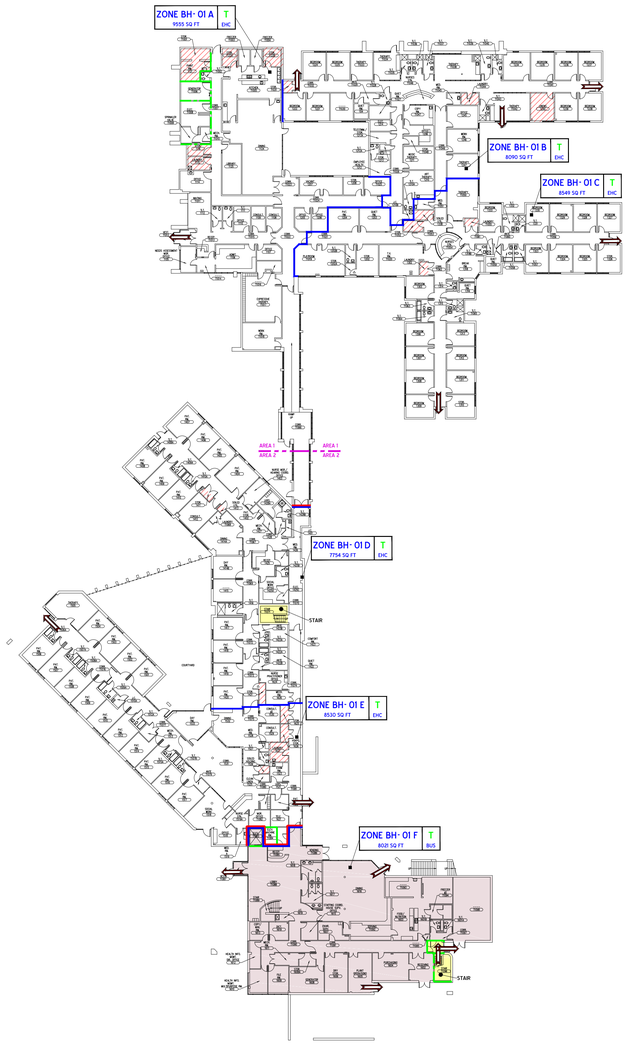
LS-0.0

DRAWING NUMBER

LIFE SAFETY CONSORTIUM, LLC™
P.O. BOX 287
West Friendship, MD 21794
443-203-2376 (Direct) 443-203- 2379(Fax)

FINAL REPORT

ADVSG-001	PROJECT NO
AS NOTED	DRAWING SCALE
06/12/17	SUBMITTAL DATE
JLF	DESIGNED BY
AMK	DRAWN BY



FIRST FLOOR - COMPOSITE
SCALE: 1/32" = 1'-0"

REVISIONS

NO	DATE	DESCRIPTION
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-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-

LIFE SAFETY SYMBOLS

- BUILDING SEPARATION
- 3 HOUR FIRE BARRIER
- 2 HOUR FIRE BARRIER
- 1 HOUR FIRE BARRIER
- 1/2 HOUR FIRE BARRIER
- SMOKE BARRIER
- HORIZONTAL EXIT
- EXIT
- EXIT STAIRWELL
- BUSINESS SMOKE ZONE
- HAZARDOUS AREA
- SLEEPING SUITE
- NON-SLEEPING SUITE
- NON-PATIENT SUITE
- 2 HOUR FLOOR CEILING
- 1 HOUR FLOOR CEILING
- HORIZONTAL SMOKE BARRIER TRANSFER
- LINEN/TRASH CHUTE
- FP — FIRE PUMP
- XXXXX-XXXX / XXXXXXXXXXXXXXXX — DEFICIENCY NUMBER

ZONE ID

EQUIVALENCY INFORMATION:

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ABBREVIATIONS

T	COMPLETE SPRINKLER PROTECTION	STR	STORAGE
PT	PARTIAL SPRINKLER PROTECTION	ASM	ASSEMBLY
NT	NO SPRINKLER PROTECTION	INS	INSTITUTIONAL
EHC	EXISTING HEALTH CARE	EDU	EDUCATION
NHC	NEW HEALTH CARE	FAM	FAMILY DWELLING
AHC	AMBULATORY HEALTH CARE	APT	APARTMENT BUILDING
BUS	BUSINESS AND OTHER USES	APT	APARTMENT BUILDING
HAD	HOTEL AND DORMITORY	BCA	BORD AND CARE
LOR	LODGING OR ROOMING	MER	MERCANTILE
DAY	DAYCARE	IND	INDUSTRIAL

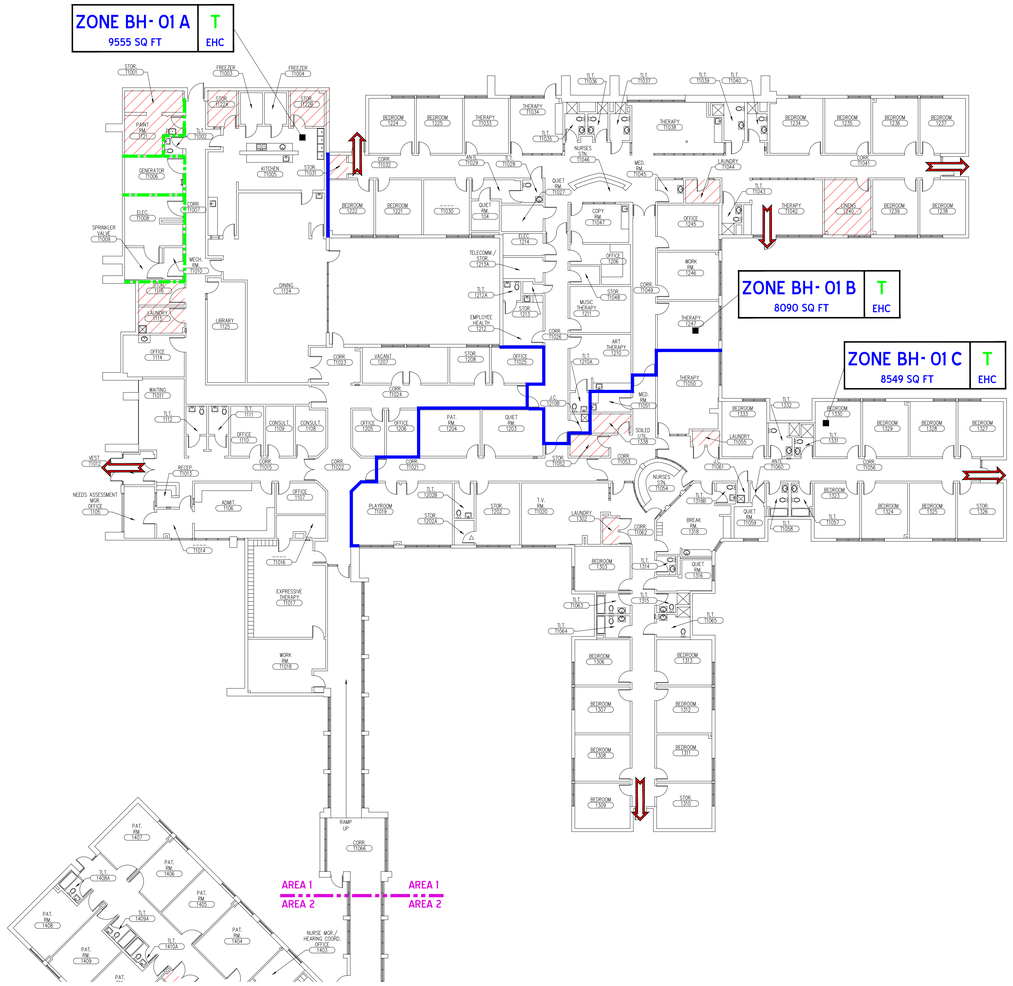
ADVENTIST HEALTHCARE
BEHAVORIAL HEALTH
ROCKVILLE. MD
PROJECT TITLE

LIFE SAFETY PLAN
FIRST FLOOR
COMPOSITE
SHEET TITLE

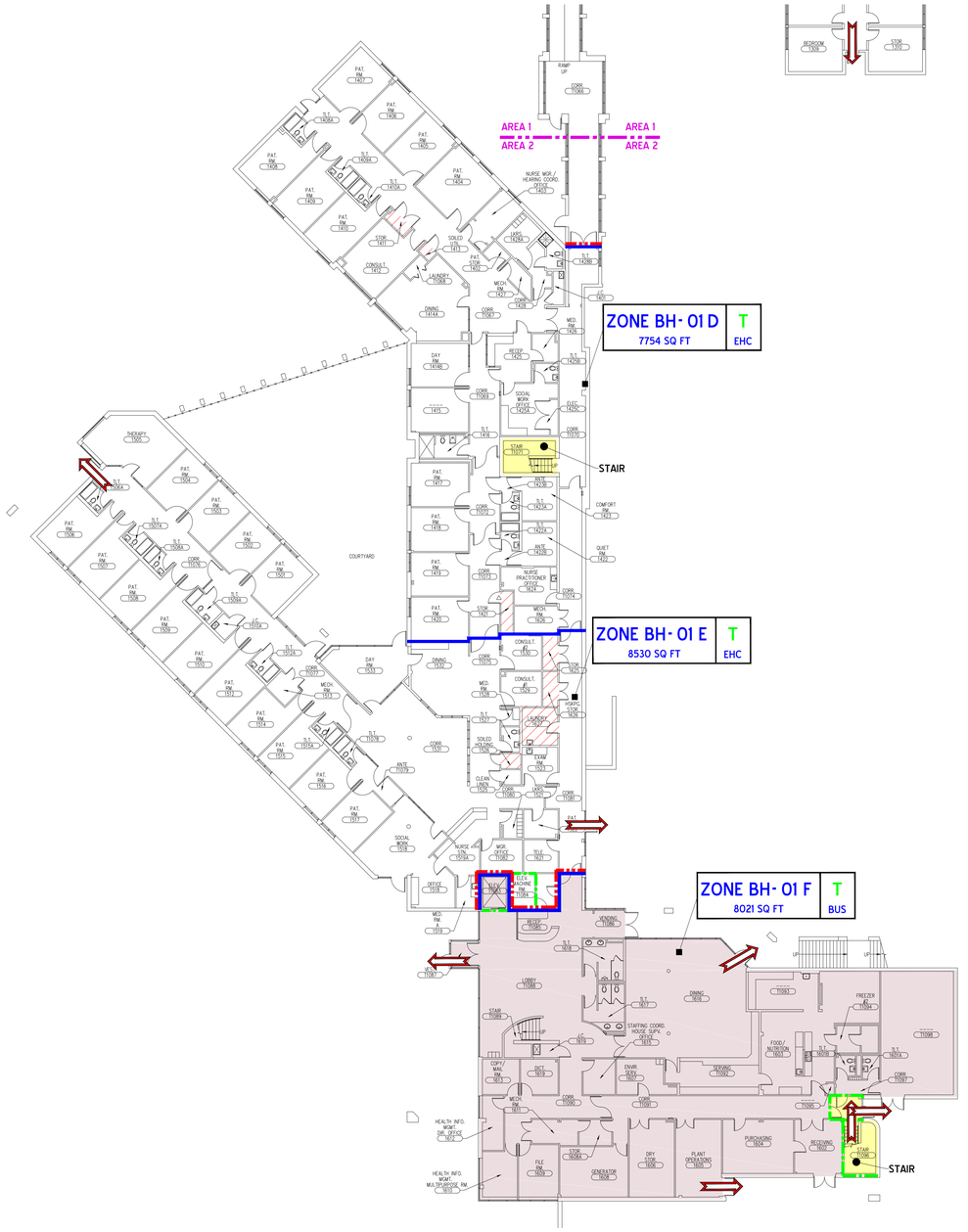
LS-01.0
DRAWING NUMBER

LIFE SAFETY CONSORTIUM, LLC™
P.O. BOX 287
West Friendship, MD 21794
443-203-2376 (Direct) 443-203- 2379(Fax)

FINAL REPORT
ADVBH-001
PROJECT NO
AS NOTED
DRAWING SCALE
10/04/16
SUBMITTAL DATE
JLF
DESIGNED BY
AMK
DRAWN BY



FIRST FLOOR - AREA 1
SCALE: 1/16" = 1'-0"



FIRST FLOOR - AREA 2
SCALE: 1/16" = 1'-0"

REVISIONS

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LIFE SAFETY SYMBOLS

- BUILDING SEPARATION
- 3 HOUR FIRE BARRIER
- 2 HOUR FIRE BARRIER
- 1 HOUR FIRE BARRIER
- 1/2 HOUR FIRE BARRIER
- SMOKE BARRIER
- HORIZONTAL EXIT
- EXIT
- EXIT STAIRWELL
- BUSINESS SMOKE ZONE
- HAZARDOUS AREA
- SLEEPING SUITE
- NON-SLEEPING SUITE
- NON-PATIENT SUITE
- 2 HOUR FLOOR CEILING
- 1 HOUR FLOOR CEILING
- HORIZONTAL SMOKE BARRIER TRANSFER
- LINEN/TRASH CHUTE
- FP — FIRE PUMP
- XXXX-XXXX — DEFICIENCY NUMBER

ZONE ID

FACILITY ABBREVIATION · FLOOR · ZONE SPRINKLERED · DRAWING · ZONE SQ FT · ZONE LETTER · TYPE OF OCCUPANCY

ZONE XX-XXX T XXX
XXX SQ FT

NORTH

EQUIVALENCY INFORMATION:

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ADVENTIST HEALTHCARE
BEHAVORIAL HEALTH
ROCKVILLE, MD
PROJECT TITLE

LIFE SAFETY PLAN
FIRST FLOOR
AREAS 1 & 2
SHEET TITLE

LS-01.1
DRAWING NUMBER

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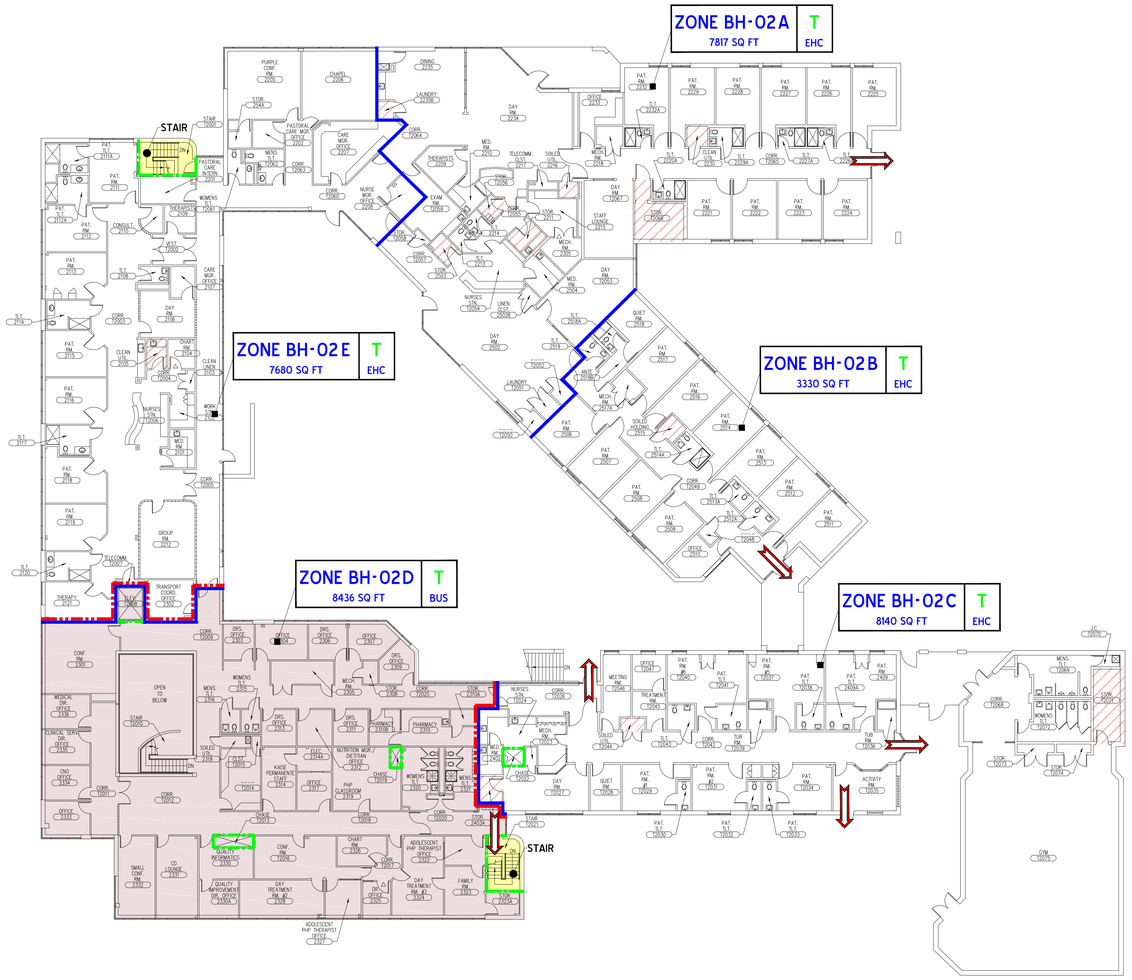

SECOND FLOOR
SCALE: 1/16" = 1'-0"

REVISIONS

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LIFE SAFETY SYMBOLS

- BUILDING SEPARATION
- 3 HOUR FIRE BARRIER
- 2 HOUR FIRE BARRIER
- 1 HOUR FIRE BARRIER
- 1/2 HOUR FIRE BARRIER
- SMOKE BARRIER
- HORIZONTAL EXIT
- EXIT
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- BUSINESS SMOKE ZONE
- HAZARDOUS AREA
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- LINEN/TRASH CHUTE
- FP — FIRE PUMP
- XXXXX-XXXXX / XXXXXXXXXXXXXXXX — DEFICIENCY NUMBER

ZONE ID

FACILITY ABBREVIATION · FLOOR · ZONE SPRINKLERED

ZONE XX-XXX T

XXX SQ FT · XXX · DRAWING NORTH

ZONE SQ FT · ZONE LETTER · TYPE OF OCCUPANCY

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ADVENTIST HEALTHCARE
BEHAVORIAL HEALTH
ROCKVILLE, MD
PROJECT TITLE

LIFE SAFETY PLAN
SECOND FLOOR
SHEET TITLE

LS-02.0
DRAWING NUMBER

LIFE SAFETY CONSORTIUM, LLC™
P.O. BOX 287
West Friendship, MD 21794
443-203-2376 (Direct) 443-203- 2379(Fax)

FINAL REPORT
ADVBH-001 PROJECT NO
AS NOTED DRAWING SCALE
10/04/16 SUBMITTAL DATE
JLF DESIGNED BY
AMK DRAWN BY

EXHIBIT 17

Adventist HealthCare, Inc. and Controlled Entities

Financial Statements and
Supplementary Information

December 31, 2017 and 2016

BAKER TILLY

Candor. Insight. Results.

Adventist HealthCare, Inc. and Controlled Entities

Table of Contents
December 31, 2017 and 2016

Independent Auditors' Report

Board of Trustees
Adventist HealthCare, Inc. and Controlled Entities

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Adventist HealthCare, Inc. and controlled entities (collectively, the "Corporation"), which comprise the consolidated balance sheets as of December 31, 2017 and 2016, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated 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 consolidated 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, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Adventist HealthCare, Inc. and controlled entities as of December 31, 2017 and 2016, and the results of their operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating and combining information presented on pages 42 to 46 is presented for purposes of additional analysis rather than to present the financial position, results of operations, and cash flows of the individual companies and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Baker Tilly Virchow Krause, LLP

Wilkes-Barre, Pennsylvania
April 25, 2018

Adventist HealthCare, Inc. and Controlled Entities

Consolidated Balance Sheets
December 31, 2017 and 2016

	2017	2016
Assets		
Current Assets		
Cash and cash equivalents	$ 40,714,884	$ 30,198,079
Short-term investments	197,803,029	188,594,181
Assets whose use is limited	2,923,796	2,870,341
Patient accounts receivable, net of estimated allowance for doubtful collections of $22,487,000 in 2017 and $27,415,000 in 2016	93,209,946	91,827,593
Other receivables, net of estimated allowance for doubtful collections of $628,000 in 2017 and $2,436,000 in 2016	16,070,981	15,244,017
Inventories	9,410,777	10,211,601
Prepaid expenses and other current assets	7,653,048	7,366,320
Total current assets	367,786,461	346,312,132
Property and Equipment, Net	511,609,795	431,961,901
Assets Whose Use is Limited		
Under trust indentures and capital lease purchase financing facilities, held by trustees and banks	244,332,570	269,595,205
Professional liability trust fund	11,878,591	12,233,224
Deferred compensation fund	1,403,371	1,466,041
Cash and Cash Equivalents Temporarily Restricted for Capital Acquisitions	2,322,753	2,264,115
Investments and Investments in Unconsolidated Subsidiaries	15,665,245	13,283,684
Land Held for Healthcare Development	47,660,070	48,706,305
Intangible Assets, Net	8,343,130	8,966,166
Deposits and Other Noncurrent Assets	5,610,693	5,784,836
Total assets	$ 1,216,612,679	$ 1,140,573,609

See notes to consolidated financial statements

Adventist HealthCare, Inc. and Controlled Entities

Consolidated Balance Sheets
December 31, 2017 and 2016

	2017	2016
Liabilities and Net Assets		
Current Liabilities		
Accounts payable and accrued expenses	$ 86,818,184	$ 83,843,748
Accrued compensation and related items	37,260,446	34,851,454
Interest payable	9,747,294	2,021,390
Due to third party payors	17,818,402	18,665,027
Estimated self-insured professional liability	1,179,664	1,150,302
Current maturities of long-term obligations	13,019,860	12,749,886
Total current liabilities	165,843,850	153,281,807
Construction Payable	14,828,539	3,027,323
Long-Term Obligations, Net		
Bonds payable	551,211,489	515,091,030
Notes payable	22,089,282	26,381,525
Capital lease obligations	11,229,970	16,263,001
Derivative Financial Instruments	1,145,303	2,073,079
Other Liabilities	11,963,765	14,864,817
Estimated Self-Insured Professional Liability	13,082,881	11,715,201
Total liabilities	791,395,079	742,697,783
Net Assets		
Unrestricted	417,328,975	391,327,657
Temporarily restricted	7,547,204	6,206,748
Permanently restricted	341,421	341,421
Total net assets	425,217,600	397,875,826
Total liabilities and net assets	$ 1,216,612,679	$ 1,140,573,609

See notes to consolidated financial statements

Adventist HealthCare, Inc. and Controlled Entities

Consolidated Statements of Operations
Years Ended December 31, 2017 and 2016

	2017	2016
Unrestricted Revenues		
Net patient service revenue	$ 801,836,667	$ 773,827,332
Provision for doubtful collections	(31,782,541)	(35,002,586)
Net patient service revenue less provision for doubtful collections	770,054,126	738,824,746
Other revenue	38,064,322	41,106,399
Total unrestricted revenues	808,118,448	779,931,145
Expenses		
Salaries and wages	360,720,746	345,296,234
Employee benefits	68,630,252	65,852,367
Contract labor	39,039,683	36,319,743
Medical supplies	103,013,363	100,324,519
General and administrative	122,036,220	117,809,537
Building and maintenance	41,922,317	42,794,430
Insurance	5,674,763	5,297,256
Interest	10,353,452	10,362,411
Depreciation and amortization	36,463,353	36,746,661
Total expenses	787,854,149	760,803,158
Income from operations	20,264,299	19,127,987
Other Income (Expense)		
Investment income	8,232,502	3,129,171
Loss on extinguishment of debt	-	(686,357)
Other (expense) income	(1,994,397)	44,281
Total other income	6,238,105	2,487,095
Revenues in excess of expenses from continuing operations	26,502,404	21,615,082
Change in net unrealized gains (losses) on investments other than trading securities	2,582,625	(1,430,441)
Change in net unrealized gain on derivative financial instruments	700,697	2,352,325
Net assets released from restriction for purchase of property and equipment	1,152,590	1,217,796
Deferred compensation plan liability adjustment	(512,305)	(521,260)
Other unrestricted net asset activity	(1,762,971)	(1,458,904)
Increase in unrestricted net assets from continuing operations	28,663,040	21,774,598
Loss from discontinued operations	(2,661,722)	(20,227,038)
Increase in unrestricted net assets	$ 26,001,318	$ 1,547,560

See notes to consolidated financial statements

Adventist HealthCare, Inc. and Controlled Entities

Consolidated Statements of Changes in Net Assets
Years Ended December 31, 2017 and 2016

	2017	2016
Unrestricted Net Assets		
Revenues in excess of expenses from continuing operations	$ 26,502,404	$ 21,615,082
Change in net unrealized gains (losses) on investments other than trading securities	2,582,625	(1,430,441)
Change in net unrealized gain on derivative financial instruments	700,697	2,352,325
Net assets released from restriction for purchase of property and equipment	1,152,590	1,217,796
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Other unrestricted net asset activity	(1,762,971)	(1,458,904)
Increase in unrestricted net assets from continuing operations	28,663,040	21,774,598
Loss from discontinued operations	(2,661,722)	(20,227,038)
Increase in unrestricted net assets	26,001,318	1,547,560
Temporarily Restricted Net Assets		
Restricted gifts and donations	4,933,934	3,438,671
Net assets released from restriction for purchase of property and equipment	(1,152,590)	(1,217,796)
Net assets released from restriction used for operations	(2,480,828)	(2,075,440)
Change in value of beneficial interest in trusts and charitable gift annuity obligation	18,397	(30,449)
Change in discount of pledges receivable and provision for doubtful pledges	11,309	(496,776)
Donor restricted investment income	10,234	4,098
Increase (decrease) in temporarily restricted net assets	1,340,456	(377,692)
Permanently Restricted Net Assets		
Other permanently restricted net asset activity	-	(410,000)
Increase in net assets	27,341,774	759,868
Net Assets, Beginning	397,875,826	397,115,958
Net Assets, Ending	$ 425,217,600	$ 397,875,826

See notes to consolidated financial statements

Adventist HealthCare, Inc. and Controlled Entities

Consolidated Statements of Cash Flows
Years Ended December 31, 2017 and 2016

	2017	2016
Cash Flows from Operating Activities		
Increase in net assets	$ 27,341,774	$ 759,868
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for doubtful collections	31,782,541	36,284,410
Depreciation and amortization	36,453,533	38,098,970
Amortization of deferred financing costs	200,349	189,890
Deferred compensation plan liability adjustment	512,305	521,260
Loss on extinguishment of debt	-	686,357
Restricted contributions and grants	(3,782,795)	(1,878,488)
Earnings recognized from unconsolidated subsidiaries and affiliates	(2,040,340)	(2,335,147)
Amortization of physician income guarantees	9,105	31,530
Net realized (gain) loss on investments	(3,628,355)	710,869
Change in net unrealized (gains) losses on investments other than trading securities	(2,582,625)	1,430,441
Change in net unrealized gain on derivative financial instruments	(700,697)	(2,352,325)
Change in value of beneficial interest in trusts and charitable gift annuity	(18,397)	30,449
Change in discount on pledges receivable and provision for doubtful pledges	(11,309)	496,776
Loss on disposal of BH&WS Eastern Shore	2,911,706	-
Loss on sale of HRMC	-	16,967,178
Changes in assets and liabilities:		
Patient accounts receivable, net	(33,960,881)	(26,011,792)
Other receivables, net	(836,069)	628,056
Inventories, prepaid expenses and other current assets	514,096	(2,229,881)
Accounts payable and accrued expenses	2,880,926	(3,167,435)
Accrued compensation and related items	2,408,992	1,749,437
Interest payable	7,725,904	(309,870)
Estimated self-insured professional liability	1,397,042	573,922
Due to third party payors	(846,625)	(1,495,631)
Other noncurrent assets and liabilities	(3,415,492)	(3,889,927)
Net cash provided by operating activities	$ 62,314,688	$ 55,488,917

See notes to consolidated financial statements

Adventist HealthCare, Inc. and Controlled Entities

Consolidated Statements of Cash Flows
Years Ended December 31, 2017 and 2016

	2017	2016
Cash Flows from Investing Activities		
Purchase of property and equipment	$ (105,592,446)	$ (45,840,372)
Increase in investments and investments in unconsolidated subsidiaries	(3,959,138)	(52,498,944)
Additions to land held for healthcare development	(6,675,741)	(4,729,611)
Proceeds from sale of land for healthcare development	7,721,976	5,938,458
Proceeds from sale of HRMC	-	47,000,550
Distributions from investments in unconsolidated subsidiaries	321,113	389,555
Purchase of investment in unconsolidated subsidiary	(674,626)	(2,435,579)
Decrease (increase) in trustee held funds and restricted cash	26,520,312	(264,548,939)
Net cash used in investing activities	(82,338,550)	(316,724,882)
Cash Flows from Financing Activities		
Payment of financing costs	(423,227)	(3,509,604)
Proceeds from issuance of bonds	40,000,000	296,979,390
Repayments on long-term obligations, net	(12,818,901)	(32,710,743)
Proceeds from capital lease facility	-	32,922
Payment of termination fee for derivative financial instrument	-	(16,875,000)
Proceeds from restricted contributions and grants	3,782,795	1,878,488
Net cash provided by financing activities	30,540,667	245,795,453
Net increase (decrease) in cash and cash equivalents	10,516,805	(15,440,512)
Cash and Cash Equivalents, Beginning	30,198,079	45,638,591
Cash and Cash Equivalents, Ending	$ 40,714,884	$ 30,198,079
Supplemental Disclosure of Cash Flow Information		
Interest paid	$ 4,138,018	$ 12,490,712
Supplemental Disclosure of Noncash Investing and Financing Activities		
Capital lease obligation incurred for equipment	$ 469,249	$ 14,740,520
Construction payable for property and equipment	$ 14,828,539	$ 3,027,323
Long-term debt refinanced	$ -	$ 110,035,000

See notes to consolidated financial statements

1. Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations

Adventist HealthCare, Inc. ("AHC") is a nonstock membership corporation organized to effectuate coordinated administration of hospitals and other health care organizations through the provision of key management and administrative services. The mission of AHC is to extend God's care through the ministry of physical, mental and spiritual healing. AHC is tax-exempt under Section 501(c)(3) of the Internal Revenue Code. AHC is not exempt from income taxes for unrelated business income. AHC's sole corporate member is Mid-Atlantic Adventist HealthCare, Inc. AHC is comprised of several operating divisions and controlled entities, as follows:

Shady Grove Medical Center ("SGMC") is a 266-bed acute care hospital located in Rockville, Maryland.

Washington Adventist Hospital ("WAH") is a 236-bed acute care hospital located in Takoma Park, Maryland.

Hackettstown Community Hospital d.b.a. Hackettstown Regional Medical Center ("HRMC") is a 111-bed not-for-profit acute care hospital organized under the laws of the State of New Jersey. On March 31, 2016, the Corporation sold the operating assets to an unrelated third party, and discontinued the operations of the facility. See Note 3 for further details.

Behavioral Health & Wellness Services ("BH&WS") is comprised of two separate facilities located in Maryland. BH&WS - Rockville is a 107-bed psychiatric hospital. BH&WS - Eastern Shore is an acute care and residential mental health resource for children and adolescents, which had 15 acute care psychiatric beds and 59 residential treatment rooms. In November, 2016, AHC made the decision to discontinue the operations of the BH&WS - Eastern Shore location. See Note 3 for further details.

Rehabilitation ("Rehab") operates one inpatient hospital with two sites in Maryland, as well as two outpatient locations. Rehab - Rockville is a 55-bed rehabilitation facility and Rehab - Takoma Park is a 32-bed rehabilitation facility.

Adventist HealthCare Imaging ("Imaging") operates six clinical sites and provides inpatient and outpatient imaging services at SGMC and WAH.

Clinical Integration Services ("CIS") is comprised of Adventist Medical Group ("AMG"). AMG is a not-for-profit entity that provides primary care and specialty care physician professional health services to the communities it serves. AHC contracted with Medical Faculty Associates, Inc. ("MFA") to employ the AMG employees, through a wholly owned affiliate of MFA, in exchange for certain economic support to facilitate the growth by MFA of the AMG physician practices. In December 2017, however, AHC terminated its contract with MFA as it relates to the primary care, physiatry and endocrinology practices. The termination is effective July 2018, at which time the primary care, physiatry and endocrinology practices will be operated by AHC. The remaining specialty care practices will continue to be operated by MFA, with the respective operating results recorded in SGMC and WAH. CIS also includes the administration needed to facilitate the coordination of patient care across conditions, providers and settings.

The Other Health Services operating division is comprised of two entities. Lifework Strategies ("LWS") provides employee assistance and employee wellness programs to client employees. LWS's mission is to help individuals live healthier, happier and more productive lives. Capital Choice Pathology Lab ("CCPL") provides full pathology production services to client hospitals.

The Support Center is comprised of the Corporate Office ("CO") and the AHC benefit business unit. The CO provides corporate and centralized shared service functions that benefit the entire AHC system. The AHC benefit business unit administers the self-insurance health benefit program including health insurance, dental and vision coverage for AHC and controlled entities.

The Lourie Center for Infants and Young Children ("Lourie Center") is a not-for-profit organization that specializes in the diagnosis, treatment and prevention of developmental and emotional disorders in children from birth through ten years of age.

Adventist Home Care Services, Inc. ("AHCS") is a nonstock membership corporation organized to provide home health services in Maryland and includes Adventist Home Assistance ("AHA"). AHA provides non clinical assistance to homebound patients who cannot perform certain daily activities on their own.

The Urgent Care operating division is comprised of three urgent care centers located in Germantown, Laurel, and Rockville, Maryland. These centers provide ambulatory services to patients without life threatening conditions, as well as occupational health screenings to the community. The operating division started in October 2013 when Adventist HealthCare Urgent Care Centers, Inc. ("Urgent Care"), a Maryland non-profit corporation and Adventist Health System/Sunbelt, Inc. d/b/a Florida Hospital Centra Care, a Florida non-profit corporation, entered into a management services and license agreement to establish free standing urgent care centers in Montgomery and Prince Georges County, Maryland. This agreement was terminated effective October 10, 2017 and going forward an unrelated third party will assist in management of these centers.

One Health Quality Alliance ("OHQA") is a physician-led clinically integrated network designed to deliver value to payors, employers and consumers through the highest quality care at a lower cost. Through this alliance, participating physicians gain access to resources to support the transition to value-based care, while maintaining their independence. Through this collaboration, OHQA aims to improve the health of patient populations and communities, while enhancing the patient experience and reducing the costs of health care. The OHQA currently has over 450 physician members, most of whom are on the medical staff of AHC, including primary care, orthopedics and other community and hospital based specialists.

Mid-Atlantic Primary Care Accountable Care Organization ("ACO") was managed by AHC and cared for approximately 13,500 patients through its 1,000 providers. The ACO was a program designed to provide a high level of access and coordination of care for Medicare fee for service patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. The final performance year for the ACO was calendar year 2016, with a final distribution of $3,140,869 made to its members in October 2017, after which the ACO no longer existed. AHC's portion of this payment was approximately $1,356,000 and is included in other income in the accompanying consolidated statements of operations in 2017.

The Foundations operating division is comprised of Washington Adventist Hospital Foundation, Inc., Shady Grove Medical Center Foundation, Inc., and Adventist Behavioral Health & Wellness Services Foundation, Inc. (collectively, the "Foundations"). Each are separate nonstock corporations that operate for the furtherance of each named hospital's health care objectives primarily through the solicitation of contributions, gifts and bequests. The Foundations also exist to help fund new equipment purchases and capital improvement projects for their respective hospitals. Prior to March 31, 2016, the Foundations also included the operations of the Hackettstown Community Hospital Foundation, Inc. ("HRMC Foundation"). On March 31, 2016, however, AHC sold the operating assets of the HRMC Foundation to an unrelated third party and discontinued the operations of the foundation. See Note 3 for further details.

All of the operating divisions and controlled entities mentioned above are tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

Principles of Consolidation

The consolidated financial statements for 2017 and 2016 include the accounts of AHC, the controlling parent, SGMC, WAH, HRMC, BH&WS, Rehab, Imaging, CIS, LWS, CCPL, the Support Center, the Lourie Center, AHCS, Urgent Care, OHQA, ACO and the Foundations, which include their majority-owned subsidiaries and controlled affiliates (collectively, the "Corporation"). All significant intercompany balances and transactions have been eliminated in the consolidated financial statements of the Corporation.

Subsequent Events

The Corporation evaluated subsequent events for recognition or disclosure through April 25, 2018, the date the consolidated financial statements were issued.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America 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 consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Risk Factors

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations is subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time. Government activity continues to increase with respect to investigations and allegations concerning possible violations by healthcare providers of fraud and abuse statutes and regulations, which could result in the imposition of significant fines and penalties as well as significant repayments for patient services previously billed. Management is not aware of any material incidents of noncompliance; however, the possible future financial effects of this matter on the Corporation, if any, are not presently determinable.

Maryland Health Services Cost Review Commission

Certain hospital charges are subject to review and approval by the Maryland Health Services Cost Review Commission ("HSCRC"). The HSCRC has jurisdiction over hospital reimbursement in Maryland by agreement with the Centers for Medicare and Medicaid Services ("CMS"). This agreement is based on a waiver from the Medicare Prospective Payment System reimbursement principles granted under Section 1814(b) of the Social Security Act. Management has filed the required forms with the Commission and believes all entities that fall under the HSCRC's jurisdiction are in compliance with applicable requirements.

In January 2014, the Centers for Medicare and Medicaid Services approved a modernized waiver that grants Maryland (via the HSCRC) the authority to regulate hospital revenue within a rigorous per capita expenditure limit. Maryland's All Payer Model Agreement builds on decades of innovation and equity in healthcare payment and delivery – with an aim to enhance patient care, improve health outcomes and lower costs.

As a result of the new waiver, the HSCRC introduced new revenue arrangements, including the Global Budget Revenue ("GBR") model. The GBR methodology encourages hospitals to focus on population health strategies by establishing a fixed annual revenue cap for each GBR hospital. The agreement establishes a fixed amount of charging authority (i.e. revenue) at the beginning of the rate year. It is evergreen in nature and covers both regulated inpatient and outpatient revenues. 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 from one health system to another and from a regulated setting to an unregulated setting (or vice versa).

In April 2014, Adventist Healthcare entered into a Global Budget Revenue Agreement with the HSCRC for SGMC, WAH and Shady Grove Germantown Emergency Center, retroactive to July 1, 2013. This agreement sets a fixed amount of revenue for each entity for the period July 1, 2013 through June 30, 2014 and is subsequently updated on an annual basis every July 1.

The HSCRC requires rate-regulated hospitals under its jurisdiction to calculate the amount of revenue lost or gained due to variances from approved rates. Revenue lost due to undercharges in rates is recouped through increases in prospective rates. Similarly, revenue gained due to overcharges in rates is paid back, wholly or in part, through reductions in prospective rates. The Corporation reported net undercharges of $3,043,105 and $4,183,452 as of December 31, 2017 and 2016, respectively. These price variances reflect the variance between actual patient charges and the pro-rata share of approved rate orders. The net amounts are reported as a component of net patient service revenue and patient accounts receivable in the accompanying consolidated financial statements. Since the HSCRC's rate year extends from July 1 through June 30, these amounts will continue to fluctuate until the end of the rate year as actual patient charges deviate from the total approved charging authority. At the conclusion of the rate year, any over/under charges are amortized on the straight-line basis over the following rate year when the price variance adjustments are actually built into each entity's rate order.

Under Maryland law, charges of specialty hospitals such as BH&WS and Rehab are subject to review and approval by the HSCRC. HSCRC regulations also include a provision whereby a hospital may apply for an exemption from the requirements to charge for services in accordance with HSCRC regulations. Certain conditions regarding the percentage of revenue related to Medicare and Medicaid patients and total revenues must be met to receive the initial exemption and must be met each year thereafter. Reporting requirements as established by the HSCRC continue even if an exemption regarding charging for services is received. The Corporation's management believes BH&WS-Eastern Shore and Rehab met the conditions for exemption during 2017 and 2016.

BH&WS-Rockville is subject to HSCRC rate setting. For 2016 and 2017, BH&WS-Rockville did not enter into a Global Budget Revenue Agreement. Instead, BH&WS-Rockville continues to generate charging authority based on the volume of services it provides to patients. Unit rates are set for all payers, however Medicare and Medicaid are not required to reimburse at HSCRC rates. Services provided to Medicare beneficiaries are reimbursed under the Inpatient Psychiatric Facility Prospective Payment System. Services provided to Medicaid patients are cost-settled for outpatient services and reimbursed for inpatient services at a rate of 94% percent of charges (as set forth in the Code of Maryland Regulations 10.09.06.09).

Cash and Cash Equivalents

Cash and cash equivalents include investments in money market funds and certificates of deposit purchased with original maturities of less than 90 days, excluding assets whose use is limited.

Patient Accounts Receivable

Patient accounts receivable are reported at net realizable value. Accounts are written off when they are determined to be uncollectible based upon management's assessment of individual accounts. In evaluating the collectability of patient accounts receivable, the Corporation analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful collections and provision for doubtful collections. For patient accounts receivable associated with services provided to patients who have third-party coverage, the Corporation analyzes contractually due amounts and provides an allowance for doubtful collections and provision for doubtful collections, 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 Corporation records a provision for doubtful collections in the period of service on the basis of its past experience, which indicates that many patients are unable to pay the portion of their bill for which they are financially responsible. The difference between the billed rates and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful collections.

The Corporation's allowance for doubtful collections for self-pay patients as a percentage of self-pay accounts receivable was 44% and 52% at December 31, 2017 and 2016, respectively. In addition, the Corporation's self-pay account bad debt writeoffs, net of recoveries, decreased from $31,701,926 in 2016 to $31,495,503 in 2017 which was the result of small positive trends experienced in the collection of amounts from self-pay patients in 2017.

Other Receivables

Other receivables represent amounts due to the Corporation for charges other than providing health care services to patients and pledges from donors. These services include, but are not limited to, fees from educational programs, rental of health care facility space, interest earned, and management services provided to unconsolidated subsidiaries. Other receivables are written off when they are determined to be uncollectible based on management's assessment of individual accounts. The allowance for doubtful collections is estimated based upon historical collection experience and other managerial information.

Assets Whose Use Is Limited

Assets whose use is limited includes assets held by bond trustees under trust indentures, assets set aside as required by the Corporation's self-funded professional liability trust, and assets set aside for deferred compensation agreements. Amounts available to meet current liabilities of the Corporation have been reclassified as current assets in the accompanying consolidated balance sheets.

Investments and Investment Risk

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the accompanying consolidated balance sheets. Cash and cash equivalents and certificates of deposit are carried at cost which approximates fair value. Investments in joint ventures are accounted for using the equity or cost method of accounting depending on the Corporation's ownership interest. Investment income or loss (including realized gains and losses on investments, write-downs of the cost basis of investments due to an other-than-temporary decline in fair value, interest, and dividends) is included in the determination of revenues in excess of expenses from continuing operations unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the determination of revenues in excess of expenses from continuing operations unless the investments are trading securities. Donor-restricted investment income is reported as an increase in temporarily restricted net assets. Investments available for current operations have been classified as short-term investments in the accompanying consolidated balance sheets.

The Corporation's investments are comprised of a variety of financial instruments. The fair values reported in the consolidated balance sheets are subject to various risks including changes in the equity markets, the interest rate environment, and general economic conditions. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the fair value of investment securities, it is reasonably possible that the amounts reported in the accompanying consolidated financial statements could change materially in the near term.

Inventories

Inventories of drugs, medical supplies and surgical supplies are valued at the lower of cost or net realizable value. Cost is determined primarily by the weighted average cost method.

Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful lives of the assets using the straight-line method. Equipment under capital leases is amortized on the straight-line method over the shorter period of the lease term or estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the accompanying consolidated statements of operations.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Impairment losses are recognized in the consolidated statements of operations as a component of revenues in excess of expenses from continuing operations as they are determined. The Corporation reviews its long-lived assets whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. In that event, the Corporation calculates the estimated future net cash flows to be generated by the asset. If those future net cash flows are less than the carrying value of the asset, an impairment loss is recognized for the difference between the estimated fair value and the carrying value of the asset. There were no impairment losses reported in 2017 or 2016.

Intangible Assets

The Corporation's intangible assets primarily include costs in excess of net assets acquired related to certain business acquisitions. The Corporation is amortizing certain intangible assets over a period not to exceed 40 years. Amortization of these intangible assets was $221,457 in 2017 and $273,535 in 2016. Accumulated amortization of intangible assets was $3,608,016 and $3,386,559 as of December 31, 2017 and 2016, respectively.

Goodwill, which is included in intangible assets in the accompanying consolidated balance sheet, is reviewed annually for impairment or more frequently if events or circumstances indicate the carrying amount of the goodwill will not be recoverable.

Goodwill related to HRMC of $867,660 was written off in 2016 related to the sale of HRMC (Note 3) and is included in loss from discontinued operations in the accompanying consolidated statements of operations.

Goodwill related to BH&WS Eastern Shore of $411,579 and $241,359 were written off in 2017 and 2016, respectively, related to the closure of this location (Note 3) and is included in loss from discontinued operations in the accompanying consolidated statements of operations.

Deferred Financing Costs

Costs incurred in connection with the issuance of long-term obligations have been deferred and are being amortized over the term of the related obligation using the straight-line method. Deferred financing costs of $423,227 and $3,509,604 were paid in 2017 and 2016, respectively, in relation to the Series 2016A and 2016B Bonds issued in 2016. In addition, deferred financing costs of $686,357 were written-off in 2016 related to redemption of the Series 2005A and 2011B Bonds and are included in the loss on extinguishment of debt in the accompanying consolidated statements of operations in 2016. Deferred financing costs remaining as of December 31, 2017 and 2016 totaled $5,062,797 and $4,839,919, respectively, and are included in the consolidated balance sheets as a reduction of bonds payable.

Amortization expense was $200,349 and $189,890 in 2017 and 2016, respectively, and is included as a component of interest expense in the consolidated statements of operations. Amortization for HRMC was $5,799 in 2016 and is included in loss from discontinued operations in the consolidated statements of operations. Accumulated amortization of deferred financing costs was $2,861,822 and $2,661,473 at December 31, 2017 and 2016, respectively, and is included as a component of bonds payable in the consolidated balance sheets.

Due to Third Party Payors

The Corporation receives advances from third party payors to provide working capital for services rendered to the beneficiaries of such services. These advances are principally determined based on the timing differences between the provision of care and the anticipated payment date of the claim for service in accordance with HSCRC's rate regulations. These advances are subject to periodic adjustment.

For certain Corporation subsidiaries, services provided on behalf of Medicaid beneficiaries are ultimately reimbursed at cost. For cost reimbursement programs, statements of reimbursable costs are filed with the program to compute the difference between reimbursable cost and interim payments, in order to determine a final settlement for services rendered to patients covered under the Medicaid program. Reimbursements are affected by limitations relating to charges and the reasonableness of costs (subject to limitations) and are subject to audits by the agencies administering the applicable program.

The Corporation's working capital advances and all expected third party payor settlement activity are classified as a net current liability in the accompanying consolidated balance sheets.

Derivative Financial Instruments

The Corporation has an interest rate swap agreement, which is considered a derivative financial instrument, to manage its interest rate exposure on certain long-term obligations (Note 11). The interest rate swap agreement is reported at fair value in the accompanying consolidated balance sheets. The interest rate swap agreement is not designated as a cash flow hedge. Changes in fair value are reported as a component of other non-operating (expense) income. The Corporation had an interest rate swap agreement that was designated as a cash flow hedge and terminated in 2016 (Note 10).

Estimated Self-Insured Professional Liability

The provision for estimated self-insured professional liability includes estimates of the ultimate costs for both reported claims and claims incurred but not reported, including costs associated with litigating or settling claims. Anticipated insurance recoveries associated with reported claims are reported separately in the Corporation's consolidated balance sheets at net realizable value.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Corporation has been limited by donors to a specific time period or purpose, including the purchase of capital renovations and equipment, providing health education to the community, and designation for the furtherance of programs provided by specific operating departments. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation in perpetuity.

Revenues in Excess of Expenses from Continuing Operations

The consolidated statements of operations include the determination of revenues in excess of expenses from continuing operations. Revenues in excess of expenses from continuing operations is the Corporation's performance indicator. Changes in unrestricted net assets which are excluded from the determination of revenues in excess of expenses from continuing operations, consistent with industry practice, include the loss from discontinued operations, unrealized gains and losses on investments other than trading securities, the effective portion of the unrealized gain (loss) on derivative financial instruments, the deferred compensation plan liability adjustment, transfers with unconsolidated subsidiaries, contributions of long-lived assets (including contributions which by donor restriction were to be used for the purpose of acquiring such long-lived assets), and other unrestricted net asset activity.

Net Patient Service Revenue

The Corporation reports net patient service revenue at the estimated net realizable amounts from patients, third party payors, and others for services rendered, including an estimate for retroactive adjustments that may occur as a result of future audits, reviews and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period they become known, and such amounts are adjusted in future periods as adjustments become finalized or as years are no longer subject to such audits, review and investigations. Net patient service revenue reported in the accompanying consolidated statements of operations is reduced by (1) estimated allowances for the excess of charges over anticipated patient or third party payor payments and (2) a provision for doubtful collections. Certain of the health care services provided by the Corporation are reimbursed by third party payors on the basis of the lower of cost or charges, with costs subject to certain imposed limitations.

Patient accounts receivable are reported at net realizable value and include charges for accounts due from Medicare, Medicaid, other commercial and managed care insurers, and self-paying patients (Note 16). Patient accounts receivable also includes management's estimate of the impact of certain undercharges to be recouped or overcharges to be paid back for inpatient and outpatient services in subsequent years rates as discussed earlier. The Corporation also deducts from patient accounts receivable an estimated allowance for doubtful collections related to patients and allowances for the excess of charges over the payments to be received from third party payors.

The Corporation has agreements with third-party payors that provide for payments to the Corporation at amounts different from its established rates. The Corporation recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of these established rates for the services rendered. For uninsured patients that do not qualify for charity care, the Corporation recognizes revenues on the basis of its standard rates, discounted in accordance with the Corporation's financial assistance policy. On the basis of historical experience, a significant portion of the Corporation's uninsured patients will be unable to pay for the services provided. Thus, the Corporation records a significant provision for doubtful collections related to uninsured patients in the period the services are provided. Patient service revenues, net of contractual allowances and discounts (but before the provision for doubtful collections), recognized in 2017 and 2016 from these major payor sources, are as follows:

	Patient Service Revenues (Net of Contractual Allowances and Discounts)				
	Medicare	Medicaid	Other Third Party Payors	Self-Pay and Other	Total
December 31, 2017	$ 299,641,313	$ 84,024,467	$ 386,516,398	$ 31,654,489	$ 801,836,667
December 31, 2016	$ 304,061,127	$ 67,425,014	$ 396,777,024	$ 33,464,551	$ 801,727,716

Patient service revenues (net of contractual allowances and discounts) for HRMC were $22,165,831 in 2016. Patient service revenues (net of contractual allowances and discounts) for BH&WS - Eastern Shore were $5,734,553 in 2016. These amounts have been classified in loss from discontinued operations in the consolidated statements of operations.

Income Taxes

The Corporation accounts for uncertainty in income taxes using a recognition threshold of more-likely-than-not to be sustained upon examination by the appropriate taxing authority. Measurement of the tax uncertainty occurs if the recognition threshold is met. Management determined there were no tax uncertainties that met the recognition threshold in 2017 or 2016.

The Corporation's policy is to recognize interest related to unrecognized tax benefits in interest expense and penalties in operating expenses.

Charity Care

The Corporation provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Such patients are identified based on financial information obtained from the patient (or their guarantor) and subsequent analysis which includes the patient's ability to pay for services rendered. Because the Corporation does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as a component of net patient service revenue or patient accounts receivable.

The Corporation maintains records to identify and monitor the level of charity care it provides. The costs associated with the charity care services provided are estimated by applying a cost-to-charge ratio to the amount of gross uncompensated charges for the patients receiving charity care. The level of charity care provided by the Corporation amounted to approximately $7,748,000 in 2017 and $9,395,000 in 2016.

Donor Restricted Gifts

Unconditional promises to give cash and other assets 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 or when the underlying conditions have been substantially met. The gifts are reported as either temporarily or permanently restricted support 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 purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net assets released from restrictions. Restricted funds to be used for capital acquisitions have been reported as noncurrent assets in the accompanying consolidated balance sheets, while other restricted cash and investments are included with the cash and cash equivalents of unrestricted net assets.

Investment income that is earned on donor restricted net assets and subject to similar restrictions is reported as temporarily restricted net assets. Gifts, grants, and bequests not restricted by donors are reported as other operating income.

Advertising Costs

The Corporation expenses advertising costs as they are incurred.

Reclassifications

Certain amounts relating to 2016 have been reclassified to conform to the 2017 reporting format.

2. Adoption of Accounting Standards

Revenue Recognition

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*. ASU No. 2014-09 supersedes the revenue recognition requirements in Topic 605, Revenue Recognition, and most industry-specific guidance. Under the requirements of ASU No. 2014-09, the core principle is that entities should recognize revenue to depict the transfer of promised goods or services to customers (patients) in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The Corporation will be required to retrospectively adopt the guidance in ASU No. 2014-09 for years beginning after December 15, 2017. The Corporation has not yet determined the impact of adoption of ASU No. 2014-09 will have on its consolidated financial statements.

Financial Instruments

During January 2016, the FASB issued ASU No. 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities*. ASU No. 2016-01: a) requires equity investments (except those accounted for under the equity method of accounting or those that result in consolidation of the investee) to be measured at fair value with changes in fair value recognized in net income; (b) simplifies the impairment assessment of equity investments without readily determinable fair values by requiring a qualitative assessment to identify impairment; (c) eliminates the requirement to disclose the fair value of financial instruments measured at amortized cost for entities that are not public business entities; (d) eliminates the requirement for public business entities to disclose the method(s) and significant assumptions used to estimate the fair value that is required to be disclosed for financial instruments measured at amortized cost on the balance sheet; (e) requires public business entities to use the exit price notion when measuring the fair value of financial instruments for disclosure purposes; (f) requires an entity to present separately in other comprehensive income the portion of the total change in the fair value of a liability resulting from a change in the instrument-specific credit risk when the entity has elected to measure the liability at fair value in accordance with the fair value option for financial instruments; (g) requires separate presentation of financial assets and financial liabilities by measurement category and form of financial asset (that is, securities or loans and receivables) on the balance sheet or the accompanying notes to the financial statements; and (h) clarifies that an entity should evaluate the need for a valuation allowance on a deferred tax asset related to available-for-sale securities in combination with the entity's other deferred tax assets. ASU No. 2016-01 is effective for annual periods and interim periods within those annual periods beginning after December 15, 2017. Early adoption of certain amendments is permitted for financial statements of fiscal years or interim periods that have not yet been issued. The Corporation has not yet determined the impact of adoption of ASU No. 2016-01 will have on its consolidated financial statements.

Not-for-Profit Financial Statement Presentation

In August 2016, FASB issued ASU No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statement of Not-for-Profit Entities*. The new guidance is intended to improve and simplify the current net asset classification requirements and information presented in financial statements and notes that is useful in assessing a not-for-profit's liquidity, financial performance and cash flows. ASU No 2016-14 is effective for fiscal years beginning after December 15, 2017, with early adoption permitted. ASU No. 2016-14 is to be applied retrospectively with transition provisions. The Corporation has not yet determined the impact of adoption of ASU No. 2016-14 will have on its consolidated financial statements.

Statement of Cash Flows

During August 2016, the FASB issued ASU No. 2016-15, *Classification of Certain Cash Receipts and Cash Payments*. ASU No. 2016-15 addresses eight cash flow issues with specific guidance on how certain cash receipts and cash payments should be presented on the statement of cash flows. ASU No. 2016-15 is effective for annual periods and interim periods within those annual periods beginning after December 15, 2017. Early adoption is permitted. The Corporation has not yet determined the impact of adoption of ASU No. 2016-15 will have on its consolidated statement of cash flows.

Restricted Cash

During November 2016 the FASB issued ASU No. 2016-18, *Statement of Cash Flows (Topic 30), Restricted Cash.* ASU No. 2016-18 requires that a statement of cash flows explain the change during the period in the total cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. Amounts generally described as restricted cash and restricted cash equivalents should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts showing on the statement of cash flows. ASU No. 2016-18 is effective for fiscal years beginning after December 15, 2017, and interim periods within those fiscal years. Early adoption is permitted. The ASU should be applied using the retrospective transition method to each period presented. The Corporation has not yet determined the impact of adoption of ASU No. 2016-18 will have on its consolidated statement of cash flows.

Lease Accounting

In February 2016, FASB issued ASU No. 2016-02, *Leases (Topic 842)*. ASU No. 2016-02 was issued to increase transparency and comparability among organizations by recognizing lease assets and lease liabilities on the balance sheet and disclosing key information about leasing arrangements. Under the provisions of ASU No. 2016-02, a lessee is required to recognize a right-to-use asset and lease liability, initially measured at the present value of the lease payments, in the balance sheet. In addition, lessees are required to provide qualitative and quantitative disclosures that enable users to understand more about the nature of the Corporation's leasing activities. The Corporation will be required to retrospectively adopt the guidance in ASU No. 2016-02 for years beginning after December 15, 2018. The Corporation has not yet determined the impact of adoption of ASU No. 2016-02 will have on its consolidated financial statements.

Goodwill

During January 2017, FASB issued ASU No. 2017-04, *Simplifying the Test for Goodwill Impairment*. ASU No. 2017-04 simplifies how an entity is required to test goodwill for impairment by eliminating Step 2 from the goodwill impairment test. ASU No. 2017-04 is effective for annual or any interim goodwill impairment tests in fiscal years beginning after December 15, 2021. Early adoption is permitted for interim or annual goodwill impairment tests performed on testing dates after January 1, 2017. The Corporation does not believe that the adoption of ASU No. 2017-04 will have a material effect on its consolidated financial statements.

3. Discontinued Operations

On March 31, 2016, the Corporation sold the operating assets of HRMC and the HRMC Foundation to an unrelated third party, and discontinued the operations of the facility. The Corporation received net proceeds from the sale of approximately $44,500,000, which was net of a contribution paid by the Corporation of $2,500,000 to the HRMC Foundation. The Corporation recorded a loss on sale of $16,967,178 in 2016 which was included in the loss from discontinued operations in the accompanying consolidated statements of operations. The largest component of the loss on sale in 2016 is related to the write-off of costs associated with HRMC's electronic medical records system, which totaled approximately $11,518,000. During 2017, the Corporation recorded a gain from discontinued operations of $249,984 related to the final settlement of receivables and payables that existed at the time of sale. The amount is included in the net loss from discontinued operations in the accompanying consolidated statements of operations.

The following amounts related to discontinued operations are included in the gain (loss) from discontinued operations in the accompanying consolidated statements of operations:

	2017	2016
Total unrestricted revenues	$ -	$ 22,901,438
Total expenses	-	(22,769,646)
Other non-operating income (loss), including loss on sale in 2016 of $16,967,178	249,984	(17,063,626)
Revenues in excess of (less than) expenses	$ 249,984	$ (16,931,834)

During 2016, AHC discontinued operations at the BH&WS – Eastern Shore facility and made the decision to no longer provide services on Maryland's eastern shore. The following amounts related to discontinued operations are included in loss from discontinued operations in the accompanying consolidated statements of operations:

	2017	2016
Total unrestricted revenues	$ -	$ 6,706,337
Total expenses	-	(10,001,541)
Other non-operating loss	(2,911,706)	-
Revenues less than expenses	$ (2,911,706)	$ (3,295,204)

The majority of the property and equipment was disposed as a result of the closure and a loss of approximately $1,611,000 and $358,000 for 2017 and 2016, respectively, was recognized and included in the loss from discontinued operations in the accompanying consolidated statements of operations. In addition, goodwill of approximately $412,000 and $241,000 related to BH&WS Eastern Shore was written off and included in the loss from discontinued operations in the accompanying consolidated statements of operations in 2017 and 2016, respectively.

4. Investments

Short-Term Investments

The Corporation's short-term investments at December 31, 2017 and 2016 are comprised of the following:

	2017	2016
Cash and cash equivalents	$ 827,792	$ 3,653,630
Fixed Income:		
Corporate bonds	72,558,705	48,547,456
Asset backed securities	34,501,068	29,703,673
U.S. government securities,		
U.S. treasury notes	61,937,170	83,195,405
Mutual Funds:		
Equity - balanced	17,575,243	19,683,702
Equity - growth	10,403,051	3,810,315
Total	$ 197,803,029	$ 188,594,181

Assets Whose Use is Limited

The composition of assets whose use is limited at December 31, 2017 and 2016 is set forth in the following tables:

	2017	2016
Under trust indentures and capital lease purchase financing facilities, held by trustees and banks:		
Cash and cash equivalents	$ 56,604,016	$ 265,926,780
U.S. government securities,		
U.S. treasury notes	166,238,057	5,388,464
U.S. government agency notes	23,234,629	-
Total	246,076,702	271,315,244
Less funds held for current liabilities	1,744,132	1,720,039
Noncurrent portion of assets held under trust indentures and capital lease purchase financing facilities	$ 244,332,570	$ 269,595,205

	2017	2016
Professional liability trust fund:		
Cash and cash equivalents	$ 228,643	$ 864,028
Mutual funds:		
Equity - balanced	801,545	9,191,703
Equity - large value	3,869,027	-
Equity - growth	1,137,927	-
Fixed income - intermediate	3,912,844	-
Fixed income - multi-sector	960,543	-
Fixed income - short term	2,147,726	3,327,795
Total	13,058,255	13,383,526
Less funds held for current liabilities	1,179,664	1,150,302
Noncurrent portion of professional liability trust fund	$ 11,878,591	$ 12,233,224
Deferred compensation fund:		
Mutual funds,		
Equity - growth	$ 1,403,371	$ 1,466,041

The indenture requirements of certain tax exempt financings provide for the establishment and maintenance of various accounts with a trustee (Note 10). These arrangements require the trustee to control the payment of interest and the ultimate repayment of respective debt to bondholders.

The composition of trustee held and escrow funds at December 31, 2017 and 2016 is as follows:

	2017	2016
Debt service reserve funds	$ 28,224,212	$ 28,118,144
Principal and interest funds	29,448,690	35,363,487
Project fund	188,403,800	207,833,613
Total	$ 246,076,702	$ 271,315,244

Unrestricted investment income and gains and losses for investments, assets whose use is limited, and cash and cash equivalents are comprised of the following in 2017 and 2016:

	2017	2016
Investment income:		
Interest and dividends, net	$ 4,555,234	$ 3,853,355
Interest on trustee held funds	48,913	62,244
Net realized gains (losses) on sale of investments	3,628,355	(710,869)
Total	$ 8,232,502	$ 3,204,730
Other changes in unrestricted net assets,		
Change in net unrealized gains (losses) on investments other than trading securities	$ 2,582,625	$ (1,430,441)

Investment income for HRMC was $75,559 in 2016, which is included in loss from discontinued operations in the consolidated statements of operations. Included in these amounts are net realized losses on sale of investments of $60,700, interest on trustee held funds of $4,030, and interest and dividends, net of $132,229 in 2016.

5. Fair Value Measurements and Financial Instruments

Fair Value Measurements

The Corporation measures its short-term investments, assets whose use is limited, investments, beneficial interest in trusts, and derivative financial instruments at fair value on a recurring basis in accordance with accounting principles generally accepted in the United States of America.

Fair value is defined as the price that would be received to sell an asset or the price that would be paid to transfer a liability in an orderly transaction between market participants at the measurement date. The framework that the authoritative guidance establishes for measuring fair value includes a hierarchy used to classify the inputs used in measuring fair value. The hierarchy prioritizes the inputs used in determining valuations into three levels. The level in the fair value hierarchy within which the fair value measurement falls is determined based on the lowest level input that is significant to the fair value measurement.

The levels of the fair value hierarchy are as follows:

Level 1 - Fair value is based on unadjusted quoted prices in active markets that are accessible to the Corporation for identical assets. These generally provide the most reliable evidence and are used to measure fair value whenever available.

Level 2 - Fair value is based on significant inputs, other than Level 1 inputs, that are observable either directly or indirectly for substantially the full term of the asset through corroboration with observable market data. Level 2 inputs include quoted market prices in active markets for similar assets, quoted market prices in markets that are not active for identical or similar assets, and other observable inputs.

Level 3 - Fair value would be based on significant unobservable inputs. Examples of valuation methodologies that would result in Level 3 classification include option pricing models, discounted cash flows, and other similar techniques.

The fair value of the Corporation's financial instruments was measured using the following inputs at December 31:

	2017				
	Carrying Value	Fair Value	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
Reported at Fair Value					
Assets:					
Cash and cash equivalents	$ 58,471,764	$ 58,471,764	$ 58,471,764	$ -	$ -
Mutual funds:					
Fixed income – intermediate	3,970,702	3,970,702	3,970,702	-	-
Fixed income – multi - sector	960,543	960,543	960,543	-	-
Fixed income – short term	2,147,726	2,147,726	2,147,726	-	-
Equity - growth	12,960,164	12,960,164	12,960,164	-	-
Equity - large value	3,887,685	3,887,685	3,887,685	-	-
Equity - balanced	18,376,788	18,376,788	18,376,788	-	-
U.S. government securities:					
U.S. treasury notes	228,175,227	228,175,227	-	228,175,227	-
U.S. government agency notes	23,234,629	23,234,629	-	23,234,629	-
Asset backed securities	34,501,068	34,501,068		34,501,068	-
Corporate bonds and other debt securities	72,558,705	72,558,705	-	72,558,705	-
Beneficial interest in trusts	1,052,891	1,052,891	-	-	1,052,891
	$ 460,297,892	$ 460,297,892	$ 100,775,372	$ 358,469,629	$ 1,052,891
Liabilities,					
Derivative financial instruments	$ 1,145,303	$ 1,145,303	$ -	$ 1,145,303	$ -

Disclosed at Fair Value					
Cash and cash equivalents	$ 40,714,884	$ 40,714,884	$ 40,714,884	$	$
Pledges receivable	4,333,990	4,181,880	-	-	-
Long-term debt, excluding capital leases (Note 10):					
Fixed rate revenue bonds	526,076,559	578,746,439	-	578,746,439	-
Variable rate revenue bonds	22,985,000	22,985,000	-	22,985,000	-
Note payable	22,861,750	22,861,750	-	-	22,861,750
Secured line of credit	3,500,000	3,500,000	-	-	3,500,000

	2016				
	Carrying Value	**Fair Value**	**Quoted Prices in Active Markets (Level 1)**	**Other Observable Inputs (Level 2)**	**Unobservable Inputs (Level 3)**
Reported at Fair Value					
Assets:					
Cash and cash equivalents	$ 270,610,738	$ 270,610,738	$ 270,610,738	$ -	$ -
Mutual funds:					
Fixed income – short term	3,327,795	3,327,795	3,327,795	-	-
Equity - growth	5,284,502	5,284,502	5,284,502	-	-
Equity - other	716,929	716,929	716,929	-	-
Equity - mid-cap	6,803	6,803	6,803	-	-
Equity - balanced	28,875,405	28,875,405	28,875,405	-	-
U.S. government securities,					
U.S. treasury notes	88,583,869	88,583,869	-	88,583,869	-
Asset backed securities	29,703,673	29,703,673	-	29,703,673	-
Corporate bonds and other debt securities	48,547,456	48,547,456	-	48,547,456	-
Beneficial interest in trusts	1,310,686	1,310,686	-	-	1,310,686
	$ 476,967,856	$ 476,967,856	$ 308,822,172	$ 166,834,998	$ 1,310,686
Liabilities,					
Derivative financial instruments	$ 2,073,079	$ 2,073,079	$ -	$ 2,073,079	$ -
Disclosed at Fair Value					
Cash and cash equivalents	$ 30,198,079	$ 30,198,079	$ 30,198,079	$ -	$ -
Pledges receivable	3,669,290	3,562,332	-	-	-
Long-term debt, excluding capital leases (Note 10):					
Fixed rate revenue bonds	488,299,967	521,087,175	-	521,087,175	-
Variable rate revenue bonds	23,985,000	23,985,000	-	23,985,000	-
Note payable	23,613,911	23,613,911	-	-	23,613,911
Secured lines of credit	7,032,921	7,032,921	-	-	7,032,921

The following table presents the fair value measurements for beneficial interest in trusts that have unobservable inputs at December 31, 2017 and 2016:

Balance, January 1, 2016	$ 1,373,458
Decrease in value, included in changes in temporarily restricted net assets	(30,449)
Write-off of HRMC's beneficial interest in trusts	(32,323)
Balance, December 31, 2016	1,310,686
Distributions	(276,192)
Increase in value, included in changes in temporarily restricted net assets	18,397
Balance, December 31, 2017	$ 1,052,891

The following represents a reconciliation of the assets reported at fair value included in the fair value table within the accompanying consolidated balance sheets at December 31:

	2017	2016
Short-term investments (Note 4)	$ 197,803,029	$ 188,594,181
Assets whose use is limited (Note 4):		
Current portion	2,923,796	2,870,341
Under trust indentures and capital lease purchase financing facilities, held by trustees and banks	244,332,570	269,595,205
Professional liability trust fund	11,878,591	12,233,224
Deferred compensation fund	1,403,371	1,466,041
Investments held by foundations	903,644	898,178
Beneficial interest in trusts	1,052,891	1,310,686
	$ 460,297,892	$ 476,967,856

The Corporation did not have any financial assets or financial liabilities measured at fair value.

The following is a description of the valuation methodologies used for assets and liabilities measured at fair value and for financial instruments disclosed at fair value. There have been no changes in methodologies used at December 31, 2017 and 2016.

Cash and cash equivalents: The carrying amounts approximate fair value because of the short maturity of these financial instruments.

Marketable certificates of deposit and mutual funds: Valued based on quoted market prices.

U.S. government securities, corporate bonds and other debt securities: Valued based on estimated quoted market prices of similar securities.

Beneficial interest in trusts: Beneficial interest in trusts are valued based on the fair value of the trusts underlying assets which represents a proxy for discounted present value of future cash flows. Beneficial interest in trusts are included in deposits and other noncurrent assets in the accompanying consolidated balance sheets.

Pledges receivable: Valued based on the original pledge amount, adjusted by a discount rate that a market participant would demand and an evaluation of uncollectible pledges. Pledges receivables are included in prepaid expenses and other current assets and deposits and other noncurrent assets in the accompanying consolidated balance sheets.

Long-term debt: The fair value of the fixed rate debt is estimated based on market data provided by the Corporation's financial consultants. Fair values of the remaining long-term debt are considered to approximate their carrying amounts in the accompanying consolidated balance sheets.

The Corporation measures its derivative financial instruments at fair value based on proprietary models of an independent third-party valuation specialist. The fair value takes into consideration the prevailing interest rate environment and the specific terms and conditions of the derivative financial instrument, and considers the credit risk of the Corporation and counterparty. The method used to determine the fair value calculates the estimated future payments required by the derivative financial instrument and discounts these payments using an appropriate discount rate. The value represents the estimated exit price the Corporation would pay to terminate the agreement.

6. Property and Equipment and Accumulated Depreciation and Amortization

Property and equipment and accumulated depreciation and amortization at December 31, 2017 and 2016 consist of the following:

	2017	2016
Land and improvements	$ 32,566,971	$ 27,532,713
Buildings and improvements	457,474,313	448,226,562
Office furniture and equipment	194,126,065	183,173,853
Computer software and hardware	133,864,945	129,964,265
Equipment under capital leases	24,749,717	24,749,717
Total	842,782,011	813,647,110
Less accumulated depreciation and amortization	(474,343,085)	(440,159,685)
Total	368,438,926	373,487,425
Construction in progress	143,170,869	58,474,476
	$ 511,609,795	$ 431,961,901

Interest incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. During 2017 and 2016, the Corporation incurred interest expense, including amortization expense related to deferred financing costs, of approximately $12,064,000 and $12,012,000, respectively, of which approximately $1,711,000 was capitalized in 2017 and $1,650,000 was capitalized in 2016. HRMC incurred interest expense of approximately $337,000, including amortization expense related to deferred financing costs, in 2016 which is included in loss from discontinued operations in the accompanying consolidated statements of operations of which there were no amounts capitalized. Investment earnings of approximately $12,000 and $16,000 were offset against capitalized interest in 2017 and 2016, respectively.

Depreciation expense, including amortization of equipment under capital leases, was approximately $36,604,000 in 2017 and $37,825,000 in 2016. Depreciation expense, including amortization of equipment under capital leases, for HRMC was approximately $1,247,000 in 2016 and is included in loss from discontinued operations in the accompanying consolidated statements of operations. HRMC did not incur depreciation expense in 2017. Depreciation expense, including amortization of equipment under capital leases, for BH&WS - Eastern Shore was approximately $54,000 in 2016 and is included in loss from discontinued operations in the accompanying consolidated statements of operations. BH&WS - Eastern Shore did not incur any depreciation expense in 2017. Accumulated amortization of equipment under capital lease as of December 31, 2017 and 2016 was approximately $20,314,000 and $19,354,000, respectively.

Construction in progress as of December 31, 2017 consists primarily of major renovation and expansion projects of clinical facilities. Purchase commitments related to these and other miscellaneous projects were approximately $155,237,000 at December 31, 2017. The cost of these projects is expected to be funded through the project fund established through bond proceeds as well as transfers from the Corporation's related foundations and operations.

7. Investments and Investments in Unconsolidated Subsidiaries

The Corporation's investments and investments in unconsolidated subsidiaries include the following at December 31, 2017 and 2016:

	2017	2016
Investment in healthcare entities	$ 6,447,367	$ 5,887,970
Investment in Premier	8,409,290	6,595,929
Investments held by foundations	808,588	799,785
Total	$ 15,665,245	$ 13,283,684

Investment in Healthcare Entities

The Corporation recognized earnings of $258,193 and $509,587 during 2017 and 2016, respectively, related to its ownership interest in the healthcare entities accounted for under the equity method. The Corporation recognized earnings of $98,332 during 2016, which is included in the loss from discontinued operations in the consolidated statement of operations, related to HRMC's ownership interest in healthcare entities accounted for under the equity method. A brief description of these investments is presented below:

Chesapeake Potomac Regional Cancer Center ("CPRCC") - CPRCC provides outpatient radiation oncology services to patients in Maryland. The Corporation has a 20% ownership interest in CPRCC.

Doctors Regional Cancer Center ("DRCC") - DRCC provides outpatient radiation oncology services to patients in Bowie and Lanham, Maryland. The Corporation has a 20% ownership interest in DRCC.

Shady Grove Medical Building, LLC ("SGMB") - SGMB was organized for the purpose of developing and constructing a cancer care center on the campus of Shady Grove Medical Center. The Corporation has a 50% ownership interest in SGMB.

The Corporation has invested $259,100 in Advanced Health Collaborative, LLC for a 25% ownership interest. This organization was formed to share ideas and explore opportunities to enhance quality of healthcare in the state of Maryland.

The Corporation has invested $2,702,672 in Advanced Health Collaborative II, LLC ("AHC II") for a 25% interest. AHC II was formed to hold a 24% interest in Maryland Health Advantage, LLC which is a Medicare preferred provider network providing health services to its members.

Summarized financial information related to these entities is presented below:

	2017	2016
Net revenue	$ 17,682,566	$ 17,258,901
Revenues in excess of expenses	958,934	1,705,494
Total assets	30,265,624	29,861,576
Total liabilities	15,478,915	15,834,676

Investment in Premier

The Corporation is a partner in Premier, Inc. ("Premier"), a health care system group purchasing organization. In 2013, the Corporation recorded its Premier investment under the cost method of accounting. In October 2013, Premier converted from a privately held company to a public company through the issuance of an Initial Public Offering. At the time of conversion, the Corporation was issued 493,810 Class B common units of which 78,946 units were sold.

The remaining 414,864 Class B common units held by the Corporation are exchangeable for Class A common stock over a 7-year quarterly vesting period. The Corporation recognized a gain of $1,782,147 and $1,727,228 during 2017 and 2016, respectively, based on the market value of the units available for exchange. In addition, the Corporation recognized earnings of $707,426 and $802,812 during 2017 and 2016, respectively, related to distributions. Both the gain and the distributions are included in other revenue in the accompanying consolidated statements of operations.

Investments Held by Foundations

The Foundations also hold marketable debt and equity securities for funds not required to be expended in less than 90 days. These marketable securities are subject to credit and market risks.

8. Land Held for Healthcare Development

From 2002 through 2011, the Corporation acquired various parcels of land in Clarksburg, Maryland totaling approximately 200 acres. Several parcels of the land are fully owned by the Corporation, and the remainder is owned by Cabin Branch Commons, LLC ("Cabin Branch"), of which the Corporation owns 45%.

In May 2013, the Corporation and Cabin Branch entered into a purchase and sale agreement with an unrelated third party to sell 48.8 acres of the land located in Clarksburg. In June 2015, the Corporation and Cabin Branch closed on the sale of the land at a purchase price of $28,250,000. The Corporation's portion of the proceeds was $25,101,980. As of December 31, 2015, the Corporation received $13,225,064 of their portion of the purchase price, with the additional proceeds being held in escrow to be received upon the completion of certain infrastructure improvements to the property, for which the Corporation and Cabin Branch are collectively responsible. Those infrastructure improvements were made during 2016 and 2017, and the Corporation received the remaining proceeds from the escrow of $4,806,542 and $7,070,374 in 2016 and 2017, respectively, as reimbursement for the infrastructure improvements made to the property.

In April 2017, the Corporation entered into a purchase and sale agreement with an unrelated third party to sell 1.6 acres of the land located in Clarksburg. The Corporation closed on the sale of the land in April 2017 at a purchase price of $1,330,000, the entire proceeds of which were received in April 2017.

The total proceeds received related to the parcels of land sold by the Corporation in June 2015 and April 2017 noted above, was $26,431,980. No gain or loss was recognized on the sale of the parcels of land as of December 31, 2017 and 2016. Total remaining land held for healthcare development in Clarksburg as of December 31, 2017 and 2016, was $47,660,070 and $48,706,305, respectively.

9. Short-Term Financing

The Corporation has a $3,000,000 unsecured line of credit with a commercial bank, with interest at LIBOR plus 1.50% (3.06% at December 31, 2017). There were no borrowings outstanding under this line of credit as of December 31, 2017 or 2016.

10. Long Term Obligations

Long term obligations as of December 31, 2017 and 2016 are comprised of the following:

	2017	2016
Fixed rate revenue bonds	$ 526,076,559	$ 488,299,967
Variable rate revenue bonds	22,985,000	23,985,000
Secured lines of credit	3,500,000	7,032,921
Note payable	22,861,750	23,613,911
Other long term liabilities	16,683,010	21,524,170
Total obligations	592,106,319	564,455,969
Plus bond premium	10,507,079	10,869,392
Less:		
Current maturities	(13,019,860)	(12,749,886)
Deferred financing costs	(5,062,797)	(4,839,919)
Noncurrent portion of long term obligations, net	$ 584,530,741	$ 557,735,556

Fixed Rate Revenue Bonds

Fixed rate revenue bonds consist of the Maryland Health and Higher Educational Facilities Authority Refunding Revenue Bonds. Fixed rate revenue bonds consist of the following at December 31:

	Par Amounts	Interest Rates	2017	2016
Adventist Healthcare, Inc.:				
Series 2011A	$ 57,205,000	5-6.25%	$ 57,205,000	$ 57,205,000
Series 2013	15,623,500	3.21%	9,886,559	11,384,967
Series 2014A	24,280,000	3.56%	22,840,000	23,565,000
Series 2016A	269,750,000	5.00%	269,750,000	269,750,000
Series 2016B	126,395,000	3.23%	126,395,000	126,395,000
Series 2017	40,000,000	2.77%	40,000,000	-
Total			$ 526,076,559	$ 488,299,967

The above bond issues are subject to trust indentures which impose various covenants on SGMC, WAH, HRMC, BH&WS, Rehab, Imaging, CIS, Other Health Services and the Support Center (collectively, the "Obligated Group") which include restrictions on the transfer or disposition of property, the incurrence of additional liabilities, and the achievement of certain pre-established financial indicators. Management believes it has complied with these required financial covenants for the years ended December 31, 2017 and 2016. Debt service reserve funds are required on the Series 2011A, Series 2016A and Series 2017 bonds.

Variable Rate Revenue Bonds

The variable rate revenue bonds consist of the Maryland Health and Higher Educational Facilities Authority Revenue Refunding Bonds, Series 2014B, Adventist HealthCare, Inc. which had an outstanding balance of $22,985,000 and $23,985,000 as of December 31, 2017 and 2016, respectively. The Series 2014B Bonds bear interest at a variable rate of one month LIBOR plus 2.3% (3.86% at December 31, 2017). The Series 2014B bonds are subject to an Amended and Restated Master Trust Indenture that imposes various covenants on the Obligated Group which include restrictions on the transfer or disposition of property, the incurrence of additional liabilities, and the achievement of certain pre-established financial indicators. Management believes it has complied with these required financial covenants for the years ended December 31, 2017 and 2016.

The bonds subject to the Amended and Restated Master Trust Indenture are secured by the unrestricted revenues of the Obligated Group as well as a mortgage interest in the facilities of SGMC, WAH, HRMC, BH&WS and Rehab. In conjunction with the closing of the transfer of HRMC to Atlantic Health System as of March 31, 2016, HRMC is no longer a member of the Obligated Group, and as such, the mortgage on HRMC was released.

In December 2016, the variable rate revenue bonds Series 2005A and Series 2011B were refunded with the issuance of the Series 2016B bonds. The Series 2016B bonds were issued as a direct placement with a commercial bank. As a result of this refunding, a loss on extinguishment of debt was recognized in 2016 for $686,357 which is comprised of the remaining unamortized deferred financing costs related to the Series 2005A and Series 2011B bonds.

Secured Lines of Credit

The Corporation has a secured line of credit for $16,000,000 that bears interest at LIBOR plus 2.00% (3.56% at December 31, 2017) and expires on June 30, 2018. The balance on the line of credit was $3,500,000 and $7,032,921 at December 31, 2017 and 2016, respectively.

Note Payable

In December 2014, the corporation entered into a taxable term note for $25,000,000 with a commercial bank, which is secured by a Master Note issued under the Amended and Restated Master Trust Indenture dated as of February 1, 2003. The note bears interest at one month LIBOR plus 2.45% (3.825% as of December 31, 2017). The amortization on the note extends to December 18, 2034, however, the note matures on December 18, 2024. As of December 31, 2017 and 2016, the outstanding balance was $22,861,751 and $23,613,911, respectively.

Other Long Term Liabilities

This category consists of several capital lease obligations and notes payable on various types of medical and IT equipment. The financed equipment serves as security on these leases. Interest rates on these other long term liabilities range from 2.70% - 3.40%.

Scheduled principal repayments of long-term obligations at December 31, 2017 are as follows:

Years ending December 31:	
2018	$ 13,019,860
2019	8,547,724
2020	14,048,645
2021	13,385,399
2022	13,758,949
Thereafter	529,345,742
Total	$ 592,106,319

11. Derivative Financial Instruments

The Corporation has one interest rate swap agreement, which is considered a derivative financial instrument. The agreement is for a notional amount of $50,880,000 and requires the Corporation to pay a fixed interest rate of 3.457% while receiving variable interest rates based upon 67% of LIBOR, maturing January 2021. The agreement was entered into in order to manage interest rate exposure. The principal objective of the swap agreement is to minimize the risks associated with financing activities by reducing the impact of changes in interest rates on its debt portfolio. The notional amount of the swap agreements is used to measure the interest to be paid or received and does not represent the amount of exposure to credit loss. Exposure to credit loss is limited to the receivable, if any, which may be generated as a result of the swap agreement. The interest rate swap agreement is reported at fair value in the consolidated balance sheets. At December 31, 2017 and 2016, the fair value of the Corporation's derivative financial instruments was $1,145,303 and $2,073,079, respectively.

During 2016, the Corporation terminated one of its interest rate swap agreements with a notional amount of $78,000,000 that was designated as a cash flow hedge with the counterparty for $16,875,000. The Corporation borrowed the termination fee, which was included as a component of the proceeds for the 2016B bonds. No gain or loss was recognized on the termination of the swap. As of December 31, 2017 and 2016, $12,288,864 and $12,971,579, respectively, remained in unrestricted net assets. Beginning in January 2017, this amount is being amortized over the remaining term of the hedge, or through January 2035.

The net cash paid or received under the swap agreements is recognized as either an adjustment to interest expense or other income. The net cash paid under the interest rate swap agreements was $928,616 in 2017 and $3,791,973 in 2016. For 2016, $2,548,804 is reported as a component of interest expense in the accompanying consolidated statements of operations which represents the net cash paid related to the swap agreement that was accounted for, prior to the termination, using hedge accounting. The remaining amounts for 2017 and 2016 are reported as a component of other (expense) income in the accompanying consolidated statements of operations, which is related to the swap agreement that does not qualify for hedge accounting.

The fair value of the interest rate swap agreement is estimated to be the amount the Corporation would receive or pay to terminate the swap agreements at the reporting date and was based on information supplied by an independent third party valuation agent (Note 5). Additionally, the fair value reflects a credit risk assessment required under accounting principles generally accepted in the United States of America. Gains or losses resulting from the interest rate swap agreement are entirely recognized as a component of revenues in excess of expenses from continuing operations. The impact on the consolidated statements of operations were gains of $964,909 in 2017 and $1,035,104 in 2016.

On October 3, 2008, the counterparty for the Corporation's fixed pay swap maturing in January 2035, Lehman Brothers, Inc., commenced proceedings under Chapter 11 of the Bankruptcy Code. This action triggered an Event of Default under the ISDA Master Agreement in effect with said party and gave the Corporation the right to terminate the transaction.

On October 16, 2008, the Corporation terminated this agreement and concurrently entered into an agreement with a new counterparty that assumed all existing terms and conditions of the original agreement. The termination of the original swap agreement resulted in a loss of $472,023 which is included in unrestricted net assets in the consolidated balance sheets. This loss is being amortized over the remaining term of the designated period of the hedge, or through January 2035. As of December 31, 2017 and 2016, accumulated amortization of $161,837 and $143,855, respectively, is included in other changes in net assets and interest expense in the consolidated statements of operations and changes in net assets.

12. Leases

The Corporation has entered into various operating leases primarily for office space as well as certain equipment items. Rental expense for operating leases was $20,924,709 in 2017 and $21,263,623 in 2016. Rental expense for operating leases of HRMC was $540,820 in 2016 and is included in loss from discontinued operations in the accompanying consolidated statements of operations. Rental expense for operating leases of BH&WS - Eastern Shore was $692,074 in 2016 and is included in loss from discontinued operations in the accompanying consolidated statements of operations. Future minimum payments under non-cancelable operating leases with initial terms of one year or more consist of the following during the years ending December 31:

Years ending December 31:	
2018	$ 13,368,551
2019	12,665,499
2020	12,554,912
2021	12,649,566
2022	12,537,323
Thereafter	36,643,188
Total	$ 100,419,039

The Corporation has also entered into various sub-lease agreements with tenants that occupy space in the Corporation's buildings. The terms of these sub-leases vary and extend through 2030. Rental income was $3,303,484 in 2017 and $4,506,295 in 2016, which has been reported as a component of other operating revenue in the consolidated statements of operations. Future rent payments expected to be received by the Corporation during the years ending December 31, are as follows:

Years ending December 31:	
2018	$ 4,166,546
2019	3,580,156
2020	3,299,498
2021	2,922,089
2022	2,499,530
Thereafter	3,284,905
Total	$ 19,752,724

13. Retirement, Health Plan and Life Insurance

Defined Contribution Retirement Plan

The Corporation sponsors a 401(a) defined contribution retirement plan, which covers substantially all full-time employees. After twelve months of full-time or regular part-time employment of at least 1,000 base hours, the Corporation will contribute a total of 2% of eligible employees' compensation, plus a matching employer contribution equal to 50% of employee contributions (to the 403(b) plan) up to 6% of base salary. The Corporation also has a 403(b) retirement savings plan for employees. Employee contributions are made to the 403(b) retirement savings plan. Retirement plan expense was $7,983,472 in 2017 and $8,760,252 in 2016. Retirement plan expense for HRMC was $174,378 in 2016 which is included in loss from discontinued operations in the consolidated statements of operations. Retirement plan expense for BH&WS - Eastern Shore was $60,686 in 2016 which is included in loss from discontinued operations in the consolidated statements of operations.

Supplemental Executive Retirement Plan

The Corporation also has a Supplemental Executive Retirement Plan ("SERP") that became effective in 2015 and covers a group of key executives. SERP expense was $404,894 in 2017 and $300,900 in 2016. In addition, a SERP liability adjustment was recorded for $512,305 in 2017 and $521,260 in 2016, which was recognized in other changes in net assets in the consolidated statements of changes in net assets. At December 31, 2017 and 2016, the Corporation's liability for the SERP was $3,811,232 and $2,894,032, respectively, which is included in other liabilities in the consolidated balance sheets.

Executive Retention 457(F) Plan

Effective January 1, 2015, the Corporation established the Executive Retention 457(F) Plan (the "457(F) Plan"). The 457(F) Plan is a tax-deferred plan offered to key executives, whereby annual employer contributions are made to the Plan. Plan participants become vested in the contributions and receive plan payments in the second calendar year after the contribution is made, if the participant is still employed. The final contribution will be made to the Plan for the year in which the plan participant becomes 62. The 457(F) plan expense was $1,451,249 in 2017 and $1,501,925 in 2016. The Corporation's liability for the 457(F) plan at December 31, 2017 and 2016 was $2,792,809 and $2,975,057, respectively, which is included in other liabilities in the consolidated balance sheets.

Salary Deferral (457(b)) Plan

Employees who contribute the maximum allowable amount to the 403(b) retirement plan have an opportunity to contribute additional funds on a tax-deferred basis to a 457(b) retirement plan up to the maximum tax-sheltered opportunity. There are no employer contributions to this plan.

Health Plan

The Corporation maintains a self-insurance employee program for its health insurance coverage. The Corporation accrues the estimated costs of incurred and reported and incurred but not reported claims, after consideration of its stop-loss insurance coverage, based upon data provided by the third-party administrator of the program and historical claims experience.

Life Insurance

Full-time and part-time employees are insured, through a third-party carrier, for an amount equal to one times their base salary at time of enrollment up to $450,000 for full-time employees and $10,000 for part-time employees. In addition, if death is caused by accident, the employee is insured for an additional benefit equal to the amount of their life insurance.

14. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for betterments to plant facilities and purchases of equipment or to support operating programs sponsored by the Corporation and its affiliates.

Permanently restricted net assets have been restricted by donor to be maintained by the Corporation in perpetuity.

Net assets were released from donor restriction by satisfying their restricted purposes in the amount of $3,633,418 in 2017 and $3,293,236 in 2016.

15. Commitments and Contingencies

Litigation and Claims

The Corporation is subject to asserted and unasserted claims (in addition to litigation) encountered in the ordinary course of business. In the opinion of management and after consultation with legal counsel, the Corporation has established adequate reserves related to all known matters. The outcome of any potential investigative, regulatory or prosecutorial activity that may occur in the future cannot be predicted with certainty. However, any associated potential future losses resulting from such activity could have a material adverse effect on the Corporation's future financial position, results of operations and liquidity.

Insurance

The Corporation's primary coverage for professional liability is provided through a self-funded insurance retention trust (the "Trust") established on January 1, 1993. The Trust is funded based on actuarial estimates and provides coverage of $4,000,000 per occurrence with no annual aggregate limitation. The Trust also provides general liability coverage up to $1,000,000 per occurrence and $3,000,000 in the aggregate. The Corporation also carries umbrella excess liability insurance on a claims made basis with a commercial carrier, with limits of $20,000,000 per occurrence and in aggregate.

It is the Corporation's policy to accrue for the ultimate cost of uninsured asserted and unasserted malpractice claims, if any, when incidents occur. Based on a review of the Corporation's prior experience and incidents occurring through December 31, 2017, management determined that the fully-funded professional liability reserve reported at December 31, 2017 and 2016 is adequate in light of the program's excess umbrella policy currently in force and historical claims experience. The estimated professional liability for both asserted and unasserted claims was $14,262,545 and $12,865,503 at December 31, 2017 and 2016, respectively. The discount rate used in determining these liabilities was 2.5% at both December 31, 2017 and 2016.

The Corporation is self-insured for unemployment and workers' compensation benefits. The liability for unemployment and worker's compensation claims payable is an estimate based on the Corporation's past experience and is included in the accompanying consolidated balance sheets. It is reasonably possible that the estimates used could change materially in the near term.

Remediation

Certain buildings, which were constructed prior to the passage of the Clean Air Act, contain encapsulated asbestos material. Current law requires that this asbestos be removed in an environmentally safe fashion prior to demolition and renovation of these buildings. At this time, the Corporation has no plans to demolish or renovate these buildings and, as such, cannot reasonably estimate the fair value of the liability for such asbestos removal.

16. Business and Credit Concentrations

The Corporation grants credit to patients, substantially all of whom are local residents. The Corporation generally does not require collateral or other security in extending credit; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits receivable under their health insurance programs, plans or policies.

At December 31, 2017 and 2016, concentrations of gross receivables from third-party payors and others are as follows:

	2017	2016
Medicare	22 %	22 %
Medicaid	11	12
Other third party payers	39	45
Self-pay and others	28	21
	100 %	100 %

Net patient service revenue, by payor class, consisted of the following for the years ended December 31:

	2017	2016
Medicare	37 %	38 %
Medicaid	11	9
Other third party payers	48	49
Self-pay and others	4	4
	100 %	100 %

The Corporation maintains its cash and cash equivalents with several financial institutions. Cash and cash equivalents on deposit with any one financial institution are insured up to $250,000.

17. Functional Expenses

A summary of the Corporation's operating expenses by function for the years ended December 31, is as follows:

	2017	2016
Hospital acute and ambulatory services	$ 559,232,278	$ 545,995,612
Home care services	26,374,013	19,113,770
Other health care services	196,113,197	184,260,531
Other, including general and administrative	5,702,160	10,751,002
Fundraising	432,501	682,243
Total	$ 787,854,149	$ 760,803,158

The Corporation also incurred hospital acute and other health care services expenses related to HRMC and BH&WS Eastern Shore that were included in loss from discontinued operations in the consolidated statements of operations. HRMC hospital acute services expenses were $22,769,646 in 2016. BH&WS Eastern Shore other healthcare services expenses were $10,001,541 in 2016. No operating expenses were incurred in 2017 for HRMC for BH&WS Eastern Shore.

Adventist HealthCare, Inc. and Controlled Entities

Consolidating Schedule, Balance Sheet

December 31, 2017

	Shady Grove Medical Center	Washington Adventist Hospital	Hackettstown Regional Medical Center	Behavioral Health & Wellness Services	Rehabilitation	Imaging Services	Clinical Integration Services	Other Health Services	Support Center	Eliminating Entries	Total Combined Obligated Group	Lourie Center	Adventist Home Care Services	Urgent Care Centers	One Health Quality Alliance	Mid-Atlantic Primary Care	Adventist HealthCare, Inc. Foundations	Eliminating Entries	Consolidated Adventist HealthCare, Inc.
Assets																			
Cash and cash equivalents	$ 169,434,502	$ (48,120,660)	$ 76,562,848	$ (21,307,114)	$ 15,664,304	$ (24,043,730)	$ (22,721,885)	$ 976,421	$ (102,774,082)	$ -	$ 43,670,604	$ (683,588)	$ 6,073,433	$ (10,347,048)	$ (2,292,572)	$ 1,184,117	$ 3,109,938	$ -	$ 40,714,884
Short-term investments	-	-	-	-	-	-	-	-	197,803,029	-	197,803,029	-	-	-	-	-	-	-	197,803,029
Assets whose use is limited	-	-	-	-	-	-	-	-	2,923,796	-	2,923,796	-	-	-	-	-	-	-	2,923,796
Patient accounts receivable, net of estimated allowance for doubtful collections of $22,487,000	48,088,584	26,969,168	-	4,934,224	4,822,816	3,033,771	642,956	(519)	-	-	88,491,000	-	4,276,085	442,861	-	-	-	-	93,209,946
Other receivables, net of estimated allowance for doubtful collections of $628,000	1,841,050	2,499,566	-	2,117,139	156,162	3,330,207	56,869	652,062	2,171,520	(597,738)	12,226,837	2,751,224	31,141	-	-	-	1,061,779	-	16,070,981
Due from third party payors	-	-	-	115,974	254,469	-	-	-	-	(370,443)	-	-	-	-	-	-	-	-	-
Inventories	5,118,233	3,982,471	-	90,779	93,906	-	-	125,388	-	-	9,410,777	-	-	-	-	-	-	-	9,410,777
Prepaid expenses and other current assets	676,417	861,007	-	56,871	65,765	58,059	19,950	148,175	5,658,068	-	7,544,312	-	52,908	55,828	-	-	-	-	7,653,048
Total current assets	225,158,786	(13,808,448)	76,562,848	(13,992,127)	21,057,422	(17,621,693)	(22,002,110)	1,901,527	105,782,331	(968,181)	362,070,355	2,067,636	10,433,567	(9,848,359)	(2,292,572)	1,184,117	4,171,717	-	367,786,461
Property and Equipment, Net	178,100,768	185,644,026	-	13,145,193	10,299,587	8,494,432	1,203,692	201,174	104,539,932	-	501,628,804	1,617,534	1,667,237	6,696,220	-	-	-	-	511,609,795
Assets Whose Use is Limited																			
Under trust indentures and capital lease purchase financing facilities, held by trustees and banks	841,316	239,237,934	-	490,768	444,028	-	-	-	3,318,524	-	244,332,570	-	-	-	-	-	-	-	244,332,570
Professional liability trust fund	-	-	-	-	-	-	-	-	11,878,591	-	11,878,591	-	-	-	-	-	-	-	11,878,591
Deferred compensation fund	-	-	-	-	-	-	-	-	1,403,371	-	1,403,371	-	-	-	-	-	-	-	1,403,371
Cash and Cash Equivalents Temporarily Restricted for Capital Acquisitions	331,900	-	-	-	96,436	-	-	-	-	-	428,336	694,688	-	-	-	-	1,199,729	-	2,322,753
Investments and Investments in Unconsolidated Subsidiaries	843,836	-	-	-	-	-	-	-	14,012,821	-	14,856,657	-	-	-	-	-	808,588	-	15,665,245
Land Held for Healthcare Development	-	-	-	-	-	-	-	-	47,660,070	-	47,660,070	-	-	-	-	-	-	-	47,660,070
Intangible Assets, Net	1,018,809	-	-	841,587	845,496	5,435,091	-	36,236	7,736	-	8,184,955	-	158,175	-	-	-	-	-	8,343,130
Deposits and Other Noncurrent Assets	1,887,263	31,350	-	26,674	43,000	15,687	46,716	32,754	858,754	-	2,942,198	5,054	30,828	200,582	-	-	2,432,031	-	5,610,693
Total assets	$ 408,182,678	$ 411,104,862	$ 76,562,848	$ 512,095	$ 32,785,969	$ (3,676,483)	$ (20,751,702)	$ 2,171,691	$ 289,462,130	$ (968,181)	$ 1,195,385,907	$ 4,384,912	$ 12,289,807	$ (2,951,557)	$ (2,292,572)	$ 1,184,117	$ 8,612,065	$ -	$ 1,216,612,679

Adventist HealthCare, Inc. and Controlled Entities

Consolidating Schedule, Balance Sheet
December 31, 2017

	Shady Grove Medical Center	Washington Adventist Hospital	Hackettstown Regional Medical Center	Behavioral Health & Wellness Services	Rehabilitation	Imaging Services	Clinical Integration Services	Other Health Services	Support Center	Eliminating Entries	Total Combined Obligated Group	Lourie Center	Adventist Home Care Services	Urgent Care Centers	One Health Quality Alliance	Mid-Atlantic Primary Care	Adventist HealthCare, Inc. Foundations	Eliminating Entries	Consolidated Adventist HealthCare, Inc.
Liabilities and Net Assets																			
Current Liabilities																			
Accounts payable and accrued expenses	$ 26,268,407	$ 18,582,280	$ 673,330	$ 2,828,158	$ 1,041,179	$ 1,454,804	$ 1,669,173	$ 526,843	$ 29,413,814	$ -	$ 82,457,988	$ 1,047,774	$ 1,005,852	$ 618,064	$ 128,774	$ 1,408,826	$ 150,906	$ -	$ 86,818,184
Accrued compensation and related items	13,433,344	9,658,349	-	2,523,983	2,764,208	211,138	214,677	236,808	6,595,689	(597,738)	35,040,458	607,017	1,317,213	295,758	-	-	-	-	37,260,446
Interest payable	-	-	-	-	-	-	-	-	9,747,294	-	9,747,294	-	-	-	-	-	-	-	9,747,294
Due to third party payors	10,850,189	7,169,320	67,547	101,789	-	-	-	-	-	(370,443)	17,818,402	-	-	-	-	-	-	-	17,818,402
Estimated self-insured professional liability	-	-	-	-	-	-	-	-	1,179,664	-	1,179,664	-	-	-	-	-	-	-	1,179,664
Current maturities of long-term obligations	5,044,073	2,770,640	-	165,859	-	775,089	-	-	4,109,705	-	12,865,366	-	-	154,494	-	-	-	-	13,019,860
Total current liabilities	55,596,013	38,180,589	740,877	5,619,789	3,805,387	2,441,031	1,883,850	763,651	51,046,166	(968,181)	159,109,172	1,654,791	2,323,065	1,068,316	128,774	1,408,826	150,906	-	165,843,850
Construction Payable	1,786,159	12,402,322	-	92,500	94,556	14,286	-	-	282,306	-	14,672,129	-	152,030	4,380	-	-	-	-	14,828,539
Long-Term Obligations, Net																			
Bonds payable	123,749,836	379,651,523	-	5,954,585	4,293,277	-	-	-	37,577,507	-	551,226,728	-	-	(15,239)	-	-	-	-	551,211,489
Notes payable	-	-	-	-	-	-	-	-	17,688,481	-	17,688,481	-	-	4,400,801	-	-	-	-	22,089,282
Capital lease obligations	2,661,743	1,191,231	-	776,029	-	1,401,975	-	-	5,198,992	-	11,229,970	-	-	-	-	-	-	-	11,229,970
Derivative Financial Instruments	-	-	-	-	-	-	-	-	1,145,303	-	1,145,303	-	-	-	-	-	-	-	1,145,303
Other Liabilities	1,544,428	-	-	-	-	-	549,178	-	9,816,737	-	11,910,343	-	-	-	-	-	53,422	-	11,963,765
Estimated Self-Insured Professional Liability	-	-	-	-	-	-	-	-	13,082,881	-	13,082,881	-	-	-	-	-	-	-	13,082,881
Total liabilities	185,338,179	431,425,665	740,877	12,442,903	8,193,220	3,857,292	2,433,028	763,651	135,838,373	(968,181)	780,065,007	1,654,791	2,475,095	5,458,258	128,774	1,408,826	204,328	-	791,395,079
Net Assets (Deficit)																			
Unrestricted	222,945,080	(21,043,903)	75,821,971	(11,930,808)	24,590,615	(7,533,775)	(23,184,730)	1,408,040	152,816,329	-	413,888,819	2,095,431	9,814,712	(8,409,815)	(2,421,346)	(224,709)	2,585,883	-	417,328,975
Temporarily restricted	(100,581)	723,100	-	-	2,134	-	-	-	807,428	-	1,432,081	293,269	-	-	-	-	5,821,854	-	7,547,204
Permanently restricted	-	-	-	-	-	-	-	-	-	-	-	341,421	-	-	-	-	-	-	341,421
Total net assets (deficit)	222,844,499	(20,320,803)	75,821,971	(11,930,808)	24,592,749	(7,533,775)	(23,184,730)	1,408,040	153,623,757	-	415,320,900	2,730,121	9,814,712	(8,409,815)	(2,421,346)	(224,709)	8,407,737	-	425,217,600
Total liabilities and net assets	$ 408,182,678	$ 411,104,862	$ 76,562,848	$ 512,095	$ 32,785,969	$ (3,676,483)	$ (20,751,702)	$ 2,171,691	$ 289,462,130	$ (968,181)	$ 1,195,385,907	$ 4,384,912	$ 12,289,807	$ (2,951,557)	$ (2,292,572)	$ 1,184,117	$ 8,612,065	$ -	$ 1,216,612,679

Adventist Healthcare, Inc. and Controlled Entities
Consolidating Schedule, Statement of Operations
Year Ended December 31, 2017

	Shady Grove Medical Center	Washington Adventist Hospital	Hackettstown Regional Medical Center	Behavioral Health & Wellness Services	Rehabilitation	Imaging Services	Clinical Integration Services	Other Health Services	Support Center	Eliminating Entries	Total Combined Obligated Group	Lourie Center	Adventist Home Care Services	Urgent Care Centers	One Health Quality Alliance	Mid-Atlantic Primary Care	Adventist HealthCare, Inc. Foundations	Eliminating Entries	Consolidated Adventist HealthCare, Inc.
Unrestricted Revenues																			
Net patient service revenue	$ 375,793,489	$ 261,758,259	$ -	$ 42,080,118	$ 48,151,057	$ 30,871,761	$ 11,078,330	$ 38,286	$ -	$ (100,874)	$ 769,670,426	$ 818,945	$ 27,207,082	$ 4,156,714	$ -	$ -	$ -	$ (16,500)	$ 801,836,667
Provision for doubtful collections	(13,378,429)	(12,611,472)	-	(1,828,140)	(655,338)	(2,097,280)	(650,236)	(131,895)	-	-	(31,352,790)	(112,355)	(42,553)	(274,843)	-	-	-	-	(31,782,541)
Net patient service revenue less provision for doubtful collections	362,415,060	249,146,787	-	40,251,978	47,495,719	28,774,481	10,428,094	(93,609)	-	(100,874)	738,317,636	706,590	27,164,529	3,881,871	-	-	-	(16,500)	770,054,126
Other revenue	7,490,548	3,755,767	-	6,313,442	3,070,951	1,788,034	220,297	6,866,110	6,113,830	(10,653,269)	24,965,710	10,903,927	260,955	150	-	1,356,468	1,946,154	(1,369,042)	38,064,322
Total unrestricted revenues	369,905,608	252,902,554	-	46,565,420	50,566,670	30,562,515	10,648,391	6,772,501	6,113,830	(10,754,143)	763,283,346	11,610,517	27,425,484	3,882,021	-	1,356,468	1,946,154	(1,385,542)	808,118,448
Expenses																			
Salaries and wages	122,047,800	97,092,286	-	26,452,333	28,307,040	15,571,770	9,608,695	2,333,144	34,239,094	(2,060,361)	333,591,801	5,956,279	17,868,478	2,914,752	340,586	48,850	-	-	360,720,746
Employee benefits	25,662,739	16,874,104	-	5,161,671	5,142,120	2,952,109	351,085	422,926	7,185,299	(351,542)	63,400,511	1,280,600	3,432,002	445,078	63,799	8,262	-	-	68,630,252
Contract labor	18,763,758	13,844,823	-	2,538,947	312,986	531,457	-	747,671	259,318	(64,709)	36,934,251	1,437,866	402,529	418,974	-	-	-	(153,937)	39,039,683
Medical supplies	55,251,030	41,406,956	-	1,360,408	1,566,646	1,142,348	746,210	849,253	49,752	(64,820)	102,307,783	85,141	406,590	213,849	-	-	-	-	103,013,363
General and administrative	33,256,315	27,437,502	-	3,789,842	3,296,744	5,001,846	3,486,150	1,158,968	45,660,458	(5,867,109)	117,220,716	1,725,367	1,158,556	1,232,698	153,593	459,063	1,294,806	(1,208,579)	122,036,220
Building and maintenance	22,580,781	7,805,978	-	2,384,851	1,499,134	5,045,272	376,233	514,655	1,967,342	(2,345,603)	39,828,643	307,054	731,810	1,077,236	300	300	-	(23,026)	41,922,317
Insurance	2,101,469	1,988,032	-	344,492	140,095	630,688	164,407	4,213	43,309	-	5,416,705	28,892	75,738	153,428	-	-	-	-	5,674,763
Interest	5,632,231	1,330,250	-	263,249	158,289	84,581	-	-	2,719,498	-	10,188,098	-	-	165,354	-	-	-	-	10,353,452
Depreciation and amortization	15,188,646	5,205,877	-	1,285,983	906,729	1,312,531	253,095	75,768	11,505,885	-	35,734,514	160,196	251,761	316,882	-	-	-	-	36,463,353
IT depreciation	5,663,083	3,835,214	-	742,097	509,355	94,123	-	30,213	(10,956,906)	-	(82,821)	-	82,821	-	-	-	-	-	-
IT services	19,972,695	12,812,683	-	1,903,545	2,133,066	260,713	-	139,555	(37,940,639)	-	(718,382)	-	718,382	-	-	-	-	-	-
Shared Services	15,063,059	9,385,490	-	1,718,548	1,468,869	442,566	557,721	66,039	(29,398,034)		(695,742)	278,867	368,827	48,048			-	-	-
Management fees	8,656,970	5,857,705	-	1,615,414	1,417,193	20,923	492,538	145,592	(19,571,019)	-	(1,364,684)	338,708	875,479	150,497	-	-	-	-	-
Total expenses	349,840,576	244,876,900	-	49,561,380	46,858,266	33,090,927	16,036,134	6,487,997	5,763,357	(10,754,144)	741,761,393	11,598,970	26,372,973	7,136,796	558,278	516,475	1,294,806	(1,385,542)	787,854,149
Income (loss) from operations	20,065,032	8,025,654	-	(2,995,960)	3,708,404	(2,528,412)	(5,387,743)	284,504	350,473	1	21,521,953	11,547	1,052,511	(3,254,775)	(558,278)	839,993	651,348	-	20,264,299
Other Income (Expense)																			
Investment income (loss)	4,046,655	4,018	-	3,492	349,920	-	-	13,674	3,636,073	-	8,053,832	14,074	135,858	-	-	-	28,738	-	8,232,502
Other (expense) income	(504,187)	(2,209,514)	249,985	(2,838,286)	(16,509)	-	-	-	662,392	2,661,722	(1,994,397)	-	-	-	-	-	-	-	(1,994,397)
Total other income (expense)	3,542,468	(2,205,496)	249,985	(2,834,794)	333,411	-	-	13,674	4,298,465	2,661,722	6,059,435	14,074	135,858	-	-	-	28,738	-	6,238,105
Revenues in excess of (less than) expenses from continuing operations	23,607,500	5,820,158	249,985	(5,830,754)	4,041,815	(2,528,412)	(5,387,743)	298,178	4,648,938	2,661,723	27,581,388	25,621	1,188,369	(3,254,775)	(558,278)	839,993	680,086	-	26,502,404
Change in net unrealized gains (losses) on investments other than trading securities	770,559	(674,580)	-	548	58,735	-	-	(2,025)	2,434,283	-	2,587,520	(9,815)	24,570	-	-	-	(19,650)	-	2,582,625
Change in net unrealized gain on derivative financial instruments	-	-	-	-	-	-	-	-	700,697	-	700,697	-	-	-	-	-	-	-	700,697
Transfer from (to) subsidiaries	648,577	423,286	2,272,747	1,611,358	50,255	-	-	-	(5,065,250)	-	(59,027)	-	-	-	-	-	-	59,027	-
Net assets released from restriction for purchase of property and equipment	30,957	1,078,789	-	-	42,844	-	-	-	-	-	1,152,590	-	-	-	-	-	-	-	1,152,590
Deferred compensation plan liability adjustment	-	-	-	-	-	-	-	-	(512,305)	-	(512,305)	-	-	-	-	-	-	-	(512,305)
Other unrestricted net asset activity	(1)	6	-	2	(185,835)	8	797	-	(1,518,108)	(1)	(1,703,132)	(1)	(4)	(6)	-	(801)	-	(59,027)	(1,762,971)
Increase (decrease) in unrestricted net assets from continuing operations	25,057,592	6,647,659	2,522,732	(4,218,846)	4,007,814	(2,528,404)	(5,386,946)	296,153	688,255	2,661,722	29,747,731	15,805	1,212,935	(3,254,781)	(558,278)	839,192	660,436	-	28,663,040
Loss from discontinued operations	-	-	-	-	-	-	-	-	-	(2,661,722)	(2,661,722)	-	-	-	-	-	-	-	(2,661,722)
Increase (decrease) in unrestricted net assets	$ 25,057,592	$ 6,647,659	$ 2,522,732	$ (4,218,846)	$ 4,007,814	$ (2,528,404)	$ (5,386,946)	$ 296,153	$ 688,255	$ -	$ 27,086,009	$ 15,805	$ 1,212,935	$ (3,254,781)	$ (558,278)	$ 839,192	$ 660,436	$ -	$ 26,001,318

Adventist HealthCare, Inc. - Foundations

Combining Schedule, Balance Sheet
December 31, 2017

	Shady Grove Medical Center Foundation, Inc.	Washington Adventist Hospital Foundation, Inc.	Behavioral Health & Wellness Services Foundation, Inc.	Eliminating Entries	Combined Adventist HealthCare, Inc. Foundations
Assets					
Current Assets					
Cash and cash equivalents	$ 2,116,816	$ 755,937	$ 237,185	$ -	$ 3,109,938
Current portion pledges receivable, less allowance for doubtful pledges of $65,000	457,156	551,283	53,340	-	1,061,779
Total current assets	2,573,972	1,307,220	290,525	-	4,171,717
Cash and Cash Equivalents Temporarily Restricted for Capital Acquisitions	-	1,160,963	38,766	-	1,199,729
Investments	802,871	5,717	-	-	808,588
Beneficial Interest in Trusts	95,055	431,162	-	-	526,217
Noncurrent Portion of Pledges Receivable	659,364	1,246,450	-	-	1,905,814
Total assets	$ 4,131,262	$ 4,151,512	$ 329,291	$ -	$ 8,612,065
Liabilities and Net Assets					
Current Liabilities					
Accounts payable and accrued expenses	$ 19,866	$ 131,040	$ -	$ -	$ 150,906
Liability to Charitable Gift Annuitants	53,422	-	-	-	53,422
Total liabilities	73,288	131,040	-	-	204,328
Net Assets					
Unrestricted	2,162,088	276,285	147,510	-	2,585,883
Temporarily restricted	1,895,886	3,744,187	181,781	-	5,821,854
Total net assets	4,057,974	4,020,472	329,291	-	8,407,737
Total liabilities and net assets	$ 4,131,262	$ 4,151,512	$ 329,291	$ -	$ 8,612,065

Adventist HealthCare, Inc. - Foundations

Combining Schedule, Statement of Operations and Changes in Net Assets
Year Ended December 31, 2017

	Shady Grove Medical Center Foundation, Inc.	Washington Adventist Hospital Foundation, Inc.	Behavioral Health & Wellness Services Foundation, Inc.	Eliminating Entries	Combined Adventist HealthCare, Inc. Foundations
Changes in Unrestricted Net Assets					
Unrestricted Revenues, Gains, And Other Support					
Contributions, net	$ 630,669	$ 111,425	$ 31,376	$ -	$ 773,470
Investment income	28,500	-	238	-	28,738
Net assets released from restrictions	(219,861)	1,304,552	87,993	-	1,172,684
Total unrestricted revenues, gains, and other support	439,308	1,415,977	119,607	-	1,974,892
Expenses					
General and administrative expenses	90,104	120,306	43,746	-	254,156
In-kind gifts expended	161,164	17,181	-	-	178,345
Total expenses before transfers to the hospitals	251,268	137,487	43,746	-	432,501
Transfers to the hospitals	(314,189)	1,131,494	45,000	-	862,305
Total expenses	(62,921)	1,268,981	88,746	-	1,294,806
Revenues in excess of expenses	502,229	146,996	30,861	-	680,086
Change in net unrealized losses on investments other than trading securities	(19,650)	-	-	-	(19,650)
Increase in unrestricted net assets	482,579	146,996	30,861	-	660,436
Unrestricted net assets, beginning	1,679,509	129,289	116,649	-	1,925,447
Unrestricted net assets, ending	$ 2,162,088	$ 276,285	$ 147,510	$ -	$ 2,585,883
Changes in Temporarily Restricted Net Assets					
Contributions, net	$ 310,736	$ 1,486,275	$ 107,077	$ -	$ 1,904,088
Net assets released from restrictions	219,861	(1,304,552)	(87,993)	-	(1,172,684)
Change in discount of pledges receivable and provision for doubtful pledges	50,057	(38,581)	(167)	-	11,309
Investment income and unrealized gain on investments	10,234	-	-	-	10,234
Increase in temporarily restricted net assets	590,888	143,142	18,917	-	752,947
Temporarily restricted net assets, beginning	1,304,998	3,601,045	162,864	-	5,068,907
Temporarily restricted net assets, ending	$ 1,895,886	$ 3,744,187	$ 181,781	$ -	$ 5,821,854

EXHIBIT 18

AFFIRMATION

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

Daniel Cochran
Chief Operating Officer and Chief Financial Officer
Adventist HealthCare Shady Grove Medical Center

AFFIRMATION

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

Maureen L. Dymond
Vice President, Financial Operations
Adventist HealthCare

AFFIRMATION

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

5/4/18

Robert E. Jepson
Vice President, Business Development
Washington Adventist Hospital

AFFIRMATION

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

Kristen Pulio — 5/4/18

Kristen Pulio — Date

Vice President