CON Matter No. 16-03-2380

Responses to Completeness Questions

MedStar Franklin Square Medical Center
Surgical Services Replacement Facility

September 30, 2016

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ATTACHMENTS

Responses to Completeness Questions

COMPLETENESS QUESTION 1

1. What will MFSMC do with the space occupied by the two "pods" where the 16 ORs are currently located after implementation of the replacement surgical services facility?

   a) If the space will be renovated and repurposed as part of this project, describe that use; and

   b) Amend Tables B, C, D, and E to reflect the usage.

   c) If a decision on use is made in the future, please indicate the likely timeframe for such a decision.

RESPONSE

The spaces that will be vacated as a result of this project will not be renovated and repurposed as part of the project. Further, MFSMC and MedStar Health are still in the planning phase of determining a future use for the vacated space. Therefore, there is no impact on Tables B, C, D and E to be noted here.

Initial discussions re: the future use of the vacated spaces have centered on development of a simulation center to serve the needs of MedStar Health's Patient Safety and Graduate Medical Education Programs, as well as the use of some space for the expansion of existing non-surgical ambulatory services.

Final decisions for the uses of these spaces should be made by mid-FY18.

COMPLETENESS QUESTION 2

2. Please provide more information on the property exchange documented in Attachment 5.

   a) What property is being exchanged by HH MedStar Health, Inc. for the Baltimore County property that now holds the Eastern Family Resource Center ("EFRC")?

b) Provide a basic description of that property.

c) What is the appraised value of the parcel being exchanged?

d) What is the appraised value of the property being acquired?

RESPONSE

a) The property exchange between MedStar Health and Baltimore County was completed in October 2015. HH MedStar Health, Inc., a wholly-owned subsidiary of MedStar Health, exchanged a 3.90 acre parcel identified as the *MedStar Franklin Square Medical Center – Parking Lot Site* located on the west side of Franklin Square Drive for the Baltimore County property at 9100 Franklin Square Drive that is the current location of the Eastern Family Resource Center (EFRC). Pending the County's completion of a new EFRC facility on the *Parking Lot Site*, the County is "leasing back" the property now owned by HH MedStar Health, Inc. Completion of the new EFRC construction is anticipated at the end of 2017.

In its application (p. 16) MFSMC indicated that the land exchange with Baltimore County was a separate transaction related to MFSMC's proposed project. The statement is reproduced below:

> It should be noted that a separate project ***related to the proposed project*** involves the vacating and demolition of the building currently occupying the site of the proposed project, the Eastern Family Resource Center (EFRC).

The hospital wishes to provide the following clarification regarding the bolded section of the statement above. MFSMC has been in negotiations with Baltimore County (sometimes active, sometimes dormant) to acquire the parcel of land on which the Eastern Family Resource Center is located for the past 15 years. This property sits in front of the hospital alongside the primary access road to its main entrance and is surrounded by other MFSMC uses. Because of this location, MFSMC determined that the property was ideally located for a hospital use. During its extended negotiations with the County, the hospital has considered a variety of options for the use of this land, including surface parking, structured parking, a medical office building, a replacement surgical facility, etc The decision to use the parcel as a site for a replacement surgical services facility occurred after the acquisition of the property. By the statement "related to the proposed project" MFSMC did not intend to convey that the parcel was acquired with this specific use in mind.

b) The property exchanged to the County is a subdivided section of an 8.86 acre parcel of land of approximately 3.90 acres identified on Tax Map 82, Grid 20, Parcel 13. The parcel was undeveloped until 2008, when it was converted into an asphalt surface parking lot (see Attachment CQ 1).

c) The appraised value of the parcel exchanged to the County is $1,300,000.

d) The appraised value of the parcel acquired from the County is $3,550,000.

Both appraisals were carried out by Valbridge Property Advisors (see Attachment CQ 2 and CQ 3).

COMPLETENESS QUESTION 3

3. Please provide a line drawing that shows the current layout of the two surgical pods at MFSMC.

RESPONSE

See Attachment CQ 4.

COMPLETENESS QUESTION 4

4. Please show the calculations resulting in: a Contingency Allowance of $2,985,346; Gross Interest during construction of $3,967,000; an Inflation Allowance of $1,588,851; $614,000 in Loan Placement Fees; and $179,000 in Bond Discount.

RESPONSE

See Attachment CQ 5.

COMPLETENESS QUESTION 5

5. The response to this standard is inadequate, and speaks more to “information regarding the range and types of services “than it does to making hospital charges available to the public”.

a. Provide a copy of the written policy for the provision of information to the public concerning charges for its services that the standard calls for.

b. Document that the Representative List of Services and Charges called for in paragraph (a) is readily available to the public in written form at the hospital and on the hospital's internet web site.

c. Excerpt the sections of the policy that document that the applicant has met paragraphs (b) and (c) related to responding to individual requests and staff training, respectively.

RESPONSE

5a.- 5c.

As noted in its response to this Standard in its application (p. 19), MFSMC's practice related to providing information regarding hospital charges to the public has been to provide this information upon request, usually by phone, rather than through a list of services and charges available to the public. This has been the practice of MFSMC because the cost of hospital services can fluctuate without notice, sometimes significantly, based on the unique aspects of the Maryland regulated rate system.

MedStar Franklin Square Medical Center is committed to helping patients understand the cost of medical services, including the portion that is the responsibility of the patient. As the posting of hospital charges would not adequately disclose to prospective patients their estimated cost of care, MedStar Health has trained patient financial service representatives to assist patients in understanding the cost of their care. Patient financial service representatives utilize a pricing tool to provide an estimated cost of care, help patients understand their insurance coverage, assist eligible patients to enroll in the Medical Assistance program, and evaluate patient eligibility for MedStar Health's financial assistance program.

For this reason, the hospital believes it complies with the intent of COMAR 10.24.10.04 – Information Regarding Charges.

COMPLETENESS QUESTION 6

6. Strengthen and document your response to this standard as follows:

    a. Provide a copy of the "initial financial assistance application" upon which the determination of probable eligibility for financial assistance within two

business days is made (as described in Attachment 18, Corporate Financial Assistance Policy).

b. Provide copies of the formal notices posted at the Hospital's primary access points.

c. Please respond to paragraph (b) of this standard regarding the hospital's recent level of charity care.

RESPONSE

6a. See Attachment CQ 6.

6b. See Attachment CQ 7.

6c. As one of the region's leading not-for-profit healthcare systems, MedStar Health is committed to ensuring that uninsured patients and underinsured patients meeting medical hardship criteria within the communities we serve who lack financial resources have access to emergency and medically necessary hospital services. Over the past five fiscal years, MedStar Franklin Square Medical Center has provided an average of $10.5 million in free and reduced cost health care services

COMPLETENESS QUESTION 7

7. Please discuss the applicant's timeline for submitting an application to HSCRC for a partial rate application or GBR modification. Has the applicant contacted and received any comments or feedback from HSCRC regarding this request for an increase in rates?

RESPONSE

MedStar Franklin Square Medical Center plans to file a partial rate application with the Health Services Cost Review Commission for the incremental capital costs related to the hospital's Certificate of Need project. The partial rate application will be submitted after the Maryland Health Care Commission dockets MFSMC's CON application. To date, there have been no discussions with the HSCRC regarding this partial rate application although the rate application has been drafted and will be ready for submission once the docketing occurs.

COMPLETENESS QUESTION 8

8. The second goal in Attachment 27 does not agree with the second goal stated on p. 14 of the CON application in response to Paragraph .08G(3)(c), *Availability of More Cost-Effective Alternatives*. Please clarify how MFSMC used these two goals to demonstrate that the proposed project is the most cost effective.

RESPONSE

MFSMC has reorganized its Attachment 27 and has resubmitted it as Attachment CQ 8. The new table presents the Project Goals with a more comprehensive description and more clearly organizes the Project Goals and MFSMC's side by side evaluation of each option's ability to achieve these goals. The project goals are noted below:

1. Bring the hospital's operating rooms into compliance with all appropriate standards for the delivery of surgical services without compromising the hospital's ability to maintain a sufficient inventory of ORs to meet the current and projected future need for surgical services in its service area.

2. Design and renovate/construct the facility at the most efficient project cost, in the shortest, most efficient period of time, and with the least disruption to the delivery of services during the renovation/construction period.

3. Consolidate MFSMC's two existing OR pods into one more efficient OR suite that reduces the cost of providing surgical services at MFSMC.

MFSMC evaluated its two options for replacing its antiquated operating rooms by comparing how each option - renovating in place (Option 1) and building new ORs (Option 2) – succeeds in achieving the three project goals.

As the sections of the table shaded in green indicate, Option 2: New Construction achieves all three project goals while Option 1: Renovate in Place either does not achieve the goals or does not achieve them as well as Option 2, as the red shadings indicate.

COMPLETENESS QUESTION 9

9. Attachment 11 (p.68) states that the project is expected to reduce FTEs by 20 and save about $2 million a year; Table L attributes a reduction of 21. This is not a big difference, but which is it?

RESPONSE

The correct reduction is a total of 21 FTEs as stated in Attachment 11. MFSMC erroneously indicated 20 FTEs in its narrative in Attachment 11, section 3)a)iii., page 68 of the application.

COMPLETENESS QUESTION 10

10. Please discuss whether the applicant has a transfer and referral agreement in place with a hospital capable of managing cases that exceed the capabilities of MFSMC. If so, please identify and provide a copy of the transfer agreement with this hospital.

RESPONSE

MFSMC provides the full spectrum of primary and secondary hospital care. The hospital maintains informal clinical relationships with tertiary care providers in the area (University of Maryland, Johns Hopkins) for any case it receives that is outside its capabilities. These cases usually arrive via the hospital's ED, and transfer of the cases is governed by the policies as reflected in Attachment CQ 9. Emergent cardiac surgery cases are stabilized and transferred to MedStar Union Memorial Hospital.

In those occasions when an inpatient requires a higher level of care than is provided by MFSMC, these patients are transferred to the appropriate provider. No specific written agreements exist between MFSMC and other health care providers as these types of transfers are a routine aspect of clinical care and a normal part of day to day operations between hospitals.

COMPLETENESS QUESTION 11

11. Please provide the names of the two healthcare intelligence companies used to validate the reasonableness of the MFSMC surgical volumes, as mentioned on pp. 155-156. Please provide the executive summary or summary of the findings and results from these two companies.

RESPONSE

MFSMC used proprietary volume forecast tools developed by Sg2, headquartered in Chicago, Ill. and The Advisory Board, headquartered in Washington, D.C, to validate the reasonableness of the hospital's surgical volume projections. Both are well-known and respected healthcare intelligence companies. Both companies have created proprietary computer modeling tools that apply their internally developed drivers of hospital utilization to clients' individual volume history, projecting out five to ten years from a base year. Sg2 has created a tool called *Impact of Change Forecast* and The Advisory Board has created a tool called *Market Scenario Planner*. With the help of representatives from these two companies, MFSMC used both forecasting tools to project surgical volume in the FY15-FY25 period (FY15 was used as the base year since it was the last full year of data available at the time the application was prepared). Because the interaction between MFSMC and these consultants centered on the use of these tools, a report with an executive summary was not part of the final product. The final product was a table(s) generated by each company's tool. For this reason, MFSMC is not able to provide an executive summary in response to this question.

The projections produced by these two companies are noted below. Because this document is a public document, MFSMC will not identify which firm's volume forecast tool yielded which projected rate of change in the FY15-FY25 period. This information is available to Commission staff upon request.

Consultant A: 4.8%

Consultant B: 9.0%.

In the case of Consultant A, the company's staff produced an inpatient and outpatient forecast that together yield a rate of change for MFSMC in the period of 4.8%. In the case of Consultant B, MFSMC used internal MedStar staff to create the forecast using Consultant B's tool. It was discovered that only an inpatient forecast could be produced by this tool (data definition issues between Consultant B and MedStar prevented the

production of an outpatient surgery forecast). The outpatient surgery forecast was based on MFSMC's volume experience in the FY11-FY15 period. This forecast yielded a rate of change of 9.0% for MFSMC surgical volume in the period. MFSMC spread these 10 year forecasts over the period to calculate a rate of growth through FY22, the projected second full year of operation of its proposed project.

COMPLETENESS QUESTION 12

12. Please provide the population growth data, demographic information, and any assumptions not stated in the CON application that MFSMC used to arrive at the projections for the OR utilization.

RESPONSE

As noted in its application and in its response to Completeness Question 11 above, MFSMC used the utilization projection tools (which include factors for population and other demographic changes, as well as numerous other factors as noted in the application (p.156)) created by its two consulting partners to provide baseline 10 year surgical services forecasts. It chose this approach due to the difficulty of quantifying the impact of the increasingly complex mix of factors impacting health care utilization and the difficulty of projecting the pace at which these factors impact utilization. The complexity and pace of these impacts has limited the value of 5-10 year utilization forecasts based on use rate trends and population changes. MFSMC believes that these consultants' possess the ability to identify, analyze and quantify these factors in a way MFSMC/MedStar Health does not. Although MFSMC has access to the necessary data to create a use rate/population change based model, it believes a more accurate forecast is produced by companies with more resources devoted to understanding and quantifying the changing dynamics of health care utilization.

As a result, MFSMC did not use demographic and population projections to calculate use rates and forecast its volume in this manner. Instead, the hospital assessed its own volume trends, the mix of projected changes to its medical staff, the impact of non-hospital surgical competition, higher patient co-pays and other factors in the health care market that are holding down surgical volume, and determined that a scenario of zero growth beyond its FY15 volume of 12,908 cases was a reasonable forecast. The decline in inpatient OR utilization in Central Maryland in the FY11-FY15 period

(-14.2%, per the HSCRC Discharge Abstract for all surgical MS DRGs), further undergirded the hospital's conservative projection.

MFSMC then compared the Sg2 and the Advisory Board forecasted rates of market change in the period. In evaluating the two forecasted rates of change, MFSMC determined that the 4.8% rate of growth in the period seemed reasonable, while the 9.0% seemed too aggressive. However, given the decline in inpatient OR utilization in Central Maryland in the FY11-FY15 period noted above, and given MFSMC's own internal declines, the hospital believes that a more conservative utilization forecast than those produced by either of the two projection tools was warranted. For this reason, the hospital increased its original forecast of zero growth to a 0.5% rate of growth in the period.

There are no other assumptions not already noted in the application.

COMPLETENESS QUESTION 13

13. These questions are in reference to the table on p. 157. Please respond to the following:

    a. Please clarify whether the average minutes per case reported in this table includes or excludes the average room turnaround time of 25 minutes per case;

    b. Did the applicant use 114,000 or 144,000 minutes/room/year for optimal capacity of a mixed-use operating room.

RESPONSE

a. The average minutes per case reported in the table summarizing OR activity on p. 157 of the application **includes** the average room turnaround time. Fiscal Year 14 – Fiscal Year 16 includes actual turnaround time for those periods and Fiscal Year 17 - Fiscal Year 22 includes an estimate of 25 minutes per case for non-"First Case of Day" cases.

b. MFSMC used 114,000 minutes/room/year for optimal capacity of a mixed-use operating room (60 min./hr. X 1,900 hours). The reference to 144,000

minutes/room/year in the final paragraph of p.156 of the application is a typographical error and should read “114,000 min./yr.”

COMPLETENESS QUESTION 14

14. Please discuss when MFSMC will notify MHCC regarding the transfer of the two ORs from MFSMC to an ambulatory surgery setting in Timonium, as stated on Attachment 26, p. 158

RESPONSE

In an e-mail communication between MHCC staff and MFSMC, staff withdrew this question. MedStar Health indicated its intention to transfer two ORs from the hospital to an ambulatory surgery setting in Timonium. MHCC staff responded with the statement below:

> Such a transfer is not allowable under CON regulations. While COMAR 10.24.01.02A(2)(b) does allow relocation of *an existing health care facility* owned or controlled by a merged asset system without a CON, the two ORs that would be reduced as a result of this project are not an “existing health care facility.”

Further discussions between staff and MFSMC regarding the permissibility of this action and the applicable section(s) of COMAR will occur at a later date.

COMPLETENESS QUESTION 15

15. Please respond to the following:

    a. Explain in other words/more detail what is meant by the statement “Option 1…. would not provide floor to floor dimensions that comply with standards and industry norms (mitigating this deficiency would be cost prohibitive)” as stated on p. 14.

    b. The application did not include a cost analysis of implementing *Option 1 – Renovation of existing OR facility*; was one done, or was that option dismissed as technically unfeasible from the outset?

c. Did you consider an alternative such as moving more than two existing operating rooms to an ambulatory surgery center (either existing or new) and either (a) renovate the larger of the two existing hospital pods in the hospital's surgical facility or (b) construct a new surgical facility with fewer ORs on the MFSMC campus. How would this alternative not meet your two goals as stated on p. 14?

RESPONSE

15a. Floor to Floor to floor height refers to the distance in multi-level structures between the top of a floor and the top of the floor above it. It is a measure of available vertical space in the room. The recommended OR floor to floor height is 18 FT. The 18 FT floor to floor height allows for a clear space in the OR to accommodate the variety of imaging and other required equipment that is used in advanced surgery, as well as providing space that is necessary for air filtering and required air changes for the OR's (i.e., space for ducts, etc). The existing floor to floor height at MFSMC is12 FT. At MFSMC there is no floor above the ORs; the ORs are topped by a roof. Meeting this standard would involve removing the existing roof, adding new, longer support columns and replacing the roof. This would be prohibitively expensive. In the Cost Estimate for Option 1, this element of the project was not included.

15b. MedStar Health engaged a team of experts comprised of Cannon Design (architect), The Whiting Turner Contracting Company (construction contractor) , the Trammel Crow Company (real estate development), Leach Wallace Associates, Inc. (engineers), D.W. Kozera, Inc. (engineering/ geology) and Dewberry (design/engineering) to perform a comprehensive comparison of *Option 1 – Renovation of existing OR facility* and *Option 2 – New Construction*. This team produced a 35 page report which included an estimated cost for both options. Per this report, the cost of *Option 1* was estimated at $97M million. MFSMC has included the cost estimate for Option 1 as Attachment CQ 10[1]. This estimate includes escalation of 25%. As noted in Attachment 27, it was the combination of higher cost, longer duration of the project, significant disruption

[1] Note that the cost to renovate in place at an expected escalation of 25% is $111,349,616 per Attachment CQ 10. This cost estimate was for sixteen ORs. MFSMC's proposed project is for fourteen ORs. MFSMC's consulting partners calculated a budget for fourteen ORs by calculating and estimated cost per OR and multiplying that by fourteen ORs then adding 25% escalation to that amount ($89,079,693/16) x 14 + 25% =$97.4M) This methodology yields the $97M that MFSMC reported on its application.

of services during the project, and the difficulty/cost of meeting Facilities Guidelines Institute guidelines in the existing space that led MFSMC leadership to choose Option 2 – New Construction.

15c. MFSMC and its corporate partner MedStar Health have spent significant planning time regarding the number of ORs to build and the best location for these ORs. It was determined that the best use of its resources would be the construction of a surgical facility on its campus that would both meet the needs of the hospital's inpatient surgical service and provide the convenient, accessible and efficient design and functioning of an ambulatory surgery center. Hospital leadership believes it has accomplished this in its proposed new building.

Responding specifically to the options mentioned in 15c, MFSMC ruled out options that include renovating the ORs in place for two reasons: 1) the expense of bringing the ORs into compliance with FGI standards (see response to Completeness Question 15a); 2) the footprint of the building would not allow the hospital to consolidate fourteen ORs in one space (see Attachment CQ 8, Goal 3).

MFSMC rejected options that involve building fewer than 14 ORs on MFSMC's campus and moving them to a stand-alone surgery center because: (1) this approach would require duplication of MFSMC anesthesiology, nursing and other OR staff ; (2) it would reduce the efficiency of MFSMC surgeons, who would travel to one place to perform their less acute cases and to another place to perform their more acute cases; (3) Many of the cases that are appropriate for an ambulatory surgery center (ENT, Ophthalmology, Plastic Surgery/Dermatology, Hand Surgery) have already migrated out of MFSMC to stand-alone centers.

COMPLETENESS QUESTION 16

16. How much has been raised or pledged toward the $20 million fundraising goal? What would the contingency funding plan be if you fail to meet the proposed $20 million fundraising campaign goal?

RESPONSE

MFSMC is awaiting approval of its CON before announcing a community-wide fundraising appeal; as a result, to date a small amount of support has been raised for this project. However, the hospital is currently involved in serious conversations with two potential one million dollar plus donors, both of whom have a meaningful history with MFSMC and have made significant contributions to the hospital in the past. Further, it should be noted that MedStar Franklin Square has a history of meeting and surpassing its fundraising goals in campaigns that call for capital improvements to the hospital. This is evidenced most recently by MFSMC's campaign to help build the Neonatal Intensive Care Unit (NICU) in which philanthropy accounted for approximately 38% of the total cost of the project.

If the hospital fails to meet its proposed $20 million fundraising target, the project will proceed in one of two ways: (1) the scope of the projected will be reduced in accordance with the project budget shortfall; (2) the scope of the project will remain unchanged and other MedStar Health resources will serve as a contingency for any shortfall in fundraising.

COMPLETENESS QUESTION 17

17. Please provide details as to the terms and type of tax-exempt bonds to be issued for approximately $40 million. Provide evidence that you have contacted a firm about issuing this debt financing.

RESPONSE

MedStar Health anticipates that tax-exempt bonds with a final maturity of 30 years will be issued for this project. A final decision by the MedStar Board of Directors as to the Project's financing will be made in the future including whether the bonds will be at fixed or variable interest rates. The MedStar Board of Directors has approved the project in MedStar Health's 5-year Capital Plan. In addition, MedStar Health has shared its financing plan for this project with the rating agencies and investment banks mirroring the assumptions noted in the application, which is inserted below:

> The practice of MedStar Health is to fund major facility projects with a combination of tax-exempt debt, cash, and philanthropy. In evaluating alternative funding approaches for the MedStar Franklin Square Medical Center Surgical Services Replacement Facility project, and giving consideration to other capital investments

planned across MedStar in the next few years, we have decided to fund this project with approximately $40.0 million tax-exempt debt and $30.0 million cash and fund raising. The type of tax-exempt debt to be issued will be determined based on market conditions at the time of the financing. MedStar currently maintains the following credit ratings: Moody's Investors Service A2, Positive outlook; Fitch Ratings A Stable outlook; and Standard and Poor's A Positive outlook. Given MedStar's strong credit ratings and favorable ratings outlook, the Company is confident that financing can be obtained. In addition, MedStar currently holds approximately $1.7 billion unrestricted cash and investments, which supports the Company's ability to issue the additional debt and fund any necessary capital from current cash and investment balances. *(Application, Part IV, p. 15)*

COMPLETENESS QUESTION 18

18. Please Regarding Attachment 14, Table L, please respond to the following:

    a. Explain the changes described in this table as "other expected changes in operations through the last year of projection (current dollars)." What is the basis for these changes in work force?

    b. The table shows a reduction of 21 FTEs "as a result of the project." Is that correct? What is the current staffing level from which this 21 would be reduced?

RESPONSE

a. The basis of the projected changes in MFSMC's workforce identified in Attachment 14, Table L of the hospital's application as "Other expected changes in operations through the last year of projection (current dollars)" is ongoing cost reductions related to a MedStar-wide performance transformation initiative (detailed in Attachment 11, Section 3, pp. 68-69 of the application). The cost reductions in this section of Table L are not specifically linked to the project, but are the result of organization wide cost reduction and efficiency improvement measures. The quantity of the projected FTE reduction is based on MFSMC's experience in implementing the MedStar performance and operational excellence initiative in

FY15 and FY16.

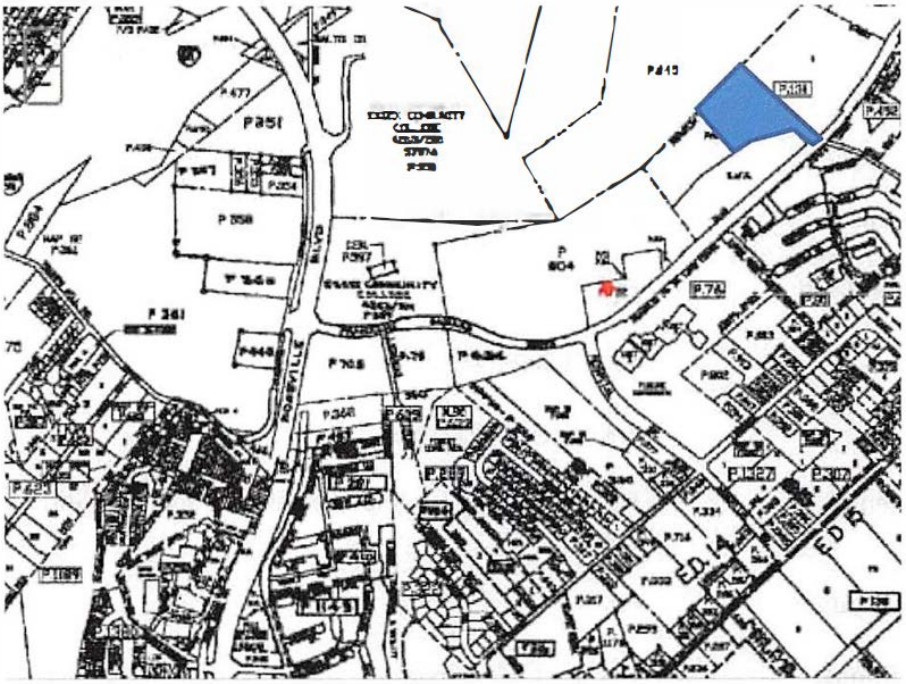
b. Attachment 14, Table L of the hospital's application correctly identifies a reduction of 21 FTEs "as a result of the project." MFSMC erroneously indicated 20 FTEs in its narrative in Attachment 11, section 3)a)iii., page 68 of the application.

These savings will be realized by the consolidation of the hospital's two separate OR pods, enabling the hospital to eliminate the duplicated patient intake, pre-op and post-op functions.

The current Operating Room staffing level from which the 21 FTEs would be reduced is 210 FTEs.

Attachment CQ 1: Question 2b

TAX MAP



AERIAL VIEW {EXISTING PARKING LOT IMPROVEMENTS)

Valbridge PROPERTY ADVISORS

Attachment CQ 2 - Question 2c

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valbridge.com

March 17, 2015

Mr. Sam Moskowitz
President
MedStar Franklin Square Hospital Center
9000 Franklin Square Drive
Baltimore County, Maryland 21237

RE: MedStar Franklin Square Hospital – Parking Lot Site
W/s Franklin Square Drive
Rosedale, Baltimore County, Maryland 21237

Dear Mr. Moskowitz:

In accordance with your request, we have prepared a real property appraisal of the above-referenced property, presented in an appraisal report format. This appraisal report sets forth the data gathered, the techniques employed, and the reasoning leading to our value opinions.

The property is known as the Medstar Franklin Square Hospital Center – Parking Lot Site, located on the west side of Franklin Square Drive in the Rosedale area of Baltimore County, Maryland 21237. The subject is further identified as a portion of the larger 8.86 acre parcel, yet to be subdivided and identified on Tax Map 82, Grid 20, Parcel 131. The site measures approximately 3.90 acres or 169,884± sq.ft. The site is currently improved with a fully improved parking lot supporting the MedStar Franklin Square Hospital Center, which is planned to be subdivided into a separate 3.90 acre building site to be accessed from Franklin square Drive. For the purposes of this appraisal per the client's instructions, we assume that the site has been subdivided. Therefore this is a hypothetical appraisal.

We developed our analyses, opinions, and conclusions and prepared this report in conformity with the Uniform Standards of Professional Appraisal Practice (USPAP) of the Appraisal Foundation; the Financial Institutions Reform, Recovery, and Enforcement Act (FIRREA); the Interagency Appraisal and Evaluation Guidelines; the Code of Professional Ethics and Standards of Professional Appraisal Practice of the Appraisal Institute; and the requirements of our client.

The MedStar Franklin Square Hospital Center is the client in this assignment and is the sole intended user of the appraisal and report. The intended use is for internal decisions regarding the subject property and its planned transfer to Baltimore County, Maryland for the relocation of the Eastern Family Resource Center which is currently located at 9100 Franklin Square Drive. The value opinions reported herein are subject to the definitions, assumptions and limiting conditions, and certification contained in this report.

Based on the analysis contained in the following report, our value conclusions involving the subject property are summarized as follows:

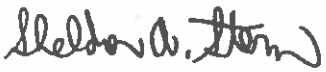
VALUE CONCLUSIONS

	As Is
Date of Value	March 11, 2015
Market Value Conclusion	**$1,300,000**

This valuation assumes that the subject property can be subdivided from the larger parking lot site and access is available from Franklin Square Drive.

This letter of transmittal must be accompanied by all sections of this report as outlined in the Table of Contents, in order for the value opinions set forth above to be valid.

Respectfully submitted,
Valbridge Property Advisors
LIPMAN FRIZZELL & MITCHELL LLC



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Valbridge
PROPERTY ADVISORS
Lipman Frizzell & Mitchell LLC

March 17, 2015

Mr. Sam Moskowitz
President
MedStar Franklin Square Hospital Center
9000 Franklin Square Drive
Baltimore County, Maryland 21237

RE: Appraisal Report
Eastern Family Resource Center
9100 Franklin Square Drive
Rosedale, Baltimore County, Maryland 21237

Dear Mr. Moskowitz:

In accordance with your request, we have prepared a real property appraisal of the above-referenced property, presented in an appraisal report format. This appraisal report sets forth the data gathered, the techniques employed, and the reasoning leading to our value opinions.

The property is known as the Baltimore County Eastern Family Resource Center, located at 9100 Franklin square Drive in the Rosedale area of Baltimore County, Maryland. The subject is further identified as Tax Map 82, Grid 20, Parcels 84 and 732. The site measures approximately 3.12 acres or 135,907 square feet. The site is improved with a 54,500-square-foot, three story office building, which is owned and occupied by Baltimore County agencies and several non-profit organizations.

We developed our analyses, opinions, and conclusions and prepared this report in conformity with the Uniform Standards of Professional Appraisal Practice (USPAP) of the Appraisal Foundation, the Code of Professional Ethics and Standards of Professional Appraisal Practice of the Appraisal Institute; and the requirements of our client.

MedStar Franklin Square Hospital Center is the client in this assignment and is the sole intended user of the appraisal and report. The intended use is for internal decision-making regarding the asset and its swap with a parcel of land located on the west side of Franklin Square Drive currently owned by MedStar. The value opinions reported herein are subject to the definitions, assumptions and limiting conditions, and certification contained in this report.

Based on the analysis contained in the following report, our value conclusions involving the subject property are summarized as follows:

VALUE CONCLUSIONS

	As Is
Date of Value	March 11, 2015
Market Value Conclusion	**$3,550,000**

The value conclusion above excludes two portable structures located on the parking lot of the subject property which we consider to be temporary structures and not part of the permanent real estate.

This letter of transmittal must be accompanied by all sections of this report as outlined in the Table of Contents, in order for the value opinions set forth above to be valid.

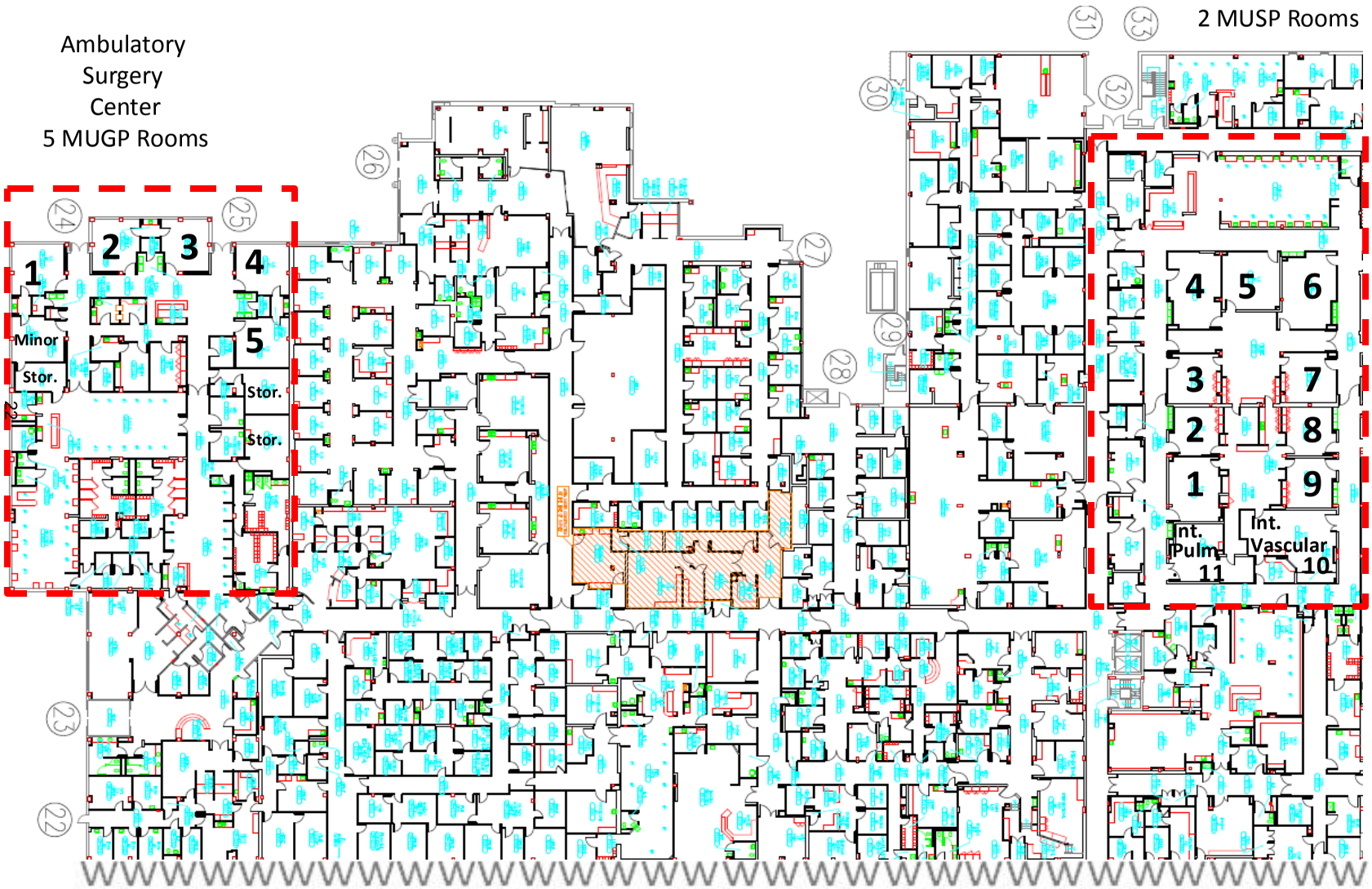
Respectfully submitted,
Valbridge Property Advisors
LIPMAN FRIZZELL & MITCHELL LLC

Sheldon A. Stern, MAI
Senior Appraiser
Certified General Real Estate Appraiser
State License # 04-1976
sstern@valbridge.com

Attachment CQ 4: Question 3 - MFSMC Surgical Service
Partial 2nd Floor – Main (Original) Building

Main OR
9 MUGP Rooms
2 MUSP Rooms

Ambulatory
Surgery
Center
5 MUGP Rooms



Scale: 0.5" = appx. 27'

MUGP = Mixed Used General Purpose
MUSP = Mixed Used Special Purpose
Stor. = Storage

Minor = Minor Procedure Room
Int. Pulm. = Interventional Pulmonology MUSP
Int. Vascular = Interventional Vascular MUSP

Attachment CQ 5: Question 4: Requested Calculations for Indicated Line Items of Project Budget

Numbers are from CON APPLICATION Attachment 9: Part II: TABLE E. PROJECT BUDGET

Contingency

Table E, A. 1. b.

(1) Building		$39,863,917
(3) Site and Infrastructure		$2,783,886
	Total Building & Site	$42,647,803
Contingency @ 7.0%[1] of Total Building & Site		**$2,985,346**

[1] 4% Construction Contingency and 3% Design Contingency

Gross Interest during construction period

MFSMC's financial projections assume a $40M project borrowing during FY18. Interest costs of approximately $2M per year ($40M borrowing at estimated interest rate of 5%) will be capitalized during the FY 18 and FY19 construction period for total estimated capitalized interest costs of $3,967,000.

Table E, A. 1. d.

Authorized Bonds	$39,670,000
Estimate Interest Rate	5%
Yearly Interest	**$1,983,500**
Estimate Construction Period (in years)	2
Gross Interest During Construction Period	**$3,967,000**

Inflation Allowance MFSMC utilized the index which the MHCC uses to calculate inflation (Building Cost Index in the IHS ECONOMICS Healthcare Cost Review, accessed from the MHCC website) to calculate this project's inflation from the approximate date that the costs were developed to the anticipated midpoint of construction.

Table E, A. 1. e.

Filing Date	2016.3				
Mid-Point of Construction	2018.2				
Step 1	2017.3	%MOVAVG	1.3	1.013	*A*
Step 3	2017.3	CIS Proxy	1.158		*B*
	2018.2	CIS Proxy	1.17		*C*
	C/B			1.010363	*D*
	*A*D*			**1.023497**	

Total Capital Cost (w/o Inflation)	67,618,149
Marshal Swift allowable inflation rate	**2.349740%**
Total Inflation	**$1,588,851**

Loan Placement Fees/ Bond Discount Loan placement fees and bond discount are assumed to be approximately 2% of the $40M borrowing or a combined $793,000. Based on other financing transactions in the market, the bond discount is estimated at .45% of the $40M borrowing or approximately $179,000 with the balance of $614,000 related to loan placement fees.

Table E, A. 2. a.

Authorized Bonds	$39,670,000
Assumed Cost of Issuance @ 2%	**$793,400**
Bond Discount (Underwriting Costs)	$179,000
Loan Placement Fees	**$614,400**

Bond Discount

Table E, A. 2. b.

Bonds Sold	39,777
Underwriting Costs ($4.50 per 1,000 bonds sold)	$4.50/1,000
Bond Discount	**$179,000**

MedStar Health

SUBMIT COMPLETED APPLCATION TO:
MEDSTAR HEALTH
Financial Assistance Department
8020 Corporate Drive
Baltimore, MD 21236

MEDSTAR FINANCIAL ASSISTANCE DATA REQUIREMENT CHECKLIST

We are in receipt of your financial assistance application. In order to complete **your eligibility determination, your application with support documents must be returned within fifteen (15) days from the date of this data request. Failure to comply with requirement will result in an automatic denial for MedStar Financial Assistance.**

****Please return the required documentation attached to this checklist ****

A: MEDSTAR UNIFORM FINANCIAL ASSISTANCE APPLICATION

_____ Complete **in full and sign** attached MedStar Uniform Financial Assistance Application

_____ If you are non-US citizen, please provide copies of permanent resident identification

B: SECTION I. FAMILY INCOME :

_____ 1) Two current pay stubs showing year-to-date income; or 4 months gross income
_____ 2) Most recent income tax return with W2s - Self employed/profit and loss statement
_____ 3) Current Social Security Award Letters, proof of pension and/or DSS Award Letter, Workman's Compensation, TEHMA, SSDI
_____ 4) Unemployment Benefit History Payment Statement or denial
- **Can be obtained at your unemployment office**

_____ 5) Proof of child support
_____ 6) Proof of alimony
_____ 7) **Copies of all other forms of income as listed on the MedStar Uniform Financial Assistance Application Section I: FAMILY INCOME**
_____ 8) **If claiming zero income, letter of support from person providing financial support.**

C: SECTION II. LIQUID ASSETS

_____ 1) Copies of bank statements for ALL Savings and/or Checking Accounts
_____ 2) Copies of statements for ALL Stocks, Bonds, CD, or Money Market Accounts
_____ 3) If there are no liquid assets, please provide a written/signed letter stating $0 assets.

D : SECTION III. OTHER ASSETS

_____ **1) If you own your home(s) , please provide:**
a. Current loan balance: $_____
b. Current home market value: $_____

E: SECTION IV. MONTHLY EXPENSE

_____ **1) Provide copies of all unpaid medical bills for the past 12 months.**

To discuss your application, please contact our office at 410-933-2424 or 1800-280-9006
Monday – Friday 7:00 am – 7:00 pm.

MedStar Health Uniform Financial Assistance Application

Patient Account Number(s): _____

Information About You

Name _____
First Middle Last

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

Home Address _____ Phone _____

_____

_____ _____
City State Zip code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip code

Household members:

Name	Age	Relationship

Have you applied for Medical Assistance Yes No
If yes, what was the date you applied? _____
If yes, what was the determination? _____
Do you receive any type of state or county assistance? Yes No
Advocate that completed or mailed F/A Application: _____ Date: _____

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	
Retirement/pension benefits	
Social security benefits	
Public assistance benefits	
Disability benefits	
Unemployment benefits	
Veterans benefits	
Alimony	
Rental property income	
Strike benefits	
Military allotment	
Farm or self employment	
Other income source	
Total	

II. Liquid Assets

	Current Balance
Checking account	
Savings account	
Stocks, bonds, CD, or money market	
Other accounts	
Total	

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____	Approximate value _____
Automobile	Make __N/A___ Year __N/A____	Approximate value _____N/A_____
Additional vehicle	Make ___N/A__ Year _ N/A____	Approximate value ____ N/A_____
Additional vehicle	Make ___N/A____ Year __N/A__	Approximate value _____N/A_____
Other property		Approximate value _____N/A_____
		Total _____

IV. Monthly Expenses

	Amount
Rent or Mortgage	____N/A_____
Utilities	____N/A_____
Car payment(s)	____N/A_____
Credit card(s)	____N/A_____
Car insurance	____N/A_____
Health insurance	____N/A_____
Other medical expenses	
Other expenses	____N/A_____
Total	

Do you have any other unpaid medical bills? Yes No

For what service? _____

If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____ _____

Applicant signature Date

_____

Relationship to Patient

MEDSTAR FINANCIAL ASSISTANCE POLICY

MedStar Health provides partial or complete financial assistance for certain patients who do not qualify for Medicare and Medicaid and are not covered by health insurance. Patients who need financial assistance for emergency or medically necessary care may apply for assistance and should be prepared to demonstrate their financial condition.

To obtain free copies of MedStar's Financial Assistance Policy and Application, and instructions on applying please visit our website at: www.medstarhealth.org/FinancialAssistance , or visit the Admitting Department at any MedStar Hospital.

Additional Contact Information:

- **Call 1-800-280-9006 with questions concerning:**
  - **Your hospital bill.**
  - **Your rights and obligations with regards to your hospital bill.**
  - **How to apply for Maryland Medicaid.**
  - **How to obtain copies of the MedStar Financial Assistance Policy and Application by mail.**
  - **How to apply for MedStar Health's Financial Assistance Program for free or reduced cost-care.**
  - **Language translations for all Financial Assistance Policy related documents and information can be found on MedStar Hospital websites and patient portals.**

MedStar Health

Attachment CQ 8: Question 8
Comparison of MFSMC Replacement of Surgical Services Options

	Option 1: Renovate in Place*	Option 2: New Construction
GOAL 1: Bring the hospital's operating rooms into compliance with all appropriate standards for the delivery of surgical services without compromising the hospital's ability to maintain a sufficient inventory of ORs to meet the current and projected future need for surgical services in the hospital's service area.		
Correct current OR physical plant deficiencies related to FGI/ Industry Norms.	**Does Not Achieve Project Goal 1**	**Achieves Project Goal 1**
(1) Current facility lacks the square footage to accommodate the 14 ORs MFSMC projects it will need in one consolidate location with a minimum of 600 SF of clear floor area. (See also Goal 3).	Available square footage of footprint does not provide an area necessary for 14 ORs with a minimum 600 SF of clear floor area in one location	Provides space for 14 ORs with a minimum 600 SF of clear floor area.
(2) Current facility does not meet Standard of 16 FT floor to floor space	This deficiency cannot be mitigated. Changes necessary to increase the floor to floor space are cost prohibitive.	Provides Standard 16 FT floor to floor space in all rooms
GOAL 2: Design and renovate/construct the facility at the most efficient project cost, in the shortest, most efficient period of time, and with the least disruption to the delivery of services during the renovation/construction period.		
2a. Project Cost	**Does Not Achieve Project Goal 2a $97M****	**Achieves Project Goal 2a $70M**
	Renovations in place incur costs associated with demolition, infrastructure upgrades, etc., that are both time consuming and costly. Moreover, one impact of a long project schedule is the additional expense associated with cost inflation in later project years.	Achieves efficient project cost
2b. Project Timeline	**Does Not Achieve Project Goal 2b 75 Months**	**Achieves Project Goal 2b 24 Months**
	Because the project would entail ongoing OR functioning and construction/renovation in the same location, there will a repeated sequential process of room closure - renovation - room re-opening. This will significantly lengthen the project duration.	New construction on a separate site, unencumbered by mixing ongoing services with simultaneous renovations, provides the shortest project timeline.
2c. Disruption of Services During Renovation/Construction	**Does Not Achieve Project Goal 2c Significant Disruption to Current Services**	**Achieves Project Goal 2c No Disruption to Current Services**
	A renovation in place project produces significant disruptions to currently surgical services and other related services: (1) Significant noise disruptions in the OR (2) Heightened risk to sterile climate (3) Significant scheduling and access disruptions (4) Department displacements	New construction on a separate site eliminates disruption to current services.
GOAL 3: Consolidate two OR pods into one more efficient OR Suite that reduces the cost of providing surgical services at MFSMC.		
Improved Operational Efficiency	**Does Not Achieve Project Goal 3 Limited Oppurtunity for Expense Reduction**	**Achieves Project Goal $2.0M/Year Expense Reduction 3**
	The deficiency in existing square footage noted in A(1) prevents the consolidation of all surgical services into one location. This limits the opportunity for expense reduction associated with the eliminating the current duplication of series (pre-op, post-op, etc.)	Provides full consolidation of surgical services and full potential for expense reductions. Consolidating the hospital's two currently separate locations will create staffing efficiencies through the elimination of duplicated services and the streamlining of existing services through improved design and adjacencies.

*This option assumes renovation of the existing OR space in the central core of the original hospital and an expansion into other adjacent spaces that are currently housing other hospital functions. The space available for renovation does not yield enough square footage to achieve the proscribed 600 SF clear floor area in its ORs.
**Excludes escalation

Attachment CQ 9: Question 10

MEDSTAR FRANKLIN SQUARE MEDICAL CENTER
CLINICAL POLICIES AND PROCEDURES

TRANSFER OF PATIENTS: INTER-HOSPITAL

Initiating Department: Nursing Administration **Section: Clinical Practice**
Policy Owner: Clinical Practice Council **____ New X Revised ___Reviewed**
Index (keywords):Transfer, Communication Handoff, report
Effective Date: 9/18/2013
Next Review Date: 9/18/2016

Approval:

Larry Strassner, PhD, RN, FACHE, NEA-BC
SVP Operations, Chief Nursing Officer

Attachments:
Communication Handoff Form
Inpatient Valuables / Properties
Emergency Medical Condition Evaluation, Treatment, and Transfer EMTALA
Printing MedConnect Reports

1.0 **PURPOSE:**

1.1 To provide information to other facilities, including long-term care facilities, concerning status of patient's present condition and routine care provided on day of transfer. To provide direction to the nursing staff when the need to transfer a patient has been identified. Excludes newborns and neonates.

2.0 **DEFINITIONS:**

2.1 MOLST: Maryland order for life sustaining treatment

2.2 PASRR: Preadmission Screening and Resident Review. Screening tool for all patients going to a long-term care facility or assisted living facility for mental illness and or mental retardation

2.3 EMTALA: Emergency Medical Condition Evaluation, Treatment, and Transfer form. To be completed on all patients going to another hospital.

3.0 **LEVEL OF RESPONSIBILITY:**

3.1 RN

MEDSTAR FRANKLIN SQUARE MEDICAL CENTER
CLINICAL POLICIES AND PROCEDURES

TRANSFER OF PATIENTS: INTER-HOSPITAL

4.0 **POLICY:**

4.1 The Communication Handoff Form is completed by the nurse, indicating the clinical status, assessment of the patient and care administered on day of transfer to another nursing facility or long-term care facility. This document is copied and placed in the medical record.

4.2 The original Communication Handoff form is sent with the abstract of patient's chart, a written or dictated discharge summary, and a completed PASRR screen for patients going to either a long-term care facility or assisted living facility.

4.2.1 Abstract contains copies of

4.2.1 Advanced Directives

4.2.2 MOLST form

4.2.3 Pertinent Lab, EKG and X-ray reports

4.4.3.1 See Medical Record – 24 hour lab summary

4.2.4 Chest X-ray to R/O TB or negative PPD and date read

4.2.5 Rehab notes, if applicable

4.2.6 Last 24 hours of Progress notes

4.2.7 Consults

4.2.8 Documentation of Patient Education in medical record

4.2.9 Last TPN order, if applicable

4.2.10 Medication Administration Record

4.2.10.1 See Medication Transfer Report

4.2.11 Medication Reconciliation Form

4.2.12 If discharge summary not available send the initial History and physical

4.2.13 Valuables form with signed receipt from transport personnel.

4.3 A MOLST form must be completed by either a physician or nurse practitioner licensed in the state of Maryland on all patients who are being transferred to a nursing home, assisted living facility, home health agency, hospice, kidney dialysis center, or another health care facility.

4.3.1 The MOLST form is then copied and original will be sent with patient and the copy placed in the medical record.

5.0 **DOCUMENTATION:**

5.1 Document on the Communication Handoff Form

5.2 Updates not included on the completed Communication Handoff Form are to be included in a narrative note in the progress notes.

5.3 Complete EMTALA form.

6.0 **REFERENCES:**

Handoff Communication- Practical Strategies and Tools for TJC Compliance-

TJC 2010 National Patient Safety Goals

Oxford Journal. International Journal for Quality Health Care. (2004). Handoff Strategies In Settings with High Consequence for Failure: lessons for health care operations. Retrieved May 10, 2009 from http://intqhc.oxforjournal.org/cgi/content/full/16/2/123.

World Health Organization. Patient Safety Solutions. (2007, May). Communication During patient Handoffs. Retrieved May 10, 2009 from http://www.who.int/en/.

Franklin Square Hospital Center
Centered on You
9000 Franklin Square Drive
Baltimore, Maryland 21237-3998
443-777-7000
www.franklinsquare.org

Communication Handoff

This tool is designed to provide accurate information about a patient's care when responsibilities are handed off from one care provider to another, such as: Unit to Unit, shift to shift, &Transfer Out of Facility.

Patient Label

Date:_____ Time:_____ Room Assignment:_____

Admitting Diagnosis & Pertinent PMH: _____

Chief Complaint: _____

Attending Physician: **Code Status:**

Allergies: ☐NKDA ☐Latex ☐PCN ☐Sulfa ☐Food:_____
☐Other:_____ **Advance Directives:** ☐Yes ☐On chart ☐No

Isolation: ☐MRSA ☐VRE ☐C.Diff ☐Contact ☐Airborne ☐Other:_____

Special Needs: ☐Bariatric ☐Amputee ☐Dialysis ☐Ostomy

Impairment: ☐Hearing ☐Visual ☐Cognitive

Language:_____ Needs Language Line/Interpreter: ☐Yes ☐No

Status of Family/Significant Other: ☐Present ☐Notified ☐No Notification

Mental Status: ☐Alert ☐Confused ☐Combative ☐Lethargic ☐Unresponsive
☐CAM_____

Skin assessment: ☐Intact ☐Warm & Dry ☐Dusky ☐Cool ☐Clammy
☐Pink ☐Pressure Ulcer:_____Dressings:_____
☐Braden Scale:_____

Safety issues: ☐Fall Risk ☐Elopement Risk/Wristband ☐Suicide/Withdrawal Precaution
☐Restraints ☐Sitter ☐Weakness ☐Diligent

Invasive Lines: ☐IV Access:_____ ☐Central Line ☐Portacath
☐NGT ☐Chest Tube ☐Foley ☐Drains:_____

Miscellaneous: ☐Oxygen____Liters/Min ☐Telemetry ☐NPO

Vaccination assessment complete: Pneumococcal ☐Yes ☐No ☐N/A Influenza ☐Yes ☐No ☐N/A

Vital Signs	Time	T	P	R	BP	O2 Sat	Blood Glucose
Initial							
Ready to Move							

Current Pain Level	PCA	Pain Medications Given	Last Dose	Response
1-2-3-4-5-6-7-8-9-10 Numerical Scale	☐IV_____ ☐Epidural_____	☐Morphine mg		
		☐		
		☐		

IV Drips/Medications Infusing: _____

Abnormal Labs/Test Results & Treatment Given: _____

Meds Given, Dose/Time/Route/Effect: _____

Pending Labs/Treatment/Test Results/Consults: _____

For Questions about this Patient, Call RN:_____ Ext:_____

Fax Was Received By(Name Unit):_____ Date/Time:_____

T-20725-5 (Rev.12/08) (Progress Note)_____

T20725-5

MedStar Franklin Square
Medical Center

MFSMC – Hospital Policy Manual

Title:	Inpatient Property/ Valuables	**Section**	
Purpose:	To provide guidelines to secure/ account for competent and incompetent patient personal property and valuables. To prevent loss of personal items and to provide for safe disposition of the property and valuables.	**Number**	
Forms:	Inpatient_Property_ 2.20.13.pdf Patient Valuable Record.pdf Security Envelope.pdf	**Effective Date of This Version:**	01/08/2013

1.0 POLICY

1.1. Patients admitted to Medstar Franklin Square Medical Center will be encouraged to send their personal items and valuables home. If they choose not to, they may store these items with Security until discharged from the Medical Center. Patient Care staff will secure patient property/valuables as outlined in this policy at the time of admission to the hospital.

1.2. Patients are to be considered:

1.2.1. Able to understand and take care of their property.
1.2.2. Unable to care for their personal items.

1.3 Standard infection control precautions are observed.

1.4 Patients with dentures or hearing aids will be issued a container/cup, labeled with patient's name and room number.

2.0 PROCEDURE

2.1. Able Patient

2.1.1. If the able patient has no one to take his or her belongings home, the property will be inventoried on a Patient Property Record (T2700-0) during the admission procedure. Valuables will be placed in a Medical Center valuable envelope (S-0820-5) and taken to Security. Clear valuable bags are used for Behavioral Health Patient property for safety reasons. Valuables, i.e. glasses, hearing aids, dentures, jewelry, wallets, purses, laptops, etc., may be kept in the patient's room safe (Tower only). It should be made clear by the person admitting the patient that the hospital

does not recommend the patient keep valuables in their rooms, and that if the patient chooses to do so, the patient will assume all risk for any loss. The able patient will sign this record. See copy of Records- attached.

2.2. Unable Patient

2.2.1. If the patient is unable, valuables and property must be inventoried.
Valuables and personal items to be secured will be inventoried and signed by two associates and taken to Security. The immediate family or authorized family representative may sign for and accept the property. Items of authorization may include photo identification (i.e. driver's license), official court document (i.e. power of attorney, and an executor of the estate, etc.).

2.3. Patients are discouraged from keeping valuables and/or other belongings in their room. The areas (Admitting, Patient Care, and Emergency Department) as part of the admission process, will request patients to send their property home.

2.3.1. The Medical Center assumes no liability for patient property not turned over to security for safe keeping. Patients are asked to sign the Patient Valuables Record/ Valuables Bag.

2.3.2. The Security Department will receive all patient valuables and/or property turned over to them for safekeeping, and will maintain an accountability system.

2.3.3. Patients may utilize in room safes (Tower only) to secure valuables, including up to 17" laptops, or turn them over for safekeeping with Security. The caregiver team or Security personnel will review the use of the in room safe with the patient and/or family.

2.4. Patients being admitted to the Medical Center will be requested by the Patient Care staff to send their belongings such as jewelry, currency, and other valuables home.

2.4.1. Patients admitted to the Medical Center through the Emergency Department will have their belongings inventoried and turned over to Security by the Emergency Department assigned caregiver.

2.4.2. If a patient arrives on a Patient Care unit with excess belongings or valuables, or if the patient is no longer competent to take care of his or her belongings, the responsible nurse along with another Patient Care staff member will inventory the belongings and release them to a third party (i.e. family member) or turn them over to Security for safekeeping.

2.4.3. When a patient is transferred from unit to unit, Patient Care is to complete the Patient Valuables Record, indicating the articles are being transferred with the patient. The receiving staff and the sending staff must sign off on the form.

2.4.4. Patients being admitted after outpatient surgery will be encouraged to give their valuables to a third party or have them inventoried and then turned over to Security for safekeeping. The staff will complete a Patient Valuables Record and keep it with the Patient's Records. If outpatient surgery patients are not admitted, their property is store in a locked locker and the key is maintained by the patient or third party.

2.4.5. When patients arrive at the Emergency Department and are placed under observation, their valuables are surrendered and placed in a lock cabinet controlled by Security and/or the Charge Nurse. If discharged, valuables are returned. If the patient is admitted, the valuables are transported with the patient and secured in the ED CIS area. If the patient is admitted under medical to a medical floor, the valuables are secured with Security, or taken home by an authorized third party. If the patient is admitted to Behavioral Health, the valuables are turned over to the behavioral health staff.

2.5. Personal belongings of patients who if deceased (i.e. patient arriving DOA in the Emergency Department) are handled in accordance with this policy.

2.5.1. In the presence of an authorized family member, the Patient Care staff rendering care lists all patient belongings on the Patient Valuables Record with any other personal effects. The patients authorized family member signs the Patient Valuables Record, assuming responsibility for taking effects home. The Patient Valuables Record remains with the patients' medical record. Valuables must be listed in detail (i.e. make of watch, color, features; list cash as $5.00- five one-dollar bills, etc.) on the Patient Valuables Envelope. (See attachment)

2.5.2. In the absence of the patient of authorized family member, the nurse rendering care places all valuables in the Patient Valuables Envelope in the presence of another Patient Care staff member who witnesses the action and seals it. The entire envelope is carried to Security for safekeeping.

2.5.3. Patient Care staff collect and itemize all patient clothing and personal effects, (e.g. teeth, prosthesis) other than those already placed in a valuables envelope, and will carry them to Security.

2.6. The steps for turning in patient valuables are listed below (Patient valuables are items of significant value such as U.S currency, jewelry, checkbooks, credit cards, or items which could be subject to theft.)

2.6.1. The Patient Care staff prepares the valuables envelope (5-0820-5), seals the envelope, and then signs the envelope. Refer to 2.5.2.

2.6.2. The valuables envelope is carried to Security, where they will check to determine the envelope is properly sealed in accordance with the above, 3.3.2, and then sign for it in the appropriate space. The top copy of the receipt is then given to the staff member who delivered the envelope.

2.6.3. The acceptance of the envelope will be noted in the Security Department records, and the envelope will be secured.

2.6.4. The person completing the inventory will give the top copy of the receipt to the patient, authorized family member, or place in the patients' chart stapled to the Patient Valuables Record. The number of the valuables envelope is entered in the space provided on the valuables record.

2.7. The steps for turning in patient clothing and personal effects (other than valuables) are:

2.7.1. The nurse prepares an inventory of all items. One copy is attached to the property and one is placed into the patients' medical records. The clothing and other property must be placed in patient belongings bag. If there is a suitcase, garment bag or other similar container, they must have a label affixed with the patients' information. Due to minimal storage space in Security, wheelchairs, bicycles, or other large items will need to be secured in an alternate area which will be decided at the time of receipt. Security will not accept perishable items (i.e. foods, flowers, etc.). The telephone number of the patient and/or next of kin is written on the Property Record (T2700-0) for follow up by Security on disposition of the property.

2.7.2. The property will be carried to Security for safekeeping.

2.7.3. A Security Associate will receive the property and a record will be maintained.

2.8. Patient valuables and property are available for release to the patient or authorized family member twenty-four hours a day through the Security Department located on the first floor of the Medical Center next to Human Resources.

2.8.1. Valuables and/or property may be released to a holder of the receipt, i.e. designated care giver, authorized family member, (see item 3.2) or to the patient if able.

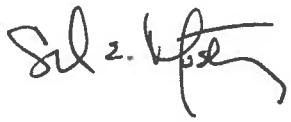
2.8.2. The Security Associate after identifying the recipient will obtain a signature on the inventory sheet.

2.8.3. In cases where all of the valuables or property is not wanted by the patient or authorized family member, at the same time, a new inventory of the remaining property must be made by the Patient Care staff. The original inventory sheet/ valuables envelope claim portion will be retained for record keeping purposes. At no time will Security release partial contents of a valuables envelope or property. The entire package/ valuables envelope will be released to the authorized party.

3.0 FINAL DISPOSITION

3.1 The Chief of Security, or designee will at shift change, conduct an inventory of all valuable envelopes being safeguarded. A written notice will be sent to discharged patients (or responsible party) whose valuables have been kept for 30 days or more. The patient will be requested to provide instructions on the disposition of the property. Unclaimed items whose owner or other responsible party cannot be located will be disposed of. Donate-able items may go to the Medical Center Thrift Boutique, or a charitable organization, and currency to a Hospital General Fund.

3.2 Any patient valuables/ property released to a third party (i.e. police, medical examiner, funeral home, etc.) must be specifically inventoried and signed for. All situations of this nature will be reviewed, prior to release, by Risk Management. Security will alert Risk Management in these cases.

Reference:	
Approved By:	 **Samuel E. Moskowitz, FACHE** **President, MedStar Franklin Square Medical Center**
Approval Date:	**February 13, 2013**
Additional Signature Information:	

MedStar Franklin Square Medical Center		Emergency Medical Condition Evaluation, Treatment, and Transfer (EMTALA)		
Date Created:	02/11/2016	Version:	1	Page 1 of 14
Date Approved:	07/28/2016	Document Number:	221	
Date Effective:	07/28/2016			
Purpose:	To ensure that individuals who seek care at any hospital facility within the MedStar Health system are provided with access to emergency services consistent with the requirements of the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), as amended, and the regulations adopted pursuant to EMTALA.			
Content Owner:	Bornstein, Katherine			
Approved By:	Moskowitz, Sam			
Affected Departments	Compliance, Emergency Department Administration, Unassigned			
Links:				

1.0 POLICY

It is the policy of MedStar Franklin Square Medical Center to comply with all elements of EMTALA.

2.0 SCOPE

Any individual who comes to a hospital facility (as further defined below) and who requests examination or treatment of a potential emergency medical condition, will receive a medical screening examination performed by a qualified provider to determine whether or not an Emergency Medical Condition (EMC), as defined below, exists. If an Emergency Medical Condition is determined to exist, the hospital will provide any treatment necessary to stabilize the EMC, within the Hospital's capability, or arrange for an appropriate transfer to another facility in accordance with the procedures set forth below. This Policy shall apply to all individuals whether or not eligible for Medicare benefits and regardless of their ability to pay. No examination or treatment will be delayed to determine a patient's insurance status or ability to pay, or to inquire about prior authorization for health care coverage.

3.0 DEFINITIONS

3.1 Capacity - Means the ability of a Hospital to accommodate the individual requesting examination or treatment. Capacity includes such things as the number and availability of qualified staff, beds and equipment and includes the hospitals past practices of accommodating additional patients in excess of its occupancy limits.

3.2 Dedicated Emergency Department (DED) - Means any department or facility of the hospital (regardless of whether it is located on or off the hospital main campus) that meets at least one of the following requirements: (a) it is licensed by the state as an emergency room or emergency department; (b) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for EMCs on an urgent basis without requiring a previously scheduled appointment (such as a labor and delivery unit); or (c) it provides at least one-third of all of its outpatient visits (during the preceding calendar year based on a

representative sample of patient visits) for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment.

3.3 Emergency Medical Condition (EMC) - Means a medical condition with symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that without immediate medical attention the patient can be expected to experience:

3.3.1 Serious impairment to any bodily functions including mental impairment; or

3.3.2 Serious dysfunction of any bodily organ or part including mental dysfunction.

With respect to a pregnant woman who is having contractions:

3.3.2.1 There is inadequate time to effect a safe transfer to another hospital before delivery, or

3.3.2.2 The transfer may pose a threat to the health or safety of the woman or the unborn child.

3.4 Hospital - Means any acute care hospital subsidiary of MedStar Health, Inc. with a DED, as defined in this Policy. For purposes of this Policy, Hospital includes off-campus clinics, departments or facilities which operate under the Hospital's Medicare provider number if such clinic, department or facility qualifies as a DED.

3.5 Hospital Property or Premises - Includes the entire main hospital campus, including the driveway, sidewalk, and parking lots of the Hospital, as well as other areas, clinics, and offices that are not strictly contiguous to the main buildings of the Hospital but are within 250 yards of the main hospital buildings. Hospital Premises does not include (a) areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, skilled nursing facilities and other medical facilities that participate separately under the Medicare program; and (b) restaurants, shops and other non-medical locations.

3.6 Inpatient - Means an individual who is admitted to the Hospital for bed occupancy to receive inpatient services.

3.7 Medical Screening Examination (MSE) - Means the process for determining, with reasonable clinical confidence, whether or not an EMC exists. This is documented in the patient's medical record. The MSE must be conducted by a physician or other qualified provider who holds the necessary clinical privileges to perform the examination under a policy approved by the medical executive committee and the Hospital's board of directors.

3.8 Stabilize - Means to provide the medical treatment, within the Hospital's capabilities, as may be necessary to assure that no material deterioration of the EMC is likely to

result from or occur during the transfer of a patient to another facility or upon discharge of the patient from the hospital. Obstetrical patients with "true" contractions are considered unstable until delivery of baby and placenta.

4.0 RESPONSIBILITIES

4.1 Patient Evaluation and Treatment

4.1.1 Medical Screening Examination

4.1.1.1 Every individual who comes to the Hospital's DED and who requests examination or treatment for a medical condition (or has such request made on his/her behalf) must be offered a MSE within the Hospital's capability, including ancillary services routinely available to the emergency department, to determine whether or not an EMC exists.

4.1.1.2 Every individual who presents on Hospital Property (other than the DED) and who requests examination or treatment for an EMC (or has such request made on his/her behalf), must be offered a MSE to determine whether or not an EMC exists.

4.1.1.3 In the absence of an explicit request, a request for examination or treatment will be inferred if a prudent layperson observer would believe, based on the individual's appearance or behavior, the individual needs emergency examination or treatment.

4.1.1.4 If an individual comes to the Hospital's DED seeking examination or treatment for a medical condition but it is apparent that the medical condition is not of an emergency nature, the Hospital is only required to provide such screening as necessary to determine that the individual does not have an EMC.

4.1.1.5 An individual who is brought to the Hospital by air or ground ambulance is considered to be on the Hospital Property or Premises from the time that the ambulance arrives on the Hospital Property. In addition, an individual on a hospital owned or operated ambulance, even if the ambulance is not on hospital grounds, should be treated as if that patient is in the emergency department, unless the Hospital is on diversionary status, the ambulance is operating under community-wide EMS protocols that direct it to transport the individual to a hospital other than the hospital that owns the ambulance, or the ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance. If a hospital is on diversionary status and the patient is still transported to the Hospital Property, the obligations of EMTALA apply.

4.1.1.6 All patients will be assessed on arrival to determine the nature of the patient's complaint and any obvious acute conditions.

4.1.1.6.1 Patients with a potential life or limb threatening condition will be taken directly to the appropriate clinical area for the MSE and stabilization.

4.1.1.6.2 All other patients will be registered by the Emergency Department Registrar using the customary registration process (as described below), provided that this process does not delay screening for treatment.

4.1.2 Registration and Prior Authorization

4.1.2.1 The Hospital may not delay the MSE or treatment to stabilize the patient's EMC to inquire about or verify the individual's ability to pay, the method of payment, or the patient's insurance status.

4.1.2.2 Subject to the above restrictions, to facilitate patient flow through a department, the Hospital may follow routine registration processes for individuals presenting to the Hospital. This may include asking whether an individual is insured and, if so, what that insurance is, as long as this process does not delay screening or treatment.

4.1.2.3 The Hospital may not seek or direct an individual to seek authorization from the individual's insurance company until after the Hospital has provided the appropriate MSE and initiated further examination and treatment necessary to stabilize the EMC. However, an emergency physician or other provider involved in the patient's emergency care may contact the patient's personal physician at any time to seek advice regarding the patient's medical history and needs that may be relevant to the medical screening and treatment of the patient, provided the consultation does not inappropriately delay screening or stabilization services.

4.1.2.4 Patients should not be asked to complete a financial responsibility form or an advanced beneficiary form prior to receiving a MSE or stabilizing treatment. Staff will inform patients who ask about financial obligations that the patient will receive a screening examination and stabilizing treatment, regardless of the patient's ability to pay for services.

4.1.2.5 Collection of copayments may take place only after the MSE and stabilizing treatment have been provided and the patient is ready for discharge or admission to the Hospital. Collection of copayments must be consistent for all patients regardless of their type of insurance.

4.1.3 No EMC

4.1.3.1 If the MSE indicates that the patient does not have an EMC, the results of the examination should be entered into the patient's medical record. If further medical treatment is offered, the patient should be advised that he/she may be asked to agree to pay for the medical treatment or to secure authorization from the third party payer for the treatment before it is rendered.

4.1.4 Presence of EMC

4.1.4.1 If the patient is determined to have an EMC, further medical examination and treatment should be offered to stabilize the condition, within the capabilities and facilities available at the Hospital, or the patient should be transferred to another appropriate facility in accordance with Section 2 of this Policy. If the EMC is stabilized, this policy and the EMTALA obligations of the Hospital no longer apply.

4.1.5 Application of this Policy and EMTALA to Inpatients and Outpatients

4.1.5.1 If a Hospital has screened an individual and determined that the individual has an EMC, and admits that individual in good faith in order to stabilize the EMC, the Hospital's obligations under this Policy and EMTALA end. In addition, this Policy and EMTALA do not apply to an individual who has begun to receive outpatient services as part of an encounter at the Hospital other than an encounter that triggers the Hospital's EMTALA obligations, as described in this Policy.

4.1.6 Off-Campus Sites

4.1.6.1 Off-Campus Provider-Based DEDs. If the patient comes to an off-campus hospital-owned clinic, facility or department, which operates under the Hospital's Medicare provider number and which qualifies as a DED (as described above), the facility must provide a MSE and stabilizing treatment (within the capability and capacity of the facility) or execute an appropriate transfer, as described in Section 2 of this Policy.

4.1.6.1.1 The Hospital should establish protocols for handling possible emergency cases at these off-campus sites.

4.1.6.1.2 The facility may transfer a patient in an unstable condition to an affiliated hospital if the off-campus facility has screened the individual and determined that treatment of the individual's condition is not within the capability or capacity of the facility and, therefore, the medical benefit of the transfer outweighs the risk.

4.1.6.1.3 The facility may transfer a patient in an unstable condition to a non-affiliated hospital if the facility determines that the benefits of transfer exceed the risks and the other requirements for an appropriate transfer are met, as described in Section 2 of this policy.

4.1.6.1.4 Off-Campus Provider-Based Sites Which Do Not Qualify as DEDs. The Hospital should establish written policies and procedures (adopted by the hospital governing body) for appraisal of emergencies and referral when appropriate, at off-campus provider-based sites (other than DEDs), as specified in the Medicare hospital conditions of participation. Such policies and procedures will only apply within the hours of operation and will vary depending upon the normal staffing capability of the facility.

4.2 Transfer Of Patients with an EMC that Requires Further Treatment

4.2.1 General Prohibition. No patient with an EMC will be transferred to another hospital based on the inability of the patient to pay for the medical care. If a patient has an EMC that has not been stabilized (as described in this Policy), a hospital may not transfer the patient UNLESS:

4.2.1.1 the patient requests the transfer in writing (after being informed of the hospital's obligations and the risks of transfer); or

4.2.1.2 The physician signs a certification that the medical benefits expected from the treatment at the other facility outweigh the risks of the transfer;

4.2.1.2.1 In the case of a national emergency, the determination as to the appropriateness of the transfer of patients to another medical facility shall be made by the applicable medical personnel of the Hospital, in collaboration with the Vice-President for Medical Affairs or designee.

4.2.2 Obligations of Transferring Hospital

4.2.2.1 Benefit and Risk Assessment. After a full medical evaluation of the patient, the responsible physician and the health care team of the transferring hospital must consider the medical benefits reasonably expected from the provision of medical treatment at the other hospital or facility and determine that those benefits outweigh the risk to the patient if treatment is continued at the hospital. Facilities or services available at another hospital are more appropriate than those of the transferring hospital for treatment to stabilize the patient when:

4.2.2.1.1 The receiving hospital has specialized capabilities or other facilities (necessary to treat the EMC) beyond those facilities or services available in the transferring hospital, such as a burn unit, trauma center, organ transplant, neonatal intensive care unit, invasive cardiology, etc.

4.2.2.1.2 The patient requires special care, and no physician with clinical privileges in that specialty is immediately available, or is acceptable to the patient at the transferring hospital; or

4.2.2.1.3 The patient requires admission and no bed is reasonably available for the patient, even after consideration of actions the Hospital customarily takes to accommodate patients in excess of its normal capacity.

4.2.3 Acceptance by Receiving Hospital.

4.2.3.1 The transferring hospital must first contact the proposed receiving hospital to confirm that the required facilities and services (including qualified personnel) are available for medical treatment of the patient and that the proposed receiving hospital agrees to accept the transfer.

4.2.3.2 The transferring hospital must send the transfer request and physician certification to the receiving hospital.

4.2.3.3 The transferring hospital must document on a patient transfer form (see below) its communication with the receiving hospital, including the date and time of a transfer request and the name of the person accepting or refusing the transfer.

4.2.3.4 If there is a disagreement between the treating physician and an off-site physician (e.g., a physician at the receiving hospital or the patient's primary care physician if not physically present at the first facility) about whether a patient is stable for transfer, the medical judgment of the treating physician takes precedence over that of the off-site physician.

4.2.4 Completion of Transfer Form.

4.2.4.1 The responsible physician from the transferring hospital must sign a completed patient transfer form, which must:

4.2.4.2 Be in writing and include the patient's consent to the transfer.

4.2.4.3 Include a written physician certification of transfer, completed by the responsible physician, who includes the reasons for transfer and a complete

description of the benefits to be expected from the receiving hospital and the risks associated with the transfer.

4.2.4.4 Indicate the reasons for the request and that the patient is aware of the benefits and risks of transfer.

4.2.4.5 The transfer request and the physician certification must be made a part of the patient's medical record.

4.2.4.6 The transfer request and physician certification must be sent with the patient to the receiving hospital.

4.2.5 Provide All Available Medical Treatment. Until the patient is transferred, the transferring hospital must provide all medical treatment within its capacity to minimize the risks to the patient's health, and in the case of a woman in labor, the health of the unborn child. The transferring hospital must ensure that the patient is transferred with qualified personnel and transportation equipment, as appropriate.

4.2.6 Provide Medical Records. After the receiving hospital grants permission for the transfer, the transferring hospital must send with the patient all necessary medical records related to the patient's emergency condition.

4.2.7 Refusal of Third-Party Payer to Authorize Care

4.2.7.1 After the screening examination and stabilizing treatment have been provided, if the hospital is notified that a managed care provider or third party payer refuses to authorize additional care at the hospital or requests the patient be transferred, the patient may be notified of his/her managed care provider's decision.

4.2.7.2 Unless the responsible physician determines that the patient can be safely transferred without risk of deterioration of health, the patient must be treated at the hospital unless the patient refuses further medical treatment after being fully informed of the risks and benefits.

4.2.7.3 No Physician or Employee Reprimands or Reprisals - No Hospital shall take any adverse action against:

4.2.7.4 A physician (or other qualified provider) based on his/her refusal to authorize the transfer of an individual who, in the opinion of the physician, has an EMC that has not been stabilized in accordance with this Section; or

4.2.7.5 Any Hospital employee who in good faith reports a violation of this Section.

4.2.8 Refusal to Accept Transfer - If the responsible physician of the transferring hospital learns that the receiving hospital cannot accept the transfer request, the physician should document and clearly delineate the reason for the transfer denial.

4.3 Receiving Hospital Responsibilities

4.3.1 Accepting a Transferring Patient – A hospital must accept an appropriate transfer of a patient from a transferring hospital within the boundaries of the United States if the patient has an EMC and the EMC requires the specialized capabilities or facilities that the receiving hospital can provide and which cannot be provided by the transferring hospital. If the receiving hospital has the specialized capabilities required by the patient and the Capacity to treat the patient at the time of the request, the hospital may not refuse to accept the transfer from another hospital.

4.3.2 Determine Availability of Treatment Services - The responsible physician receiving the transfer request and physician certification from another hospital or facility should determine the availability of an appropriate level of care, bed or specialized service, as well as scheduling availability, prior to accepting a transfer. Such determination should be made consistent with Hospital policies and procedures and in collaboration with the Vice-President for Medical Affairs of the Hospital or designee.

4.4 Patient Refusal to Consent

4.4.1 If a patient decides to leave the Hospital without being seen (LWBS) or he/she (or the person acting on the patient's behalf) refuses to consent to a MSE, the Hospital should document in the patient's medical record that the patient was LWBS or that the patient (or the person acting on the patient's behalf) refused to consent to a MSE.

4.4.2 If a patient who has received a MSE refuses to consent to further medical examination, treatment or transfer, or chooses to leave the Hospital against medical advice (AMA), then the Hospital should take reasonable steps to have the patient (or the person acting on behalf of the patient) sign an AMA/refusal to consent to treatment form, which indicates that the patient has been informed of the benefits and risks of examination, treatment and/or transfer but the patient (or the person acting on the patient's behalf) has made an informed refusal to further examination or treatment. The form should also document the reasons given (if any) for the informed refusal. The signed AMA/refusal to consent to treatment form must be made a part of the patient's medical record.

4.4.3 If after Hospital staff take reasonable steps to have the AMA form signed, the patient (or the person acting on the patient's behalf) is unwilling to sign the AMA then Hospital staff must document the refusal to sign the form and that the patient (or the person acting on the patient's behalf) was advised of the risks and benefits of further

examination and or treatment but refused to consent to further examination or treatment; and the reasons for the informed refusal (if given).

4.4.4 If a patient who has received an MSE leaves the Hospital without alerting Hospital staff to his/her departure , Hospital staff must document the patient's departure in his/her medical record.

4.5 Additional Requirements

4.5.1 Signage – Signs (in all relevant languages) must be posted conspicuously in all Hospital DEDs which specify the rights of individuals with EMCs and women in labor under EMTALA. The signs must clearly state that the Hospital participates in the Medicare and Medicaid programs and that all patients will receive a screening examination and stabilizing treatment for EMCs regardless of their insurance or ability to pay.

4.5.2 Training – All appropriate hospital personnel and medical staff (including house staff) must be trained on the key statutory and regulatory requirements under EMTALA and any changes in such requirements. Training must be conducted within forty-five (45) days of employment for all new staff and for all staff on an annual basis.

4.5.3 Central Logs - Each Hospital DED should maintain a log of all individuals who come to the facility seeking emergency care. Such logs should be retained for a period consistent with the MedStar Record Retention Policy and should include: (a) patient identification; (b) medical record and encounter number, as applicable; (c) presentation time; (d) triage time, if applicable; (e) MSE time; (f) admission, discharge or transfer time, as applicable; (g) whether the patient accepted or refused treatment; and (h) the disposition of the case (i.e., whether the individual was transferred, admitted and treated, stabilized and transferred, or discharged).

4.5.4 Medical Records - The medical record for each patient who falls within this Policy should include:

4.5.4.1 A record of the MSE process, starting with triage.

4.5.4.2 If the patient was LWBS, the record must contain documentation that the patient left the Hospital before receiving a MSE.

4.5.4.3 A report of the MSE and a determination whether the patient had an EMC

4.5.4.4 If, after the patient received a MSE, the patient left AMA or refused to consent to treatment, the record should include a signed AMA/refusal to consent to treatment form; or, if the patient refused to sign the form, the Hospital should document the reasonable steps it took to have the patient (or the

person acting on the patient's behalf) sign the AMA/refusal to consent to treatment form.4.4.3. If the patient had an EMC, the further treatment and exam which was offered to the patient and the patient's consent or refusal of further examination and or treatment .

4.5.4.5 The medical record of each patient should be maintained by the Hospital for a minimum of ten years for adults eighteen (18) and over. For those patients under 18 years of age, the medical record must be maintained until the patient reaches the age of majority, plus ten (10) years.

4.5.5 On-Call Physicians

4.5.5.1 Each Hospital must maintain a schedule and list of physicians who are on-call and available for duty to provide treatment needed to stabilize an individual with an EMC. The on-call schedule should be established and maintained in a manner that best meets the needs of the Hospital's patients, in accordance with the capability of the Hospital, taking into account the availability of on-call physicians on its medical staff.

4.5.5.2 The on-call schedule must be maintained for a minimum of seven years or longer period if so designated in the MedStar Record Retention Policy.

4.5.5.3 Physicians are permitted to be on-call at more than one Hospital (provided that each Hospital is aware of the on-call schedule) and are permitted to perform elective surgery while they are on-call. Each Hospital must have written policies and procedures in place to respond to situations in which a particular specialty is not available or when the on-call physician cannot respond because of circumstances beyond the physician's control.

4.5.5.4 The failure of any on-call physician to respond within a reasonable time after attempts to notify the physician at the phone number indicated for the physician must be reported to the administrator on call. The administrator shall notify the department head, Vice-President for Medical Affairs, and the risk management department for review and for appropriate action.

4.5.5.5 If a patient is transferred to another hospital or medical facility because an on-call specialty physician did not respond to a call, an incident report must be prepared to document the actions taken to contact the on-call specialty physician and the response of the physician to those contracts.

4.5.6 Policies, Procedures and Forms

4.5.6.1 MFSMC will use policies, procedures and forms it deems necessary to implement the requirements of EMTALA, as set forth in this Policy.

5.0 EXCEPTIONS

5.1 Exceptions to this Policy are based on the particular facts and circumstances of the case. For example, this Policy would not apply to a patient seen in a physician's office on the Hospital's main campus if that physician's office does not operate under the Hospital's Medicare provider number.

6.0 WHAT CONSTITUTES NON-COMPLIANCE

6.1 Actions or conduct by a Hospital employee, contract employee or medical staff member in violation of this policy.

7.0 CONSEQUENCES OF NON-COMPLIANCE

7.1 Violations of this policy by any Hospital employee, contract employee or medical staff member may require the employee/medical staff member to undergo additional training and may subject the employee to disciplinary action, including, but not limited to, suspension or termination of Hospital privileges and/or suspension, probation or termination of employment, as applicable.

8.0 EXPLANATION AND DETAILS/EXAMPLES

N/A

9.0 REQUIREMENTS AND GUIDELINES FOR IMPLEMENTING THE POLICY

N/A

10.0 RELATED POLICIES

10.1 MedStar Health Corporate Emergency Medical Conditional Evaluation, Treatment, and Transfer (EMTALA) Policy

10.2 Compliance Policies

10.3 Medical Record Policies

10.4 Managed Care Policies

10.5 Record Retention Policies

11.0 PROCEDURES RELATED TO POLICY

11.1 Admission and registration

11.2 Discharge and transfer acceptance of patients from one institution to another

11.3 Collection of copayments, financial responsibility forms, advance beneficiary forms

11.4 Signage

11.5 Consent and refusal of treatment or care

11.6 On-call physicians and scheduling

12.0 LEGAL REPORTING REQUIREMENTS

12.1 If a Hospital receives a patient whom it has reason to believe has been transferred from another hospital in violation of EMTALA, the responsible physician (or any other employee/medical staff member with knowledge of such occurrence) must immediately inform the administrator on-call and the Entity Compliance Officer/Hospital Counsel/Director of Risk Management so that an appropriate decision can be made as to whether or not the transfer should be reported to the state survey agency or CMS.

13.0 REFERENCE TO LAWS OR REGULATIONS OF OUTSIDE BODIES

13.1.1 Section 1867(a) of the Social Security Act

13.1.2 42 U.S.C. Section 1395dd et seq. as amended

13.1.3 42 C.F.R. Sections 413.65, 482.12 and 489.24 et seq.

State Operations Manual--Interpretive Guidelines

OIG Special Advisory Bulletin--November 10, 1999

Outpatient PPS Regulations—April 7, 2000

Final EMTALA Regulations---September 9, 2003

14.0 RIGHT TO CHANGE OR TERMINATE POLICY

14.1 Any material changes to this policy require review and approval by the Legal Department. Proposed changes to this policy will be discussed with all affected parties at both the Business Unit and Corporate levels of the organization. The Corporation's policies are the purview of the Chief Executive Officer (CEO) and the CEO's management team. The CEO has the final sign-off authority on all corporate policies.

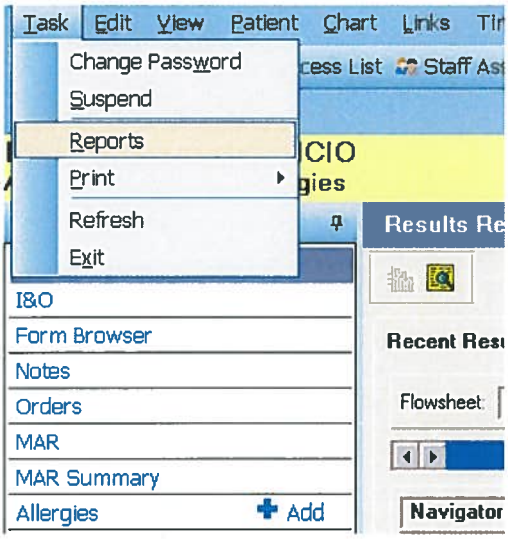
References	Section 1867(a) of the Social Security Act 42 U.S.C. Section 1395dd et seq. as amended 42 C.F.R. Sections 413.65, 482.12 and 489.24 et seq. State Operations Manual--Interpretive Guidelines OIG Special Advisory Bulletin--November 10, 1999 Outpatient PPS Regulations—April 7, 2000 Final EMTALA Regulations---September 9, 2003

MedConnect Reports Help Sheet

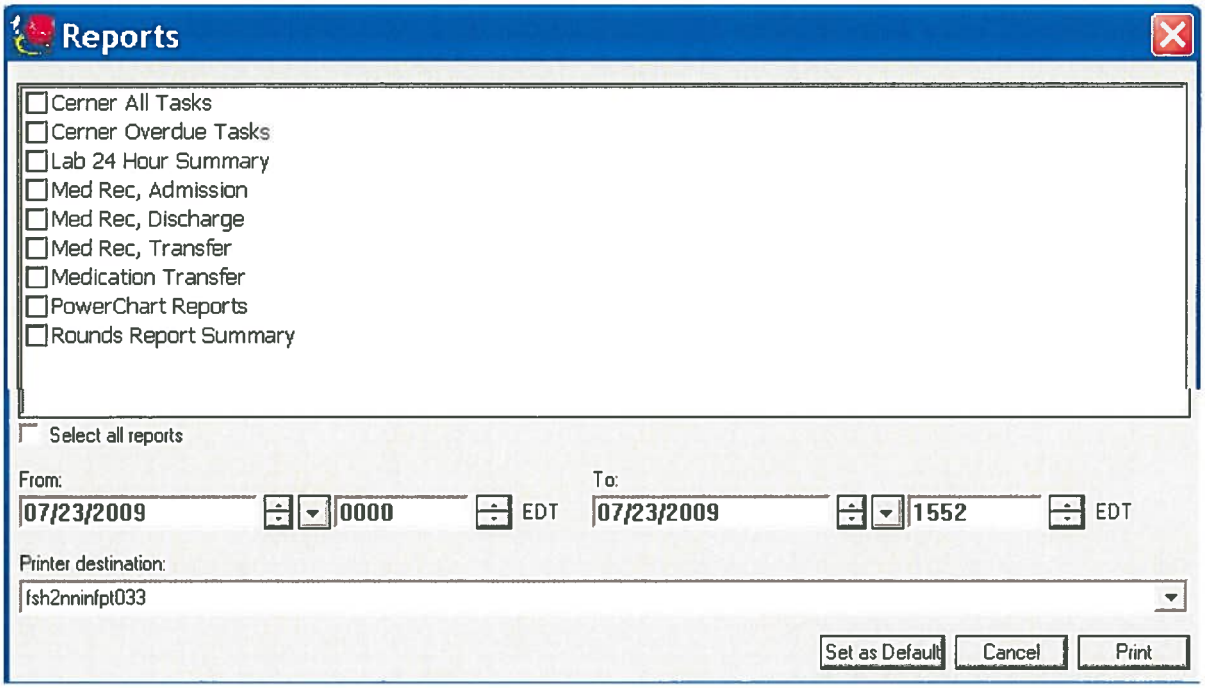
Printing Reports

1. **Double-click on the MedConnect icon on the computer screen and login with your user name and password. Your unit list should automatically appear on the screen. Double-click on the name of the patient you wish to review orders for and their electronic chart will open. * The patient chart must be open on the screen to print most of the reports!**

2. **Click on Task from the toolbar menu at the top of the screen. Select Reports from the Task sub-menu.**



3. **A Reports window will open. Select the Report you wish to print by clicking in the checkbox to the left of the Report Name and customize the From and To dates/times at the bottom of the window to reflect the time range you wish to see in the report. Click Print. The reports will print on the designated Cerner printer on your unit.**



Report Type Explanation

Cerner All Tasks – List of all Due Tasks for a Patient
Cerner Overdue Tasks – List of all Overdue Tasks for a Patient
Lab 24 Hour Summary – Prints out 24 hours worth of lab results, used for transfer of patient outside of facility
Med Rec, Admission – Currently Not Used
Med Rec, Discharge – Currently Not Used
Med Rec, Transfer – Used for medication reconciliation by physician upon patient transfer within facility to clarify if he/she would like patient to continue on existing medications upon transfer and to write for additional meds to be added with transfer
Medication Transfer – Print out that shows medications prescribed to patient and the last administered date/time
PowerChart Reports – Not Used
Rounds Report Summary – Prints our comprehensive Rounds Report for patient. Includes: Patient Name, Age, DOB, MRN, Attending Physician, Service Line, Allergies, Isolation Status, Code Status, Reason for Admission, Last several sets of vitals, Last Several Ht/Wts, Last recorded I&O, Active Inpatient/PRN/One Time/IV Medications, Last Resulted Lab values, and Glucometer readings – with Notes section at bottom.

Transfer of Patient out of Facility

The following items should be printed and sent with a patient being transferred out of FSH:

- **Communication Handoff Form (completed by nurse with a copy attached to inpatient records) which should include:**
  - **Clinical status**
  - **Assessment of the patient and care administered on day of transfer to another nursing facility or long term care facility.**
  - **This document is copied and the copy is attached to the inpatient record.**

- **Lab 24 Hour Summary Report**

- **Medication Transfer Report**

- **24 hours worth of documentation printed from the Notes section of the patient chart**
  - **Include copy of 24 hours worth of any paper progress notes also**

- **Copy of the Multidisciplinary Teaching Form**

- **XRAY Reports: Printed out of SMS/HealthConx Transcribed Reports**

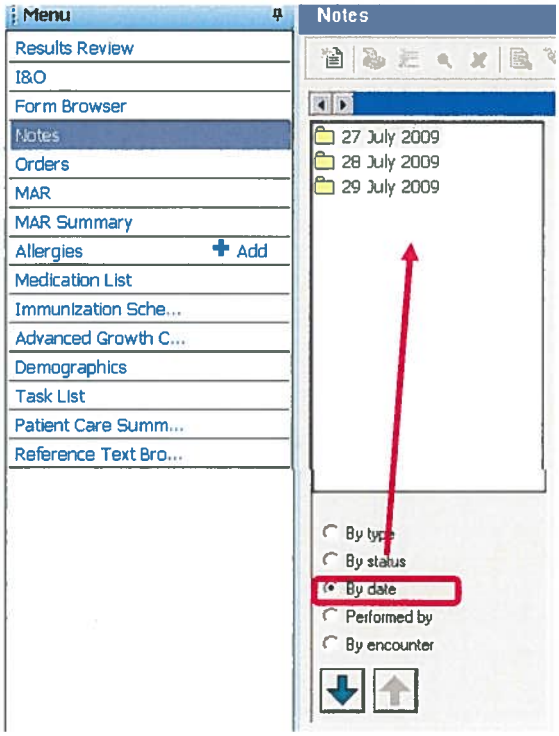
- **EKG: Photocopy out of Patient Chart**

Printing Documentation from Notes section of Chart for Transfer

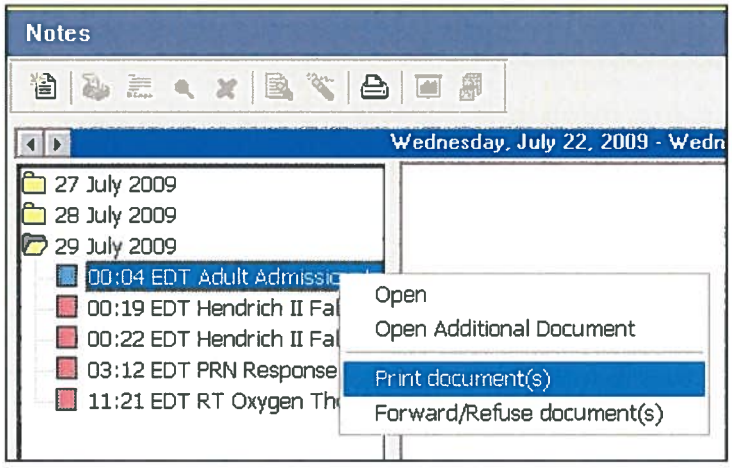
1. **Double-click on the MedConnect icon on the computer screen and login with your user name and password. Your unit list should automatically appear on the screen.**

2. **Double-click on the name of the patient you wish to print charting for and their electronic chart will open. Click on the Notes section of the patient chart.**

3. **Click on "By Date" in the sorting options section in the bottom left corner. Find the folder containing the last 24 hours worth of charting and double-click on it to open the contents.**



4. **Right click on the documents you wish to print and select Print Document(s). You can select the first document by clicking on it, then holding the shift key down and clicking on the last document – then right clicking and selecting Print to print them all at once.**



Attachment CQ 10 : Question 15b
Cost Estimate: Option 1 – Renovate in Place.

Description	April 1, 2015
Building Construction	$40,334,582
Site Work	$0
Furniture, Furnishings and Equipment (FF&E)	$9,500,000
Contingencies	$6,989,091
Professional Fees	$6,049,963
Miscellaneous Fees	$500,000
Escalation	$0
SUBTOTAL PROJECT COST	**$63,373,636**
Escalation 2014 - 2015	$0
New HVAC Units for the Surgery Suite	$1,800,000
MEP Infrastructure Upgrades	$6,131,973
Asbestos Removal Allowance	$1,381,740
Offsite Lease Agreements for temp office space	$1,775,000
Additional Contingency	$1,418,154
Additional Professional Fees	$3,499,190
MEP Services from Plant	n/a
Demolition of County Building/Utility Relocations	n/a
Sanitary Sewer Upgrade	n/a
Permitting Fees for Utility Upgrades	n/a
Civil Engineering Fees	n/a
Structure for Vertical Expansion	n/a
Ground Water Remediation	n/a
Entrance Canopy	n/a
Façade of New to Existing Link	n/a
IS/Voice/Data Budget Correction	$1,800,000
Updated FF&E assuming 20% reuse of existing Equip	$7,900,000
	$89,079,693
Escalation (To Mid Point of Anticipated Construction Schedule)	
12% Escalation (New Construction)	n/a
TOTAL PROJECT BUDGET	
25% Escalation (Low Risk Renovation)	**$22,269,923**
TOTAL PROJECT BUDGET	**$111,349,616**
31% Escalation (Med Risk Renovation)	**$27,614,705**
TOTAL PROJECT BUDGET	**$116,694,398**
37% Escalation (High Risk Renovation)	**$32,959,486**
TOTAL PROJECT BUDGET	**$122,039,179**