BAKER DONELSON

100 LIGHT STREET • BALTIMORE, MARYLAND 21202 • 410.685.1120 • bakerdonelson.com

HOWARD L. SOLLINS, SHAREHOLDER
Direct Dial: 410.862.1101
Direct Fax: 443.263.7569
E-Mail Address: hsollins@bakerdonelson.com

November 13, 2018

Via Email and Hand Delivery
Kevin McDonald, Chief
Certificate of Need Division
Center for Health Care Facilities Planning & Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Adventist Rehabilitation Hospital of Maryland, Inc.
d/b/a Adventist HealthCare Rehabilitation
Adventist HealthCare, Inc. d/b/a Washington Adventist Hospital
Matter No. 18-15-2428
Response to Completeness Questions

Dear Mr. McDonald:

On behalf of Adventist Rehabilitation Hospital of Maryland, Inc. d/b/a Adventist HealthCare Rehabilitation and Adventist HealthCare, Inc. d/b/a Washington Adventist Hospital ("ARH"), we are hereby submitting the required four (4) copies of our responses to the October 25, 2018 completeness questions regarding the above-referenced project. We will also provide Word, Excel and electronic copies of our responses and Exhibits as appropriate.

I hereby certify that a copy of this response has also been forwarded to the appropriate local health planning agency, as noted below.

If any further information is needed, please let us know.

Sincerely,

BAKER, DONELSON, BEARMAN,
CALDWELL & BERKOWITZ, PC

Howard L. Sollins

JJE/tjr
Enclosures

cc: Dr. Travis A. Gayles, M.D., Ph.D., Health Officer
Montgomery County
Ben Steffen, Executive Director
Ms. Ruby Potter
Health Facilities Coordination Officer
Brent Reitz, President, MSPT, MBA, FACHE
Adventist Rehabilitation Hospital of Maryland, Inc.
Erik D. Wangsness, President
Adventist HealthCare Washington Adventist Hospital
Robert E. Jepson, Vice President/Business Development
Washington Adventist Hospital
John J. Eller, Esquire

Adventist Rehabilitation Hospital of Maryland, Inc. d/b/a Adventist HealthCare Rehabilitation
Relocation of a Special Rehabilitation Hospital
Matter No. 18-15-2428
Additional Information Responses

Project Budget, Table E:

1. Please revise showing sources of funding for this project, which appear to be cash, based on the narrative on page 59

Response:

Table E is attached as Exhibit 21.

General Review Standard (1), Charity Care

2. The charity care policy states that probable eligibility is communicated to patients within two business days of the submission of application. Please provide a copy of the application form, and indicate any documentation that is required to accompany it.

Response:

The Adventist HealthCare (AHC) Financial Assistance Policy 3.19 and the English- and Spanish-language application forms are attached as Exhibit 22. Adventist HealthCare's financial assistance application forms include descriptions of any documentation required to accompany any application.

General Review Standard (2), Quality of Care

3. At the preapplication conference, staff informed the applicant that the proposed facility must be licensed separately from the special rehabilitation facilities operated on separate premises in Rockville, consistent with Maryland Department of Health regulations. Has Adventist HealthCare ("AHC") initiated any action to correct the single license issued for separate premises?

Response:

Adventist HealthCare Rehabilitation (AHR) is currently licensed by the Office of Health Care Quality (OHCQ) to operate at its location. AHC appreciates that in the preapplication conference Commission staff outlined its position that the Takoma Park location should be placed under a separate license. AHC has been planning that upon approval of the CON it will work with the MHCC and OHCQ to ensure the relocated

facility is licensed consistent with regulations. AHC is in conversation with OHCQ on how to accomplish this.

4. Exhibit 11 includes a license issued by Montgomery County to operate Adventist Rehabilitation Hospital of Maryland as an "Acute General Hospital". This license only includes the Rockville address. Please explain the significance of this license, if any, in consideration of this application.

Response:

AHC has been in contact with the Montgomery County Department of Health and based on those conversations our understanding is that AHR is appropriately licensed. Since it is understood that County and State licenses must be in alignment, AHC will request a change to the license upon approval of the CON to be consistent with the process outlined in Question 3.

5. Does the acute rehabilitation program at WAH provide all 4 types of "specialty" rehabilitation programming: i.e., stroke, brain injury, spinal cord injury and amputee programming under CARF certification noted on pages 15-16? What portion of the total patients served at WAH program fall within these specialty categories?

Response:

Yes, the acute rehabilitation program located in Takoma Park is CARF certified in all 5 CARF programs, 4 of which are the specialty programs. See the table below.

CARF Programming Percentages for Takoma Park (2017)

Category	%
General Rehabilitation	49%
Stroke	29%
Brain Injury	11%
Spinal Cord Injury	10%
Amputee	1%

Source: AHR Internal Records

Project Review Standard (2), Need

6. Page 23 indicates that the Takoma Park facility experienced 706 discharges in CY 2015. Page 31 indicates 687 discharges in that same year. Please clarify.

Response:

The table presented on page 31 of the application is incorrect. The correct number of discharges is 706 as shown on page 23. A corrected table is presented below.

Adventist HealthCare Rehabilitation at Takoma Park
Discharges by Age Cohort
Years ended December 31

	2015		2016		2017		Total 2015 - 2017	
Age Cohort	**Discharges**	**% of Total**	**Discharges**	**% of Total**	**Discharges**	**% of Total**	**Discharges**	**% of Total**
18-44	75	10.6%	56	8.8%	60	8.8%	191	9.5%
45-64	241	34.1%	206	32.4%	199	29.4%	646	32.0%
65+	390	55.2%	373	58.7%	419	61.8%	1,182	58.5%
Total	706	100.0%	635	100.0%	678	100.0%	2,019	100.0%

Source: AHR internal records

The information presented in the table above does not alter the projected utilization in the application. Moreover, the corrected data do not affect the observation made in the application that the age 65+ cohort represented an increasing portion of the patients discharged from AHR's Takoma Park facility during the years 2015 through 2017.

7. It appears that the demand forecast for this project is based on an acute rehabilitation discharge use rate calculation for Montgomery County's population in 2016.

A. Is this use rate calculation based on all adult rehabilitation discharges of Montgomery County residents from any Maryland or D.C. hospital?

Response:

This use rate was based on all adult rehabilitation discharges of Montgomery County and Prince George's County residents from any Maryland or D.C. hospitals for 2016 based on data obtained from the MHCC's Acute Care Planning & Policy Office. These are the same data that were used to derive the Acute Rehabilitation Bed Need Projections for 2021.

B. Why is a use rate for Montgomery County used rather than a use rate for the actual service area of the program operating in Takoma Park? (We note that the 85% relevance service area definition included on pages 27 and 28 indicate that only 47% of the program's discharges in CY 2017 from that service area originated in Montgomery County.) How would the forecast change if one used the use rate for the service area population?

Response:

Use rates at the individual ZIP Code level vary widely within a county and from year to year based on relatively small changes in number of acute rehabilitation discharges. Utilizing county-wide use rates eliminates the random variations that occur among ZIP Codes and is more reflective of the general need for such services in the population.

In response to the Commission's request, a second utilization projection was performed utilizing ZIP Code specific adult acute rehabilitation use rates calculated for each ZIP Code in the Takoma Park rehabilitation service area. The results of this projection are presented below. There was an immaterial change in the projected utilization for the acute rehabilitation beds being relocated to the White Oak campus, which provides further confirmation that the acute rehabilitation beds at White Oak will be well utilized.

Projected Inpatient Utilization			
For the Years ending December 31,			
	2020	**2021**	**2022**
Discharges			
Primary Service Area	477	491	506
Secondary Service Area	259	265	271
DC Impact	50	60	70
Total Service Area Discharges	785	816	848
Other Discharges	82	84	86
Total Discharges	867	900	934
Average Length of Stay	13.5	13.5	13.5
Inpatient Days	11,702	12,153	12,611
Average Daily Census	32.0	33.3	34.6
Beds	42	42	42
Occupancy (%)	76.1%	79.3%	82.3%

Use rates calculated for the portion of Montgomery County in the Takoma Park service area were nearly the same as the use rates for Montgomery County as a whole. Namely, the use rate in 2016 for the aggregated Montgomery County ZIP Codes within the service area was 1.88 cases per 1,000 population. The use rate for Montgomery County estimated by the Maryland Health Care Commission in 2016 was 1.91 cases per 1,000 population. Since the ZIP Codes in the Takoma Park service area comprise a major portion of Montgomery County, it can be expected that the two use rates should be nearly the same. The utilization projections for Montgomery County in the application employed the MHCC use rates for Montgomery County. Hence, the change in methodology would be expected to have only a slight impact for that part of the service area.

In the original projections of patient utilization from Prince George's County, the application employed the MHCC use rate for the Southern Maryland Health

Planning Region (HPR), which was estimated to be 1.56 cases per 1,000 population. The detailed estimate of use rate prepared by aggregating the Prince George's County ZIP Codes in the Takoma Park service area was 1.73 cases per 1,000 population. The difference, (i.e., the higher use rate for the Takoma Park service area versus the use rate for the Southern Maryland HPR) is understandable and expected given the geographic proximity of Prince George's County residents in the Takoma Park Service Area to other residents in the service area, irrespective of county line.

Projected utilization calculated on a granular level results in projected utilization for the Takoma Park service area that is nearly the same as utilization that was previously presented.

8. The data on page 23 shows that case volume at the Takoma Park program grew 35% between CY 2013 and CY 2014 and, in the following four-year period, CY 2014 to CY 2017, there was no growth in case volume, indicating that the service area use rate declined over this period if the adult population of the service area increased, which we assume to be the case.

A. Given this recent experience, why did AHC feel a need to add ten beds, a 31% increase in bed capacity, in 2018?

Response:

The utilization of the Takoma Park acute rehabilitation beds actually increased in both CY 2014 and CY 2015, as shown in the table on page 23 of the CON application, based on Average Daily Census and patient discharges. This increase was a direct result of the addition of 10 beds in CY 2014, which relaxed a bed capacity constraint that had been limiting admissions at both the Takoma Park and Rockville campuses.

Capacity constraints still are present on the Takoma Park and Rockville campuses. The CON application on pp. 20-22 discusses the number of days when only a limited number of beds has been available on either campus and the number of denials of admissions due to lack of bed capacity. The recent addition of 10 beds requested in 2018 was specifically intended to address these significant capacity issues.

While admissions remained relatively static over this period of time, referrals have continued to increase. From 2015 through 2017, an average of 83 admissions every year were denied due to a lack of bed availability, while for the same time period referrals have increased from 4,075 to 4,214. From January through September 2018, 87 patients have been turned away from AHR and referrals have increased to an annual projection of 4,434. These beds are unavailable due to the need to block semi-private rooms for patients who require a private room due to infections, the need for a quiet environment due to a head injury, behavioral issues, or gender matching in rooms. Additional referrals were lost due to the lack of a private room. In 2017, 308 patients declined admission to AHR due to a lack of private rooms.

The 10 beds added in 2018 are needed to address recent capacity constraints.

B. Can AHC identify any factors underlying the spike in demand from 2013 to 2014 and the plateau experienced since 2014?

Response:

As discussed in the preceding response, the increased volume was directly attributable to the addition of 10 acute rehabilitation beds to the Takoma Park campus in 2014 which reduced denials due to a lack of available beds.

The increase in demand during 2013-14 was a result of the same factor detailed in Question 8A. Referrals in the years leading up to this period had continued to increase, and bed capacity had been reached. In 2014 when the ten beds were added it allowed for patient admissions that were being denied previously due to lack of bed availability.

The experience of 2014 informed the decision for 2018. The lack of beds constrained the availability of needed services that the addition of beds alleviated.

C. Given this plateau of no increase in case volume from 2014 to 2017, can AHC provide a credible basis for its expectation that case volume will increase over 30% in the three-year period of CY 2017 to CY 2020? How can this projection be credible given the decline in service area population use that the recent plateau implies?

Response:

There are a number of reasons why it is credible and reasonable to expect an increase in demand in the future when the Takoma Park acute rehabilitation beds are relocated to the White Oak campus. AHR does not believe there is an indication of a decline in service area use rates. Rather as explained above, the current configuration of semi-private rooms has constrained bed availability. Consider:

- The opening of the 10 beds will remove capacity constraints currently in place. As mentioned above, AHR is addressing the demand and believes that for a number of qualitative and quantitative reasons noted through this response, the data validate the addition of the beds.

- The White Oak location will have all private rooms. Takoma Park today has mostly semiprivate rooms constraining availability at times because of the need to block semi-private rooms when patients require a private room due to infections, the need for a quiet environment due to a head injury, behavioral reasons, or gender matching in rooms. The change to all private rooms will allow the full bed capacity to be utilized and the mitigation of admission denials.

- The White Oak campus will offer new, state-of-the-art facilities to serve acute rehabilitation patients. The current facilities at Takoma Park are outdated

which led to the decision to replace this facility. Patients and their families have a greater likelihood of choosing admission to modern facilities at White Oak rather than seeking care outside the service area.

- The White Oak campus is more accessible than Takoma Park. As discussed in the application, travel to the Takoma Park campus requires navigating congested streets and arriving at a campus where parking is challenging. The White Oak campus is more accessible and parking will be readily available.

The projections of utilization, which reflect constant use rates and expected population growth, demonstrate the reasonableness of attaining the expected increase in utilization once the beds are relocated to the White Oak campus.

9. The average length of stay ("ALOS") for AHC's acute rehabilitation patients is longer than the statewide average. Page 23 of the application indicates that acute rehabilitation average length of stay in Takoma Park increased by almost a full day between 2013 and 2017. (In contrast, the ALOS at the Rockville facility dropped by over a full day over the same time period.) Can AHC justify this based on data indicating that AHC has a higher case mix intensity of adult rehabilitation patients than the overall statewide patient census? Can AHC justify the recent increase in ALOS at the Takoma Park facility based on an increase in case mix intensity?

Response:

For acute rehabilitation patients ALOS is not perfectly correlated with case mix intensity. Based on data from eRehab[1] the Takoma Park rehabilitation facility has seen a material increase in its case mix index between 2013 and 2017, growing from 1.177 in 2013 to 1.368 in 2017, as summarized in the following table.

TP	2013			2014			2015			2016			2017		
	Site	Nation	Region	Site	Nation	Region	Site	Nation	Region	Site	Nation	Region	Site	Nation	Region
CMI	1.1769	1.292	1.3456	1.2715	1.2976	1.3585	1.2647	1.3176	1.3727	1.3267	1.3412	1.378	1.3683	1.3593	1.4033
ALOS	13.16	12.7	12.89	12.64	13.49	13.8	13.54	13.43	13.69	14.12	13.93	14.12	14.07	14.02	14.09

The data in the comparison group provided for the statewide average is primarily based on acute care rehabilitation units and those units are not subject to the same regulations as a licensed inpatient rehabilitation facility (IRF). As evidenced by the table below*, AHR and Chesapeake Rehabilitation's ALOS are consistent with each other.

[1] eRehab offers an inpatient rehabilitation outcomes system available to inpatient rehabilitation providers by the American Medical Rehabilitation Providers Association.

Special Rehabilitation Hospitals Utilization Statistics, CY 2012 to CY 2016

		Discharges					Patient Days					Average Length of Stay				
hospid	Hosname	2012	2013	2014	2015	2016	2012	2013	2014	2015	2016	2012	2013	2014	2015	2016
213028	CHESAPEAKE REHABILITATION	1,223	1,286	1326	1,326	1,467	17,053	17,229	18,199	18,061	19,636	13.9	13.4	13.7	13.6	13.4
213029	ADVENTIST REHABILITATION	548	1,560	1797	1,943	1,862	7,772	21,898	24,375	26,504	25,887	14.2	14.0	13.6	13.6	13.9
	MD IRF Total	**1,771**	**2,846**	**3,123**	**3,269**	**3,329**	**24,825**	**39,127**	**42,574**	**44,565**	**45,523**	**14.0**	**13.7**	**13.6**	**13.6**	**13.7**
210009	JOHNS HOPKINS	490	511	575	529	537	4,276	4,763	5,452	5,290	5,672	8.7	9.3	9.5	10.0	10.6
210012	SINAI OF BALTIMORE	1,246	1,266	1282	1,191	1,195	13,277	13,186	11,980	11,366	11,630	10.7	10.4	9.3	9.5	9.7
210024	MEDSTAR UNION MEMORIAL	221	279	333	276	55	1,517	2,292	2,805	2,311	460	6.9	8.2	8.4	8.4	8.4
210029	JOHNS HOPKINS BAYVIEW	119	133	188	219	433	1,853	2,052	2,454	2,635	6,486	15.6	15.4	13.1	12.0	15.0
210056	MEDSTAR GOOD SAMARITAN	1,522	1,381	1479	1,374	1,313	14,107	13,717	13,431	12,709	12,812	9.3	9.9	9.1	9.2	9.8
210058	UM REHABILITATION & ORTHOPAE	2,557	2,310	2068	2,091	1,755	26,356	23,864	22,357	22,607	20,903	10.3	10.3	10.8	10.8	11.9
210064	LEVINDALE HEBREW GERIATRIC	69	44	35	43	80	891	587	432	623	1,646	12.9	13.3	12.3	14.5	20.6
210037	UM SHORE AT EASTON	406	369	376	352	343	3,795	3,622	3,460	3,440	3,471	9.3	9.8	9.2	9.8	10.1
210055	UM LAUREL REGONAL	401	370	312	346	259	2,636	2,518	2,083	2,551	2,413	6.6	6.8	6.7	7.4	9.3
210001	MERITUS	556	585	508	498	439	4,556	4,617	4,614	4,446	4,527	8.2	7.9	9.1	8.9	10.3
210027	WESTERN MARYLAND REGIONAL	335	313	272	280	293	3,898	3,436	3,245	3,508	3,205	11.6	11.0	11.9	12.5	10.9
	MD Acute Unit Total	**7,922**	**7,561**	**7,428**	**7,199**	**6,702**	**77,162**	**74,654**	**72,313**	**71,486**	**73,225**	**9.7**	**9.9**	**9.7**	**9.9**	**10.9**

**Data Source: MHCC*

Furthermore, below is a table that outlines AHR's ALOS by case mix group (CMG) as compared to the CMS published final rule LOS for FFY 2018. The FFY 2018 annual ALOS target can be found in the Federal Register, Vol. 82, No. 148, published on August 3, 2017. The table demonstrates that in total, AHR's ALOS is under the CMS Final Rule. The data source for the table is eRehab and published CMS Final Rule.

AHR ALOS Data - January 1 - September 30, 2018 as compared to CMS Final Rule ALOS FFY 2018

	AHR ALOS				CMS Final Rule ALOS				AHR Variance from the Final Rule ALOS			
CMG	Tier 1	Tier 2	Tier 3	Tier 0	Tier 1	Tier 2	Tier 3	Tier 0	Tier 1	Tier 2	Tier 3	Tier 0
0101	-	-	7.00	4.00	9.00	9.00	9.00	8.00	-	-	2.00	4.00
0102	-	13.00	13.50	5.25	11.00	12.00	10.00	10.00	-	(1.00)	(3.50)	4.75
0103	-	-	-	9.67	13.00	13.00	12.00	11.00	-	-	-	1.33
0104	-	-	9.20	9.00	13.00	13.00	12.00	12.00	-	-	2.80	3.00
0105	-	-	12.24	9.82	14.00	14.00	14.00	13.00	-	-	1.76	3.18
0106	-	-	14.50	11.61	16.00	16.00	15.00	15.00	-	-	0.50	3.39
0107	-	13.00	16.93	13.08	17.00	17.00	16.00	16.00	-	4.00	(0.93)	2.92
0108	-	-	21.15	17.08	21.00	23.00	21.00	20.00	-	-	(0.15)	2.92
0109	-	-	15.45	14.71	19.00	19.00	19.00	19.00	-	-	3.55	4.29
0110	27.00	18.83	20.32	21.05	27.00	26.00	23.00	24.00	-	7.17	2.68	2.95
0202	-	-	-	7.00	12.00	11.00	10.00	9.00	-	-	-	2.00
0203	11.00	-	-	6.50	12.00	13.00	11.00	11.00	1.00	-	-	4.50
0204	-	-	9.50	11.00	11.00	12.00	12.00	12.00	-	-	2.50	1.00
0205	-	10.75	14.88	10.00	15.00	15.00	14.00	13.00	-	4.25	(0.88)	3.00
0206	-	21.00	12.20	13.29	18.00	18.00	16.00	15.00	-	(3.00)	3.80	1.71
0207	14.00	19.20	19.80	17.00	28.00	23.00	19.00	18.00	14.00	3.80	(0.80)	1.00
0301	-	8.00	8.00	7.00	10.00	11.00	10.00	10.00	-	3.00	2.00	3.00
0302	-	-	10.00	7.20	13.00	13.00	12.00	12.00	-	-	2.00	4.80
0303	-	1.00	13.20	12.67	15.00	15.00	13.00	13.00	-	14.00	(0.20)	0.33
0304	-	16.50	15.80	12.65	21.00	19.00	17.00	16.00	-	2.50	1.20	3.35
0402	-	-	15.00	12.00	13.00	14.00	13.00	12.00	-	-	(2.00)	-
0403	-	18.00	25.83	12.80	22.00	22.00	19.00	18.00	-	4.00	(6.83)	5.20
0404	2.00	19.00	16.33	-	42.00	36.00	31.00	32.00	40.00	17.00	14.67	-
0405	-	51.00	-	15.00	33.00	35.00	31.00	27.00	-	(16.00)	-	12.00
0502	-	-	8.33	9.00	12.00	10.00	10.00	10.00	-	-	1.67	1.00
0503	-	10.00	7.71	10.00	16.00	13.00	12.00	12.00	-	3.00	4.29	2.00
0504	-	10.67	10.80	8.25	17.00	15.00	14.00	13.00	-	4.33	3.20	4.75
0505	-	15.25	15.00	11.00	18.00	17.00	16.00	15.00	-	1.75	1.00	4.00
0506	-	23.80	19.00	17.88	26.00	23.00	21.00	20.00	-	(0.80)	2.00	2.12
0601	-	-	6.00	-	10.00	9.00	9.00	8.00	-	-	3.00	-
0602	-	6.00	11.00	9.43	12.00	12.00	11.00	11.00	-	6.00	-	1.57
0603	-	16.25	14.20	10.43	14.00	14.00	13.00	13.00	-	(2.25)	(1.20)	2.57
0604	-	13.70	19.53	15.24	19.00	18.00	16.00	16.00	-	4.30	(3.53)	0.76
0701	-	-	12.00	-	12.00	11.00	10.00	9.00	-	-	(2.00)	-
0702	-	-	6.67	9.78	12.00	12.00	11.00	11.00	-	-	4.33	1.22
0703	-	-	12.25	9.63	15.00	14.00	14.00	13.00	-	-	1.75	3.38
0704	-	10.33	18.22	14.61	18.00	18.00	17.00	16.00	-	7.67	(1.22)	1.39
0801	-	-	-	6.00	8.00	8.00	7.00	7.00	-	-	-	1.00
0802	-	-	7.67	10.33	11.00	10.00	9.00	9.00	-	-	1.33	(1.33)
0804	-	-	8.50	9.41	12.00	11.00	11.00	10.00	-	-	2.50	0.59
0805	-	-	11.30	10.00	14.00	13.00	12.00	12.00	-	-	0.70	2.00
0806	-	-	13.17	14.00	16.00	16.00	15.00	14.00	-	-	1.83	-
0901	-	-	5.00	7.00	10.00	10.00	9.00	8.00	-	-	4.00	1.00
0902	-	6.00	8.50	7.92	12.00	12.00	11.00	10.00	-	6.00	2.50	2.08
0903	-	17.00	9.82	10.12	15.00	14.00	13.00	13.00	-	(3.00)	3.18	2.88
0904	-	-	15.57	12.14	18.00	18.00	16.00	15.00	-	-	0.43	2.86
1001	-	-	14.00	-	10.00	11.00	10.00	9.00	-	-	(4.00)	-
1002	-	22.00	11.50	4.33	13.00	13.00	12.00	11.00	-	(9.00)	0.50	6.67
1003	14.33	29.25	17.58	11.00	18.00	18.00	17.00	16.00	3.67	(11.25)	(0.58)	5.00
1203	-	-	21.00	-	12.00	15.00	15.00	14.00	-	-	(6.00)	-
1301	-	-	5.00	-	10.00	10.00	10.00	9.00	-	-	5.00	-
1303	-	-	28.00	-	18.00	18.00	16.00	16.00	-	-	(12.00)	-
1402	-	-	8.20	7.25	12.00	11.00	10.00	10.00	-	-	1.80	2.75
1403	5.00	16.00	8.68	8.61	13.00	13.00	12.00	11.00	8.00	(3.00)	3.32	2.39
1404	13.00	12.83	12.32	10.00	17.00	16.00	15.00	14.00	4.00	3.17	2.68	4.00
1502	-	-	6.00	-	11.00	12.00	11.00	10.00	-	-	5.00	-
1503	17.00	-	8.00	9.00	14.00	14.00	12.00	12.00	(3.00)	-	4.00	3.00
1504	-	-	14.75	9.00	20.00	16.00	15.00	14.00	-	-	0.25	5.00
1701	-	-	4.00	6.00	10.00	10.00	10.00	9.00	-	-	6.00	3.00
1702	13.00	6.00	-	9.00	14.00	14.00	12.00	12.00	1.00	8.00	-	3.00
1703	-	10.00	15.00	12.25	17.00	15.00	14.00	14.00	-	5.00	(1.00)	1.75
1704	-	16.33	15.33	12.67	21.00	19.00	17.00	17.00	-	2.67	1.67	4.33
1802	-	9.00	13.75	10.00	17.00	16.00	14.00	14.00	-	7.00	0.25	4.00
1803	-	21.40	24.00	17.67	33.00	26.00	21.00	20.00	-	4.60	(3.00)	2.33
1901	-	-	-	9.43	13.00	12.00	12.00	11.00	-	-	-	1.57
1902	-	17.00	15.75	8.00	23.00	20.00	21.00	18.00	-	3.00	5.25	10.00
1903	-	-	2.00	29.00	41.00	32.00	28.00	30.00	-	-	26.00	1.00
2002	-	9.50	9.36	6.50	11.00	11.00	10.00	10.00	-	1.50	0.64	3.50
2003	12.50	10.25	10.88	8.95	14.00	14.00	13.00	12.00	1.50	3.75	2.12	3.05
2004	29.50	17.00	17.30	13.83	18.00	17.00	15.00	15.00	(11.50)	-	(2.30)	1.17
2101	-	-	14.00	-	29.00	17.00	15.00	14.00	-	-	1.00	-
	12.45	**18.64**	**15.85**	**14.94**					**58.67**	**82.15**	**90.51**	**177.98**

10. Please provide further explanation of the "DC Impact" adjustment to AHC's demand forecast. Can AHC provide any tangible evidence that patients would prefer to use AHC facilities but, instead, use D.C. facilities because Takoma Park is not accessible to Montgomery County patients? Identify the more attractive facility features and amenities of D.C. rehabilitation hospital facilities that are luring Montgomery County patients to use these facilities rather than the Takoma Park facility.

Response:

The D.C. Impact is simply the expectation that a small number of acute rehabilitation patients (70 in 2021) who currently seek care at D.C. providers will choose to receive treatment closer to home once the White Oak facility opens. Currently, more than 200 Montgomery County residents annually are choosing a D.C. rehabilitation provider, with most selecting MedStar National Rehabilitation Hospital ("National Rehab").

In 2017, AHR received 308 referrals (including both Maryland and DC residents) that chose another IRF, the majority of which selected National Rehab. Based on internal data collected by AHR liaisons the primary reason stated is the availability of private rooms and state-of-the art facilities.

The relocation of the Takoma Park beds to White Oak will present an effective Maryland alternative. With all private rooms, state-of-the-art facilities that are appropriately sized, and easier travel access, it is reasonable to expect that a portion of the out-migration of Montgomery County residents to D.C. will be reversed, as assumed in the projection model. AHR projects conservatively that 70 patients will not out-migrate to D.C.

11. As noted in the State Health Plan, "to some extent, skilled nursing facilities may substitute for acute inpatient rehabilitation services." What evidence can AHC provide that all of the patients using its rehabilitation hospital facilities require the more costly intensive rehabilitation setting of a hospital rather than the lower cost skilled nursing facility setting?

Response:

AHR performs a Pre-Admission Screening (PAS) using CMS criteria to ensure patients are appropriate for admission to an IRF. AHR is confident that the admissions reflected in its data are for individuals who require a level of care specifically provided by an IRF. Through applying these stringent criteria, patients who are both appropriate and inappropriate for admission into the facility are identified. Of the 1,199 referrals to Takoma Park in 2017, there were 43 patients identified as too functional for admission into an IRF, 42 identified as not meeting medical necessity for IRF admission and 30 who were identified as being too impaired to be admitted into an IRF. See the table below.

# Denied	Reason	Definition
43	Too Functional	The patient was not accepted for admission because his/her current level of function exceeded a level that would allow significant practical improvement during a rehabilitation course.
42	Does Not Meet Medical Necessity	The patient is not too functional or too impaired, but their medical needs are not sufficient to support the requirement for close medical supervision or 24-hour rehabilitation nursing care.
30	Too Impaired	The patient was not accepted for admission because his/her current level of function was below a level that would allow participation in an intensive level of rehabilitation services resulting in significant practical improvement in a reasonable amount of time.

AHR evaluates patients for appropriate admission and discharge. This includes discharging patients to the appropriate level of care following treatment at the facility.

Project Review Standard (3), Impact

12. AHC projects a shift in patient demand from D.C. hospitals to the proposed hospital. As required by this standard, specifically address this impact, by facility, in terms of care volume, average length of stay, and case mix.

Response:

The impact of reducing out-migration to D.C. providers is expected to be *de minimus.* The following table presents the total acute rehabilitation discharges served by the two D.C. providers (D.C. Hospital discharge data). This is the best available information; case mix and ALOS are not available.

Acute Rehabilitation Discharges of D.C. Providers from Takoma Park Service Area
2016

Facility	Total Discharges Age 18+	Discharges from Takoma Park Service Area
MedStar National Rehabilitation	2,104	1,069
George Washington University	366	11
Total	2,470	1,080

Source: MHCC DC Hospital Discharge Data

The 70 discharges projected to be redirected from the D.C. providers to the White Oak campus represent only 2.8 percent of the total discharges served by these two programs. It was assumed the impact on each provider would be proportionate to its percentage of the total patients out-migrating to D.C. The following table calculates the number of discharges and the percentage of total discharges that each provider could lose based on D.C. hospital discharge data, as a result of the approval of the relocation of beds to White Oak. Neither provider is expected to experience a material loss of volume as a result of this project.

Impact of White Oak Redirection on D.C. Providers

Facility	Total Discharges Age 18+	Discharges Redirected to White Oak	% Impact
MedStar National Rehabilitation	2,104	69	3.3%
George Washington University	366	1	0.3%
Total	2,470	70	2.8%

Source: MHCC DC Hospital Discharge Data

13. Table J, – "Rehab Takoma Park CURRENT– UNINFLATED," appears to be a financial schedule showing historic, current year and projected year revenues and expenses for a scenario in which AHC operates a special rehabilitation hospital in Takoma Park, as currently authorized.

A. Why does "interest on current debt" increase from $45,475 in the current year to $654,160 in 2019 and $1,262,845 in 2020? What borrowing is assumed to be undertaken under this scenario and what are these borrowed funds used to buy?

Response:

(In the original CON submission Table J, – "Rehab Takoma Park CURRENT– UNINFLATED," was incorrectly labeled and in this submission, it has been updated to accurate labeling, Table G - "Rehab Takoma Park Current – UNINFLATED".)

There is no additional borrowing for the option of remaining at Takoma Park. The increase in interest expense is solely a result of AHR absorbing current debt balance associated with the Takoma Park campus. The financial tables for the current scenario at Takoma Park assume that starting in July 2019 AHR will be the only hospital occupant. Therefore, AHR will be charged with campus-related costs associated with facility maintenance, infrastructure upkeep, debt obligations, and facility depreciation. The table below outlines the assumptions related to the campus cost allocation for 2019 (six-month period) and 2020-2022 (annual cost allocation).

Interest on Current Debt	2018	2019*	2020	2021	2022
AHR Expense	45,475	45,475	45,475	45,475	45,475
Takoma Park Campus Cost	-	608,685	1,217,370	1,217,370	1,217,370
	45,475	654,160	1,262,845	1,262,845	1,262,845
*2019 assumes that AHR will be sole hospital occupant for six months.					

B. Why does "current depreciation" increase from $417,526 in the current year to $1,214,794 in 2019 and $2,012,514 in 2020? What facility improvements will occur under this scenario that will quintuple the value of this asset?
Response:

The increase in current depreciation is the result of AHR being the sole hospital occupant on the Takoma Park campus, not related to facility improvements. The financial tables for the current scenario at Takoma Park assume that starting in July 2019, AHR will be the only hospital occupant. Therefore, AHR will be charged with campus-related costs associated with the campus depreciation. The table below outlines the assumptions related to the campus cost allocation for 2019 (six-month period) and 2020-2022 (annual cost allocation).

Current Depreciation	2018	2019*	2020	2021	2022
AHR Expense	417,526	417,526	417,526	417,526	417,526
Takoma Park Campus Cost	-	797,268	1,594,988	1,594,988	1,594,988
	417,526	1,214,794	2,012,514	2,012,514	2,012,514
*2019 assumes that AHR will be sole hospital occupant for six months.					

C. Why is there a contractual services expense on this schedule but no contract employees or expense shown in Table H?

Response:

Please see attached updated Table L which includes the contract employees. This table has been corrected from the previous version provided by including contract FTEs as well as updating the projection to tie to Table G. These tables are presented in Exhibit 23. (In the original CON submission Table H "Workforce Information" was incorrectly labeled and in this submission it has been updated to accurate labeling, Table L Workforce Information- AHR Remain in Takoma Park- Uninflated Projection.)

14. These same questions are applicable to Table K – "Rehab in TP – INFLATED," which appears to be a financial schedule showing historic, current year, and projected year revenues and expenses for a scenario in which AHC operates a special rehabilitation hospital in Takoma Park as currently authorized.

A. Why does "interest on current debt" increase from $45,475 in the current year to $654,160 in 2019 and $1,262,845 in 2020? What borrowing is assumed to be undertaken under this scenario and what are these borrowed funds used to buy?

Response:

(In the original CON submission Table K – "Rehab in TP – INFLATED," was incorrectly labeled and in this submission it has been updated to accurate labeling, Table H – "Rehab in TP – INFLATED".)

There is no additional borrowing assumed for the option of remaining at Takoma Park. The increase in interest expense is solely a result of AHR absorbing current debt balance associated with the Takoma Park campus. The financial tables for the current scenario at Takoma Park assume that starting in July 2019 AHR will be the only hospital occupant. Therefore, AHR will be charged with campus-related costs associated with facility maintenance, infrastructure upkeep, debt obligations, and facility depreciation. The table below outlines the assumptions related to the campus cost allocation for 2019 (six-month period) and 2020-2022 (annual cost allocation). It is assumed that there will not be inflation associated with the current debt as the repayment schedules are fixed and the projection periods reflect actual current experience.

Interest on Current Debt	2018	2019*	2020	2021	2022
AHR Expense	45,475	45,475	45,475	45,475	45,475
Takoma Park Campus Cost	-	608,685	1,217,370	1,217,370	1,217,370
	45,475	654,160	1,262,845	1,262,845	1,262,845
*2019 assumes that AHR will be sole hospital occupant for six months.					

B. Why does "current depreciation" increase from $417,526 in the current year to $1,214,794 in 2019 and $2,012,514 in 2020? What facility improvements will occur under this scenario that will quintuple the value of this asset?

Response:

The increase in current depreciation in 2019 – 2022 is the result of AHR being the sole hospital occupant on the Takoma Park campus, not related to facility improvements. The financial tables for the current scenario at Takoma Park assume that starting in July 2019, AHR will be the only hospital occupant. Therefore, AHR will be charged with campus-related costs associated with the campus depreciation. The table below outlines the assumptions related to the campus cost allocation for 2019 (six-month period) and 2020-2022 (annual cost allocation). It is assumed that there will not be inflation associated with the current depreciation as recognition is straight-line across the life of the asset and no additional asset purchases are planned.

Current Depreciation	2018	2019*	2020	2021	2022
AHR Expense	417,526	417,526	417,526	417,526	417,526
Takoma Park Campus Cost	-	797,268	1,594,988	1,594,988	1,594,988
	417,526	1,214,794	2,012,514	2,012,514	2,012,514
*2019 assumes that AHR will be sole hospital occupant for six months.					

C. Why is there a contractual services expense on this schedule but no contract employees or expense shown in Table H?

Response:

Please see the updated Table L in Exhibit 23 which includes the contract employees. This table has been corrected from the previous version by including contract FTEs as well as updating the projection to tie to Table G. (In the original CON submission Table H "Workforce Information" was incorrectly labeled and in this submission, it has been updated to accurate labeling, Table L Workforce Information- AHR Remain in Takoma Park - Uninflated Projection.)

15. Did AHC consider the operation of a special rehabilitation hospital in Takoma Park unsustainable in 2015? If not, please explain the error in the assumptions employed by AHC at that time and how these errors came to light. If so, please explain why AHC put forward the project plan approved in 2015 to MHCC as viable. The application states that it is not financially feasible for AHR to remain in Takoma Park because its current ability to share ancillary services with Washington Adventist Hospital would no longer exist. This fact was obviously known during AHC's initial planning for the general hospital relocation. Why is it an important factor now when it apparently was not an important factor then?

Response:

AHC did not err in its assumptions for plans for the Takoma Park campus developed as part of the Washington Adventist Hospital CON application filed in 2014 and approved by the MHCC in 2015. AHC developed plans to create a specialty hospital campus in Takoma Park as an effort to maintain services in Takoma Park. As noted in the WAH CON application, the Takoma Park campus was to be anchored by a specialty rehabilitation hospital and a specialty psychiatric hospital utilizing the psychiatric beds that are currently part of WAH, along with other services on the campus. A key change for the Takoma Park campus occurred when AHC, facing challenges with an unfavorable reimbursement environment for freestanding behavioral health facilities, affirmatively decided in 2017 to retain and strengthen these services by affiliating its psychiatric beds under the license of its acute care hospitals. AHC obtained approval to move the psychiatric beds currently at WAH to Shady Grove Medical Center and to WAH's new location in White Oak. AHC embraced the MHCC's recommendation that WAH have onsite acute psychiatric services at White Oak. It was never contemplated AHR would remain as the sole specialty hospital in Takoma Park. The absence of a

freestanding psychiatric hospital in Takoma Park means that AHR would have to shoulder the overhead costs for the campus.

Additionally, the White Oak hospital CON was approved shortly after the implementation of the innovative Global Budget Revenue (GBR) system and Total Cost of Care model. The experience of operating under the GBR model, which highlights, among other things, the importance of the appropriate consolidation of services and operational efficiency, has been an important factor in changes to the Takoma Park campus. As noted in the June 28, 2018 filing for approval to relocate behavioral health beds to White Oak:

"In its current iteration, with the WAH CON unchanged, the Project would result in AHC having three campuses with inpatient services in Rockville, Takoma Park and White Oak. AHC has determined that its inpatient services should be concentrated at its two acute care hospital campus locations, in Rockville and White Oak. Maintaining Takoma Park as an inpatient campus with limited specialty hospital services is not the best approach from a continuity of care, operational and cost-efficiency perspective. Furthermore, preserving critically important health care services, such as behavioral health, requires enhancing clinical outcomes and cost efficiencies consistent with the goals of Maryland's GBR model. (June 28, 2018 Request for Project Change After Certification filing, page 3)."

AHC's efforts to try and leave health care services in Takoma Park as part of an application filed four years ago in an emerging regulatory environment is in no way an error. It is not sustainable for AHR to continue to operate alone in an otherwise empty building in Takoma Park, burdened by the carrying cost of the campus. Adventist HealthCare has prudently adapted to changing circumstances by preserving inpatient health care services at two campuses rather than three.

16. Table J – "Rehab Takoma Park in White Oak – UNINFLATED," appears to be a financial schedule showing historic, current year and projected year revenues and expenses for a scenario in which AHC operates a special rehabilitation hospital in Takoma Park until sometime in 2019 and operates a replacement special rehabilitation hospital in White Oak thereafter.

A. The schedule shows no "project depreciation." Please clarify.

Response:

Please see the updated Table J in Exhibit 23 which breaks out the Project Depreciation from Current Depreciation. Current depreciation and project depreciation were previously combined.

B. Why does "current depreciation" increase from $417,526 in the current year to $1,214,794 in 2019? What is the $832,526 in "current depreciation" shown for 2020-2022 and why is it "current depreciation?"

Response:

The increase in current depreciation in 2019 is the result of AHR being the sole hospital occupant on the Takoma Park campus and represents the six months that AHR will remain on the Takoma Park Campus. As noted above in the response to 16A., Table J has been updated to reflect the separation between current depreciation and project depreciation. The table below outlines the assumptions related to the campus cost allocation for 2019 (six-month period) and 2020-2022 (AHR's portion of the White Oak project depreciation).

Depreciation	2018	2019*	2020	2021	2022
AHR Expense	417,526	417,526	417,526	417,526	417,526
Takoma Park Campus Cost	-	797,268	-	-	-
Project Depreciation		-	415,000	415,000	415,000
	417,526	1,214,794	832,526	832,526	832,526
*2019 assumes that AHR will be sole hospital occupant for six months					
and relocates to White Oak in January 2020.					

C. This schedule shows "interest on current debt" increasing by a factor of 14 from 2018 to 2019 and returning to 2016-17 levels in 2020 to 2022. Please explain.

Response:

The increase in interest expense is a result of AHR absorbing the current debt balance associated with the Takoma Park campus. The financial tables (Exhibit 23) reflect AHR absorbing the interest expense related to the Takoma Park campus for the last six months of 2019 before relocating to White Oak in January 2020. The table below outlines the assumptions related to the campus cost allocation for 2019 (six-month period) and 2020-2022 (annual cost allocation).

Interest on Current Debt	2018	2019*	2020	2021	2022
AHR Expense	45,475	45,475	45,475	45,475	45,475
Takoma Park Campus Cost	-	608,685	-	-	-
	45,475	654,160	45,475	45,475	45,475
*2019 assumes that AHR will be sole hospital occupant for six					
months and relocates to White Oak in January 2020.					

D. This schedule shows no "interest on project debt." Does this mean that none of the proposed project expense will be financed? (see Q1). Please clarify.

Response:
The source of funds for this project is cash. There will be no financing. Table E is included as Exhibit 21 and also is part of the financial tables for Exhibit 23.

E. Why is there a contractual services expense on this schedule but no contract employees or expense shown in Table H? Why isn't the "Salaries & Wages" figure consistent with Table H?

Response:

The workforce associated with relocating to White Oak is included in an additional Table L titled, "Table L. Workforce Information - AHR Relocate to White Oak - Uninflated Projection". This ties to Table J – "Rehab Takoma Park in White Oak Uninflated" as shown in Exhibit 23.

17. These same questions are applicable to Table K, "Rehab Takoma Park in White Oak – INFLATED," which appears to be a financial schedule showing historic, current year, and projected year revenues and expenses for a scenario in which AHC operates a special rehabilitation hospital in Takoma Park until sometime in 2019 and operates a replacement special rehabilitation hospital in White Oak thereafter.

A. The schedule shows no "project depreciation." Please clarify.

Response:

Please see the attached updated Table K, which breaks out the Project Depreciation from Current Depreciation. Current depreciation and project depreciation were previously combined.

B. Why does "current depreciation" increase from $417,526 in the current year to $1,214,794 in 2019? What is the $832,526 in "current depreciation" shown for 2020-2022 and why is it "current depreciation?"

Response:

The increase in current depreciation in 2019 is the result of AHR being the sole hospital occupant on the Takoma Park campus, and represents the six months that AHR will remain on the Takoma Park Campus. As noted above in 17A., Table K has been updated to reflect the separation between current depreciation and project depreciation. It is assumed that there will not be inflation associated

with the current depreciation as recognition is straight-line across the life of the asset. The table below outlines the assumptions related to the campus cost allocation for 2019 (six-month period) and 2020-2022 (AHR's portion of the White Oak project depreciation).

Depreciation	**2018**	**2019***	**2020**	**2021**	**2022**
AHR Expense	417,526	417,526	417,526	417,526	417,526
Takoma Park Campus Cost	-	797,268	-	-	-
Project Depreciation		-	415,000	415,000	415,000
	417,526	1,214,794	832,526	832,526	832,526
*2019 assumes that AHR will be sole hospital occupant for six months					
and relocates to White Oak in January 2020.					

C. This schedule shows "interest on current debt" increasing by a factor of 14 from 2018 to 2019 and returning to 2016-17 levels in 2020 to 2022. Please explain.

Response:

The increase in interest expense is solely a result of AHR absorbing current debt balance associated with the Takoma Park campus. The financial tables (Exhibit 23) reflect AHR absorbing the interest expense related to the Takoma Park campus for the last six months of 2019 before relocating to White Oak in January 2020. The table below outlines the assumptions related to the campus cost allocation for 2019 (six-month period) and 2020-2022 (annual cost allocation). It is assumed that there will not be inflation associated with the current debt as the repayment schedules are fixed.

Interest on Current Debt	**2018**	**2019***	**2020**	**2021**	**2022**
AHR Expense	45,475	45,475	45,475	45,475	45,475
Takoma Park Campus Cost	-	608,685	-	-	-
	45,475	654,160	45,475	45,475	45,475
*2019 assumes that AHR will be sole hospital occupant for six					
months and relocates to White Oak in January 2020.					

D. This schedule shows no "interest on project debt." Does this mean that none of the proposed project expense will be financed? (See Question 1.) Please clarify.

Response:

The source of funds for this project is cash. There will be no financing. Please refer to the updated Table E, in Exhibit 21 and Exhibit 23.

E. Why is there a contractual services expense on this schedule but no contract employees or expense shown in Table H? Why isn't the "Salaries & Wages" figure consistent with Table H.

Response:

The workforce associated with relocating to White Oak is included in an additional Table L titled, "Table L. Workforce Information - AHR Relocate to White Oak - Uninflated Projection". This ties to Table J – "Rehab Takoma Park in White Oak Uninflated" as shown in Exhibit 23.

18. Given the number of issues we feel exist with the table set provided please submit a revised Exhibit 4 that addresses the anomalies described in the immediately preceding questions. Explain in detail the assumptions employed in developing the expense projections for the alternative scenarios, line by line.

Response:

Included in this submission is a revised Exhibit 4, set forth as Exhibit 23, including the updated financial tables. Additionally, line-by-line assumptions are set forth and labelled as financial table assumptions adjacent to the table referred to for each scenario both inflated and uninflated.

19. What is the outstanding debt on the existing special hospital? Explain how this is treated going forward.

Response:

AHR's current outstanding debt balance is $4,347,854. This is a partial allocation of a bond issued through Adventist HealthCare. There will be no change in this debt allocation upon relocation to White Oak. The expense was allocated between inpatient (82.3% of gross patient revenue) and outpatient (17.7% of gross patient revenue). The inpatient portion was then allocated between the two inpatient locations, Rockville (64.4%) and Takoma Park (35.6%). Please see the table below for further detail.

Interest on Current Debt	
Total Interest Expense	
Inpatient - (82.3% total)	127,845
Outpatient - (17.7% total)	67,187
	195,032
Inpatient Interest Expense	
Rockville - (64.4% inpt total)	82,370
Takoma Park - (35.6% inpt total)	45,475
	127,845

Project Review Standard (8), Transfer and Referral Agreements

20. Your application states, "[you] have relationships with skilled nursing facilities, long-term acute care hospitals, home health agencies, and other providers to allow patients to transition to the most appropriate level of care." How many "transitions" from the special rehabilitation hospital in Takoma Park to a skilled nursing facility occurred in 2017? Please identify the skilled nursing facilities to which patients are referred.

Response:

AHR in Takoma Park discharged 78 patients in 2017 to a Skilled Nursing Facility (SNF). Please see the table below for the list of SNFs that were utilized by patients.

Genesis (various)	26
Manor Care (various)	11
Regency, Silver Spring	7
Hill Haven Nursing and Rehab	6
The Sanctuary at Holy Cross	4
Brookgrove Nursing and Rehab	3
Villages of Rockville	3
Doctors Community Nursing and Rehab	2
Oakview Nursing and Rehab	2
Althea Woodland	1
Arcola Health and Rehab	1
Asbury, Wilson Health Care Center	1
Forest Hills of DC	1
Hillcrest at Crabtree Valley, Raleigh, NC	1
Long Green Center	1
Lorien Columbia	1
New Bridge on the Charles, Boston, MA	1

Potomac Valley Nursing and Rehab	1
Renaissance at Sibley	1
Restore Rehab Center	1
Riderwood	1
Transitions Care, Gettysburg	1
Woodside Nursing and Rehab	1

*names of the facilities may have changed since this data was collected in 2017.

COMAR 10.24.10, State Health Plan for Facilities and Services: Acute Care Hospital Services

Project Review Standard (6), Cost Effectiveness

21. Please respond to the requirements of this standard for the alternative of consolidating special rehabilitation hospital facilities in Rockville, establishing a single hospital on one premise. For this alternative:

A. Quantify the level of effectiveness of this alternative as an effective treatment setting. The stated objective of maximizing the sharing off resources between AHR and WAH is not a project objective that allows for consideration of any alternative to this project with the exception of operating one special rehabilitation hospital at one location in Montgomery County which would be the White Oak campus. For this reason, MHCC staff rejects this delimiting objective as a useful basis for analysis of the costs and effectiveness of the only meaningful alternative, which is consolidation of rehabilitation facilities in Rockville.

Response: Please see the consolidated response under C.

B. Detail the capital and operational cost estimates and projections developed for the alternative. Merely stating that the estimated cost of the most "cost-efficient" approach is $40M does not meet the requirements of this standard. If operating a 97-bed hospital is more efficient than operating two separate hospitals with the same number of beds, which seems likely, the operational savings could make this option the most cost-effective alternative over the life of the project. It is this analysis that is the fundamental point of this standard and the application provides no meaningful information on this point.

Response: Please see the consolidated response under C.

C. Explain the basis for choosing the proposed project over this alternative, as supported by the information provided in (A) and (B).

AHR is asked to discuss the level of effectiveness of the alternative of consolidating the AHR Takoma Park beds to its Rockville location. The question suggests that it is more efficient to combine the 97 AHR beds and operate at one location rather than two locations. Information is solicited concerning related capital and cost estimates for this alternative, as compared to moving the beds to the White Oak campus as proposed in the CON application.

In considering options for the Takoma Park rehabilitation beds, AHR's leadership developed a number of objectives: (a) Ensure the community within the Takoma Park service area would continue to have access and efficient travel times to rehabilitation services; (b) Ensure the project is affordable from a capital standpoint and yields a strong, positive bottom line that allows for continued re-investment in the rehabilitation service; (c) Provide services for Maryland patients in a state-of-the-art facility.

As explained in the July 11, 2018 CON filing, maintaining AHR as the sole hospital service in in Takoma Park is not feasible, generating losses as explained in the application. Furthermore, this option would interfere with the disposition and redevelopment of the campus for an alternate use.

On a surface level, it can be assumed there are operational efficiencies associated with relocating the Takoma Park beds to the Rockville campus where all staff are combined at one site rather than two locations. However, the operational efficiency does not mean that the Rockville alternative is the more effective option. There are major drawbacks to relocating the Takoma Park beds to Rockville. First, the Rockville location would move beds out of the entire existing service area, a significant issue given that many patients face mobility issues upon admission and discharge. The Rockville campus ZIP code, 20850, is outside of the entire service area for the Takoma Park service.

Second, there are major drawbacks to construction of additional space on the Rockville campus. The existing building in Rockville has structural limitations that prevent adding additional floors on top of the facility. Given the space limitations of the campus, significant expansion would require construction of three, three-story towers yielding approximately 60,000 square feet of new construction on space currently used as parking for patients, visitors and staff. This would leave the facility with no on-site parking. Capital costs for this option would be approximately $40 million as noted in the July 11, 2018 application, an amount double the projected costs in White Oak. (The number is actually closer to $40.5 million). This option would require AHR and AHC to take on debt to afford the $40.5 million capital costs, an amount that would not include renovation of the existing facility in Rockville or necessary expansion of the gymnasium in Rockville that would be required to accommodate the additional patients. Renovation of the Rockville facility would cost $14.1 million in addition to the $40.5 million for the new construction. This does not include the cost for a new parking solution, a problem compounded by the fact that Shady Grove Medical Center utilizes AHR’s Rockville campus for some of its parking needs.

Third, the White Oak option is more financially feasible. AHC and AHR would have to acquire significant additional debt to fund the $40.5 million ($54.6 million if the Rockville facility is renovated) to relocate the beds to Rockville. AHC and AHR are not acquiring debt for the $19.5 million option in White Oak which is funded with cash. The additional borrowing would affect AHR and AHC's financial position. Any additional borrowing for AHC would exacerbate already thin measures of leverage. AHC could face a possible bond rating downgrade with additional leverage that dilutes AHC's balance sheet measures or weakens the debt measures. Furthermore, the White Oak option would yield a better financial performance. Exhibit 24 is a financial pro forma for the first year of operations in Rockville compared to the first year of operations in White Oak; assumptions are included in the exhibit. The operating margin for the service in Rockville is 6.7% while the operating margin for White Oak is 10.7%.

In summary, re-locating the Takoma Park beds to Rockville moves care outside of the existing service area, creates logistical challenges for the Rockville campus, requires assumption of significant debt as a financial burden to AHC (which is included in the pro forma), and does not yield the best operating margin. By contrast, moving the beds to White Oak means rehabilitation services will remain available within the existing service area with state-of-the art facilities, is affordable, does not require assumption of additional debt and yields a better operating margin. For these reasons, White Oak is the most effective alternative.

The affirmations for this filing are attached as Exhibit 25.

List of Exhibits

EXHIBIT 21

TABLE E. PROJECT BUDGET

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

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

	Hospital Building	Other Structure	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building	$13,448,000		$13,448,000
(2) Fixed Equipment			$0
(3) Site and Infrastructure			$0
(4) Architect/Engineering Fees	$1,626,480		$1,626,480
(5) Permits (Building, Utilities, Etc.)	$289,152		$289,152
SUBTOTAL	**$15,363,632**	**$0**	**$15,363,632**
b. Renovations			
(1) Building			$0
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees			$0
(4) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$0**	**$0**	**$0**
c. Other Capital Costs			
(1) Movable Equipment			$0
(2) Contingency Allowance	$984,641		$984,641
(3) Gross interest during construction period			$0
(4) Other *(Specify/add rows if needed)*			$0
Inspections & Certifications	$250,000		$250,000
Security / IT / Comm / Signage, etc	$2,197,050		$2,197,050
SUBTOTAL	***$3,431,691***	***$0***	**$3,431,691**
TOTAL CURRENT CAPITAL COSTS	**$18,795,323**	**$0**	**$18,795,323**
d. *Land Purchase*			
e. Inflation Allowance	$752,000		$752,000
TOTAL CAPITAL COSTS	**$19,547,323**	**$0**	**$19,547,323**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c CON Application Assistance			
c1. Legal Fees			$0
c2. Other (Specify/add rows if needed)			
d. Non-CON Consulting Fees			
d1. Legal Fees			$0
d2. Other (Specify/add rows if needed)			$0
e. Debt Service Reserve Fund			$0
f Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$0***	***$0***	**$0**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$19,547,323***	***$0***	***$19,547,323***
B. Sources of Funds			
1. Cash	**$19,547,323**		$19,547,323
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$19,547,323***		**$19,547,323**
	Hospital Building	***Other Structure***	***Total***
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

EXHIBIT 22

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance

(Formerly "Charity Care")

==========

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

==========

FINANCIAL ASSISTANCE POLICY SUMMARY

SCOPE:

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

PURPOSE:

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

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

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

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

This financial assistance policy provides guidelines for:

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

BENEFITS:

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

DEFINITIONS:

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

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

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

POLICY

1. General Eligibility

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.6. **Considerations:**

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

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

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

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

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

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

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

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

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

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

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

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

1.8.1.2. Supplemental Nutritional Assistance Program (SNAP);

1.8.1.3. Low-income-household energy assistance program;

1.8.1.4. Women, Infants and Children (WIC)

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

1.8.2.1. Montgomery Cares;

1.8.2.2. Project Access;

1.8.2.3. Care for Kids

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

1.8.3.1. categorized as homeless or indigent

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

1.8.3.3. unresponsive during care and is discharged due to expiration

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

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

1.8.3.6. Elderly and a victim of abuse

1.8.3.7. an unaccompanied minor

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

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

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

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

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

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

2.1.1. During ED registration

2.1.2. During financial counseling sessions

2.1.3. Upon request

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

2.2.1. At all registrations sites

2.2.2. In specialty area waiting rooms

2.2.3. In specialty area patient rooms

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

2.3.1. Financial Assistance Policy (FAP)

2.3.2. Financial Assistance Application Form (FAA Form)

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

3. Policy Application and Determination Period

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

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

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

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

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

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

4.1. Services deemed not medically necessary by AHC clinical team

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

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

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

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

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

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

Roles and Responsibilities

4.6. **Adventist HealthCare responsibilities**

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

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

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

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

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

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

4.6.7. AHC provides options for payment arrangements.

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

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

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

4.7. **Individual Patient's Responsibilities**

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

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

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

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

5. Identification Of Potentially Eligible Individuals

5.1. Identification through socialization and outreach

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

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

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

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

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

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

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

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

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

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

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

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

7. **POLICY REVIEW AND MAINTAINENCE:**

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

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

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

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

CONTACT INFORMATION AND ADDITIONAL RESOURCES

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

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

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

Adventist HealthCare

820 West Diamond Avenue, Suite 600
Gaithersburg, MD 20878
www.AdventistHealthCare.com

ADVENTIST HEALTHCARE FINANCIAL ASSISTANCE APPLICATION

Shady Grove Medical Center, Adventist Behavioral Health & Wellness Services, Washington Adventist Hospital, Adventist HealthCare Rehabilitation and Adventist HealthCare Germantown Emergency Center will make available a reasonable amount of health care without charge to persons eligible under community services administration guidelines. Financial Assistance is available to patients whose family income does not exceed the limits designed by the income poverty guidelines established by the Community Services Administration.

Financial Assistance may only be granted based on the receipt of the signed and completed Maryland State Uniform Financial Assistance application. Please provide copies only of the following documents.

Proof of income can be provided in the forms listed below:

- Three recent months' worth of paystubs
- Official letter from your employer that includes hourly wage and hours worked. Letter must have date, employer's name, address and phone number.
- If you are providing bank statements as your proof of income, please provide copies of 3 months' worth of bank statements
- If you are self-employed, please provide a letter explaining your monthly gross income. Letter must include your name, address, phone number and copy of last year's taxes.

If you are receiving state, county or personal assistance, please provide a letter of support or award letter from program in which you are enrolled.

- Letter of support must indicate the name of the person's name who is providing the support and what support is being provided.
- Food-stamp letter from county or state
- Housing assistance letter

Any missing documents may result in a delay in processing or denial of your application. Thank you for your cooperation.

Please mail your application to:

Adventist HealthCare

Patient Financial Services

820 West Diamond Ave. Suite 500

Gaithersburg, MD 20878

Maryland State Uniform Financial Assistance Application

Information About You

Name: _____
First *Middle Initial* *Last*

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐ Marital Status: ☐ Single ☐ Married ☐ Separated

US Citizen: ☐ Yes ☐ No Permanent Resident: ☐ Yes ☐ No

Home Address: _____ *Street Address*
_____ *City* *State* *Zip code* *Country*

Home Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐
(Area Code) ### - ####

Employer Name & Address: _____ *Employer Name*
_____ *Street Address*
_____ *City* *State* *Zip code*

Work Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐
(Area Code) ### - ####

Household Members:

Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*

Have you applied for Medical Assistance ☐ Yes ☐ No

If yes, what was the date you applied? ☐☐/☐☐/☐☐☐☐ *(MM/DD/YYYY)*

If yes, what was the determination?

Do you receive any type of state or county assistance? ☐ Yes ☐ No

I. Family Income

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

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

II. Liquid Assets

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

III. Other Assets

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

Home : Loan Balance: _____ Approximate value: _____

Automobile: Make: _____ Year: _____ Approximate value: _____

Additional vehicle: Make : _____ Year: _____ Approximate value: _____

Additional vehicle: Make: _____ Year: _____ Approximate value: _____

Other property: _____ Approximate value: _____

Total _____

IV. Monthly Expenses

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

Do you have any other unpaid medical bills? ☐ Yes ☐ No

For what service? _____

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

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make 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*

Adventist HealthCare

820 West Diamond Avenue, Suite 600
Gaithersburg, MD 20878
www.AdventistHealthCare.com

SOLICITUD PARA ASISTENCIA FINANCIERA DE ADVENTIST HEALTHCARE

Shady Grove Medical Center, Adventist Behavioral Health & Wellness Services, Washington Adventist Hospital, Adventist HealthCare Rehabilitation y Adventist HealthCare Germantown Emergency Center pondrán una cantidad razonable de atención médica sin cargo a disposición de personas elegibles de conformidad con las pautas de la Administración de Servicios Comunitarios. La Asistencia financiera está disponible para pacientes cuyos ingresos familiares no superen los límites designados por las pautas de pobreza establecidas por la Administración de Servicios Comunitarios.

Solo se podrá otorgar Asistencia financiera luego de haber recibido la solicitud de Asistencia financiera uniforme del estado de Maryland. Por favor, solo proporcione copias de los siguientes documentos.

La constancia de ingresos puede ser de cualquiera de los siguientes tipos:

- Tres meses de recibos de pago recientes.
- Carta oficial de su empleador que incluya su remuneración por hora y las horas trabajadas. La carta debe incluir la fecha, y el nombre, dirección y número de teléfono del empleador.
- Si proporciona estados de cuenta bancarios como constancia de ingresos, incluya copias de 3 meses de estados de cuenta.
- Si usted es trabajador independiente, proporcione una carta que detalle sus ingresos mensuales brutos. La carta debe incluir su nombre, dirección, número de teléfono y una copia de sus impuestos del año pasado.

Si usted recibe asistencia estatal, personal o del condado, incluya una carta de apoyo o una carta de adjudicación del programa en el que está inscripto.

- La carta de apoyo debe incluir el nombre de la persona que está brindando el apoyo y qué apoyo le está brindando.
- Carta de adjudicación de cupones de comida del condado o estado.
- Carta de asistencia para vivienda.

Cualquier documento faltante podría provocar una demora en el procesamiento de su solicitud o su rechazo. Gracias por su cooperación

Envíe su solicitud a:

Adventist HealthCare

Patient Financial Services

820 West Diamond Ave. Suite 500

Gaithersburg, MD 20878

❑*Washington Adventist Hospital* ❑*Behavioral Health & Wellness Services* ❑*Shady Grove Medical Center*

❑*Germantown Emergency Center* ❑*Adventist Rehabilitation*

Solicitud de Asistencia financiera uniforme del estado de Maryland

Información acerca de usted

Nombre: _____

Primer nombre *Inicial 2do nombre* *Apellido*

Nro. de seguridad social: ☐☐☐ - ☐☐ - ☐☐☐☐ Estado civil: ☐ Soltero ☐ Casado ☐ Separado

Ciudadano de los EE. UU.: ☐ Sí ☐ No Residente permanente: ☐ Sí ☐ No

Dirección: _____ Tel. casa:

Calle (☐☐☐) ☐☐☐ - ☐☐☐☐

_____ (Cód. de área) ### - ####

Ciudad *Estado* *Cód. postal* *País*

Nombre y dirección _____ Tel. trabajo:

del empleador: *Nombre del empleador* (☐☐☐) ☐☐☐ - ☐☐☐☐

_____ (Cód. de área) ### - ####

Dirección

_____

Ciudad *Estado* *Cód. postal* *País*

Miembros del hogar:

Nombre	Edad	Relación
Nombre	Edad	Relación
Nombre	Edad	Relación
Nombre	Edad	Relación
Nombre	Edad	Relación
Nombre	Edad	Relación
Nombre	Edad	Relación
Nombre	Edad	Relación
Nombre	Edad	Relación

¿Ha solicitado Asistencia médica? ☐ Sí ☐ No

Si la respuesta es sí, ¿en qué fecha la solicitó? ☐☐ / ☐☐ / ☐☐☐☐ (MM/DD/YYYY)

Si la respuesta es sí, ¿cuál fue la determinación?

¿Recibe algún tipo de asistencia del estado o el condado? ☐ Sí ☐ No

I. Ingresos familiares

Enumere los montos de sus ingresos mensuales de todas las fuentes. Es posible que se le exija que proporcione constancia de ingresos, activos y gastos. Si no tiene ingresos, proporcione una carta de apoyo de la persona que le proporciona su vivienda y comidas.

	Monto mensual
Empleo	
Beneficios de jubilación/pensión	
Beneficios de seguridad social	
Beneficios de asistencia pública	
Beneficios de discapacidad	
Beneficios de desempleo	
Beneficios de veteranos	
Manutención	
Ingresos por alquiler de propiedades	
Beneficios de huelgas	
Asignación militar	
Agricultura o empleo independiente	
Otra fuente de ingresos:	
Total	

II. Activos líquidos

	Saldo actual
Cuenta corriente	
Caja de ahorro	
Acciones, bonos, certificados de depósito, o mercado monetario	
Otras cuentas	
Total	

III. Otros activos

Si posee alguno de los siguientes bienes, enumere el tipo y valor aproximado.

Vivienda: Saldo del préstamo: _____ Valor aproximado: _____

Automóvil: Marca: _____ Año: _____ Valor aproximado: _____

Vehículo adicional: Marca: _____ Año: _____ Valor aproximado: _____

Vehículo adicional: Marca: _____ Año: _____ Valor aproximado: _____

Otra propiedad: _____ Valor aproximado: _____

Total

IV. Gastos mensuales

	Monto
Renta o hipoteca	
Servicios públicos	
Pagos de automóvile(s)	
Tarjeta(s) de crédito	
Seguro del automóvil	
Seguro médico	
Otros gastos médicos	
Otros gastos	
Total	

¿Tiene alguna otra factura médica impaga? ☐ Sí ☐ No

¿Por qué servicio?

Si ha acordado un plan de pagos, ¿cuál es el monto mensual?

Si solicita que el hospital le de asistencia financiera adicional, el hospital podría solicitarle información adicional para realizar una determinación suplementaria. Al firmar este formulario, usted certifica que la información proporcionada es verdadera y acepta notificar al hospital de cualquier cambio en la información proporcionada dentro de 10 días del cambio.

Firma del solicitante *Fecha* *Relación*

EXHIBIT 23

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

TABLE E. PROJECT BUDGET

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

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

	Hospital Building	Other Structure	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building	$13,448,000		$13,448,000
(2) Fixed Equipment			$0
(3) Site and Infrastructure			$0
(4) Architect/Engineering Fees	$1,626,480		$1,626,480
(5) Permits (Building, Utilities, Etc.)	$289,152		$289,152
SUBTOTAL	**$15,363,632**	**$0**	**$15,363,632**
b. Renovations			
(1) Building			$0
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees			$0
(4) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$0**	**$0**	**$0**
c. Other Capital Costs			
(1) Movable Equipment			$0
(2) Contingency Allowance	$984,641		$984,641
(3) Gross interest during construction period			$0
(4) Other *(Specify/add rows if needed)*			$0
Inspections & Certifications	$250,000		$250,000
Security / IT / Comm / Signage, etc	$2,197,050		$2,197,050
SUBTOTAL	***$3,431,691***	***$0***	**$3,431,691**
TOTAL CURRENT CAPITAL COSTS	**$18,795,323**	**$0**	**$18,795,323**
d. *Land Purchase*			
e. Inflation Allowance	$752,000		$752,000
TOTAL CAPITAL COSTS	**$19,547,323**	**$0**	**$19,547,323**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c CON Application Assistance			
c1. Legal Fees			$0
c2. Other (Specify/add rows if needed)			
d. Non-CON Consulting Fees			
d1. Legal Fees			$0
d2. Other (Specify/add rows if needed)			$0
e. Debt Service Reserve Fund			$0
f Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$0***	***$0***	**$0**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$19,547,323***	***$0***	***$19,547,323***
B. Sources of Funds			
1. Cash	**$19,547,323**		$19,547,323
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$19,547,323***		**$19,547,323**
	Hospital Building	***Other Structure***	***Total***
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

CY	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.			
Indicate CY ~~or FY~~	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
1. DISCHARGES							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	635	678	690	849	886	901	917
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL DISCHARGES	***635***	***678***	***690***	***849***	***886***	***901***	***917***
2. PATIENT DAYS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	8,968	9,538	9,344	11,498	11,955	12,165	12,379
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL PATIENT DAYS	***8,968***	***9,538***	***9,344***	***11,498***	***11,955***	***12,165***	***12,379***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

CY	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.			
Indicate CY ~~or FY~~	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)							
a. General Medical/Surgical*	0.0	0.0	0.0	0.0	0.0	0.0	0.0
b. ICU/CCU	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total MSGA	0.0	0.0	0.0	0.0	0.0	0.0	0.0
c. Pediatric	0.0	0.0	0.0	0.0	0.0	0.0	0.0
d. Obstetric	0.0	0.0	0.0	0.0	0.0	0.0	0.0
e. Acute Psychiatric	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Acute	0.0	0.0	0.0	0.0	0.0	0.0	0.0
f. Rehabilitation	14.1	14.1	13.5	13.5	13.5	13.5	13.5
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0
h. Other (Specify/add rows of needed)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL AVERAGE LENGTH OF STAY	14.1	14.1	13.5	13.5	13.5	13.5	13.5
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	32	32	35	42	42	42	42
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL LICENSED BEDS	***32***	***32***	***35***	***42***	***42***	***42***	***42***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

CY	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.			
Indicate CY ~~or FY~~	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
b. ICU/CCU	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total MSGA	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
c. Pediatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
d. Obstetric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
e. Acute Psychiatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Acute	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
f. Rehabilitation	76.6%	81.7%	72.5%	75.0%	77.8%	79.4%	80.8%
g. Comprehensive Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
h. Other (Specify/add rows of needed)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL OCCUPANCY %	**76.8%**	**81.7%**	**72.5%**	**75.0%**	**78.0%**	**79.4%**	**80.8%**
6. OUTPATIENT VISITS							
a. Emergency Department							
b. Same-day Surgery							
c. Laboratory							
d. Imaging							
e. Other (Outpt Therapy)							
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***
7. OBSERVATIONS**							
a. Number of Patients							
b. Hours							

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

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

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
1. REVENUE							
a. Inpatient Services	$ 21,285,048	$ 21,168,093	$ 20,737,540	$ 25,516,895	$ 26,532,245	$ 26,998,307	$ 27,473,246
b. Outpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Gross Patient Service Revenues	***$ 21,285,048***	***$ 21,168,093***	***$ 20,737,540***	***$ 25,516,895***	***$ 26,532,245***	***$ 26,998,307***	***$ 27,473,246***
c. Allowance For Bad Debt	$ 276,705	$ 141,668	$ 138,787	$ 170,772	$ 177,568	$ 180,687	$ 183,865
d. Contractual Allowance	$ 7,044,897	$ 6,687,431	$ 6,551,411	$ 8,061,306	$ 8,382,076	$ 8,529,314	$ 8,679,357
e. Charity Care	$ 148,995	$ 71,891	$ 70,429	$ 86,660	$ 90,109	$ 91,692	$ 93,305
Net Patient Services Revenue	***$ 13,814,451***	***$ 14,267,103***	***$ 13,976,914***	***$ 17,198,157***	***$ 17,882,493***	***$ 18,196,614***	***$ 18,516,719***
f. Other Operating Revenues (Specify)	$ 78,800	$ 112,324	$ 112,324	$ 112,324	$ 112,324	$ 112,324	$ 112,324
NET OPERATING REVENUE	***$ 13,893,251***	***$ 14,379,427***	***$ 14,089,238***	***$ 17,310,481***	***$ 17,994,817***	***$ 18,308,938***	***$ 18,629,043***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 7,511,506	$ 8,015,695	$ 7,933,420	$ 10,223,162	$ 11,140,904	$ 11,344,838	$ 11,524,682
b. Contractual Services	$ 261,535	$ 62,023	$ 60,761	$ 74,765	$ 77,740	$ 79,106	$ 80,497
c. Interest on Current Debt	$ 57,765	$ 45,475	$ 45,475	$ 654,160	$ 1,262,845	$ 1,262,845	$ 1,262,845
d. Interest on Project Debt							
e. Current Depreciation	$ 403,838	$ 417,526	$ 417,526	$ 1,214,794	$ 2,012,514	$ 2,012,514	$ 2,012,514
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 328,478	$ 313,685	$ 307,305	$ 378,129	$ 393,175	$ 400,082	$ 407,120
j. IT Services	$ 460,605	$ 624,287	$ 624,287	$ 624,287	$ 624,287	$ 624,287	$ 624,287
k. Professional Fees	$ 52,308	$ 59,583	$ 58,371	$ 71,824	$ 74,682	$ 75,994	$ 77,330
l. Building & Maintenance	$ 456,976	$ 435,016	$ 435,016	$ 1,246,580	$ 2,493,160	$ 2,493,160	$ 2,493,160
m. Insurance	$ 27,003	$ 27,360	$ 27,360	$ 27,360	$ 27,360	$ 27,360	$ 27,360
m. G&A	$ 1,434,777	$ 1,750,269	$ 1,750,269	$ 2,969,732	$ 3,122,577	$ 3,122,577	$ 3,122,577
TOTAL OPERATING EXPENSES	***$ 10,994,791***	***$ 11,750,919***	***$ 11,659,790***	***$ 17,484,792***	***$ 21,229,244***	***$ 21,442,761***	***$ 21,632,372***
3. INCOME							
a. Income From Operation	**$ 2,898,460**	**$ 2,628,508**	**$ 2,429,448**	**$ (174,312)**	**$ (3,234,427)**	**$ (3,133,823)**	**$ (3,003,329)**
b. Non-Operating Income							
SUBTOTAL	***$ 2,898,460***	***$ 2,628,508***	***$ 2,429,448***	***$ (174,312)***	***$ (3,234,427)***	***$ (3,133,823)***	***$ (3,003,329)***
c. Income Taxes							
NET INCOME (LOSS)	***$ 2,898,460***	***$ 2,628,508***	***$ 2,429,448***	***$ (174,312)***	***$ (3,234,427)***	***$ (3,133,823)***	***$ (3,003,329)***

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	59.2%	60.7%	62.2%	62.2%	62.2%	62.2%	62.2%
2) Medicaid	7.8%	8.3%	6.7%	6.7%	6.7%	6.7%	6.7%
3) Blue Cross	15.8%	13.0%	13.8%	13.8%	13.8%	13.8%	13.8%
4) Commercial Insurance	5.8%	7.6%	7.0%	7.0%	7.0%	7.0%	7.0%
5) HMO	9.1%	8.7%	8.6%	8.6%	8.6%	8.6%	8.6%
6) Self-pay	0.1%	0.0%	0.8%	0.8%	0.8%	0.8%	0.8%
7) Other	2.2%	1.7%	0.9%	0.9%	0.9%	0.9%	0.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	59.9%	60.7%	62.1%	62.1%	62.1%	62.1%	62.1%
2) Medicaid	7.8%	8.3%	6.8%	6.8%	6.8%	6.8%	6.8%
3) Blue Cross	15.4%	13.0%	13.9%	13.9%	13.9%	13.9%	13.9%
4) Commercial Insurance	5.7%	7.7%	6.9%	6.9%	6.9%	6.9%	6.9%
5) HMO	9.0%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
6) Self-pay	0.1%	0.0%	0.8%	0.8%	0.8%	0.8%	0.8%
7) Other	2.2%	1.7%	1.0%	1.0%	1.0%	1.0%	1.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Assumptions & Drivers

AHR Current State at Takoma Park - NO Inflation (Table G)

	Historical		Projection				
	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
IP Hospital Revenue	21,285,048	21,168,093	20,737,540	25,516,895	26,532,245	26,998,307	27,473,246
OP Hospital Revenue	-	-	-	-	-	-	-
EIPA Factor ("Equivalent IP Admission")	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
Regulated Deductions:							
Contractual Allowances	33.10%	31.59%	31.59%	31.59%	31.59%	31.59%	31.59%
Charity	0.70%	0.34%	0.34%	0.34%	0.34%	0.34%	0.34%
Bad Debt	1.30%	0.67%	0.67%	0.67%	0.67%	0.67%	0.67%
Pro Fee Deductions:							
Contractual Allowances	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Charity	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Bad Debt	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
IP Revenue per Admission	$ 33,520	$ 31,221	$ 31,221	$ 31,221	$ 31,221	$ 31,221	$ 31,221
OP Revenue per EIPD ("Equivalent IP Day")	-	-	-	-	-	-	-
Physician Revenue per EIPD	-	-	-	-	-	-	-
		2,219	2,219	2,219	2,219	2,219	2,219
Other Operating Revenue Growth			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Revenue Inflation Update			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Rehab Growth	*-10.06%*	*6.77%*	*1.70%*	*23.00%*	*4.36%*	*1.69%*	*1.78%*
Rehab Discharges	635	678	690	849	886	901	917
Rehab Days	8,968	9,538	9,344	11,498	11,955	12,165	12,379
Rehab ADC	24.50	26.13	25.60	31.50	32.66	33.33	33.92
Rehab ALOS	14.12	14.07	13.54	13.54	13.49	13.50	13.50
Length of Stay	*4.3%*	*-0.4%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
EIPA	635	678	690	849	886	901	917
EIPD	8,968	9,538	9,344	11,498	11,955	12,165	12,379
Adjusted Occupied Bed	24.6	26.1	25.6	31.5	32.7	33.3	33.9
Acute Licensed Beds	32	32	35	42	42	42	42
Acute Occupancy Rate	76.8%	81.7%	72.5%	75.0%	77.8%	79.4%	80.8%

Assumptions & Drivers

AHR Current State at Takoma Park - NO Inflation (Table G)

	Historical		Projection				
	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Non-pro fee FTEs	81.41	91.58	90.64	110.39	114.47	116.80	118.86
Takoma Park Facilities FTEs				7.00	14.00	14.00	14.00
FTEs per AOB	3.31	3.50	3.50	3.50	3.50	3.50	3.50
Salary per FTE	76,915	72,864	72,864	72,864	72,864	72,864	72,864
Salary/Benefit per Takoma Park Facility FTE				80,102	80,102	80,102	80,102
Salary Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Benefit %	20.0%	20.1%	20.1%	20.1%	20.1%	20.1%	20.1%
Supply per EIPD	$ 37	$ 33	$ 33	$ 33	$ 33	$ 33	$ 33
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Contract Labor per EIPD	$ 29	$ 7	$ 7	$ 7	$ 7	$ 7	$ 7
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
General & Administrative	$ 397,360	$ 282,299	$ 282,299	$ 364,689	$ 447,079	$ 447,079	$ 447,079
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Professional Fees per EIPD	$ 5.83	$ 6.25	$ 6	$ 6	$ 6	$ 6	$ 6
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Building and Maintenance	$ 456,976	$ 435,016	$ 435,016	$ 1,246,580	$ 2,493,160	$ 2,493,160	$ 2,493,160
Inflation			*0.00%*	*186.56%*	*100.00%*	*0.00%*	*0.00%*
Insurance	$ 27,003	$ 27,360	$ 27,360	$ 27,360	$ 27,360	$ 27,360	$ 27,360
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Depreciation and Amortization	$ 257,200	$ 268,452	$ 268,452	$ 1,065,720	$ 1,863,440	$ 1,863,440	$ 1,863,440
Inflation			*0.00%*	*197.16%*	*49.71%*	*0.00%*	*0.00%*
IT Depreciation	$ 146,638	$ 149,074	$ 149,074	$ 207,074	$ 265,074	$ 265,074	$ 265,074
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
IT Services	$ 460,605	$ 624,287	$ 624,287	$ 624,287	$ 624,287	$ 624,287	$ 624,287
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Interest Expense	$ 57,765	$ 45,475	$ 45,475	$ 654,160	$ 1,262,845	$ 1,262,845	$ 1,262,845
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Other - Overhead Allocation	$ 396,370	$ 844,668	$ 844,668	$ 844,668	$ 844,668	$ 844,668	$ 844,668
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Purchased Services	$ 641,047	$ 623,302	$ 623,302	$ 1,760,375	$ 1,830,830	$ 1,830,830	$ 1,830,830
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
1. REVENUE							
a. Inpatient Services	$ 21,285,048	$ 21,168,093	$ 21,401,142	$ 26,570,437	$ 27,669,150	$ 28,295,958	$ 28,937,694
b. Outpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Gross Patient Service Revenues	***$ 21,285,048***	***$ 21,168,093***	***$ 21,401,142***	***$ 26,570,437***	***$ 27,669,150***	***$ 28,295,958***	***$ 28,937,694***
c. Allowance For Bad Debt	$ 276,705	$ 141,668	$ 143,228	$ 177,823	$ 185,176	$ 189,371	$ 193,666
d. Contractual Allowance	$ 7,044,897	$ 6,687,431	$ 6,761,056	$ 8,394,141	$ 8,741,247	$ 8,939,269	$ 9,142,006
e. Charity Care	$ 148,995	$ 71,891	$ 72,682	$ 90,238	$ 93,970	$ 96,099	$ 98,278
Net Patient Services Revenue	***$ 13,814,451***	***$ 14,267,103***	***$ 14,424,176***	***$ 17,908,234***	***$ 18,648,756***	***$ 19,071,220***	***$ 19,503,744***
f. Other Operating Revenues (Specify/add rows of needed)	$ 78,800	$ 112,324	$ 114,009	$ 115,719	$ 117,455	$ 117,455	$ 119,217
NET OPERATING REVENUE	***$ 13,893,251***	***$ 14,379,427***	***$ 14,538,185***	***$ 18,023,953***	***$ 18,766,211***	***$ 19,188,675***	***$ 19,622,960***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 7,511,506	$ 8,015,695	$ 8,084,155	$ 10,593,823	$ 11,722,934	$ 12,144,243	$ 12,551,268
b. Contractual Services	$ 261,535	$ 62,023	$ 62,281	$ 78,550	$ 83,718	$ 87,318	$ 91,075
c. Interest on Current Debt	$ 57,765	$ 45,475	$ 45,475	$ 654,160	$ 1,262,845	$ 1,262,845	$ 1,262,845
d. Interest on Project Debt							
e. Current Depreciation	$ 403,838	$ 417,526	$ 417,526	$ 1,214,794	$ 2,012,514	$ 2,012,514	$ 2,012,514
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 328,478	$ 313,685	$ 314,987	$ 397,272	$ 423,407	$ 441,615	$ 460,618
j. IT Services	$ 460,605	$ 624,287	$ 639,894	$ 649,493	$ 659,235	$ 669,124	$ 679,160
k. Professional Fees	$ 52,308	$ 59,583	$ 59,830	$ 75,460	$ 80,424	$ 83,883	$ 87,492
l. Building & Maintenance	$ 456,976	$ 435,016	$ 445,891	$ 1,246,580	$ 2,493,160	$ 2,555,489	$ 2,619,376
m. Insurance	$ 27,003	$ 27,360	$ 28,044	$ 28,745	$ 29,464	$ 30,200	$ 30,955
m. G&A	$ 1,434,777	$ 1,750,269	$ 1,794,026	$ 3,033,709	$ 3,253,609	$ 3,326,030	$ 3,400,127
TOTAL OPERATING EXPENSES	**$ 10,994,791**	**$ 11,750,919**	**$ 11,892,109**	**$ 17,972,586**	**$ 22,021,309**	**$ 22,613,260**	**$ 23,195,432**
3. INCOME							
a. Income From Operation	**$ 2,898,460**	**$ 2,628,508**	**$ 2,646,075**	**$ 51,367**	**$ (3,255,098)**	**$ (3,424,586)**	**$ (3,572,472)**
b. Non-Operating Income							
SUBTOTAL	***$ 2,898,460***	***$ 2,628,508***	***$ 2,646,075***	***$ 51,367***	***$ (3,255,098)***	***$ (3,424,586)***	***$ (3,572,472)***
c. Income Taxes							
NET INCOME (LOSS)	***$ 2,898,460***	***$ 2,628,508***	***$ 2,646,075***	***$ 51,367***	***$ (3,255,098)***	***$ (3,424,586)***	***$ (3,572,472)***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	59.2%	60.7%	62.2%	62.2%	62.2%	62.2%	62.2%
2) Medicaid	7.8%	8.3%	6.7%	6.7%	6.7%	6.7%	6.7%
3) Blue Cross	15.8%	13.0%	13.8%	13.8%	13.8%	13.8%	13.8%
4) Commercial Insurance	5.8%	7.6%	7.0%	7.0%	7.0%	7.0%	7.0%
5) HMO	9.1%	8.7%	8.6%	8.6%	8.6%	8.6%	8.6%
6) Self-pay	0.1%	0.0%	0.8%	0.8%	0.8%	0.8%	0.8%
7) Other	2.2%	1.7%	0.9%	0.9%	0.9%	0.9%	0.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	59.9%	60.7%	62.1%	62.1%	62.1%	62.1%	62.1%
2) Medicaid	7.8%	8.3%	6.8%	6.8%	6.8%	6.8%	6.8%
3) Blue Cross	15.4%	13.0%	13.9%	13.9%	13.9%	13.9%	13.9%
4) Commercial Insurance	5.7%	7.7%	6.9%	6.9%	6.9%	6.9%	6.9%
5) HMO	9.0%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
6) Self-pay	0.1%	0.0%	0.8%	0.8%	0.8%	0.8%	0.8%
7) Other	2.2%	1.7%	1.0%	1.0%	1.0%	1.0%	1.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Assumptions & Drivers

AHR Current State at Takoma Park - with Inflation (Table H)

	Historical		Projection				
	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
IP Hospital Revenue	21,285,048	21,168,093	21,401,142	26,570,437	27,669,150	28,295,958	28,937,694
OP Hospital Revenue	-	-	-	-	-	-	-
EIPA Factor ("Equivalent IP Admission")	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
Regulated Deductions:							
Contractual Allowances	33.10%	31.59%	31.59%	31.59%	31.59%	31.59%	31.59%
Charity	0.70%	0.34%	0.34%	0.34%	0.34%	0.34%	0.34%
Bad Debt	1.30%	0.67%	0.67%	0.67%	0.67%	0.67%	0.67%
Pro Fee Deductions:							
Contractual Allowances	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Charity	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Bad Debt	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
IP Revenue per Admission	$ 33,520	$ 31,221	$ 32,220	$ 33,252	$ 34,316	$ 34,316	$ 35,414
OP Revenue per EIPD ("Equivalent IP Day")	-	-	-	-	-	-	-
Physician Revenue per EIPD	-	-	-	-	-	-	-
		2,219	2,290	2,311	2,314	2,326	2,338
Other Operating Revenue Growth			*1.50%*	*1.50%*	*1.50%*	*1.50%*	*1.50%*
Revenue Inflation Update			*3.20%*	*0.90%*	*0.15%*	*0.50%*	*0.50%*
Rehab Growth	*-10.06%*	*6.77%*	*1.70%*	*23.00%*	*4.36%*	*1.69%*	*1.78%*
Rehab Discharges	635	678	690	849	886	901	917
Rehab Days	8,968	9,538	9,344	11,498	11,955	12,165	12,379
Rehab ADC	24.50	26.13	25.60	31.50	32.66	33.33	33.92
Rehab ALOS	14.12	14.07	13.54	13.54	13.49	13.50	13.50
Length of Stay	*4.3%*	*-0.4%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
EIPA	635	678	690	849	886	901	917
EIPD	8,968	9,538	9,344	11,498	11,955	12,165	12,379
Adjusted Occupied Bed	24.6	26.1	25.6	31.5	32.7	33.3	33.9
Acute Licensed Beds	32	32	35	42	42	42	42
Acute Occupancy Rate	76.8%	81.7%	72.5%	75.0%	77.8%	79.4%	80.8%
Non-pro fee FTEs	81.41	91.58	90.64	110.39	114.47	116.80	118.86

Assumptions & Drivers

AHR Current State at Takoma Park - with Inflation (Table H)

	Historical		Projection				
	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Takoma Park Facilities FTEs				7.00	14.00	14.00	14.00
FTEs per AOB	3.31	3.50	3.50	3.50	3.50	3.50	3.50
Salary per FTE	76,915	72,864	74,248	75,659	77,096	78,561	80,054
Salary/Benefit per Takoma Park Facility FTE				80,102	80,102	80,102	80,102
Salary Inflation			*1.90%*	*1.90%*	*1.90%*	*1.90%*	*1.90%*
Benefit %	20.0%	20.1%	20.1%	20.1%	20.1%	20.1%	20.1%
Supply per EIPD	$ 37	$ 33	$ 34	$ 35	$ 35	$ 36	$ 37
Inflation			*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
Contract Labor per EIPD	$ 29	$ 7	$ 7	$ 7	$ 7	$ 7	$ 7
Inflation			*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
General & Administrative	$ 397,360	$ 282,299	$ 289,356	$ 378,980	$ 470,845	$ 482,616	$ 494,681
Inflation			*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
Professional Fees per EIPD	$ 5.83	$ 6.25	$ 6	$ 7	$ 7	$ 7	$ 7
Inflation			*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
Building and Maintenance	$ 456,976	$ 435,016	$ 445,891	$ 1,246,580	$ 2,493,160	$ 2,555,489	$ 2,619,376
Inflation			*2.50%*	*179.57%*	*100.00%*	*2.50%*	*2.50%*
Insurance	$ 27,003	$ 27,360	$ 28,044	$ 28,745	$ 29,464	$ 30,200	$ 30,955
Inflation			*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
Depreciation and Amortization	$ 257,200	$ 268,452	$ 268,452	$ 1,065,720	$ 1,863,440	$ 1,863,440	$ 1,863,440
Inflation			*0.00%*	*197.16%*	*49.71%*	*0.00%*	*0.00%*
IT Depreciation	$ 146,638	$ 149,074	$ 149,074	$ 207,074	$ 265,074	$ 265,074	$ 265,074
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
IT Services	$ 460,605	$ 624,287	$ 639,894	$ 649,493	$ 659,235	$ 669,124	$ 679,160
Inflation			*2.50%*	*1.50%*	*1.50%*	*1.50%*	*1.50%*
Interest Expense	$ 57,765	$ 45,475	$ 45,475	$ 654,160	$ 1,262,845	$ 1,262,845	$ 1,262,845
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Other - Overhead Allocation	$ 396,370	$ 844,668	$ 865,785	$ 878,771	$ 891,953	$ 905,332	$ 918,912
Inflation			*2.50%*	*1.50%*	*1.50%*	*1.50%*	*1.50%*
Purchased Services	$ 641,047	$ 623,302	$ 638,885	$ 1,775,957	$ 1,890,811	$ 1,938,081	$ 1,986,533
Inflation			*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY ~~or FY~~	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
1. DISCHARGES							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	635	678	690	849	886	901	917
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL DISCHARGES	***635***	***678***	***690***	***849***	***886***	***901***	***917***
2. PATIENT DAYS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	8,968	9,538	9,344	11,498	11,955	12,165	12,379
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL PATIENT DAYS	***8,968***	***9,538***	***9,344***	***11,498***	***11,955***	***12,165***	***12,379***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)							
a. General Medical/Surgical*	0.0	0.0	0.0	0.0	0.0	0.0	0.0
b. ICU/CCU	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total MSGA	0.0	0.0	0.0	0.0	0.0	0.0	0.0
c. Pediatric	0.0	0.0	0.0	0.0	0.0	0.0	0.0
d. Obstetric	0.0	0.0	0.0	0.0	0.0	0.0	0.0
e. Acute Psychiatric	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Acute	0.0	0.0	0.0	0.0	0.0	0.0	0.0
f. Rehabilitation	14.1	14.1	13.5	13.5	13.5	13.5	13.5
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0
h. Other (Specify/add rows of needed)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL AVERAGE LENGTH OF STAY	14.1	14.1	13.5	13.5	13.5	13.5	13.5

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY ~~or FY~~	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	32	32	35	42	42	42	42
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL LICENSED BEDS	***32***	***32***	***35***	***42***	***42***	***42***	***42***
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
b. ICU/CCU	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total MSGA	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
c. Pediatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
d. Obstetric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
e. Acute Psychiatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Acute	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
f. Rehabilitation	76.6%	81.7%	72.5%	75.0%	77.8%	79.4%	80.8%
g. Comprehensive Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
h. Other (Specify/add rows of needed)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL OCCUPANCY %	**76.8%**	**81.7%**	**72.5%**	**75.0%**	**78.0%**	**79.4%**	**80.8%**
6. OUTPATIENT VISITS							
a. Emergency Department							
b. Same-day Surgery							
c. Laboratory							
d. Imaging							
e. Other (Specify/add rows of needed)							
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***
7. OBSERVATIONS**							
a. Number of Patients							
b. Hours							

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

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

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

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
1. REVENUE							
a. Inpatient Services	$ 21,285,048	$ 21,168,093	$ 20,737,540	$ 25,516,895	$ 26,532,245	$ 26,998,307	$ 27,473,246
b. Outpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Gross Patient Service Revenues	***$ 21,285,048***	***$ 21,168,093***	***$ 20,737,540***	***$ 25,516,895***	***$ 26,532,245***	***$ 26,998,307***	***$ 27,473,246***
c. Allowance For Bad Debt	$ 276,705	$ 141,668	$ 138,787	$ 170,772	$ 177,568	$ 180,687	$ 183,865
d. Contractual Allowance	$ 7,044,897	$ 6,687,431	$ 6,551,411	$ 8,061,306	$ 8,382,076	$ 8,529,314	$ 8,679,357
e. Charity Care	$ 148,995	$ 71,891	$ 70,429	$ 86,660	$ 90,109	$ 91,692	$ 93,305
Net Patient Services Revenue	***$ 13,814,451***	***$ 14,267,103***	***$ 13,976,914***	***$ 17,198,157***	***$ 17,882,493***	***$ 18,196,614***	***$ 18,516,719***
f. Other Operating Revenues (Specify)	$ 78,800	$ 112,324	$ 112,324	$ 112,324	$ 112,324	$ 112,324	$ 112,324
NET OPERATING REVENUE	***$ 13,893,251***	***$ 14,379,427***	***$ 14,089,238***	***$ 17,310,481***	***$ 17,994,817***	***$ 18,308,938***	***$ 18,629,043***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 7,511,506	$ 8,015,695	$ 7,933,420	$ 10,223,162	$ 10,019,481	$ 10,223,415	$ 10,403,259
b. Contractual Services	$ 261,535	$ 62,023	$ 60,761	$ 74,765	$ 77,740	$ 79,106	$ 80,497
c. Interest on Current Debt	$ 57,765	$ 45,475	$ 45,475	$ 654,160	$ 45,475	$ 45,475	$ 45,475
d. Interest on Project Debt							
e. Current Depreciation	$ 403,838	$ 417,526	$ 417,526	$ 1,214,794	$ 417,526	$ 417,526	$ 417,526
f. Project Depreciation	$ -	$ -	$ -	$ -	$ 415,000	$ 415,000	$ 415,000
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 328,478	$ 313,685	$ 307,305	$ 378,129	$ 393,175	$ 400,082	$ 407,120
j. IT Services	$ 460,605	$ 624,287	$ 624,287	$ 624,287	$ 624,287	$ 624,287	$ 624,287
k. Professional Fees	$ 52,308	$ 59,583	$ 58,371	$ 71,824	$ 74,682	$ 75,994	$ 77,330
l. Building & Maintenance	$ 456,976	$ 435,016	$ 435,016	$ 1,246,580	$ 1,850,000	$ 1,850,000	$ 1,850,000
m. Insurance	$ 27,003	$ 27,360	$ 27,360	$ 27,360	$ 27,360	$ 27,360	$ 27,360
m. G&A	$ 1,434,777	$ 1,750,269	$ 1,750,269	$ 2,436,423	$ 2,120,433	$ 2,120,433	$ 2,120,433
TOTAL OPERATING EXPENSES	***$ 10,994,791***	***$ 11,750,919***	***$ 11,659,790***	***$ 16,951,484***	***$ 16,065,159***	***$ 16,278,677***	***$ 16,468,288***
3. INCOME							
a. Income From Operation	**$ 2,898,460**	**$ 2,628,508**	**$ 2,429,448**	**$ 358,997**	**$ 1,929,658**	**$ 2,030,262**	**$ 2,160,756**
b. Non-Operating Income							
SUBTOTAL	***$ 2,898,460***	***$ 2,628,508***	***$ 2,429,448***	***$ 358,997***	***$ 1,929,658***	***$ 2,030,262***	***$ 2,160,756***
c. Income Taxes							
NET INCOME (LOSS)	***$ 2,898,460***	***$ 2,628,508***	***$ 2,429,448***	***$ 358,997***	***$ 1,929,658***	***$ 2,030,262***	***$ 2,160,756***

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

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	59.2%	60.7%	62.2%	62.2%	62.2%	62.2%	62.2%
2) Medicaid	7.8%	8.3%	6.7%	6.7%	6.7%	6.7%	6.7%
3) Blue Cross	15.8%	13.0%	13.8%	13.8%	13.8%	13.8%	13.8%
4) Commercial Insurance	5.8%	7.6%	7.0%	7.0%	7.0%	7.0%	7.0%
5) HMO	9.1%	8.7%	8.6%	8.6%	8.6%	8.6%	8.6%
6) Self-pay	0.1%	0.0%	0.8%	0.8%	0.8%	0.8%	0.8%
7) Other	2.2%	1.7%	0.9%	0.9%	0.9%	0.9%	0.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	59.9%	60.7%	62.1%	62.1%	62.1%	62.1%	62.1%
2) Medicaid	7.8%	8.3%	6.8%	6.8%	6.8%	6.8%	6.8%
3) Blue Cross	15.4%	13.0%	13.9%	13.9%	13.9%	13.9%	13.9%
4) Commercial Insurance	5.7%	7.7%	6.9%	6.9%	6.9%	6.9%	6.9%
5) HMO	9.0%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
6) Self-pay	0.1%	0.0%	0.8%	0.8%	0.8%	0.8%	0.8%
7) Other	2.2%	1.7%	1.0%	1.0%	1.0%	1.0%	1.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Assumptions & Drivers

AHR Relocate to White Oak - NO Inflation (Table J)

	Historical		Projection				
	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
IP Hospital Revenue	21,285,048	21,168,093	20,737,540	25,516,895	26,532,245	26,998,307	27,473,246
OP Hospital Revenue	-	-	-	-	-	-	-
EIPA Factor ("Equivalent IP Admission")	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
Regulated Deductions:							
Contractual Allowances	33.10%	31.59%	31.59%	31.59%	31.59%	31.59%	31.59%
Charity	0.70%	0.34%	0.34%	0.34%	0.34%	0.34%	0.34%
Bad Debt	1.30%	0.67%	0.67%	0.67%	0.67%	0.67%	0.67%
Pro Fee Deductions:							
Contractual Allowances	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Charity	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Bad Debt	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
IP Revenue per Admission	$ 33,520	$ 31,221	$ 31,221	$ 31,221	$ 31,221	$ 31,221	$ 31,221
OP Revenue per EIPD ("Equivalent IP Day")	-	-	-	-	-	-	-
Physician Revenue per EIPD	-	-	-	-	-	-	-
		2,219	2,219	2,219	2,219	2,219	2,219
Other Operating Revenue Growth			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Revenue Inflation Update			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Rehab Growth	*-10.06%*	*6.77%*	*1.70%*	*23.00%*	*4.36%*	*1.69%*	*1.78%*
Rehab Discharges	635	678	690	849	886	901	917
Rehab Days	8,968	9,538	9,344	11,498	11,955	12,165	12,379
Rehab ADC	24.50	26.13	25.60	31.50	32.66	33.33	33.92

Assumptions & Drivers

AHR Relocate to White Oak - NO Inflation (Table J)

	Historical		Projection				
	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Rehab ALOS	14.12	14.07	13.54	13.54	13.49	13.50	13.50
Length of Stay	*4.3%*	*-0.4%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
EIPA	635	678	690	849	886	901	917
EIPD	8,968	9,538	9,344	11,498	11,955	12,165	12,379
Adjusted Occupied Bed	24.6	26.1	25.6	31.5	32.7	33.3	33.9
Acute Licensed Beds	32	32	35	42	42	42	42
Acute Occupancy Rate	76.8%	81.7%	72.5%	75.0%	77.8%	79.4%	80.8%
Non-pro fee FTEs	81.41	91.58	90.64	110.39	114.47	116.80	118.86
Takoma Park Facilities FTEs				7.00			
FTEs per AOB	3.31	3.50	3.50	3.50	3.50	3.50	3.50
Salary per FTE	76,915	72,864	72,864	72,864	72,864	72,864	72,864
Salary/Benefit per Takoma Park Facility FTE				80,102			
Salary Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Benefit %	20.0%	20.1%	20.1%	20.1%	20.1%	20.1%	20.1%
Supply per EIPD	$ 37	$ 33	$ 33	$ 33	$ 33	$ 33	$ 33
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Contract Labor per EIPD	$ 29	$ 7	$ 7	$ 7	$ 7	$ 7	$ 7
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
General & Administrative	$ 397,360	$ 282,299	$ 282,299	$ 364,689	$ 282,299	$ 282,299	$ 282,299
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Professional Fees per EIPD	$ 5.83	$ 6.25	$ 6	$ 6	$ 6	$ 6	$ 6
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Building and Maintenance	$ 456,976	$ 435,016	$ 435,016	$ 1,246,580	$ 1,850,000	$ 1,850,000	$ 1,850,000
Inflation			*0.00%*	*186.56%*	*48.41%*	*0.00%*	*0.00%*
Insurance	$ 27,003	$ 27,360	$ 27,360	$ 27,360	$ 27,360	$ 27,360	$ 27,360
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Depreciation and Amortization	$ 257,200	$ 268,452	$ 268,452	$ 1,065,720	$ 268,452	$ 268,452	$ 268,452
Inflation			*0.00%*	*197.16%*	*0.00%*	*0.00%*	*0.00%*

Assumptions & Drivers

AHR Relocate to White Oak - NO Inflation (Table J)

	Historical		Projection				
	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
IT Depreciation	$ 146,638	$ 149,074	$ 149,074	$ 207,074	$ 149,074	$ 149,074	$ 149,074
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
IT Services	$ 460,605	$ 624,287	$ 624,287	$ 624,287	$ 624,287	$ 624,287	$ 624,287
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Interest Expense	$ 57,765	$ 45,475	$ 45,475	$ 654,160	$ 45,475	$ 45,475	$ 45,475
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Other - Overhead Allocation	$ 396,370	$ 844,668	$ 844,668	$ 844,668	$ 844,668	$ 844,668	$ 844,668
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Purchased Services	$ 641,047	$ 623,302	$ 623,302	$ 1,227,066	$ 993,466	$ 993,466	$ 993,466
Inflation			*0.00%*	*0.00%*	*-100.00%*	*0.00%*	*0.00%*

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

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
1. REVENUE							
a. Inpatient Services	$ 21,285,048	$ 21,168,093	$ 21,401,142	$ 26,570,437	$ 27,669,150	$ 28,295,958	$ 28,937,694
b. Outpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Gross Patient Service Revenues	***$ 21,285,048***	***$ 21,168,093***	***$ 21,401,142***	***$ 26,570,437***	***$ 27,669,150***	***$ 28,295,958***	***$ 28,937,694***
c. Allowance For Bad Debt	$ 276,705	$ 141,668	$ 143,228	$ 177,823	$ 185,176	$ 189,371	$ 193,666
d. Contractual Allowance	$ 7,044,897	$ 6,687,431	$ 6,761,056	$ 8,394,141	$ 8,741,247	$ 8,939,269	$ 9,142,006
e. Charity Care	$ 148,995	$ 71,891	$ 72,682	$ 90,238	$ 93,970	$ 96,099	$ 98,278
Net Patient Services Revenue	***$ 13,814,451***	***$ 14,267,103***	***$ 14,424,176***	***$ 17,908,234***	***$ 18,648,756***	***$ 19,071,220***	***$ 19,503,744***
f. Other Operating Revenues (Specify/add rows of needed)	$ 78,800	$ 112,324	$ 114,009	$ 115,719	$ 117,455	$ 117,455	$ 119,217
NET OPERATING REVENUE	***$ 13,893,251***	***$ 14,379,427***	***$ 14,538,185***	***$ 18,023,953***	***$ 18,766,211***	***$ 19,188,675***	***$ 19,622,960***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 7,511,506	$ 8,015,695	$ 8,084,155	$ 10,593,823	$ 10,601,511	$ 11,022,820	$ 11,429,845
b. Contractual Services	$ 261,535	$ 62,023	$ 62,281	$ 78,550	$ 83,718	$ 87,318	$ 91,075
c. Interest on Current Debt	$ 57,765	$ 45,475	$ 45,475	$ 654,160	$ 45,475	$ 45,475	$ 45,475
d. Interest on Project Debt							
e. Current Depreciation	$ 403,838	$ 417,526	$ 417,526	$ 1,214,794	$ 417,526	$ 417,526	$ 417,526
f. Project Depreciation	$ -	$ -	$ -	$ -	$ 415,000	$ 415,000	$ 415,000
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 328,478	$ 313,685	$ 314,987	$ 397,272	$ 423,407	$ 441,615	$ 460,618
j. IT Services	$ 460,605	$ 624,287	$ 639,894	$ 649,493	$ 659,235	$ 669,124	$ 679,160
k. Professional Fees	$ 52,308	$ 59,583	$ 59,830	$ 75,460	$ 80,424	$ 83,883	$ 87,492
l. Building & Maintenance	$ 456,976	$ 435,016	$ 445,891	$ 1,246,580	$ 1,850,000	$ 1,896,250	$ 1,943,656
m. Insurance	$ 27,003	$ 27,360	$ 28,044	$ 28,745	$ 29,464	$ 30,200	$ 30,955
m. G&A	$ 1,434,777	$ 1,750,269	$ 1,794,026	$ 2,516,372	$ 2,182,009	$ 2,227,640	$ 2,274,278
TOTAL OPERATING EXPENSES	**$ 10,994,791**	**$ 11,750,919**	**$ 11,892,109**	**$ 17,455,249**	**$ 16,787,769**	**$ 17,336,851**	**$ 17,875,082**
3. INCOME							
a. Income From Operation	**$ 2,898,460**	**$ 2,628,508**	**$ 2,646,075**	**$ 568,704**	**$ 1,978,443**	**$ 1,851,824**	**$ 1,747,878**
b. Non-Operating Income							
SUBTOTAL	***$ 2,898,460***	***$ 2,628,508***	***$ 2,646,075***	***$ 568,704***	***$ 1,978,443***	***$ 1,851,824***	***$ 1,747,878***
c. Income Taxes							

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

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	CY 2016	CY 2017	CY 2018 Proj	CY 2019 Proj	CY 2020 Proj	CY 2021 Proj	CY 2022 Proj
NET INCOME (LOSS)	*$ 2,898,460*	*$ 2,628,508*	*$ 2,646,075*	*$ 568,704*	*$ 1,978,443*	*$ 1,851,824*	*$ 1,747,878*

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

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	59.2%	60.7%	62.2%	62.2%	62.2%	62.2%	62.2%
2) Medicaid	7.8%	8.3%	6.7%	6.7%	6.7%	6.7%	6.7%
3) Blue Cross	15.8%	13.0%	13.8%	13.8%	13.8%	13.8%	13.8%
4) Commercial Insurance	5.8%	7.6%	7.0%	7.0%	7.0%	7.0%	7.0%
5) HMO	9.1%	8.7%	8.6%	8.6%	8.6%	8.6%	8.6%
6) Self-pay	0.1%	0.0%	0.8%	0.8%	0.8%	0.8%	0.8%
7) Other	2.2%	1.7%	0.9%	0.9%	0.9%	0.9%	0.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	59.9%	60.7%	62.1%	62.1%	62.1%	62.1%	62.1%
2) Medicaid	7.8%	8.3%	6.8%	6.8%	6.8%	6.8%	6.8%
3) Blue Cross	15.4%	13.0%	13.9%	13.9%	13.9%	13.9%	13.9%
4) Commercial Insurance	5.7%	7.7%	6.9%	6.9%	6.9%	6.9%	6.9%
5) HMO	9.0%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
6) Self-pay	0.1%	0.0%	0.8%	0.8%	0.8%	0.8%	0.8%
7) Other	2.2%	1.7%	1.0%	1.0%	1.0%	1.0%	1.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Assumptions & Drivers

AHR Relocate to White Oak - with Inflation (Table K)

	Historical		Projection				
	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
IP Hospital Revenue	21,285,048	21,168,093	21,401,142	26,570,437	27,669,150	28,295,958	28,937,694
OP Hospital Revenue	-	-	-	-	-	-	-
EIPA Factor ("Equivalent IP Admission")	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
Regulated Deductions:							
Contractual Allowances	33.10%	31.59%	31.59%	31.59%	31.59%	31.59%	31.59%
Charity	0.70%	0.34%	0.34%	0.34%	0.34%	0.34%	0.34%
Bad Debt	1.30%	0.67%	0.67%	0.67%	0.67%	0.67%	0.67%
Pro Fee Deductions:							
Contractual Allowances	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Charity	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Bad Debt	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
IP Revenue per Admission	$ 33,520	$ 31,221	$ 32,220	$ 33,252	$ 34,316	$ 34,316	$ 35,414
OP Revenue per EIPD ("Equivalent IP Day")	-	-	-	-	-	-	-
Physician Revenue per EIPD	-	-	-	-	-	-	-
		2,219	2,290	2,311	2,314	2,326	2,338
Other Operating Revenue Growth			*1.50%*	*1.50%*	*1.50%*	*1.50%*	*1.50%*
Revenue Inflation Update			*3.20%*	*0.90%*	*0.15%*	*0.50%*	*0.50%*
Rehab Growth	*-10.06%*	*6.77%*	*1.70%*	*23.00%*	*4.36%*	*1.69%*	*1.78%*
Rehab Discharges	635	678	690	849	886	901	917
Rehab Days	8,968	9,538	9,344	11,498	11,955	12,165	12,379

Assumptions & Drivers

AHR Relocate to White Oak - with Inflation (Table K)

	Historical		Projection				
	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Rehab ADC	24.50	26.13	25.60	31.50	32.66	33.33	33.92
Rehab ALOS	14.12	14.07	13.54	13.54	13.49	13.50	13.50
Length of Stay	*4.3%*	*-0.4%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
EIPA	635	678	690	849	886	901	917
EIPD	8,968	9,538	9,344	11,498	11,955	12,165	12,379
Adjusted Occupied Bed	24.6	26.1	25.6	31.5	32.7	33.3	33.9
Acute Licensed Beds	32	32	35	42	42	42	42
Acute Occupancy Rate	76.8%	81.7%	72.5%	75.0%	77.8%	79.4%	80.8%
Non-pro fee FTEs	81.41	91.58	90.64	110.39	114.47	116.80	118.86
Takoma Park Facilities FTEs				7.00			
FTEs per AOB	3.31	3.50	3.50	3.50	3.50	3.50	3.50
Salary per FTE	76,915	72,864	74,248	75,659	77,096	78,561	80,054
Salary/Benefit per Takoma Park Facility FTE				80,102			
Salary Inflation			*1.90%*	*1.90%*	*1.90%*	*1.90%*	*1.90%*
Benefit %	20.0%	20.1%	20.1%	20.1%	20.1%	20.1%	20.1%
Supply per EIPD	$ 37	$ 33	$ 34	$ 35	$ 35	$ 36	$ 37
Inflation			*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
Contract Labor per EIPD	$ 29	$ 7	$ 7	$ 7	$ 7	$ 7	$ 7
Inflation			*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
General & Administrative	$ 397,360	$ 282,299	$ 289,356	$ 378,980	$ 296,590	$ 304,005	$ 311,605
Inflation			*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
Professional Fees per EIPD	$ 5.83	$ 6.25	$ 6	$ 7	$ 7	$ 7	$ 7
Inflation			*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
Building and Maintenance	$ 456,976	$ 435,016	$ 445,891	$ 1,246,580	$ 1,850,000	$ 1,896,250	$ 1,943,656
Inflation			*2.50%*	*179.57%*	*48.41%*	*2.50%*	*2.50%*
Insurance	$ 27,003	$ 27,360	$ 28,044	$ 28,745	$ 29,464	$ 30,200	$ 30,955
Inflation			*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*

Assumptions & Drivers

AHR Relocate to White Oak - with Inflation (Table K)

	Historical		Projection				
	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Depreciation and Amortization	$ 257,200	$ 268,452	$ 268,452	$ 1,065,720	$ 268,452	$ 268,452	$ 268,452
Inflation			*0.00%*	*197.16%*	*0.00%*	*0.00%*	*0.00%*
IT Depreciation	$ 146,638	$ 149,074	$ 149,074	$ 207,074	$ 149,074	$ 149,074	$ 149,074
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
IT Services	$ 460,605	$ 624,287	$ 639,894	$ 649,493	$ 659,235	$ 669,124	$ 679,160
Inflation			*2.50%*	*1.50%*	*1.50%*	*1.50%*	*1.50%*
Interest Expense	$ 57,765	$ 45,475	$ 45,475	$ 654,160	$ 45,475	$ 45,475	$ 45,475
Inflation			*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Other - Overhead Allocation	$ 396,370	$ 844,668	$ 865,785	$ 878,771	$ 891,953	$ 905,332	$ 918,912
Inflation			*2.50%*	*1.50%*	*1.50%*	*1.50%*	*1.50%*
Purchased Services	$ 641,047	$ 623,302	$ 638,885	$ 1,258,620	$ 993,466	$ 1,018,303	$ 1,043,760
Inflation			*2.50%*	*2.50%*	*-100.00%*	*2.50%*	*2.50%*

TABLE L. WORKFORCE INFORMATION - AHR Remain in Takoma Park - Uninflated Projection

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

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Facility Mgmt	4.0	$100,906	$403,623			$0	1.3	$100,906	$131,177	5.3	$534,800
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration	4.0	$100,906	$403,623			$0	1.3	$100,906	$131,177	5.3	$534,800
Direct Care Staff *(List general categories, add rows if needed)*											
Nursing	27.8	$97,237	$2,698,326			$0	9.0	$97,237	$875,133	36.8	$3,573,459
Therapy	27.7	$87,292	$2,421,489			$0	8.6	$87,292	$746,349	36.3	$3,167,838
Patient Care Tech	24.2	$46,775	$1,131,014			$0	7.1	$46,775	$332,101	31.3	$1,463,115
						$0	0.0	$0	$0	0.0	$0
						$0	0.0	$0	$0	0.0	$0
						$0	0.0	$0	$0	0.0	$0
Total Direct Care	79.7	$231,304	$6,250,829	0.0	0.0	0.0	24.7	$231,304	$1,953,582	104.3	$8,204,411
Support Staff *(List general categories, add rows if needed)*											
Case Mgmt	3.8	$95,218	$360,878			$0	1.2	$95,218	$117,216	5.0	$478,094
Unit Secretary	3.2	$44,072	$138,828			$0	1.02	$44,072	$45,086	4.2	$183,914
Overhead and Corporate Allocation	0.0	$0	$779,262			$0			$222,777	0.0	$1,002,039
TP Facilities	0.0	$0	$0	14.0	$80,102	$1,121,423			$0	12.0	$0
						$0			$0	0.0	$0
						$0			$0	0.0	$0
						$0			$0	0.0	$0

TABLE L. WORKFORCE INFORMATION - AHR Remain in Takoma Park - Uninflated Projection

						$0			$0	0.0	$0
						$0			$0	0.0	$0
						$0			$0	0.0	$0
Total Support	6.9	$139,291	$1,278,968	14.0	80,101.7	1,121,423	2.3	$139,291	$385,079	21.2	$1,664,047
REGULAR EMPLOYEES TOTAL	90.6	***$87,556***	$7,933,420	14.0		$1,121,423	28.2		$2,469,839	132.8	$11,524,682
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
Nursing	1.3	$46,739	$60,761			$0	0.4	$49,340	$19,736	1.7	$80,497
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff	1.3	46,739.2	60,761.0			$0	0.4	49,340.0	19,736.0	1.7	$80,497
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOT	***1.3***	***46,739.2***	$60,761			$0	***0.4***	***49,340.0***	***19,736.0***	1.7	$80,497
Benefits *(State method of calculating benefits below)**:***											
TOTAL COST	***91.9***		***$7,994,181***	***14.0***		***$1,121,423***	***28.6***		***$2,489,575***		***$11,605,179***

TABLE L. WORKFORCE INFORMATION - AHR Relocate to White Oak - Uninflated Projection

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

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Facility Mgmt	4.0	$100,906	$403,623			$0	1.3	$100,906	$131,177	5.3	$534,800
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration	4.0	$100,906	$403,623			$0	1.3	$100,906	$131,177	5.3	$534,800
Direct Care Staff *(List general categories, add rows if needed)*											
Nursing	27.8	$97,237	$2,698,326			$0	9.0	$97,237	$875,133	36.8	$3,573,459
Therapy	27.7	$87,292	$2,421,489			$0	8.6	$87,292	$746,349	36.3	$3,167,838
Patient Care Tech	24.2	$46,775	$1,131,014			$0	7.1	$46,775	$332,101	31.3	$1,463,115
						$0	0.0	$0	$0	0.0	$0
						$0	0.0	$0	$0	0.0	$0
						$0	0.0	$0	$0	0.0	$0
Total Direct Care	79.7	$231,304	$6,250,829	0.0	0.0	0.0	24.7	$231,304	$1,953,583	104.3	$8,204,411
Support Staff *(List general categories, add rows if needed)*											
Case Mgmt	3.8	$95,218	$360,878			$0	1.2	$95,218	$117,216	5.0	$478,094
Unit Secretary	3.2	$44,072	$138,828			$0	1.02	$44,072	$45,086	4.2	$183,914
Overhead and Corporate Allocation	0.0	$0	$779,262			$0			$222,777	0.0	$1,002,039

TABLE L. WORKFORCE INFORMATION - AHR Relocate to White Oak - Uninflated Projection

						$0			$0	0.0	$0
						$0			$0	0.0	$0
						$0			$0	0.0	$0
						$0			$0	0.0	$0
						$0			$0	0.0	$0
						$0			$0	0.0	$0
Total Support	6.9	$139,291	$1,278,968	0.0	0.0	0.0	2.3	$139,291	$385,079	9.2	$1,664,047
REGULAR EMPLOYEES TOTAL	90.6	***$87,556***	$7,933,420	0.0		$0	28.2		$2,469,839	118.8	$10,403,259
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
Nursing	1.3	$46,739	$60,761			$0	0.4	$49,340	$19,736	1.7	$80,497
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff	1.3	46,739.2	60,761.0			$0	0.4	49,340.0	19,736.0	1.7	$80,497
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TC	***1.3***	***46,739.2***	$60,761			$0	***0.4***	***49,340.0***	***19,736.0***	1.7	$80,497
Benefits *(State method of calculating benefits below)* **:**											
TOTAL COST	***91.9***		***$7,994,181***	***0.0***		***$0***	***28.6***		***$2,489,575***		***$10,483,756***

EXHIBIT 24

Adventist HealthCare Rehabilitation
Pro Forma Development - Rehab Consolidation at RV

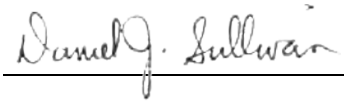
	TP Beds at RV Campus	TP Beds at White Oak	Assumptions
Inpatient Revenue	$ 26,532,245	$ 26,532,245	Same revenue assumptions
Total Patient Revenue	**$ 26,532,245**	**$ 26,532,245**	
Contractual Allowance	$ 8,382,076	$ 8,382,076	Same contractual assumptions
Bad Debt, Charity & Other	$ 267,677	$ 267,677	Same other deductions assumptions
Deductions From Revenue	**$ 8,649,752**	**$ 8,649,752**	
Net Patient Revenue	**$ 17,882,493**	**$ 17,882,493**	
Other Operating Revenue	$ 112,324	$ 112,324	
Total Operating Revenue	**$ 17,994,817**	**$ 17,994,817**	
Salaries & Wages (including Benefits)	$ 10,710,822	$ 10,019,481	Removed additional managers for nursing and therapy; added additional assistant nurse manager due to proposed layout with beds on various floors/wings and unit support coordinator; added EVS and nutrition services staff, which previously were charged through purchased services.
Contract Labor	$ 77,740	$ 77,740	Same assumptions
Professional Fees	$ 74,682	$ 74,682	Same assumptions
Medical Supplies	$ 393,175	$ 393,175	Same assumptions
General & Administrative	$ 1,983,249	$ 2,120,433	Includes Purchased Services, G&A, and overhead and corporate allocation. Reduced expense at RV due to hiring staff, which were previously contracted through White Oak such as EVS, dietary services, facilities, security
Building & Maintenance	$ 251,352	$ 1,850,000	Removed White Oak lease expense and replaced with additional utility expense for added floor space at RV
Insurance	$ 27,360	$ 27,360	Same assumptions
Interest	$ 613,325	$ 45,475	Interest expense related to $20.5m borrowing
Depreciation & Amortization	$ 417,526	$ 417,526	Same assumptions
Project Depreciation	$ 1,620,000	$ 415,000	Depreciation on $40.5m project
Allocation: IT Services	$ 624,287	$ 624,287	Same assumptions
Total Operating Expenses	**$ 16,793,518**	**$ 16,065,159**	
Operating Margin	**$ 1,201,299**	**$ 1,929,658**	
Operating Margin	6.7%	10.7%	

***Assumptions:**
1. $40.5m project cost
2. Borrowing of $20.5m
3. 32.6 ADC
4. No assumption for revenue impact due to being colocated in RV

EXHIBIT 25

AFFIRMATION

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



11/7/18

Daniel Sullivan, President Date

AFFIRMATION

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

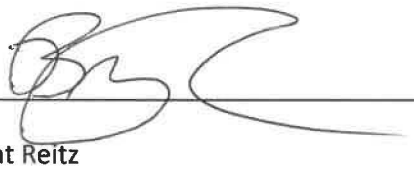
Elizabeth Kotroba 11/2/18

Elizabeth Kotroba
Associate Vice President of Operations
Adventist Rehabilitation Hospital of Maryland

Date

AFFIRMATION

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



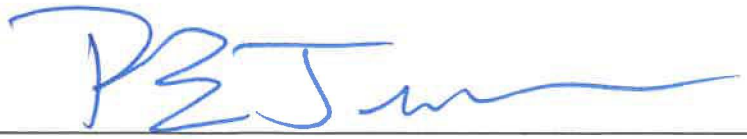
11/2/18

Brent Reitz
President, Adventist Rehabilitation Hospital of Maryland

Date

AFFIRMATION

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



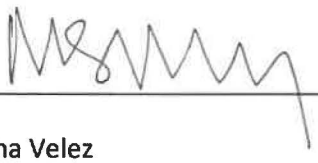
11/2/18

Robert E. Jepson
Vice President
Business Development

Date

AFFIRMATION

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



11/2/18

Martha Velez
Associate Vice President of Finance
Adventist Rehabilitation Hospital of Maryland

Date

AFFIRMATION

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

11/2/18

Linda Beth Berman
Manager, Grants Management Department
Adventist HealthCare, Inc.

Date

AFFIRMATION

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

John F. Hill — November 2, 2018

John F. Hill, Consultant — Date
Sullivan Consulting Group, Inc.