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June 28, 2018

Via Email and Overnight Delivery
Kevin McDonald, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: **Adventist HealthCare Shady Grove Medical Center**
Adventist HealthCare Washington Adventist Hospital
Request for Determination of Exemption from Certificate of Need Review

Dear Mr. Steffen:

On behalf of Adventist HealthCare, Inc. ("AHC"), and pursuant to COMAR 10.24.01.04 governing an "Exemption From Certificate of Need Review," we request a determination of exemption from certificate of need ("CON") review (the "Request") for the merger, consolidation and relocation of 29 acute, general hospital beds used for psychiatric service (the "Beds") between two AHC hospitals, to a single location under an acute general hospital license within the AHC merged asset system. The Beds represent 29 of the 39 acute psychiatric beds that are presently licensed under Adventist HealthCare Washington Adventist Hospital ("WAH") in Takoma Park. The Beds would be moved to Adventist HealthCare Shady Grove Medical Center ("SGMC") in Rockville and added to 117 acute general psychiatric hospital beds. This would result in a total of 146 acute general psychiatric beds at SGMC. This represents a consolidation of services, but not a change in legal entities. For ease of reference, the proposed merger, consolidation and relocation addressed in this Request will be referred to as the "Consolidation."

The remaining 10 of WAH's 39 acute general psychiatric hospital beds will stay a part of WAH and be relocated to the new White Oak campus, pursuant to a separate "Project Change After Certification" request filed at the same time as this Consolidation Request. This will preserve geographic access to acute general hospital beds with a psychiatric focus for the projected service area of WAH when it moves to its White Oak campus, approximately six miles from its current location. WAH will continue to operate its current 39 adult psychiatric beds in Takoma Park until the hospital moves to its White Oak campus in the summer of 2019.

Sustaining a Vital Health Care Service

This filing is part of an overall effort by AHC to ensure the continued viability of its behavioral health services, a vital part of the region's health care infrastructure. AHC is the largest provider of behavioral health services in Montgomery County and one of the larger providers of these services in Maryland. Adventist Behavioral Health ("ABH") in Rockville was a free standing psychiatric facility operated by AHC where many of the organization's key behavioral health services were provided.

Despite reimbursement challenges with operating a freestanding behavioral health facility, AHC made the intentional decision to preserve behavioral health services for the community and initiated several steps to accomplish this goal.

The initial step was the consolidation of ABH into SGMC, which put the Rockville behavioral health services under a stable, predictable revenue model as part of SGMC's Global Budget Revenue ("GBR"). The request was approved at the May 17, 2018, Commission meeting. The integration between these two entities will be operationally complete this summer.

AHC's other inpatient behavioral health services are currently operated as the psychiatric service at WAH in Takoma Park as part of an AHC hospital's license and its GBR negotiated with the Health Services Cost Review Commission ("HSCRC"). WAH will move to the White Oak campus in the summer of 2019. Phase 3 of the WAH CON project, approved in 2015, included a plan for the WAH acute general hospital inpatient psychiatric beds to remain in Takoma Park as a separately licensed specialty hospital. However, the federal regulations prohibiting reimbursement from the Centers for Medicare and Medicaid Services ("CMS") governing the Federal Medical Assistance Percentage ("FMAP") to an Institution for Mental Diseases ("IMD") with more than 16 beds remains in effect. In addition, a former CMS waiver enabling Maryland's Medicaid program to receive FMAP for IMD services in larger specialty hospitals is no longer in effect. These factors, combined with the challenges of operating ABH as an IMD, caused AHC to reevaluate its plan for operating behavioral health services in Takoma Park. Now, AHC plans to continue operating the 39 Takoma Park adult psychiatric beds in acute care hospitals, with 10 of these beds moving to WAH's new White Oak campus and 29 beds moving to SGMC in Rockville. These behavioral health initiatives accomplish three important goals:

- First, ensure the long-term sustainability of AHC's behavioral health services, which care for more than 6,500 patients annually, by providing a stable,

predictable revenue stream through an acute care hospital's GBR, while avoiding a $2 million annual negative impact on the Maryland Medicaid budget.

- Second, these initiatives ensure continued access to acute behavioral health services for residents of the WAH service area with the transition of psychiatric beds to the White Oak campus.
- Third, the relocation of 29 Beds from WAH to SGMC enhances the clinical specialization of the AHC regional behavioral health services in Rockville, which benefits patients who have access to more specialized care.

Financial Overview

The accompanying documents (Exhibit 1: Tables I, J and K) reflect the financial impact of relocating 29 of the 39 currently licensed adult psychiatric beds from WAH into the psychiatric service at SGMC. This relocation will result in transitioning a portion of the current WAH Global Budget of $6.2 million in charges, or approximately $5.3 million in net revenue (in today's dollars) annually, to SGMC[1]. This transition is expected to move 768 admissions and 4,638 patient days (12.7 ADC) from WAH to SGMC. The salaries, benefits and all other related expenses total approximately $4.4 million, which includes new depreciation expenses of $341,820 related to renovation of space to accommodate the additional patients. The total capital cost of renovations and furnishings for converting this space, previously used for residential treatment services, into an inpatient unit will be approximately $3.4 million.

As noted in the attached Table J, the net financial impact of these changes to SGMC is expected to be approximately $888,000 in calendar year 2020. The 29 beds from WAH will transition midway through 2019, and 2020 is the first full year the beds will be operational at SGMC.

Merged Asset System

There is a strong regulatory basis to support a CON exemption for the Consolidation of 29 of the WAH beds to SGMC. AHC is, as noted, a merged asset system. SGMC and WAH are separate hospitals organized as unincorporated divisions of one legal entity. Thus, the

[1] The psychiatric services within WAH received a Global Budget amount of $11.3 million in CY 2017. Of this amount $1.2 million is related to outpatient services and $10.1 million is related to inpatient services. As the outpatient services are expected to relocate when WAH moves to White Oak, 100% of this amount is expected to be included in the WAH global budget. The recommended relocation of the psychiatric beds to White Oak and Rockville will result in the inpatient global revenue of $10.1 million to be split between WAH and SGMC based on the expected patient utilization. This breakdown is expected to be $3.9 million to WAH and $6.2 million to SGMC in 2017 dollars.

Consolidation will not result in any acquisition of a health care facility under COMAR 10.24.01.03A.

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

> (1) Merger or consolidation of two or more hospitals or other health care facilities, if the facilities or an organization that operates the facilities give the Commission 45 days written notice of their intent to merge or consolidate;
>
> (2) Relocation of an existing health care facility owned or controlled by a merged asset system, if:
>
> > (a) The relocation is to a site outside the primary service area of the health care facility to be relocated, but within the primary service area of the merged asset system; and
> >
> > (b) The relocation of the existing health care facility does not:
> >
> > (i) Change the type or scope of health care services offered; and
> >
> > (ii) Does not require a capital expenditure for its construction that exceeds the capital review threshold, adjusted for inflation, except as provided by Regulation .03I of this chapter;

The individual AHC health care facilities, and AHC itself as a "merged asset system," are eligible to seek a CON exemption under these regulations. Under the Commission's State Health Plan ("SHP") for Acute Care Hospital Services under COMAR 10.24.10.06B(8) a "consolidation" is defined as:

> a merger such that one or more acute inpatient services are eliminated or centralized at one or more of the hospitals of the merged organization.

This Consolidation of AHC's inpatient behavioral health services fits squarely under this SHP definition.

Elements of the Consolidation

SGMC, located in Rockville, Maryland, is an acute general hospital, with an adjacent ABH facility on the same campus. AHC recently obtained Commission approval to consolidate all of ABH's psychiatric services, including 117 acute psychiatric beds, under SGMC's general acute hospital license. Of these 117 beds, 30 are allocated to children and adolescents and 87 are allocated to adults. It also provides outpatient behavioral health services.

The 29 Beds from WAH will be consolidated to SGMC when WAH relocates to White Oak in 2019. Following the Consolidation, (a) the Beds will be consolidated within and located at SGMC, and (b) all of the Beds will be located within the buildings in which SGMC provides inpatient psychiatric services, and (c) all of the buildings in which inpatient psychiatric services are provided will be part of SGMC. Attached as Exhibit 2 is a chart detailing where the Beds will be located within existing space. The relocated bed capacity (29 beds) will be added primarily in space previously used for Residential Treatment Center ("RTC") services (Cypress – 22 beds), with the remaining beds added to three units currently operating below the available number of beds (Seneca – 4 beds; Montgomery – 2 beds; and Magnolia – 1 bed).

Existing space can accommodate the Beds, as the SGMC buildings used for acute psychiatric services have an overall capacity for 164 inpatient beds, but will only house 146 beds after the Consolidation. See Drawings at Exhibit 3. The total capital cost of any renovations to consolidate the Beds at this location is estimated to be approximately $3.4 million, well below the capital threshold for CON approval. The source of these funds will be cash from the SGMC annual operating budget.

The staff associated with the psychiatric services anticipated to be relocated from Takoma Park to SGMC includes staffing for the inpatient census of 12.7 and dedicated security coverage for the entire facility housing the psychiatric services around the clock. The breakout for this staffing is highlighted in the following table.

Job	FTEs
RN II	9.8
Psych Tech	9.8
USC/Receptionist	4.7
LCSW	1.6
Activities Therapist	1.0
Case Manager	1.6
Nurse Manager	1.0
Security	4.7
	34.2

WAH is an acute general hospital located in Takoma Park, in Montgomery County, Maryland, which is also within the AHC Primary Service Area. WAH received CON approval (Docket No. 13-15-2349) to relocate all of its services to White Oak, except for the beds used for adult psychiatric services. The Commission's decision to approve the relocation of WAH to White Oak, in Docket No. 13-15-2349, envisioned there would be an ongoing evaluation of the establishment of a freestanding, special hospital-psychiatric in Takoma Park. On pages 68 and 70, the decision states:

> "Clearly, there is a risk that Medicaid reimbursement policy could change if federal policy with respect to the IMD exclusion does not change and, if there are significant reductions in Medicaid reimbursement for freestanding psychiatric hospitals of the size of the Takoma Park special psychiatric hospital, a rethinking of how to provide acute psychiatric hospital care on a viable basis will be required."
>
> * * *
>
> "I recognize that one of the risks presented by this project is the permanent loss of Maryland's IMD Exclusion waiver. This makes the long-term viability of the psychiatric facility at Takoma Park more tenuous and the benefit of lower upfront capital cost that drove this part of AHC's plan more questionable. As I have considered my recommendation on this application, DHMH is again pursuing an IMD Exclusion Waiver and, for now at least, the Maryland Medicaid program is continuing to provide funding at previous levels. I think it likely that, by the time the replacement hospital will go into operation at White Oak, a rational solution to this funding issue will be in place. Under a worst case scenario, AHC would have to reassess its ability to continue to viably serve all acute psychiatric patients in need of service and this reassessment would

> undoubtedly focus on bringing psychiatric beds back within the general hospital setting. If that turns out to be the ultimate solution to this potential future problem, I believe that AHC would have an excellent chance of being able to accomplish that change in direction. For these reasons, I believe it is reasonable to allow the plan for the psychiatric facility to proceed."

Rather than this being a "worst case" scenario, the Merger/Consolidation represents a "best case" scenario for behavioral health services provided by AHC.

Thus, consolidating the Beds into SGMC on the Rockville campus will ensure coordinated, efficient and effective services and new construction will not be needed to accomplish this. The Commission's approval of the consolidation of the ABH and SGMC behavioral health services already on the AHC Rockville campus will save the Medicaid budget $4.5 million annually, according to the Maryland Department of Health. Moreover, under the HSCRC total cost of care demonstration approved by CMS, there is an additional financial benefit of $2 million annually for the Maryland Department of Health for WAH's psychiatric services to remain covered under a GBR agreement. As noted earlier, the Maryland Department of Health's Medical Assistance Program has written a letter supporting this consolidation of behavioral health beds, including the combination of acute psychiatric services into SGMC, instead of the establishment of a new acute specialty hospital in Takoma Park. (Exhibit 4).

Merger and Consolidation Parameters

The general CON regulations do not define the terms "merger" or "consolidation." However, in COMAR 10.24.10, the State Health Plan for Facilities and Services: Acute Hospital Services (the "Acute Hospital Chapter"), definitions of these terms may be found.

It is instructive to review the Acute Hospital Chapter's definitions of "merger" and "consolidation." They are the only regulatory definitions the Commission has published that might be relied upon in interpreting the general CON regulations addressing exemptions from CON review for hospitals and other health care facilities.

> (8) "Consolidation" means a merger such that one or more acute inpatient services are eliminated or centralized at one or more of the hospitals of the merged organization.

* * *

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

The definition of "merger" identifies a number of alternative scenarios that would qualify as a "merger." In pertinent part, the definition of "merger" includes "… the reapportionment and reconfiguration of beds or services among the health care facilities of a merged or consolidation organization that operates more than one health care facility . . ." The proposed aggregation of the Beds at SGMC will be a "merger" as part of a reapportionment and reconfiguration of AHC psychiatric beds and services.

The Beds may simply be considered to be "relocated" by AHC as a merged asset system pursuant to § .04A(2). The relocation of the Beds to the SGMC campus constitutes a relocation "within the primary service area of the merged asset system," since the great majority of the health care facilities owned and operated by AHC, and the patients served by those facilities, are located in Montgomery County, which is the primary service area of AHC as a merged asset system.

In addition, the relocation and re-licensure of the WAH Beds, just like the re-licensure of the ABH beds, would neither change the type nor scope of health care services offered. They would continue to serve involuntary psychiatric patients, which is important, since AHC is the sole provider of that service in Montgomery County.

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

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

a. Adventist HealthCare Shady Grove Medical Center
b. Adventist HealthCare Washington Adventist Hospital

(2) The location of each health care facility

a. 9901 Medical Center Drive, Rockville, MD 20850
b. 7600 Carroll Avenue, Takoma Park, MD 20912

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

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

See above.

(b) Renovation of existing facilities

Renovation of former, closed residential treatment center space, now within SGMC, will be used to accommodate the Beds.

(c) New construction

None is required.

(d) Relocation or reconfiguration of existing medical services

SGMC will operate 146 inpatient psychiatric beds, combining 117 ABH licensed beds, and 29 WAH Beds. Physical capacity currently at ABH is 164 beds in 8 units:

Unit	Service Type	Room Count	Bed Count	Current Licensed Beds	Future Licensed
Chesapeake	Adolescent General Psychiatric (13 to 18)	12	24	22	22
Shenandoah	Child General Psychiatric (7 to 13)	6	12	8	8
Potomac	Adult SPMI	12	24	22	22
Seneca	Adult General Psychiatric/Co-occurring	14	28	24	28
Montgomery	Adult Mood Disorders	7	14	12	14
Magnolia	Seniors (Geriatric Psychiatry)	10	14	13	14
Azalea	Adult General Psychiatric/Co-occurring	8	16	16	16
Cypress	Adult Psychiatric Beds	16	32	0	22
Total		**85**	**164**	**117**	**146**

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

See (d) above.

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

The ABH beds will move under the SGMC license this summer, while the WAH adult psychiatric beds will transfer to SGMC in the summer of 2019, when WAH relocates to White Oak.

(5) Identification of any outstanding public body obligation

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

(6) Information demonstrating that the project:

(a) Is consistent with the State Health Plan

The proposed relocation meets the standards in the State Health Plan chapters on Acute Hospital Services and Acute Psychiatric Services. Detailed analyses are attached as Exhibits 5 and 17 respectively.

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

The consolidation of 29 beds from WAH to SGMC will be both efficient and effective. As noted in the letter from the Maryland Department of Health's Medical Assistance Program, keeping the WAH adult psychiatric beds under a GBR agreement will avoid an increase in funding requirements by maintaining the federal match for Medicaid admissions. (See DHMH Letter, Exhibit 4). Furthermore, the consolidation of behavioral health services into one centralized location enhances clinical and operational efficiency by providing for a wider breadth of services and specialization in one location. At WAH, there is one inpatient unit for all adult psychiatric patients, irrespective of the specific diagnosis. By contrast, Rockville has separate specialty units for mood disorders, geriatrics and other conditions, which enhances patient experience and provides specialized services, according to patient need. Co-location will allow these patients to take advantage of multiple, specialized services in one location. Also, the continuity of care for this regional service is enhanced by having a wide breadth of services in one location. Moreover, SGMC will continue to serve as

Montgomery County's involuntary admission inpatient center and the Consolidation will ensure that SGMC has the capacity to absorb all of the involuntary admissions currently seen at WAH.

(c) Is in the public interest

The public has an interest in the preservation and continued availability of quality, efficient and effective behavioral health services in the region. The reimbursement for this service will be regulated by the HSCRC under the SGMC GBR. This will provide a stable, predictable revenue stream that ensures the continued availability of inpatient and outpatient behavioral health services, including for both voluntary and involuntary admissions. Patients treated at the Rockville facility will have access to a wide breadth of specialty psychiatric services, including units focusing on mood disorders, geriatrics and other specialties.

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

Sincerely,

Howard L. Sollins

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

EXHIBITS

1. Tables I, J, K
2. Bed Listing For Psychiatric Beds
3. Drawings of Adventist Behavioral Health
4. Letter from Maryland Department of Health
5. Acute Hospital Services State Health Plan Standards COMAR 10.24.10
6. Public Disclosure of Charges
7. AHC Financial Assistance Policy AHC 3.19
8. AHC Asistencia Financiera AHC 3.19.B
9. 2017 Public Notice Washington Post
10. 2017 Affidavit of Performance El Tiempo Latino
11. Adventist Behavioral Health State License # 15-039
12. Adventist HealthCare Shady Grove Medical Center State License #15-023
13. Adventist HealthCare Washington Adventist Hospital State License #15-031
14. The Joint Commission Quality Report Adventist Behavioral Health
15. The Joint Commission Quality Report Shady Grove Medical Center
16. The Joint Commission Quality Report Washington Adventist Hospital
17. Acute Psychiatric Services State Health Plan Standards COMAR 10.24.07
18. SGMC Patient Care Standards Manual Behavioral Health Assessment and Management Policy #101-01-010
19. Department of Health and Mental Hygiene Behavioral Health Administration Designated Psychiatric Emergency Facilities Calendar Year 2017
20. Adventist Behavioral Health & Wellness Services Discharge Policy PC-14
21. Affirmations

EXHIBIT 1

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**CY 2019**	**CY 2020**	**CY 2021**				
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	384	768	768				
Total Acute	***384***	***768***	***768***	***0***	***0***	***0***	***0***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL DISCHARGES	***384***	***768***	***768***	***0***	***0***	***0***	***0***
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	2,319	4,638	4,638				
Total Acute	***2,319***	***4,638***	***4638***	***0***	***0***	***0***	***0***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL PATIENT DAYS	***2,319***	***4,638***	***4,638***	***0***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY							
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	6.04	6.04	6.04	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	6.04	6.04	6.04	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	6.04	6.04	6.04	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**CY 2019**	**CY 2020**	**CY 2021**				
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	29	29	29				
Total Acute	***29***	***29***	***29***	***0***	***0***	***0***	***0***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL LICENSED BEDS							
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:*** *Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	44.2%	43.8%	43.8%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	**44.2%**	**43.8%**	**43.8%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
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.

Relocate 29 Licensed Beds (12.7 ADC) From WAH to SGMC - UNINFLATED

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2019**	**CY 2020**	**CY 2021**				
1. REVENUE							
a. Inpatient Services	$ 3,235,251	$ 6,470,502	$ 6,470,502				
b. Outpatient Services	-	-	-	-	-	-	-
Gross Patient Service Revenues	***$ 3,235,251***	***$ 6,470,502***	***$ 6,470,502***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 299,190	$ 598,380	$ 598,380				
d. Contractual Allowance	217,145	434,289	434,289				
e. Charity Care	83,527	167,053	167,053				
Net Patient Services Revenue	***$ 2,635,390***	***$ 5,270,779***	***$ 5,270,779***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
NET OPERATING REVENUE	***$ 2,635,390***	***$ 5,270,779***	***$ 5,270,779***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 1,216,142	$ 2,432,284	$ 2,432,284	$ -	$ -	$ -	$ -
b. Contractual Services				$ -	$ -	$ -	$ -
c. Interest on Current Debt				$ -	$ -	$ -	$ -
d. Interest on Project Debt				$ -	$ -	$ -	$ -
e. Current Depreciation				$ -	$ -	$ -	$ -
f. Project Depreciation	170,910	341,820	341,820	$ -	$ -	$ -	$ -
g. Current Amortization				$ -	$ -	$ -	$ -
h. Project Amortization				$ -	$ -	$ -	$ -
i. Supplies	101,158	202,316	202,316	$ -	$ -	$ -	$ -
j. Purchased Services	132,399	264,798	264,798	$ -	$ -	$ -	$ -
k. Professional Fees	147,544	295,089	295,089	$ -	$ -	$ -	$ -
l. Building & Maintenance	130,384	260,768	260,768	$ -	$ -	$ -	$ -
m. Insurance	10,385	20,769	20,769	$ -	$ -	$ -	$ -
n. G&A	89,258	178,517	178,517	$ -	$ -	$ -	$ -
o. Other - Overhead Allocations	193,099	386,198	386,198	$ -	$ -	$ -	$ -
TOTAL OPERATING EXPENSES	***$ 2,191,279***	***$ 4,382,559***	***$ 4,382,559***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	***$ 444,110***	***$ 888,221***	***$ 888,221***	***$ -***	***$ -***	***$ -***	***$ -***
b. Non-Operating Income							
SUBTOTAL	***$ 444,110***	***$ 888,221***	***$ 888,221***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							

Relocate 29 Licensed Beds (12.7 ADC) From WAH to SGMC - UNINFLATED

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	CY 2019	CY 2020	CY 2021				
NET INCOME (LOSS)	$ 444,110	$ 888,221	$ 888,221	$ -	$ -	$ -	$ -

Relocate 29 Licensed Beds (12.7 ADC) From WAH to SGMC - UNINFLATED

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2019**	**CY 2020**	**CY 2021**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	25.7%	25.7%	25.7%				
2) Medicaid	39.1%	39.1%	39.1%				
3) Blue Cross	3.9%	3.9%	3.9%				
4) Commercial Insurance	6.3%	6.3%	6.3%				
5) HMO	20.0%	20.0%	20.0%				
6) Self-pay	2.7%	2.7%	2.7%				
7) Other	2.3%	2.3%	2.3%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	24.1%	24.1%	24.1%				
2) Medicaid	38.7%	38.7%	38.7%				
3) Blue Cross	4.1%	4.1%	4.1%				
4) Commercial Insurance	6.7%	6.7%	6.7%				
5) HMO	21.3%	21.3%	21.3%				
6) Self-pay	2.8%	2.8%	2.8%				
7) Other	2.3%	2.3%	2.3%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

Relocate 29 Licensed Beds (12.7 ADC) from WAH to SGMC -INFLATED

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2019**	**CY 2020**	**CY 2021**				
1. REVENUE							
a. Inpatient Services	$ 3,235,251	$ 6,619,324	$ 6,771,568				
b. Outpatient Services							
Gross Patient Service Revenues	***$ 3,235,251***	***$ 6,619,324***	***$ 6,771,568***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 299,190	$ 612,143	$ 626,222				
d. Contractual Allowance	$ 217,145	$ 444,278	$ 454,496				
e. Charity Care	$ 83,527	$ 170,896	$ 174,826				
Net Patient Services Revenue	***$ 2,635,390***	***$ 5,392,007***	***$ 5,516,024***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
NET OPERATING REVENUE	***$ 2,635,390***	***$ 5,392,007***	***$ 5,516,024***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 1,216,142	$ 2,468,768	$ 2,505,800	$ -	$ -	$ -	$ -
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	170,910	341,820	341,820				
g. Current Amortization							
h. Project Amortization							
i. Supplies	101,158	206,362	210,490				
j. Purchased Services	132,399	270,094	275,495				
k. Professional Fees	147,544	300,991	307,010				
l. Building & Maintenance	130,384	265,983	271,303				
m. Insurance	10,385	21,185	21,608				
n. G&A	89,258	182,087	185,729				
o. Other - Overhead Allocations	193,099	393,922	401,801	-	-	-	-
TOTAL OPERATING EXPENSES	***$ 2,191,279***	***$ 4,451,212***	***$ 4,521,056***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ 444,110**	**$ 940,795**	**$ 994,968**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ 444,110***	***$ 940,795***	***$ 994,968***	***$ -***	***$ -***	***$ -***	***$ -***
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.

	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 2019**	**CY 2020**	**CY 2021**				
NET INCOME (LOSS)	***$ 444,110***	***$ 940,795***	***$ 994,968***	***$ -***	***$ -***	***$ -***	***$ -***

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2019**	**CY 2020**	**CY 2021**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	25.7%	25.7%	25.7%				
2) Medicaid	39.1%	39.1%	39.1%				
3) Blue Cross	3.9%	3.9%	3.9%				
4) Commercial Insurance	6.3%	6.3%	6.3%				
5) HMO	20.0%	20.0%	20.0%				
6) Self-pay	2.7%	2.7%	2.7%				
7) Other	2.3%	2.3%	2.3%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
a. Percent of Total Revenue	24.1%	24.1%	24.1%				
1) Medicare	38.7%	38.7%	38.7%				
2) Medicaid	4.1%	4.1%	4.1%				
3) Blue Cross	6.7%	6.7%	6.7%				
4) Commercial Insurance	21.3%	21.3%	21.3%				
5) HMO	2.8%	2.8%	2.8%				
6) Self-pay	2.3%	2.3%	2.3%				
7) Other							
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

EXHIBIT 2

Bed Count at SGMC Psychiatric Service

Unit	Service Type	Room Count	Bed Count	Current Licensed Beds	Future Licensed Beds
Chesapeake	Adolescent General Psych (13 to 18)	12	24	22	22
Shenandoah	Child General Psych (7 to 13)	6	12	8	8
Potomac	Adult SPMI	12	24	22	22
Seneca	Adult General Psych/Co-occurring	14	28	24	28
Montgomery	Adult Mood	7	14	12	14
Magnolia	Seniors (Geri-psych)	10	14	13	14
Azalea	Adult General Psych/Co-occurring	8	16	16	16
Cypress	(Future Adult Psych Beds)	16	32	0	22
Total		**85**	**164**	**117**	**146**

EXHIBIT 3

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

Smoke-Resistive Construction

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

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

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

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

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

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

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

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

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

Smoke Barrier

Line on drawing looks like:

Wall
Must extend to slab above [8.5.2]

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

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

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

1-Hour Fire Barrier

Line on drawing looks like:

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

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

Doors
3/4-hour fire rated [8.3.4.2]

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

2-Hour Fire Barrier

Line on drawing looks like:

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

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

Doors
1 ½-hour fire rated [8.3.4.2]

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

Building Separation (Minimum of 2-hour Fire Rating)

Line on drawing looks like:

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

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

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

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

REVISIONS

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LIFE SAFETY SYMBOLS

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

ZONE ID

EQUIVALENCY INFORMATION:

EQUIVALENCY/ WAIVER NO.	EQUIVALENCY / WAIVER
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ABBREVIATIONS

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

ADVENTIST HEALTH CARE
SHADY GROVE HOSPITAL
ROCKVILLE, MD
PROJECT TITLE

LIFE SAFETY PLAN COVER SHEET

SHEET TITLE

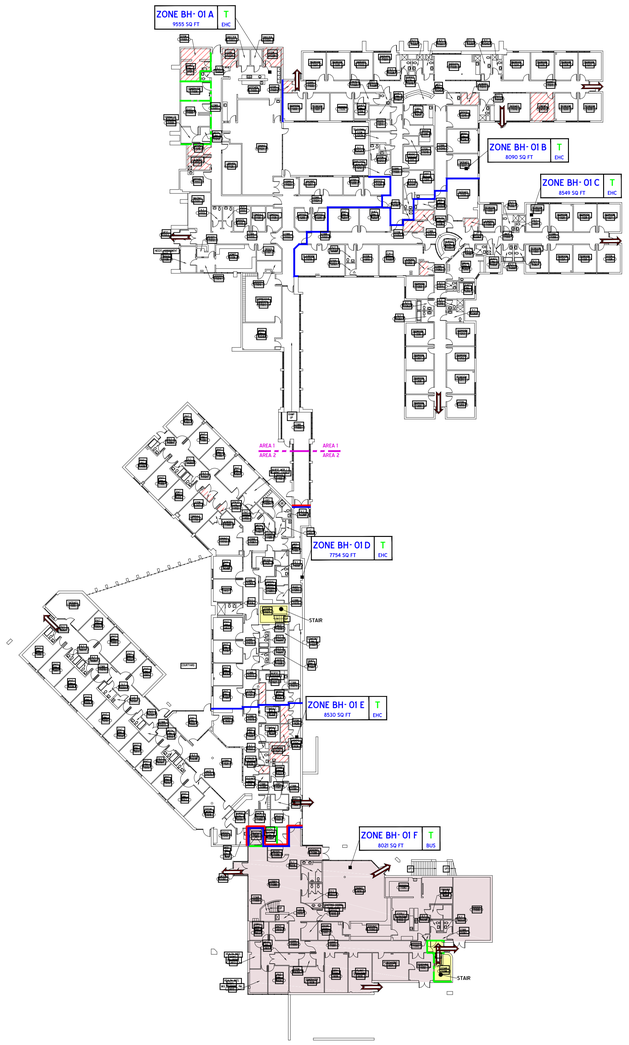
LS-0.0

DRAWING NUMBER

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

FINAL REPORT

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



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

REVISIONS

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LIFE SAFETY SYMBOLS

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

ZONE ID

EQUIVALENCY INFORMATION:

EQUIVALENCY/ WAIVER NO.	EQUIVALENCY / WAIVER
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ABBREVIATIONS

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

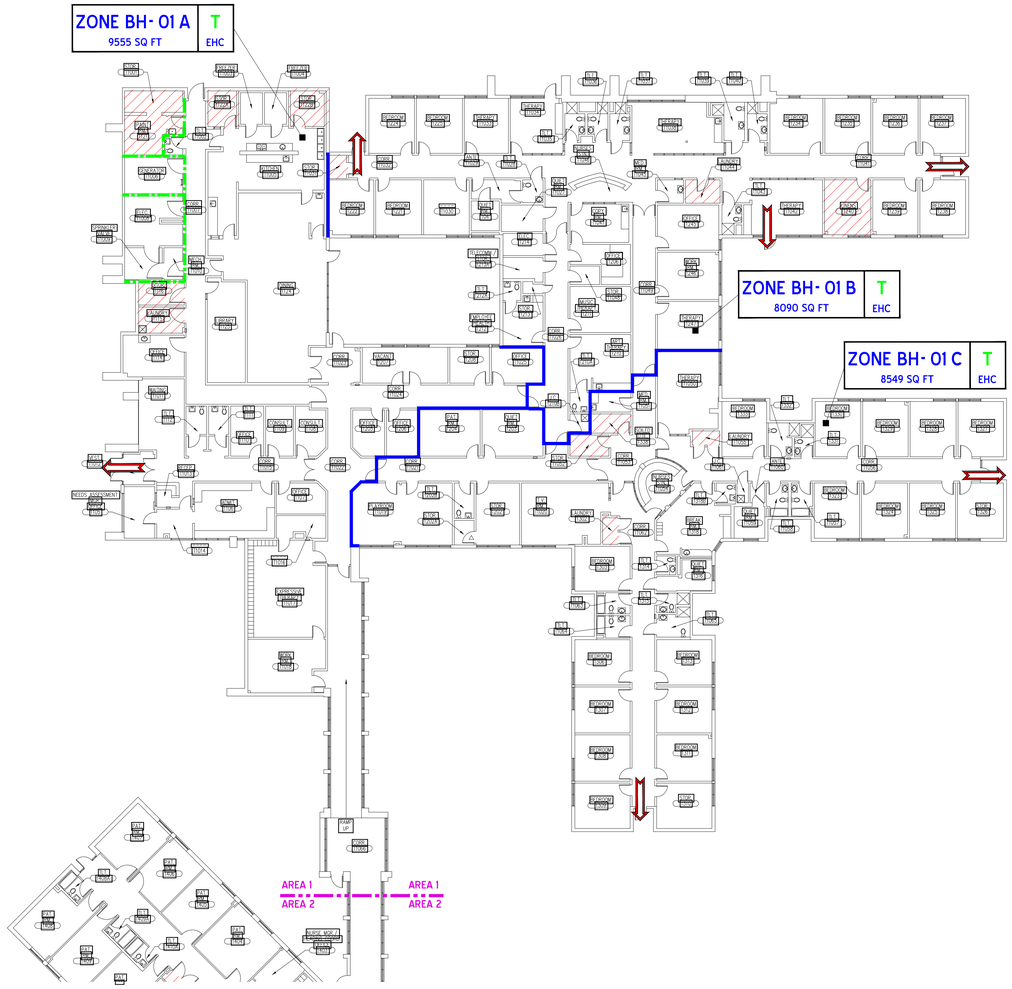
ADVENTIST HEALTHCARE
BEHAVORIAL HEALTH
ROCKVILLE. MD
PROJECT TITLE

LIFE SAFETY PLAN
FIRST FLOOR
COMPOSITE
SHEET TITLE

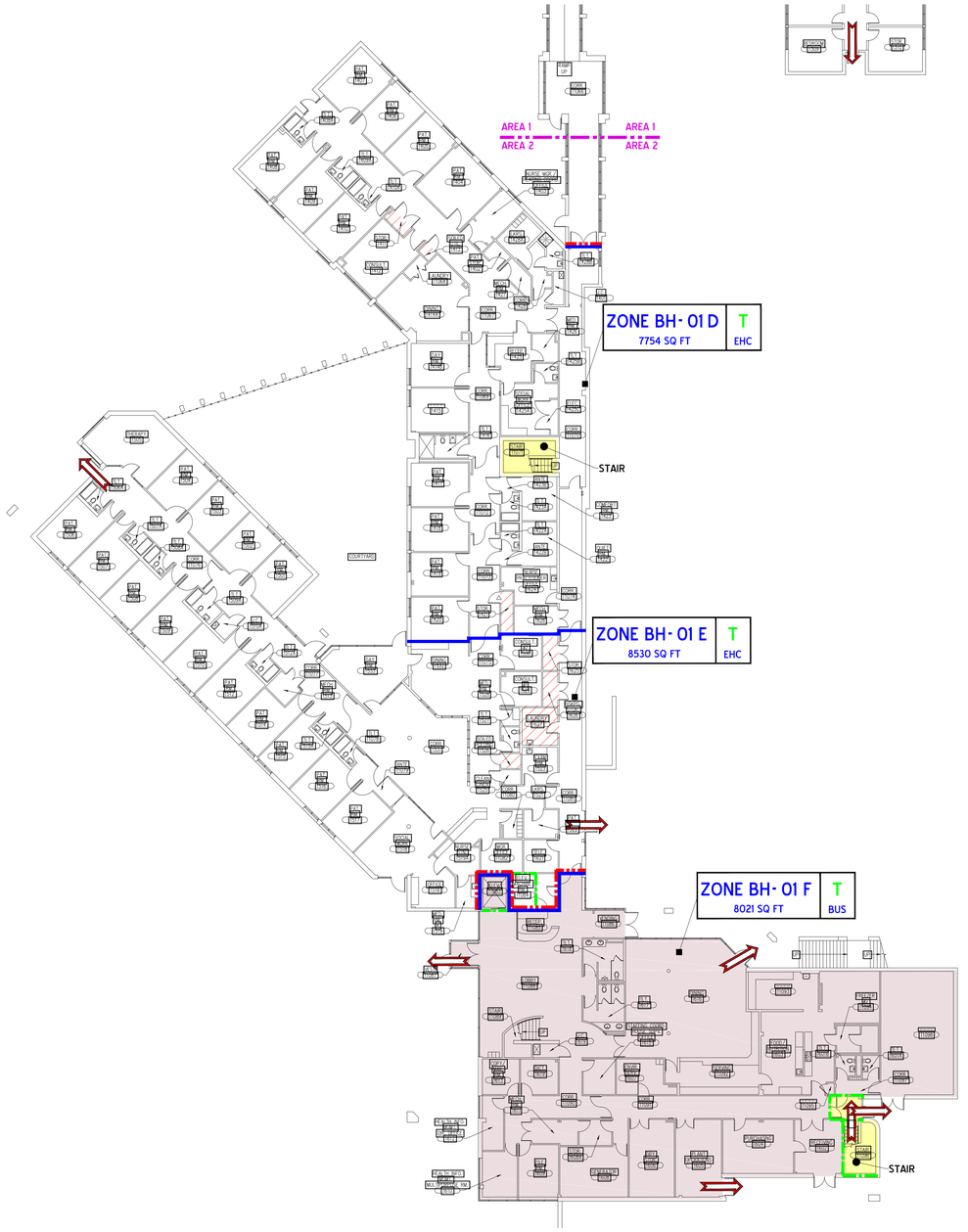
LS-01.0
DRAWING NUMBER

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

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



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



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

REVISIONS

NO	DATE	DESCRIPTION
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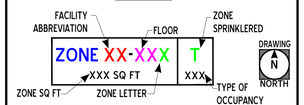
-	-	-

LIFE SAFETY SYMBOLS

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

ZONE ID



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ABBREVIATIONS

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

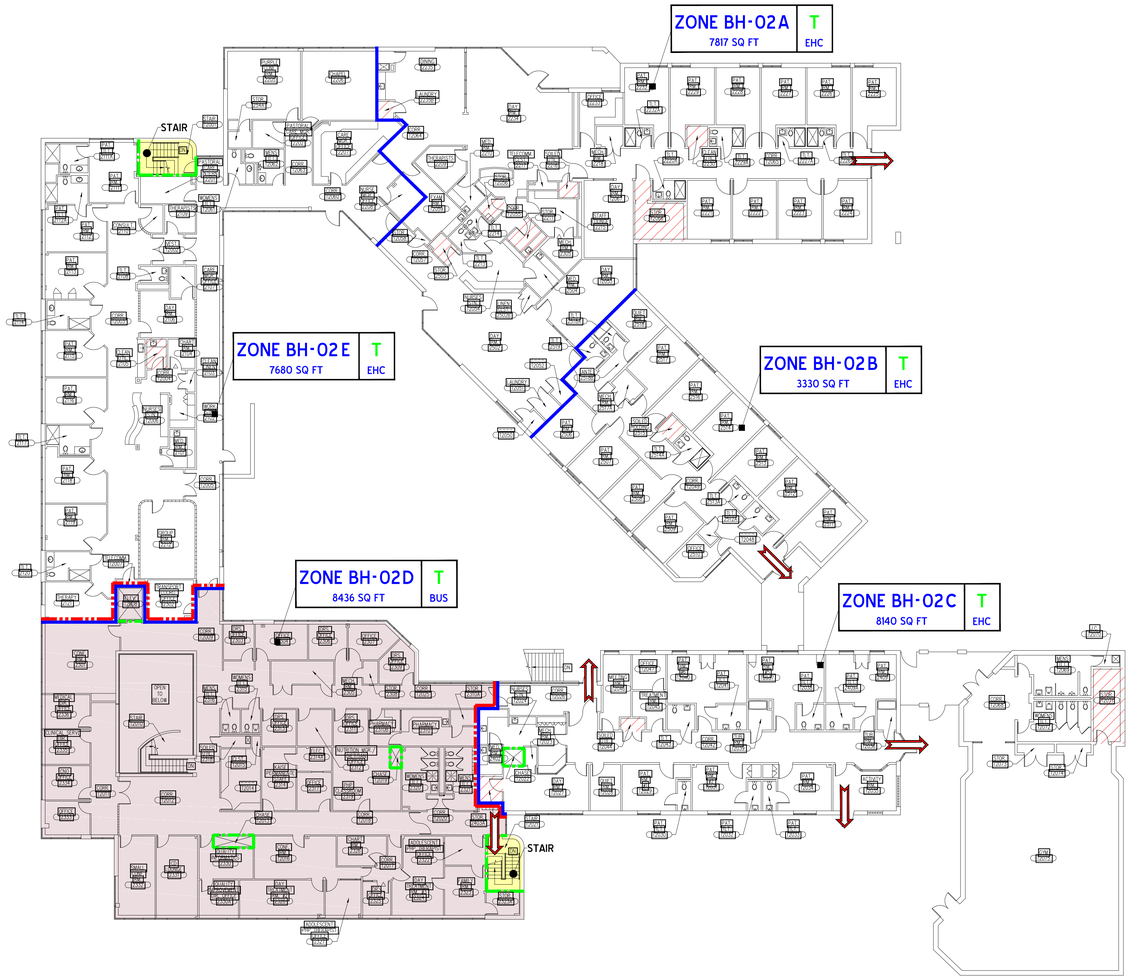
ADVENTIST HEALTHCARE
BEHAVORIAL HEALTH
ROCKVILLE, MD
PROJECT TITLE

LIFE SAFETY PLAN
FIRST FLOOR
AREAS 1 & 2
SHEET TITLE

LS-01.1
DRAWING NUMBER

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

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



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

REVISIONS

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LIFE SAFETY SYMBOLS

- BUILDING SEPARATION
- 3 HOUR FIRE BARRIER
- 2 HOUR FIRE BARRIER
- 1 HOUR FIRE BARRIER
- 1/2 HOUR FIRE BARRIER
- SMOKE BARRIER
- HORIZONTAL EXIT
- EXIT
- EXIT STAIRWELL
- BUSINESS SMOKE ZONE
- HAZARDOUS AREA
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LOR	LODGING OR ROOMING	MER	MERCANTILE
DAY	DAYCARE	IND	INDUSTRIAL

ADVENTIST HEALTHCARE
BEHAVORIAL HEALTH
ROCKVILLE. MD
PROJECT TITLE

LIFE SAFETY PLAN
SECOND FLOOR
SHEET TITLE

LS-02.0
DRAWING NUMBER

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

FINAL REPORT
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AMK
DRAWN BY

EXHIBIT 4

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

December 20, 2017

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

Dear Mr. Steffen,

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

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

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

Sincerely,

Tricia Roddy

Tricia Roddy
Director, Planning Administration
Office of Health Care Financing

EXHIBIT 5

.04 Standards.

A. General Standards.

The following general standards encompass Commission expectations for the delivery of acute care services by all hospitals in Maryland. Each hospital that seeks a Certificate of Need for a project covered by this Chapter of the State Health Plan must address and document its compliance with each of the following general standards as part of its Certificate of Need application. Each hospital that seeks a Certificate of Need exemption for a project covered by this Chapter of the State Health Plan must address and demonstrate consistency with each of the following general standards as part of its exemption request.

(1) Information Regarding Charges.

Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

APPLICANT RESPONSE:

Policy 3.19.2 Public Disclosure of Charges (Exhibit 6) details the Adventist HealthCare, Inc. policy and procedure for the provision of information regarding hospital services and policies to the public. Quarterly updates to the Representative List of Services and Charges are made and posted to the hospital internet web site (https://www.adventisthealthcare.com/app/files/public/364/SGMC-Billing-HospitalCharges.pdf) and are available on request to the public. The Patient Access Department of SGMC ensures that requests made for current charges for specific procedures are provided in a timely manner. The Patient Access Department provides staff training on this and other policies on a regular basis.

(2) **Charity Care Policy.**

Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.

(a) The policy shall provide:

(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.

(ii) Minimum Required Notice of Charity Care Policy.

1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;

2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital; and

3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

APPLICANT RESPONSE:

Adventist HealthCare, Inc. maintains written policies in English and Spanish pertaining to the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. Policy number AHC 3.19 Financial Assistance Policy, and Policy 3.19.B Financial Assistance Policy, Spanish Language Version apply to all Adventist HealthCare-affiliated facilities including SGMC, WAH and ABH (Exhibits 7 and 8). These policies are summarized and included on the website of Adventist HealthCare, Inc. and SGMC

(https://www.adventisthealthcare.com/app/files/public/4274/AHC-FinancialAssistance-Policy.pdf and https://www.adventisthealthcare.com/app/files/public/4275/AHC-FinancialAssistance-Policy-ESP.pdf)

Notices of the availability of financial assistance are prominently posted in English and Spanish in the SGMC Department, Registration/Admissions Department and business offices. The charity care policy is made available to patients during the preadmission and/or admission process.

Public notice of nondiscrimination policy and access to care regardless of ability to pay is posted annually in The Washington Post. The most recent posting was made on July 6, 2017 (Exhibit 9). The same notice was posted in Spanish in El Tiempo Latino, a daily newspaper in the Washington metropolitan area on July 6, 2017. (Exhibit 10).

In 2017, WAH provided a total community benefit of 16.21% total operating expenses, respectively, as reported in the May 1, 2018 Maryland Hospital Community Benefit Report FY 2017 (http://www.hscrc.state.md.us/Pages/init_cb.aspx). The total net community benefit was 12.13% of operating expenses, ranking the hospital as providing the 6th highest amount of net community benefit for all hospitals in Maryland, with an average for all hospitals of 6.81%.

(3) Quality of Care.

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;

(ii) Accredited by the Joint Commission; and

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

APPLICANT RESPONSE: ABH is in possession of Maryland Department of Health and Mental Hygiene, Office of Health Care Quality License Number 15-039 issued on May 28, 2018 (Exhibit 11). SGMC is licensed by the Maryland Department of Health and Mental Hygiene, Office of Health Care Quality and Exhibit 12 is License Number 15-023 issued on November 12, 2016. Adventist HealthCare Washington Adventist Hospital is licensed by the

Maryland Department of Health and Mental Hygiene, Office of Health Care Quality, License Number 15-031 issued August 19, 2016 (Exhibit 13).

ABH is accredited by the Joint Commission for Behavioral Health Care after the last full survey and on-site survey of October 17, 2017 and ABH is also fully accredited as a hospital Effective October 21, 2017, after the last full survey of October 20, 2017 and last on-site survey of December 1, 2017. Both programs met 2017 National Patient Safety Goals (Exhibit 14). SGMC is fully accredited by the Joint Commission effective November 12, 2016 after its last full survey and on-site survey of November 11, 2016 and met the 2016 National Patient Safety Goals. (Exhibit 15). WAH is fully accredited by the Joint Commission effective October 19, 2016 after its last full survey and on-site survey of August 18, 2016 (Exhibit 16).

The hospitals are in compliance with the conditions of participation of the Medicare and Medicaid programs.

B. Project Review Standards.

The standards in this section are intended to guide reviews of Certificate of Need applications and exemption requests involving acute care general hospital facilities and services. An applicant for a Certificate of Need must address, and its proposed project will be evaluated for compliance with, all applicable review standards. An applicant for a Certificate of Need exemption must address, and its proposed project will be evaluated for consistency with, all applicable review standards.

(1) Geographic Accessibility.

A new acute care general hospital or an acute care general hospital being replaced on a new site shall be located to optimize accessibility in terms of travel time for its likely service area population. Optimal travel time for general medical/surgical, intensive/critical care and pediatric services shall be within 30 minutes under normal driving conditions for 90 percent of the population in its likely service area.

APPLICANT RESPONSE:
This standard is not applicable as AHC is not developing a new acute care general hospital or replacement of an acute care general hospital related to this filing.

(2) Identification of Bed Need and Addition of Beds.

Only medical/surgical/gynecological/addictions ("MSGA") beds and pediatric beds identified as needed and/or currently licensed shall be developed at acute care general hospitals.

(a) Minimum and maximum need for MSGA and pediatric beds are determined using the need projection methodologies in Regulation .05 of this Chapter.

(b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients is included in the MSGA need projection.

(c) Additional MSGA or pediatric beds may be developed or put into operation only if:

(i) The proposed additional beds will not cause the total bed capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital made pursuant to Health-General §19-307.2; or

(ii) The proposed additional beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter; or

(iii) The proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection; or

(iv) The number of proposed additional MSGA or pediatric beds may be derived through application of the projection methodology, assumptions, and targets contained in Regulation .05 of this Chapter, as applied to the service area of the hospital.

APPLICANT RESPONSE:

This standard is not applicable to the proposed project since no MSGA or pediatric beds are being requested nor is an increase in beds being requested.

(3) Minimum Average Daily Census for Establishment of a Pediatric Unit.

An acute care general hospital may establish a new pediatric service only if the projected average daily census of pediatric patients to be served by the hospital is at least five patients, unless:

(a) The hospital is located more than 30 minutes travel time under normal driving conditions from a hospital with a pediatric unit; or

(b) The hospital is the sole provider of acute care general hospital services in its jurisdiction.

APPLICANT RESPONSE:

This standard is not applicable.

(4) Adverse Impact.

A capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The Commission will grant a Certificate of Need only if the hospital documents the following:

(a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and

(b) If the project reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish, for the population in the primary service area, the availability or accessibility to care, including access for the indigent and/or uninsured.

APPLICANT RESPONSE:

The consolidation of psychiatric beds from Takoma Park into SGMC will bring most of AHC's behavioral health services under SGMC's license and its GBR agreement with the HSCRC. Psychiatric services at WAH will continue to be offered to the community through SGMC, including programs for children, adolescents, adults, geriatric patients and acceptance of involuntary admissions. The Rockville location is easily accessible from I-270, is close to the Intercounty Connector (Route 200) which connects Montgomery County and Prince George's County, and is accessible by bus service including connections from the Shady Grove metro rail stop. This consolidation of behavioral health services enhances clinical and operational efficiency by providing for a wider breadth of services and specialization in one location. At

WAH there is one inpatient unit for all adult psychiatric patients, irrespective of their specific diagnosis. In contrast, Rockville has separate specialty units for mood disorders, geriatrics, and other conditions which enhances patient experience and provides specialized services according to patient need. Co-location will allow these patients to take advantage of a multiplicity of specialized services in one location and continuity of care is enhanced by having a wide breadth of services in one location. Communication between providers is enhanced when a patient goes from one level of care to another (example: from acute to a partial hospitalization program [PHP] or outpatient) and patients do not have to receive care in different locations.

AHC is the largest provider of behavioral health services in Montgomery County and one of the larger behavioral health providers in the region. This initiative helps to preserve this regional service consistent with state and federal goals of enhancing health care efficiency and avoiding duplication of services. As noted previously, the Maryland Medical Assistance Program supports this consolidation.

(5) Cost-Effectiveness.

A proposed hospital capital project should represent the most cost effective approach to meeting the needs that the project seeks to address.

(a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:

(i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;

(ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and

(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.

(b) An applicant proposing a project involving limited objectives, including, but not limited to, the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization, may address the cost-effectiveness of the project without undertaking the analysis outlined in (a) above, by demonstrating that there is only one practical approach to achieving the project's objectives.

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within

a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:

(i) That it has considered, at a minimum, an alternative project site located within a Priority Funding Area that provides the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);

(ii) That it has quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed project site;

(iii) That it has detailed the capital and operational costs associated with implementing the project at each alternative project site and at the proposed project site, with a full accounting of the cost associated with transportation system and other public utility infrastructure costs; and

(iv) That the proposed project site is superior, in terms of cost effectiveness, to the alternative project site or sites located within a Priority Funding Area.

APPLICANT RESPONSE:

This initiative is not the introduction of a new service but the consolidation of existing services. Further, this project is not a major hospital capital project as the only expense involved is an approximately $3.4 million renovation of existing space to accommodate additional psychiatric beds in Rockville, a number well below the capital threshold for hospital projects requiring a CON. The source of these funds will be cash from the SGMC annual operating budget. Thus 5(b) of this standard is the most relevant part. AHC is committed to continue providing behavioral health services for the region consistent with its mission and its role as one of the largest providers of behavioral health services in the region.

Inpatient psychiatric services in Maryland that are independent of acute care hospitals face reimbursement challenges to cover the expenses for services. The elimination of Maryland's IMD Exclusion waiver creates additional uncertainty about the future of Medicaid reimbursement for independent inpatient psychiatric facilities. The acute psychiatric services operated by AHC are located in Rockville, which is an IMD and Takoma Park, where 39 acute adult psychiatric beds are operated as part of WAH's license. When WAH relocates to White Oak in the summer of 2019, AHC had planned to leave the 39-bed psychiatric unit in Takoma Park as a separately licensed IMD. However, reimbursement challenges facing the IMD facility in Rockville and the continued uncertainty about the future of reimbursement for these services

in Maryland forced AHC to consider the future of these services. To avoid closing the service, AHC chose to consolidate all 117 ABH beds and 29 of WAH's 39 acute adult psychiatric beds into SGMC to enhance clinical, operational and financial efficiency, and initiated dialogue with the HSCRC about possible reimbursement options for a consolidated service under the license of SGMC, which shares a campus with ABH. The remaining 10 acute psychiatric beds at WAH will be relocated to White Oak when the new WAH facility is completed, pursuant to a concomitant WAH project modification being submitted.

This consolidation of the psychiatric beds and services under the SGMC license provides four important benefits: (1) Improved operational efficiency with combined administrative services under SGMC; (2) Improved clinical efficiency by enhancing communication among providers as patients move from one level of service to another; (3) Improved access to a wider breadth of specialty services in one location for all psychiatric patients; and, most importantly, (4) preserved psychiatric services for the region through more stable reimbursement under an HSCRC GBR agreement that is in alignment with the all payer model.

The goal is to move the ABH services under the license of SGMC in July 2018 with the relocation of the 29 of WAH's 39 acute psychiatric beds occurring in the summer of 2019 when WAH relocates to White Oak. Most of the relatively low capital costs for this project will be used to renovate existing space to accommodate the beds from Takoma Park. In its 2015 approval of the WAH relocation project, the Commission noted that the possible need to consider co-location of the Takoma Park psychiatric beds with an acute care hospital depended upon the future regulatory environment. The Commission's Decision to approve the relocation of WAH to White Oak, in Docket No. 13-15-2349 pages 69-70, noted in part: "Under a worst case scenario, AHC would have to reassess its ability to continue to viably serve all acute psychiatric patients in need of service and this reassessment would undoubtedly focus on bringing psychiatric beds back within the general hospital setting." Indeed, this turned out to be the case.

Finally, we note that the Rockville campus of Adventist Behavioral Health is located within a Priority Funding Area in Maryland.

(6) **Burden of Proof Regarding Need.**

A hospital project shall be approved only if there is demonstrable need. The burden of demonstrating need for a service not covered by Regulation .05 of this Chapter or by another chapter of the State Health Plan, including a service for which need is not separately projected, rests with the applicant.

APPLICANT RESPONSE:

AHC is not seeking an expansion in beds but plans to keep the same number of beds that currently exist in both Takoma Park and Rockville, which means 146 psychiatric beds (29 from Takoma Park and 117 from Rockville) will be located in Rockville as part of the SGMC license, and the remaining 10 WAH beds to be moved to White Oak when the new facility is constructed. This consolidation of psychiatric beds and services under the SGMC license achieves four important goals: (1) Improved operational efficiency with combined administrative services

under SGMC; (2) improved clinical efficiency by enhancing communication among providers as patients move from one level of service to another; (3) all psychiatric patients have access to a wider breadth of services in one location, given that WAH has one adult inpatient unit while combining services in Rockville provides all patients access to a variety of specialty services; and, (4) most importantly, the preservation of these services for the region through more stable reimbursement under an HSCRC GBR agreement in connection with an acute care hospital, SGMC. This is all the more important as AHC is one of the largest providers of behavioral health services in the region and is the only Montgomery County provider that accepts involuntary psychiatric admissions and this will continue with consolidated services in Rockville.

(7) **Construction Cost of Hospital Space.**

The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

APPLICANT RESPONSE:

No construction is being proposed by this application, only renovations and alterations of existing space in Rockville.

(8) **Construction Cost of Non-Hospital Space.**

The proposed construction costs of non-hospital space shall be reasonable and in line with current industry cost experience. The projected cost per square foot of non-hospital space shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide for the appropriate structure. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the non-hospital space shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost. In

general, rate increases authorized for hospitals should not recognize the costs associated with construction of non-hospital space.

APPLICANT RESPONSE:

No construction of non-hospital space is required.

(9) Inpatient Nursing Unit Space.

Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. If the Inpatient Unit Program Space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost for the space that exceeds the per bed square footage limitation in this standard or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

APPLICANT RESPONSE:

This standard is not applicable.

(10) Rate Reduction Agreement.

A high-charge hospital will not be granted a Certificate of Need to establish a new acute care service, or to construct, renovate, upgrade, expand, or modernize acute care facilities, including support and ancillary facilities, unless it has first agreed to enter into a rate reduction agreement with the Health Services Cost Review Commission, or the Health Services Cost Review Commission has determined that a rate reduction agreement is not necessary.

APPLICANT RESPONSE:

This proposal would place the service line under the GBR of SGMC which is not a high charge hospital.

(11) Efficiency.

A hospital shall be designed to operate efficiently. Hospitals proposing to replace or expand diagnostic or treatment facilities and services shall:

(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in

which the planning and design of the project took efficiency improvements into account; and

(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or

(c) Demonstrate why improvements in operational efficiency cannot be achieved.

APPLICANT RESPONSE:

This standard is not applicable, since AHC is not seeking to replace or expand diagnostic or treatment facilities.

(12) Patient Safety.

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety. A hospital proposing to replace or expand its physical plant shall provide an analysis of patient safety features included for each facility or service being replaced or expanded, and document the manner in which the planning and design of the project took patient safety into account.

APPLICANT RESPONSE:

As the ABH's primary service offering is adult inpatient psychiatry, an approved set of guidelines for physical design that enhance patient safety is already in place. These guidelines will be utilized as the space formerly used for residential treatment services is renovated.

(13) Financial Feasibility.

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

(a) Financial projections filed as part of a hospital Certificate of Need application must be accompanied by a statement containing each assumption used to develop the projections.

(b) Each applicant must document that:

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

(ii) **Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;**

(iv) **Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals; and (iv) The hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate that overall hospital financial performance will be positive and that the services will benefit the hospital's primary service area population.**

APPLICANT RESPONSE:

AHC is not seeking a CON for this merger and consolidation initiative. Nevertheless, financial projections for this initiative demonstrated that it is financially feasible.

(14) Emergency Department Treatment Capacity and Space.

(a) An applicant proposing a new or expanded emergency department shall classify service as low range or high range based on the parameters in the most recent edition of *Emergency Department Design: A Practical Guide to Planning for the Future* from the American College of Emergency Physicians. The number of emergency department treatment spaces and the departmental space proposed by the applicant shall be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians Emergency Department Design: A Practical Guide to Planning for the Future, given the classification of the emergency department as low or high range and the projected emergency department visit volume.

(b) **In developing projections of emergency department visit volume, the applicant shall consider, at a minimum:**

(i) **The existing and projected primary service areas of the hospital, historic trends in emergency department utilization at the hospital, and the number of hospital emergency department service providers in the applicant hospital's primary service areas;**

(ii) **The number of uninsured, underinsured, indigent, and otherwise underserved patients in the applicant's primary service area and the impact of these patient groups on emergency department use;**

(iii) **Any demographic or health service utilization data and/or analyses that support the need for the proposed project;**

(iv) **The impact of efforts the applicant has made or will make to divert non-emergency cases from its emergency department to more appropriate primary care or urgent care settings; and**

(v) **Any other relevant information on the unmet need for emergency department or urgent care services in the service area.**

(c) **An applicant proposing a new or expanded emergency department shall classify service as low range or high range based on the parameters in the most recent edition of *Emergency Department Design: A Practical Guide to Planning for the Future* from the American College of Emergency Physicians. The number of emergency department treatment spaces and the departmental space proposed by the applicant shall be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians *Emergency Department Design: A Practical Guide to Planning for the Future*, given the classification of the emergency department as low or high range and the projected emergency department visit volume.**

(d) **In developing projections of emergency department visit volume, the applicant shall consider, at a minimum:**

(i) **The existing and projected primary service areas of the hospital, historic trends in emergency department utilization at the hospital, and the number of hospital emergency department service providers in the applicant's primary service areas;**

(ii) **The number of uninsured, underinsured, indigent, and otherwise underserved patients in the applicant's primary service area and the impact of these patient groups on emergency department use;**

(iii) **Any demographic or health service utilization data and/or analyses that support the need for the project;**

(iv) **The impact of efforts the applicant has made or will make to divert non-emergency cases from its emergency department to more appropriate primary care or urgent care settings;**

(v) **Any other relevant information on the unmet need for emergency department or urgent care services in the service area.**

APPLICANT RESPONSE:

This standard does not apply.

(15) **Emergency Department Expansion.**

A hospital proposing expansion of emergency department treatment capacity shall demonstrate that it has made appropriate efforts, consistent with federal and state law, to maximize effective use of existing capacity for emergent medical needs and has appropriately integrated emergency department planning with planning for bed capacity, and diagnostic and treatment service capacity. At a minimum:

(a) **The applicant hospital must demonstrate that, in cooperation with its medical staff, it has attempted to reduce use of its emergency department for non-emergency medical care. This demonstration shall, at a minimum, address the feasibility of reducing or redirecting patients with non-emergent illnesses, injuries, and conditions, to lower cost alternative facilities or programs;**

(b) The applicant hospital must demonstrate that it has effectively managed its existing emergency department treatment capacity to maximize use; and

(c) The applicant hospital must demonstrate that it has considered the need for bed and other facility and system capacity that will be affected by greater volumes of emergency department patients.

APPLICANT RESPONSE:

This standard does not apply.

(16) Shell Space.

(a) Unfinished hospital shell space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective.

(b) If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that:

(i) Considers the most likely use identified by the hospital for the unfinished space;

(ii) Considers the time frame projected for finishing the space; and most likely identified use in the projected time frame.

(iii) Demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.

(c) Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants shall provide information on the cost, the most likely uses, and the likely time frame for using such shell space.

(d) The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be

excluded from consideration in any rate adjustment by the Health Service Cost Review Commission.

APPLICANT RESPONSE:

This standard is not applicable for this project.

EXHIBIT 6

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Public Disclosure of Charges

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

SCOPE:

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

PURPOSE:

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

BENEFITS:

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

POLICY:

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

PROCEDURE

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

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

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

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

Document Information

Document Title

AHC 3.19.2 Public disclosure of charges policy

Document Description

N/A

Approval Information

Approved On: 10/02/2013

Approved By: Executive Council

Approval Expires: 10/02/2018

Approval Type: Manual Entry

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

Keywords: N/A

Printed By: Guest User

Standard References: N/A

Note: This copy will expire in 24 hours

EXHIBIT 7

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance

(Formerly "Charity Care")

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

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FINANCIAL ASSISTANCE POLICY SUMMARY

SCOPE:

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

PURPOSE:

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

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

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

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

This financial assistance policy provides guidelines for:

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

BENEFITS:

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

DEFINITIONS:

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

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

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

POLICY

1. General Eligibility

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.6. **Considerations:**

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

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

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

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

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

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

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

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

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

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

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

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

1.8.1.2. Supplemental Nutritional Assistance Program (SNAP);

1.8.1.3. Low-income-household energy assistance program;

1.8.1.4. Women, Infants and Children (WIC)

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

1.8.2.1. Montgomery Cares;

1.8.2.2. Project Access;

1.8.2.3. Care for Kids

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

1.8.3.1. categorized as homeless or indigent

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

1.8.3.3. unresponsive during care and is discharged due to expiration

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

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

1.8.3.6. Elderly and a victim of abuse

1.8.3.7. an unaccompanied minor

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

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

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

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

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

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

2.1.1. During ED registration

2.1.2. During financial counseling sessions

2.1.3. Upon request

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

2.2.1. At all registrations sites

2.2.2. In specialty area waiting rooms

2.2.3. In specialty area patient rooms

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

2.3.1. Financial Assistance Policy (FAP)

2.3.2. Financial Assistance Application Form (FAA Form)

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

3. Policy Application and Determination Period

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

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

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

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

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

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

4.1. Services deemed not medically necessary by AHC clinical team

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

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

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

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

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

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

Roles and Responsibilities

4.6. **Adventist HealthCare responsibilities**

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

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

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

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

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

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

4.6.7. AHC provides options for payment arrangements.

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

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

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

4.7. **Individual Patient's Responsibilities**

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

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

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

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

5. Identification Of Potentially Eligible Individuals

5.1. Identification through socialization and outreach

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

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

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

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

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

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

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

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

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

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

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

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

7. **POLICY REVIEW AND MAINTAINENCE:**

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

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

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

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

CONTACT INFORMATION AND ADDITIONAL RESOURCES

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

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

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

Document Information

Document Title

AHC 3.19 Financial Assistance

Document Description

N/A

Approval Information

Approved On: 11/09/2017

Approved By: Veronica Harker, Risk Management Specialist

Approval Expires: 11/08/2019

Approval Type: Manual Entry

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

Keywords: N/A

Printed By: Guest User

Standard References: N/A

Note: This copy will expire in 24 hours

EXHIBIT 8

ADVENTIST HEALTH CARE, INC.

Manual de política corporativa

Asistencia financiera

(Anteriormente "Atención de beneficencia")

Fecha de entrada en vigencia	01/08	Nro. de política:	AHC 3.19
Referencia: Anteriormente: Política de asistencia financiera		Origen:	PFS
	(consulte AHC 3.19.1 para ver las Reglas de decisión/aplicación)		
Revisada:	02/09, 19/9/13, 7/17	Autoridad:	EC
Modificada:	10/09, 15/06/10, 2/3/11, 02/10/13, 1/2/16, 11/17	Página:	1 de 14

RESUMEN DE LA POLÍTICA DE ASISTENCIA FINANCIERA

ALCANCE:

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

PROPÓSITO:

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

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

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

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

Esta política de asistencia financiera proporciona pautas para:

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

BENEFICIOS:

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

DEFINICIONES:

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

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

POLÍTICA

1. Elegibilidad general

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.6. **Consideraciones:**

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

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

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

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

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

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

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

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

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

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

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

1.8.1.2. Programa de Asistencia Nutricional Suplementaria (SNAP);

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

1.8.1.4. Mujeres, infantes y niños (WIC)

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

1.8.2.1. Montgomery Cares;

1.8.2.2. Project Access;

1.8.2.3. Care for Kids

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

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

1.8.3.1. está categorizado como una persona sin hogar o indigente

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

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

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

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

1.8.3.6. es anciano y víctima de un abuso

1.8.3.7. es un menor no acompañado

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

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

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

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

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

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

      2.1.1. Durante el registro en el Departamento de Emergencias

      2.1.2. Durante sesiones de asesoramiento financiero

      2.1.3. A petición

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

      2.2.1. En todos las oficinas de registro

      2.2.2. En las salas de espera de áreas de especialidad

      2.2.3. En las habitaciones de pacientes de áreas de especialidad

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

      2.3.1. Política de Asistencia financiera:

      2.3.2. Formulario de solicitud de Asistencia financiera

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

3. Periodo de solicitud y determinación de la Política

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Funciones y responsabilidades

4.6. **Responsabilidades de Adventist HealthCare**

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

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

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

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

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

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

4.6.7. AHC brinda opciones para planes de pago.

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

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

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

4.7. **Responsabilidades individuales de los pacientes**

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

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

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

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

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

5. Identificación de personas potencialmente elegibles

5.1. Identificación a través de socialización y divulgación

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.1. Esta política se revisará bianualmente.

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

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

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

INFORMACIÓN DE CONTACTO Y RECURSOS ADICIONALES

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

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

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

EXHIBIT 9

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

PROOF OF PUBLICATION

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

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

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

Account 2010239567

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

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

My commission expires _____

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

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

358 Moving Sale

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

360 Estate Sales

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

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

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

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

610 Dogs for Sale

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

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

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

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

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

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

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

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

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

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

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

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

CLERK, Circuit Court
Montgomery County, Maryland

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

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

PUBLICATION NOTICE

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

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

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

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

PUBLICATION NOTICE

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

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

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

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

PUBLICATION NOTICE

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

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

JN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

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

PUBLICATION NOTICE

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

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

STATE OF CONNECTICUT
Superior Court/Juvenile Matters
ORDER OF NOTICE

NOTICE TO UNIDENTIFIED PERSON

of parts unknown

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

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

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

Name of Judge
Randolph J.

Date: 6/14/2017

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

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

CECELIA E. JONES PRO SE

NOTICE OF STANDARD PROBATE

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

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

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

UKBAB TSEGA PRO SE

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

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

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

Debra A. Carroll
Personal Representative
Anne Meister
Register of Wills

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

JONATHAN LEROY DAWSON PRO SE

NOTICE OF STANDARD PROBATE

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

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

820 Official Notices

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

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

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

allows for the permit to s
if they are unaltered follo
effective dates are change
change beyond only effec
automatic reopening as a n
public participation. Shoul
rule be triggered, the perm
For FGD wastewater, the
permittee to either elect
untary limits at 40 CFR
established in a finalized
meeting mandatory limits
as possible and apply for
If neither is submitted to
months, new limits for a
maximum), mercury (0.35
mum), selenium (12 µg/L
nitrate-nitrite (4.4 mg/L a
become effective at Mon
compliance date specified
finalized rule. For bottom
permit allows twelve mont
date for cessation of botto
as soon as possible and a
the cessation date shall
specified at 40 CFR 423.13(
The permit requires biomo
tices for fly ash handling
Act 316(a) for thermal di
water intake structures, a
restrictions on PCBs, biocid
The facility must also obtai
General Discharge Permit
Industrial Activities (12-SW)
If a written request is rec
hearing on the tentative d
can be scheduled. The
**Maryland Department of
agement Administration,
more, Maryland 21230-17
Chief, Industrial and Gen**
include the name, address
and work) of the person
any other party whom the
represent, and the name o
Failure to request a hearing
a waiver of the right to a
determination for this perm
Written comments concer
will be considered in the pr
if submitted to the Departm
Richardson at the above a
2017. Any hearing-impaire
may request an interprete
Mr. Richardson at (410) 53
written request to the abo
days prior to the scheduled
Information supporting the
ing the draft permit and f
contacting Mr. Richardson
to make an appointment
Richardson at the above ad
be obtained at a cost of $0.3

851 Prince Georges County

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

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

CASE NO. CAEF14-05776

NOTICE

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

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

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

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

EXHIBIT 10

El Tiempo Latino

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

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

WWW.ELTIEMPOLATINO.COM

Affidavit of Performance

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

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

Date: July 21, 2017

Dear Ms. McKy:

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

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

Sincerely,

Zulema Tijero, VP of Advertising
El Tiempo Latino

El Tiempo Latino

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

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

WWW.ELTIEMPOLATINO.COM

July 21, 2017

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

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

Wendy Hawa Wendy Hawa, Asst. to Zulema Tijero

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

My commission expires 8/14/2021.


CLASIFICADOS

VDOT

SOLICITUD DE PROPUESTAS

NOTIFICACIÓN PÚBLICA

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

NOTARY PUBLIC
My Commission Expires 8/14/21

My Commission Expires
August 14, 2021

Anuncio Público

VDOT
Virginia Department of Transportation

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

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

NOTIFICACIÓN PÚBLICA

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

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

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

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

Closing Date: July 19, 2017

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

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

EXHIBIT 11

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. 15-039

Issued to:

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

Type of Facility: Special Hospital - Psychiatric

Number of beds: 117

Date Issued: January 1, 2017

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Section 318 Annotated Code of Maryland, 1982 Edition, and subsequent supplements and is subject to any and all statutory provisions, including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration Date: March 5, 2018

Patricia Tomko May M.D.

Director

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

EXHIBIT 12

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY
SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. 15-023

Issued to:

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

Type of Facility: Acute General Hospital

Date Issued: November 12, 2016

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Section 318 Annotated Code of Maryland, 1982 Edition, and subsequent supplements and is subject to any and all statutory provisions, including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration Date: February 12, 2020

Patricia Tomko May MD

Director

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

EXHIBIT 13

COPY

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY
SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. 15-031

Issued to:

Adventist Healthcare Washington Adventist Hospital
7600 Carroll Avenue
Takoma Park, MD 20912

Type of Facility: Acute General Hospital

Date Issued: August 19, 2016

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Section 318 Annotated Code of Maryland, 1982 Edition, and subsequent supplements and is subject to any and all statutory provisions, including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration Date: November 19, 2019

Patricia Tomko May MD

Director

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

EXHIBIT 14

Quality Check®

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

Quality Report

The Joint Commission®

Adventist Health Care, Inc.

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

Summary of Quality Information

Accreditation Programs

View Accreditation History

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

Sites

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

Available Services

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

Other Clinics/Practices Located at This Site:

- Outpatient Wellness Clinic

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

Available Services

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

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

Available Services

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

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

Available Services

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

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

Available Services

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

National Patient Safety Goals and National Quality Improvement Goals

Symbol Key

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

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

Measures Footnote Key

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

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

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

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

New Changes to Quarterly Measure

Download Quarterly Measure Results

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

EXHIBIT 15

Quality Check®

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

Quality Report

The Joint Commission®

Adventist HealthCare Shady Grove Medical Center

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

Summary of Quality Information

Accreditation Programs

View Accreditation History

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

Core Certification Programs

View Certification History

Joint Replacement - Hip

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

Joint Replacement - Knee

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

Sites

Adventist HealthCare Germantown Emergency Center

19735 Germantown Road
Rockville, MD, 20850

Available Services

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

Adventist HealthCare Shady Grove Medical Center

9901 Medical Center Drive
Rockville, MD, 20850

Available Services

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

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

Certification Programs

- Joint Replacement - Hip
- Joint Replacement - Knee

Aquilino Cancer Center

9905 Medical Center Drive,
Rockville, MD, 20850

Available Services

- Outpatient Clinics (Outpatient)

Other Clinics/Practices Located at This Site:

- Lymphedema Clinic
- Radiation Oncology

Shady Grove Adventist Hospital Maternity Center

19735 Germantown Rd. # 270
Germantown, MD, 20874

Available Services

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

Special Quality Awards

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

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

Cooperative Agreements

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

National Patient Safety Goals and National Quality Improvement Goals

Symbol Key

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

Measures Footnote Key

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

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

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

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

New Changes to Quarterly Measure

Download Quarterly Measure Results

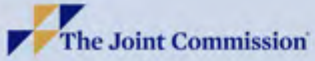
The Joint Commission only reports measures endorsed by the **National Quality Forum**.
* State results are not calculated for the National Patient Safety Goals.

EXHIBIT 16

Quality Check

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

Quality Report


The Joint Commission

Quality Report

Washington Adventist Hospital

HCO ID: 6302
7600 Carroll Ave.
Takoma Park, MD, 20912
(301) 891-6186
www.adventisthealthcare.com

Summary of Quality Information

Accreditation Programs

View Accreditation History

Behavioral Health Care

Accreditation Decision
Accredited

Effective Date
10/19/2016

Last Full Survey Date
8/18/2016

Last On-Site Survey Date
8/18/2016

Hospital

Accreditation Decision
Accredited

Effective Date
8/20/2016

Last Full Survey Date
8/19/2016

Last On-Site Survey Date
8/19/2016

Sites

Washington Adventist Hospital

7600 Carroll Ave.
Takoma Park, MD, 20912

Available Services

- Behavioral Health (Day Programs - Adult)
- Behavioral Health (Non 24 Hour Care - Adult)
- Behavioral Health (24-hour Acute Care/Crisis Stabilization - Adult)
- Behavioral Health (Partial - Adult)
- Brachytherapy (Imaging/Diagnostic Services)
- Cardiac Catheterization Lab (Surgical Services)
- Cardiac Surgery (Surgical Services)
- Cardiothoracic Surgery (Surgical Services)
- Cardiovascular Unit (Inpatient)
- Community Integration (Non 24 Hour Care)
- CT Scanner (Imaging/Diagnostic Services)
- Dialysis Unit (Inpatient)
- Ear/Nose/Throat Surgery (Surgical Services)
- EEG/EKG/EMG Lab (Imaging/Diagnostic Services)
- Family Support (Non 24 Hour Care)
- Gastroenterology (Surgical Services)
- General Laboratory Tests
- Gynecological Surgery (Surgical Services)
- Gynecology (Inpatient)
- Hematology/Oncology Unit (Inpatient)
- Inpatient Unit (Inpatient)
- Interventional Radiology (Imaging/Diagnostic Services)
- Labor & Delivery (Inpatient)
- Magnetic Resonance Imaging (Imaging/Diagnostic Services)
- Medical /Surgical Unit (Inpatient)
- Medical ICU (Intensive Care Unit)
- Neurosurgery (Surgical Services)

- Neurosurgery (Surgical Services)
- Normal Newborn Nursery (Inpatient)
- Nuclear Medicine (Imaging/Diagnostic Services)
- Ophthalmology (Surgical Services)
- Orthopedic Surgery (Surgical Services)
- Orthopedic/Spine Unit (Inpatient)
- Outpatient Clinics (Outpatient)
- Peer Support (Non 24 Hour Care)
- Plastic Surgery (Surgical Services)
- Positron Emission Tomography (PET) (Imaging/Diagnostic Services)
- Post Anesthesia Care Unit (PACU) (Inpatient)
- Radiation Oncology (Imaging/Diagnostic Services)
- Teleradiology (Imaging/Diagnostic Services)
- Thoracic Surgery (Surgical Services)
- Ultrasound (Imaging/Diagnostic Services)
- Urology (Surgical Services)
- Vascular Surgery (Surgical Services)

Washington Adventist Hospital Conference Center

Washington Adventist Hospital Conference Center
7620 Carroll Avenue
Takoma Park, MD, 20912

Available Services

Available Services

- Outpatient Clinics (Outpatient)

Other Clinics/Practices Located at This Site:

Other Clinics/Practices Located at This Site:

- Washington Adventist Hospital Cardiac Rehabilitation Service
- Women's Health Center

Special Quality Awards

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

- 2013 Gold Plus Get With The Guidelines - Stroke

Cooperative Agreements

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

National Patient Safety Goals and National Quality Improvement Goals

Show Keys +

Symbol Key

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

N/A This measure is not applicable for this organization

N/D Not displayed

Measures Footnote Key

1. The measure or measure set was not reported.
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7. The measure results are based on a sample of patients.
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* This information can also be viewed at Hospital Compare.

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

Hospital

2016 National Patient Safety Goals

Nationwide Comparison:

Statewide Comparison: N/A

Behavioral Health Care

2016 National Patient Safety Goals

Nationwide Comparison:

Statewide Comparison: N/A

Reporting Period: October 2016 - September 2017

National Quality Improvement Goals:

Emergency Department

National Comparison: N/D [2]

Statewide Comparison: N/D [2]

Immunization

National Comparison: N/D [2]

Statewide Comparison: N/D [2]

Perinatal Care

National Comparison: N/D [2]

Statewide Comparison: N/D [2]

New Changes to Quarterly Measure

Download Quarterly Measure Results

The Joint Commission only reports measures endorsed by the National Quality Forum.

* State results are not calculated for the National Patient Safety Goals.

EXHIBIT 17

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

APPLICANT RESPONSE:

Pursuant to the May 17, 2018 SGMC Commission approval of the consolidation of acute psychiatric beds of Adventist Behavioral Health ("ABH") into SGMC, there are 117 licensed specialty hospital psychiatric beds that will come under the SGMC license that are currently licensed at ABH located on the SGMC campus in Rockville; 87 designated for adults and 30 for children and adolescents. An additional 29 licensed psychiatric acute hospital beds for adults will be relocated from Adventist HealthCare Washington Adventist Hospital ("WAH"). All of SGMC's licensed psychiatric beds will be located within the facilities currently occupied by ABH. The consolidation of the beds within the Adventist HealthCare ("AHC") system will not affect access or usage particularly since ABH is the only provider offering admission to involuntary patients in the area. All of the affected beds will remain in Montgomery County. At SGMC, following the consolidation of the WAH beds, there will be 116 adult beds, 22 adolescent beds, and 8 beds for children, for a total of 146 beds.

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

APPLICANT RESPONSE:

ABH is located on the same Rockville campus as SGMC, next to SGMC's emergency department. ABH accepts involuntary and emergency psychiatric emergency admissions on a 24/7 basis with no special limitation for weekdays or late night shifts. This will not change when the consolidation of all beds is consummated under the SGMC license. The additional beds to be relocated from the WAH acute care hospital will enhance the availability of this service by ensuring additional inpatient beds are available to accept inpatient psychiatric admissions from area emergency departments.

Procedures at SGMC for psychiatric emergency inpatient treatment are in place at SGMC and will not change following this consolidation (Exhibit 18).

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

APPLICANT RESPONSE:

SGMC is already designated by the Maryland Department of Health's Behavioral Health Administration as a psychiatric emergency facility, designated to perform mental disorder evaluations of persons brought in on emergency petition. (*See* Exhibit 19).

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

APPLICANT RESPONSE:

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

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

APPLICANT RESPONSE:

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

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

APPLICANT RESPONSE:

Inpatient psychiatric services for children and adolescents to be provided at SGMC are currently provided at the ABH facility in units separate from one another and the adult and geriatric

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

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

APPLICANT RESPONSE:

SGMC and ABH have full-time and part-time psychiatrists on staff and available for consultation. This will continue after the WAH consolidation.

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

APPLICANT RESPONSE:

AHC is requesting a consolidation of 29 licensed psychiatric beds from WAH in furtherance of the approved consolidation of 117 ABH beds, currently licensed to ABH as 87 adult/geriatric beds and 30 child and adolescent beds to be consolidated into a 146 bed psychiatric service of SGMC. The configuration of the consolidated service will be 8 child, 22 adolescent and 116 adult/geriatric beds at SGMC. This proposed consolidation is part of a concomitant request for a project change to an approved Certificate of Need.

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

APPLICANT RESPONSE:

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

Accessibility

> **Standard AP 5. Once a patient has requested admission to an acute psychiatric inpatient facility, the following services must be made available:**
>
> **(i) intake screening and admission;**
>
> **(ii) arrangements for transfer to a more appropriate facility for care if medically indicated;**

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

(iv) emergency treatment.

APPLICANT RESPONSE:

SGMC Needs Assessment department clinical staff will provide the face-to-face evaluation to determine psychiatric criteria and the most appropriate level of care. A physician will evaluate and determine that the individual is medically stable to participate in psychiatric care. These services will be provided by SGMC staff on campus in Rockville. The Needs Assessment staff will arrange for an appropriate transfer only if needed services and/or appropriate space are not available.

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

APPLICANT RESPONSE:

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

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

APPLICANT RESPONSE:

Although AHC is not proposing new psychiatric services, no individual will be denied psychiatric services based on legal status. The SGMC facility will continue to be the only psychiatric facility in Montgomery County accepting adult involuntary admissions.

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

APPLICANT RESPONSE:

AHC has a strong record of providing uncompensated care as needed by its patients. In FY 2016 (the last publicly available data for all hospitals) SGMC provided 4.18%, WAH provided 7.42% in overall uncompensated care (8.84% to psychiatric patients) and ABH provided 7.49% compared to the Montgomery County straight average for all acute hospitals of 6.37%. ABH, WAH and SGMC are all governed by the AHC financial assistance policy (Exhibits 7, 8) and will continue to be governed by this policy upon the movement of these beds to White Oak.

> **Standard AP 9. If there are no child acute psychiatric beds available within a 45 minute travel time under normal road conditions, then an acute child psychiatric patient may be admitted, if appropriate, to a general pediatric bed. These hospitals must develop appropriate treatment protocols to ensure a therapeutically safe environment for those child psychiatric patients treated in general pediatric beds.**

APPLICANT RESPONSE:

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

Quality

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

APPLICANT RESPONSE:

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

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

APPLICANT RESPONSE:

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

Continuity

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

APPLICANT RESPONSE:

The SGMC staff will follow the current ABH discharge planning and referral policies (Exhibit 20) to ensure the patient's next level of care needs are met through a variety of services including inpatient, outpatient, partial hospitalization, aftercare treatment programs and other alternative treatment programs. These policies will be available for review by appropriate licensing and certifying bodies.

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

> **Standard AP 14: Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all the following:**
>
> **(i) the local and state mental health advisory council(s);**
>
> **(ii) the local community mental health center(s);**
>
> **(iii) the Department of Health and Mental Hygiene; and**
>
> **(iv) the city/county mental health department(s).**
>
> **Letter from other consumer organizations are encouraged.**

APPLICANT RESPONSE:

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

EXHIBIT 18

Behavioral Health Assessment and Management Policy

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

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

Risk Scale

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

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

Implement Precautions

Implementing Behavioral Management Precautions:

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

Psych Consult

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

Restraints

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

Removal of Restraints/ Pre-Cautions

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

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

Providing a Safe Environment for the High Risk Patient:

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

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

Provide Safe Environment

Behavioral management precautions

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

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

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

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

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

a. The CC:

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

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

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

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

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

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

4. Other Safety Measures:

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

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

Completing Documentation for Behavioral Management Precautions:

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

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

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

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

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

Determining the Plan of Care in the Emergency Department

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

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

EXHIBIT 19

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

Allegany County

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

Anne Arundel County

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

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

Baltimore City

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

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

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

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

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

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

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

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

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

Baltimore County

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

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

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

Calvert County

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

Caroline County

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

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

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

Carroll County

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

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

Cecil County

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

Charles County

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

Dorchester County

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

Frederick County

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

Garrett County

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

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

Harford County

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

Howard County

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

Kent County

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

Montgomery County

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

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

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

Prince George's County

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

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

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

Queen Anne's County

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

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

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

St. Mary's County

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

Somerset County

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

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

Talbot County

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

Washington County

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

Wicomico County

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

Worcester County

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

*10 Beds total for all three counties

EXHIBIT 20

Adventist HealthCare
Behavioral Health & Wellness Services

Adventist Behavioral Health & Wellness Services
POLICY MANUAL
DISCHARGE POLICY

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

SCOPE:
ABHWS

PURPOSE:

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

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

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

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

POLICY:
24 hours before discharge

Physician Duties:

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

Social Work:

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

Nursing:

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

Care Management:

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

Day of Discharge

Physician:

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

Social Work:

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

Nursing:

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

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

Needs Assessment:
- Discharge patient out of electronic system

Day After Discharge

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

Social Work:
- Fax discharge and medication reconciliation

Care Management:
- Save HBIPS information on shared drive

HIMS:
- Pick up medical record from unit

Document Information

Document Title

PC 14 Discharge Policy

Document Description

N/A

Approval Information

Approved On: 01/01/2016

Approved By: PIC, MEC

Approval Expires: 01/01/2019

Approval Type: Manual Entry

Document Location: / Behavioral Health & Wellness Services / Clinical

Keywords: N/A

Printed By: Guest User

Standard References: N/A

Note: This copy will expire in 24 hours

EXHIBIT 21

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.

6/27/18

Daniel L Cochran
Chief Operating Officer and Chief Financial Officer
Shady Grove Medical Center

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.

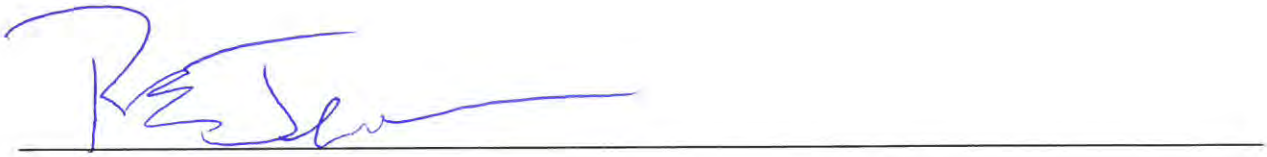
6/27/18

H. Marcel Wright
Vice President, Behavioral Health Services
Adventist HealthCare Shady Grove Medical Center

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.



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

AFFIRMATION

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

Geoffrey Morgan
Vice President, Project Executive
Washington Adventist Hospital

AFFIRMATION

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

Kristen Pulio 6/25/18

Type Name Kristen Pulio Date

Type Title Vice President, Revenue Management

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.

Yuesha Chen
Vice President /Chief Financial Officer
Washington Adventist Hospital

AFFIRMATION

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

Maureen L. Dymond
Vice President, Financial Operations
Adventist HealthCare

AFFIRMATION

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

Linda Beth Berman 6/27/18

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

Date