### BAKER DONELSON

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HOWARD L. SOLLINS, SHAREHOLDER

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October 9, 2020

#### VIA FEDERAL EXPRESS AND E-MAIL

Kevin McDonald Chief - Certificate of Need Division Maryland Health Care Commission 4160 Patterson Avenue Baltimore, Maryland 21215-2299

Re: Adventist HealthCare Shady Grove Medical Center

**Certificate Of Need Application** 

Dear Mr. McDonald:

Enclosed please find four copies of a Certificate of Need Application being filed on behalf of Adventist HealthCare, Inc. d/b/a Adventist HealthCare Shady Grove Medical Center ("Shady Grove") regarding Shady Grove's plan to construct a patient tower on the Shady Grove campus along with other renovations to existing space. A full copy of the application will also be emailed to you in searchable PDF, Word and Excel forms as appropriate. Enclosed is one set of full size project drawings.

I hereby certify that a copy of the CON application has been provided to the affected local health department.

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

Sincerely,

Howard L. Sollins

HLS/tjr Enclosures Kevin McDonald, Chief - Certificate of Need Division October 9, 2020 Page 2

cc: Travis A. Gayles, M.D., Ph.D., Health Officer
Montgomery County Department of Health and Human Services
Dan Cochran, AHC Shady Grove Medical Center
Robert Jepson, AHC
Andrew Nicklas, AHC
Ms. Ruby Potter

# APPLICATION FOR CERTIFICATE OF NEED To Construct A Patient Tower And Renovate Existing Facilities



# Applicant: ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER

Submitted to The Maryland Health Care Commission October 9, 2020

#### **Table of Contents**

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION	1
1. Facility	. 1
2. Owner	.1
3. Applicant	.1
4. Name Of Licensee Or Proposed Licensee	. 1
5. Legal Structure Of Applicant	.1
6. Person(S) To Whom Questions Regarding This Application Should Be Directed	.2
7. Type Of Project	.2
8. Project Description	.3
9. Current Physical Capacity And Proposed Changes	3.
10. Required Approvals And Site Control	.9
11. Project Schedule	.9
12. Project Drawings	11
13. Features Of Project Construction	11
PART II - PROJECT BUDGET 1	15
PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE1	17
PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3)2	20
10.24.01.08G(3)(a). The State Health Plan	20
10.24.01.08G(3)(b). Need	21
10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives	39
10.24.01.08G(3)(d). Viability of the Proposal	14
10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need	17
10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System4	19
PART V - COMAR 10.24.10 – ACUTE CARE HOSPITAL SERVICES SECTION OF THE STATE HEALTH PLAN5	51
.04 Standards5	51
A. General Standards5	51
(1) Information Regarding Charges5	51
(2) Charity Care Policy.	
(3) Quality of Care5	54
B. Project Review Standards5	57
(1) Geographic Accessibility	57

i

(2) Identification of Bed Need and Addition of Beds	58
(3) Minimum Average Daily Census for Establishment of a Pediatric Unit	59
(4) Adverse Impact.	59
(5) Cost-Effectiveness	63
(6) Burden of Proof Regarding Need.	67
(7) Construction Cost of Hospital Space.	67
(8) Construction Cost of Non-Hospital Space.	73
(9) Inpatient Nursing Unit Space.	73
(10) Rate Reduction Agreement.	74
(11) Efficiency.	74
(12) Patient Safety	75
(13) Financial Feasibility.	76
(14) Emergency Department Treatment Capacity and Space	81
(15) Emergency Department Expansion.	88
(16) Shell Space.	88
List of Exhibits	90

# PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

For internal staff use

MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO	).
DATE DOCKETED	

## HOSPITAL APPLICATION FOR CERTIFICATE OF NEED

#### PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1.	FACIL	LITY						
Name o	f Facility	y: Adve	ntist HealthCare	Shady Grove I	Medical Ce	enter		
Address		enter Drive	Rockville		208	50	Montgomery	
Street			City		Zip		County	
Name o	f Owner	(if differs fr	om applicant):					
2.	OWNE	ER						
Name o	f owner:	Adventi	st HealthCare, I	nc.				
3.		•	he application ha s an attachment.	s co-applicant	s, provide	the detail re	garding each co-ap <sub>l</sub>	plicant in
Legal N	lame of I	Project Appl	icant: <u>Ad</u>	ventist Health	Care Shad	y Grove Med	dical Center	
Address 9901 M		enter Drive	Rockville		20850	MD	Montgomery	
Street			City		Zip	State	County	
Telepho	_	240-826-600						
Name o	f Owner	/Chief Execu	itive: <u>Terry</u>	Forde, Danie	L. Cochra	an		
4. N/A	NAME	OF LICEN	NSEE OR PRO	POSED LICE	ENSEE, if	different fi	rom applicant:	
5.	LEGA	L STRUCT	URE OF APPL	ICANT (and	LICENS	EE, if diffe	rent from applica	nt).
	Check	or fill ir	applicable info	ormation belo	w and at	tach an org	anizational chart	showing
	the ow		licant (and licen				,	
				<u> </u>				
		Governmen						
	B.	Corporation						
		(1) Non-pro		X				
		(2) For-prof	t1t	$\sqcup$	~	0.1.00	. —	
		(3) Close		$\sqcup$	State 6	& date of in	corporation	
	C	Partnership						

	D.	Limited Limited liability p Limited liabil partnership Other (Specify): Limited Liability	lity limited			
I	OIREC A. Lea	CTED  d or primary cor	ntact:			
Mailing A	Address	5:	•			
	Diamo	ond Avenue		hersburg		
Street		201 215 2215	City		Zip	State
_	_				_	
E-mail A	partnership Other (Specify):  D. Limited Liability Company E. Other (Specify):  To be formed: Existing:  PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED  A. Lead or primary contact:  me and Title: Andrew R. Nicklas, Director, Government Relations & Deputy General Counsel stilling Address:  West Diamond Avenue Gaithersburg 20878 MD  State sephone: Siling Address (required):  B. Additional or alternate contact: Linda Berman, Manager Grants Management Department, Adventist HealthCare me and Title: siling Address:  OWest Diamond Avenue Gaithersburg 20878 MD  State sephone: Siling Address: City Zip State sephone: Siling Address: Sili					
Name and Mailing A 820 West	d Title: Address	Linda Berm	an, Manager Gr Gait		20878	MD
Street			City		Zip	State
Telephon E-mail A Fax:	ddress	(required): <u>lb</u>	erman@adventi	sthealthcare.com	<u>n</u>	
T	he foll	owing list include		ategories that	require a CON under	Maryland law.
(2 (3 (4	2) An 3) A c 4) A c hea	existing health ca change in the bed change in the type alth care facility	are facility move capacity of a hea e or scope of ar	d to another site alth care facility by health care s	e service offered by a	
(5	thr	eshold for capital	expenditures for	ınd at:		X

#### 8. PROJECT DESCRIPTION

- **A. Executive Summary of the Project:** The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is; why you need/want to do it; and what it will cost. A one-page response will suffice. Please include:
  - (1) Brief description of the project what the applicant proposes to do;
  - (2) Rationale for the project the need and/or business case for the proposed project;
  - (3) Cost the total cost of implementing the proposed project; and
  - (4) Master Facility Plans how the proposed project fits in long term plans.

#### **Executive Summary**

Adventist HealthCare Shady Grove Medical Center (Shady Grove) proposes the development and construction of a 150,352-square-foot, six-floor patient care tower and renovation of 25,696 square feet of existing space to enhance patient safety, patient experience and clinical efficiency. The project will result in all-private medical/surgical inpatient rooms; a modern Emergency Department (ED) with private treatment bays; an appropriately sized Intensive Care Unit (ICU); and a Clinical Decision Unit (CDU) to facilitate patient transitions from the ED to inpatient care, observation or discharge.

This project will enable Shady Grove to provide state-of-the-art, world-class care while improving quality, safety and operations. It will facilitate the use of the latest technology to care for patients and provide a layout that maximizes clinical efficiency. The total project cost is \$180,011,359 and does not increase the number of licensed inpatient beds. The project will enable Shady Grove to continue to meet community needs now and in the future.

- **B.** Comprehensive Project Description: The description must include details, as applicable, regarding:
  - (1) Construction, renovation, and demolition plans;
  - (2) Changes in square footage of departments and units;
  - (3) Physical plant or location changes;
  - (4) Changes to affected services following completion of the project; and
  - (5) If the project is a multi-phase project, describe the work that will be done in each phase. If the phases will be constructed under more than one construction contract, describe the phases and work that will be done under each contract.

#### **Project Description**

#### About Adventist HealthCare Shady Grove Medical Center

Shady Grove is an acute-care hospital located in the Rockville/Gaithersburg region of Montgomery County, the most populous jurisdiction in Maryland. Shady Grove serves a large geographic area in the county as well as parts of Frederick County. The hospital, part of Maryland-based Adventist HealthCare (AHC), has 345 licensed beds and offers a full array of community-based and regional clinical services including: adult and pediatric emergency care; maternity and neonatal intensive care; heart and vascular services; neuroscience services,

including interventional neurology and neurosurgery; cancer services; adult intensive care services; inpatient pediatrics; forensic medicine; and many others. Shady Grove is also the county's only comprehensive behavioral healthcare provider, with 133 inpatient behavioral health beds and outpatient mental health services for community members of all ages. Shady Grove, has the second busiest ED in Montgomery County and the 12<sup>th</sup> busiest in the state. Shady Grove, with 2,700 employees, provides 135,000 patient encounters each year and provided \$36 million in community benefit in FY2019.

The hospital has a record of measurable quality outcomes. Most notably, in 2020, Shady Grove earned the county's only 5-star designation from the Centers for Medicare and Medicaid Services (CMS) for high performance in seven groups of quality measures: mortality, safety, readmission, patient experience, effectiveness of care, efficient use of medical imaging, and timeliness of care. Only 9% of hospitals nationwide achieved this distinction. Other notable designations for quality and innovative care include: The Joint Commission's Gold Seal of Approval for joint replacement surgery; the Maryland Patient Safety Center's Circle of Honor and Distinguished Achievement awards for neonatal care, chronic obstructive pulmonary disease (COPD) treatment, colorectal surgery, mental health care, and antibiotic stewardship; and the Stroke Gold Plus Quality Achievement Award with Target: Stroke Honor Roll recognition for six consecutive years from the American Stroke Association.

#### Challenges with the Current Facility

Shady Grove provides high quality patient care, but the 41-year-old hospital faces many challenges: too few private inpatient rooms, an aging and undersized ED and ICU that require more modern equipment and patient privacy, and clinical programs that sprawl across inefficiently placed departments formed from decades old medical planning.

The lack of private ED and inpatient rooms dissatisfies patients and creates challenges when dealing with confidential patient information as required under the Healthcare Insurance Portability and Accountability Act (HIPAA). The existing ED separates treatment bays with only curtains and the square footage falls far short of the American College of Emergency Physicians (ACEP) standards. Semi-private inpatient rooms impede the efficient throughput of patients. Additionally, semiprivate rooms create issues when dealing with infectious patients – an issue that was exacerbated during the recent COVID-19 surge.

Shady Grove's growth over the four decades since its opening has created clinical inefficiencies in how services are laid out within the hospital. Many care units are not located adjacent to related service lines, requiring patients to be transported long distances to receive care. Cardiovascular Interventional Radiology (CVIR) patients, for example, need to be transported across the hospital from prep and recovery perioperative services to the CVIR interventional laboratories on the opposite side of the building.

#### The Solution

Standards of care change over time, and Shady Grove must be permitted to adapt to these changes. Private rooms are the modern standard of care in hospitals, and Shady Grove's patients

deserve to receive care in a modern, appropriately sized facility that promotes efficiency, safety, privacy and comfort.

Shady Grove proposes to build a new patient tower adjacent to the current hospital and to renovate existing hospital space. The project will include the following major elements:

- All-private inpatient rooms for medical/surgical patients;
- Private ED treatment spaces:
- A CDU to facilitate efficient care transitions:
- Appropriately sized ICU rooms;
- Vertical stacking of all critical care units to maximize clinical efficiency;
- CVIR relocation adjacent to perioperative services; and
- Relocation of the hospital's helipad for enhanced safety and efficiency.

#### Patient Care Benefits of Proposed Solution

Moving to all-private, inpatient medical/surgical rooms will improve privacy for patients and family members, bolster infection control capabilities, reduce noise levels, and provide a clearer, more efficient line of sight to each patient. Modern, private rooms, with improved lighting and open pathways, will enhance safety goals like fall prevention. Patients and family members will have an enhanced clinical experience and greater peace of mind from truly private care space.

Clinical staff will benefit from an improved workflow design and a layout that moves them closer to their supplies, workspaces, and patient rooms. Patient outcomes will be improved by creating clinical adjacencies such as having the ED located immediately above the catheterization and interventional labs and immediately below the ICU.

#### Site Layout and Organization

The new patient tower will be located immediately east of the existing hospital and adjacent to the existing parking garage. The ED will be located at the ground level of the addition. The walk-in entrance for the replacement ED will be easily identified by visitors as they approach the building along Medical Center Way. A plaza in front of the building will organize vehicular traffic, with a drop-off circle leading to the ED entrance and a driveway leading to and from the parking garage. Pedestrian paths and landscaping will ring the perimeter of the plaza, guiding visitors between the parking garage and the ED. A separate entrance and public corridor, located along the southern end of the ED, provides visitors and staff with a direct path to the hospital's main lobby and new inpatient units.

A dedicated road for ambulances will be located along the north side of the ED to clearly separate this traffic from the public entrance driveways. The road will provide direct access to the ambulance entry vestibule with appropriate room for multiple ambulances to maneuver and park. Hard and soft landscaping will surround the building providing aesthetically pleasing views and a tranquil setting for respite, as well as, serving as part of the overall storm water management strategy.

#### Building Organization, Efficiency and Safety

The project design incorporates evidence-based architectural methods to improve patient outcomes, safety and staff efficiency.

The proposed new patient tower will be 150,352-square-feet with six floors – one below grade and five above grade. The floors will be organized as follows:

1<sup>st</sup> floor: CVIR Suite, mechanical, connector corridor to existing hospital

2<sup>nd</sup> floor: Main lobby entrance, ED, courtyard, connector corridor to existing

hospital

3<sup>rd</sup> floor: ICU (26 beds), connector corridor to existing hospital

4<sup>th</sup> floor: Progressive Care Unit (24 beds), connector corridor to the existing

hospital

5<sup>th</sup> floor: Medical/Surgical Unit (24 beds)

Penthouse: Mechanical support

Roof: Helipad and elevator lobby

The proposed renovation will be 25,696 square feet of existing space on four floors of the hospital as follows:

1<sup>st</sup> floor: Connector corridor to new patient tower

2<sup>nd</sup> floor: CDU, Emergency Psychiatric Treatment Unit (EPTU), ED staff support

room, Pediatric ED waiting room, conference rooms, connector corridor

to new patient tower

3<sup>rd</sup> floor: Connector corridor to new patient tower 4<sup>th</sup> floor: Connector corridor to new patient tower

The new patient tower vertically stacks all critical units in a central location for maximum efficiency, reducing the need to transfer patients long distances between services. For example, the CVIR labs will be adjacent to perioperative services, improving patient experience and operational efficiencies. Shared waiting and registration areas will help simplify wayfinding for patients.

The replacement ED will include all-private, enclosed treatment rooms to improve patient privacy and infection control. The CDU and EPTU will be renovated for closer proximity to the main ED, minimizing travel distance and contact with other patient treatment spaces. Private patient rooms and toilets in the CDU will reduce infection risks.

The ICU location on the third floor of the new tower will provide efficient transport to and from the surgery suite. Placing the ED on the second floor, directly in between the ICU and CVIR, enhances safety and will improve patient outcomes.

The inpatient bed units on the upper floors of the new tower will have all-private rooms, enhancing patient confidentiality and infection control. Hand-washing stations will be located directly inside the entry door of each room. Within the rooms, bathrooms will be located close

to beds for easy access by patients. The rooms will provide ample light to illuminate staff and patient tasks.

New, decentralized nursing units will provide clear lines of sight into patient rooms. Optimally located supply and medication rooms will minimize the distance nurses travel.

Elevator banks separating patients, service and the public will provide more efficient vertical transport through the new tower. Direct connections to the existing hospital on four levels of the new tower will provide efficient travel between buildings. The new tower will include distinct entrances for ED walk-in patients, ambulance arrivals, and hospital visitors.

This proposal will provide Shady Grove the flexibility to expand capacity in case of a demand surge. Maintaining headwalls in rooms that will be converted from semiprivate to private accommodations, allows for an easy expansion for surge capacity. This flexibility will help Shady Grove meet surges in demand for care such as what has been experienced during the COVID-19 pandemic.

The new design will also enhance safety on the hospital campus by creating clearer traffic patterns for both people and vehicles. The hospital's helipad, which now sits between the ambulance driveway, pedestrian walkways and parking, will be relocated to the rooftop of the new tower. Moving the helipad will eliminate the need to halt foot and vehicular traffic, including the arrival of ambulances, around the ED when helicopters come and go.

In addition, the new design will create better checkpoints for visitors entering the hospital, and its simplified pathways from the ED to the main lobby will allow security personnel to better monitor visitors.

#### Sustainable Features

This project will emphasize sustainability, reducing energy consumption and water use, and improving indoor air quality. The project design will, at the very least, meet Montgomery County's minimum requirements. The ability to achieve higher LEED levels will be evaluated throughout the design process.

Green building strategies of this project include:

#### Sustainable Sites

- Construction activity pollution protection
- Public transportation access
- Stormwater quality and quantity control
- Light pollution reduction
- Use of green terraces

#### Water Efficiency

- Water use reduction
- Water efficient landscaping
- Innovative wastewater technologies

#### Energy and Atmosphere

- Building energy system commissioning
- Management of refrigerants
- Improvement over minimum requirements of energy codes
- On-site renewable energy

#### Material and Resources

- Storage and collection of recyclables
- Construction waste management
- Use of regionally sourced materials

#### Indoor Environmental Air Quality

- Improving indoor air quality
- Maintaining a tobacco free campus
- Use of low-emitting interior materials
- Controllability of lighting
- Promoting daylight and views as much as possible

#### Project Budget and Schedule

The proposed project is anticipated to cost \$180,011,359 and will be completed in 60 months in two phases after signing the contract. Phase one, constructing the new patent tower, will require an extended period of 36 months for completion due to the nature of building a tower contiguous with existing, occupied space. This is further explained in the Project Schedule Section below. Phase two will be the renovation of the current ED space and of the areas on each floor that will connect to the new patient tower. Phase two will be completed over a 24-month period.

#### Summary

The Shady Grove renovation and construction project will improve hospital operations, enhance safety and promote quality. Private ED and inpatient rooms will increase patient privacy and provide a modern care experience. The new patient tower will arrange service lines to maximize clinical efficiency and improve outcomes. This project will enable Shady Grove to continue to provide the highest level of care to the community.

Complete the DEPARTMENTAL GROSS SQUARE FEET WORKSHEET (Table B) in the CON TABLE PACKAGE for the departments and functional areas to be affected.

#### 9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

Complete the Bed Capacity (Table A) worksheet in the CON Table Package if the proposed project impacts any nursing units.

#### **Applicant Response**

See Exhibit 1 Hospital CON Application Tables, Table A: Physical Bed Capacity Before and After Project

#### 10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: 3.58 acres

B. Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained? YES\_\_\_\_\_NO\_X\_(If NO, describe below the current status and timetable for receiving necessary approvals.)

The proposed patient tower will require an amendment to the existing site plan for the property. Because the patient tower is within the existing footprint of the hospital facility we anticipate that the site plan review will take approximately four to six months to complete after the site plan application is submitted. Building permits will be issued after the site plan process has been completed.

C.	Form of Site Control (Res	pond to the one that applies. If more than one, explain.):
(1)	Owned by: Advent	ist HealthCare, Inc. (Exhibit 2)
	Please provide a copy of	the deed.
(2)	Options to purchase held	by: N/A
	Please provide a copy of	the purchase option as an attachment.
(3)	Land Lease held by:	N/A
	Please provide a copy of	the land lease as an attachment.
(4)	Option to lease held by:	N/A
	Please provide a copy of	the option to lease as an attachment.
(5)	Other:	The hospital Central Utility Plant is situated on adjacent land owned by Montgomery County and provided to the medical center via a ground lease.

#### 11. PROJECT SCHEDULE

In completing this section, please note applicable performance requirement time frames set forth at COMAR 10.24.01.12B & C. Ensure that the information presented in the following table reflects information presented in Application Item 7 (Project Description).

	Proposed Project Timeline
Single Phase Project	
Obligation of 51% of capital expenditure from CON approval date	months
Initiation of Construction within 4 months of the effective date of	
a binding construction contract, if construction project	months
Completion of project from capital obligation or purchase order,	
as applicable	months
Multi-Phase Project for an existing health care facility	

	Propose Timelin	ed Project ne
(Add rows as needed under this section)		
One Construction Contract	72	months
Obligation of not less than 51% of capital expenditure up		
to 12 months from CON approval, as documented by a		
binding construction contract.	5	months
Initiation of Construction within 4 months of the effective		
date of the binding construction contract.	1	months
Completion of 1 <sup>st</sup> Phase of Construction within 24 months		
of the effective date of the binding construction contract	36	months
Fill out the following section for each phase. (Add rows as needed)	)	
Completion of each subsequent phase within 24 months of		
completion of each previous phase		
Phase 2 – Renovations	24	months
Multiple Construction Contracts for an existing health care facil	ity	
(Add rows as needed under this section)	T	
Obligation of not less than 51% of capital expenditure for		
the 1 <sup>st</sup> Phase within 12 months of the CON approval date		months
Initiation of Construction on Phase 1 within 4 months of		
the effective date of the binding construction contract for		
Phase 1		months
Completion of Phase 1 within 24 months of the effective		
date of the binding construction contract.		months
To Be Completed for each subsequent Phase of Construction	T	
Obligation of not less than 51% of each subsequent phase		
of construction within 12 months after completion of		
immediately preceding phase		months
Initiation of Construction on each phase within 4 months		
of the effective date of binding construction contract for		
that phase		months
Completion of each phase within 24 months of the		
effective date of binding construction contract for that		
phase		months

#### **EXPLANATION OF EXTENDED PHASE 1**

Phase 1, the new bed tower construction, will require an extended construction period due to several factors relating to the existing conditions on site. First, a series of existing utilities will need to be relocated into a new tunnel in order to clear the new building footings. Second, the excavation will need to be sheeted and shored to avoid impact on the adjacent hospital structure, resulting in a longer excavation phase. Third, temporary means of access will need to be constructed, maintained and periodically revised in order to maintain access to the existing, occupied hospital. Finally, certain

extraordinary features of the new tower, such as the vegetative roofs, will extend the construction sequencing.

#### 12. PROJECT DRAWINGS

A project involving new construction and/or renovations must include scalable schematic drawings of the facility at least a 1/16" scale. Drawings should be completely legible and include dates. Project drawings must include the following before (existing) and after (proposed) components, as applicable:

- A. Floor plans for each floor affected with all rooms labeled by purpose or function, room sizes, number of beds, location of bathrooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as "shell space."
- B. For a project involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.
- C. For a project involving site work schematic drawings showing entrances, roads, parking, sidewalks and other significant site structures before and after the proposed project.
- D. Exterior elevation drawings and stacking diagrams that show the location and relationship of functions for each floor affected.

#### **Applicant Response**

Project Drawings are included in Exhibit 3 and a full-size set of drawings will be submitted.

#### 13. FEATURES OF PROJECT CONSTRUCTION

- A. If the project involves new construction or renovation, complete the Construction Characteristics (Table C) and Onsite and Offsite Costs (Table D) worksheets in the CON Table Package.
- B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project, and the steps necessary to obtain utilities. Please either provide documentation that adequate utilities are available or explain the plan(s) and anticipated timeframe(s) to obtain them.

#### TABLE C. CONSTRUCTION CHARACTERISTICS

<u>INSTRUCTION</u>: If project includes non-hospital space structures (e.g., parking garages, medical office buildings, or energy plants), complete an additional Table C for each structure.

or energy plants), complete an administration of the	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	Check if applicable	
Class of Construction (for renovations the class of the building being renovated)*	<u> </u>	~
Class A Class B	H	$\vdash$
Class B Class C	$\vdash$	$\vdash$
Class D		
Type of Construction/Renovation*		
Low		
Average	<b>✓</b>	✓
Good		
Excellent		
Number of Stories	7	4

<sup>\*</sup>As defined by Marshall Valuation Service

PROJECT SPACE	List Number of Feet,	if applicable		
Total Square Footage	Total Square Feet			
First Floor	22,502	400		
Second Floor	38,560	24,896		
Third Floor	24,193	200		
Fourth Floor	22,978	200		
Fifth Floor	21,486			
Penthouse	18,457			
Roof	2,176			
Total Square Footage	150,352	25,696		
Average Square Feet	21,479	6,424		
Perimeter in Linear Feet	Linear Feet	·		
First Floor	375			
Second Floor	810			
Third Floor	764			
Fourth Floor	821			
Fifth Floor	695			
Penthouse	695			
Roof	196			
<b>Total Linear Feet</b>	4,356			
Average Linear Feet	622			
Wall Height (floor to eaves)	Feet			
First Floor	16			
Second Floor	16			
Third Floor	16			
Fourth Floor	16			
Fifth Floor	15			
Penthouse	17			
Roof	15			

#### TABLE C. CONSTRUCTION CHARACTERISTICS

<u>INSTRUCTION</u>: If project includes non-hospital space structures (e.g., parking garages, medical office buildings, or energy plants), complete an additional Table C for each structure.

or energy plants), complete an additional Table C for each structure.					
	NEW CONSTRUCTION	RENOVATION			
BASE BUILDING CHARACTERISTICS	Check if applicable				
Average Wall Height	15.86				
OTHER COMPONENTS					
Elevators	List Number				
Passenger	2				
Freight	2				
Sprinklers	Square Feet Covered				
Wet System	150,352	25,696			
Dry System					
Other	Describe Type				
Type of HVAC System for proposed project	VAV / Reheat	VAV / Reheat			
Type of Exterior Walls for proposed project	Precast concrete and brick with glass and metal panel curtain wall system				

### TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garages, medical office buildings, or energy plants), complete an additional Table D for each structure. CONSTRUCTION RENOVATION **NEW** SITE PREPARATION COSTS **COSTS COSTS** Normal Site Preparation \$1,696,406 \$0 Utilities from Structure to Lot Line \$0 \$1,230,477 **Subtotal included in Marshall Valuation Costs** \$2,926,883 **\$0** Site Demolition Costs \$101,514 \$0 Storm Drains \$319,990 \$0 Rough Grading \$886,247 \$0 Pilings & Hillside Foundation \$3,962,135 \$0 \$0 Paving \$1,401,878 \$82,814 \$0 **Exterior Signs** Landscaping \$399,995 \$0 Walls, Stairs, Structures \$337,766 \$0 Yard Lighting \$369,143 \$0 Other (Specify/add rows if needed) Sheeting & Shoring for Excavation Adjacent to Existing Bldg. \$1,306,643 \$0 Relocate Existing Utilities to New Tunnel \$1,472,782 \$0 Sediment and Erosion Control \$0 \$73,829 Montgomery County Land Use Costs \$1,500,000 \$0 \$0 New Helipad \$799,810 Pneumatic Tube System \$461,429 \$0 **Exterior Canopies** \$952,512 \$0 Vegetated Roofs \$771,657 \$0 Additional Service Elevator \$602,934 \$0 \$139,040 **Enhanced Commissioning** \$0

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garages, medical office buildings, or energy plants), complete an additional Table D for each structure.

| NEW | CONSTRUCTION | RENOVATION |

or energy plants), complete an additional Table D for each structure.			
SITE PREPARATION COSTS	NEW CONSTRUCTION COSTS	RENOVATION COSTS	
Underground Oxygen Piping	\$470,657	\$0	
Temporary Construction for Access	\$246,095	\$0	
Extended General Conditions for Phased			
Construction	\$2,890,451	\$0	
A/E Fees Associated with Extraordinary Costs	\$1,452,052	\$0	
Subtotal On-Site excluded from Marshall			
Valuation Costs	\$21,001,373	\$0	
OFFSITE COSTS			
Jurisdictional Hook-up Fees	\$970,846	\$0	
Other (Specify/add rows if needed)	\$0	\$0	
Subtotal Off-Site excluded from Marshall			
Valuation Costs	\$970,846	\$0	
<b>TOTAL Estimated On-Site and Off-Site Costs not</b>			
included in Marshall Valuation Costs	\$21,972,219	\$0	
TOTAL Site and Off-Site Costs included and			
excluded from Marshall Valuation Service*	\$24,899,102 <sup>1</sup>	\$0	

<sup>\*</sup>The combined total site and offsite cost included and excluded from Marshall Valuation Service should typically equal the estimated site preparation cost reported in Application Part II, Project Budget (see Table E. Project Budget). If these numbers are not equal, please reconcile the numbers in an explanation in an attachment to the application.

4848-9177-7997

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<sup>&</sup>lt;sup>1</sup> The combined total site and offsite costs do not equal the estimated site preparation costs identified in the project budget because various costs are distributed throughout other budget line items. Certain extraordinary costs are included in budget categories a.(1) Building, a.(2) Fixed Equipment, a.(4) Architect/Engineering Fees and/or a.(5) Permits (Building, Utilities) in lieu of a.(3) Site and Infrastructure. For example, the pilings, helipad, exterior canopies, vegetated roofs, service elevator, enhanced commissioning, temporary construction for access and extended general conditions are in the Building line item. The pneumatic tube system is in the Fixed Equipment. The A/E fees associated with extraordinary costs are carried with A/E fees. The Montgomery County land use costs are partly within Permits and partly within A/E Fees. The jurisdictional hook-up fees are in Permits. See Exhibit 25.



#### PART II - PROJECT BUDGET

nates, contingencies, interest during construction period, and inflatior	an addomnone to the application		
TE: Inflation should only be included in the Inflation allowance line A.1	.e. The value of donated land for the		ine A.1.d as a use of
ds and on line B.8 as a source of funds			
USE OF FUNDS	Hospital Building	CUP Upgrade	Total
1. CAPITAL COSTS			
a. New Construction			
(1) Building	\$73,458,451	\$6,752,441	\$80,210,892
(2) Fixed Equipment (3) Site and Infrastructure	\$3,525,375 \$10,150,141	\$301,922 \$408,005	\$3,827,297 \$10,558,146
(4) Architect/Engineering Fees	\$5,856,282	\$501,546	\$6,357,828
(5) Permits (Building, Utilities, Etc.)	\$2,158,953	\$184,898	\$2,343,851
SUBTOTAL	\$95,149,202	\$8,148,812	\$103,298,014
b. Renovations			
(1) Building (2) Fixed Equipment (not included in construction)	\$8,840,236 \$0	\$0 \$0	\$8,840,236 \$0
(3) Architect/Engineering Fees	\$656,620	\$0	\$656,620
(4) Permits (Building, Utilities, Etc.)	\$242,067	\$0	\$242,067
SUBTOTAL	\$9,738,923	\$0	\$9,738,923
c. Other Capital Costs	#0.000.400	#000 000 <b>1</b>	#0.000.100
(1) Movable Equipment (2) Contingency Allowance	\$3,629,400 \$11,997,789	\$200,000 \$849,381	\$3,829,400 \$12,847,170
(3) Gross interest during construction period	\$13,653,795	\$957,801	\$12,847,170
(4) Other (Specify/add rows if needed)			
a. Furniture	\$2,367,000	\$25,000	\$2,392,000
b. Interior & Exterior Signage	\$723,400	\$15,000	\$738,400
c. IS/Comm d. Security system	\$6,615,000 \$1,250,000	\$50,000 \$15,000	\$6,665,000 \$1,265,000
e. Relocation expense	\$315,600	\$15,000	\$330,600
f. Certifications, inspections, etc.	\$189,360	\$25,000	\$214,360
SUBTOTAL	\$40,741,344	\$2,152,182	\$42,893,526
TOTAL CURRENT CAPITAL COSTS	\$145,629,469	\$10,300,994	\$155,930,463
d. Land Purchase e. Inflation Allowance	\$13,799,530	\$882,804	\$14,682,334
TOTAL CAPITAL COSTS	\$159,428,999	\$11,183,798	\$170,612,797
2. Financing Cost and Other Cash Requirements	\$100,120,000	<b>\$11,100,100</b>	¥
a. Loan Placement Fees	\$1,798,990	\$126,197	\$1,925,187
b. Bond Discount			\$0
c CON Application Assistance			\$0
c1. Legal Fees c2. Other (Specify/add rows if needed)	+		φυ
d. Non-CON Consulting Fees			
d1. Legal Fees			\$0
d2. Other (Specify/add rows if needed)			\$0
e. Debt Service Reserve Fund  f Other (Specify/add rows if needed)	\$6,986,996	\$486,379	\$7,473,375 \$0
SUBTOTAL	\$8,785,986	\$612,576	\$9,398,562
3. Working Capital Startup Costs	, , , , , , , , , , , , , , , , , , , ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	\$0
TOTAL USES OF FUNDS	\$168,214,985	\$11,796,374	\$180,011,359
Sources of Funds	40.007.007	#050 000 P	<b>A</b>
1. Cash Philanthrony (to date and expected)	\$9,337,090 \$14,958,694	\$659,269 \$1,041,306	\$9,996,359 \$16,000,000
Philanthropy (to date and expected)     Authorized Bonds	\$143,919,200	\$1,041,306	\$154,015,000
4. Interest Income from bond proceeds listed in #3	\$524,068	\$36,763	\$560,831
5. Mortgage			\$0
6. Working Capital Loans			\$0
7. Grants or Appropriations a. Federal	<del></del>		\$0
b. State	+		\$0
c. Local			\$0
8. Other (Specify/add rows if needed)			\$0
TOTAL SOURCES OF FUNDS	\$168,214,984	\$11,796,375	\$180,011,359
nual Lease Costs (if applicable)	Hospital Building	CUP Upgrade	Total
1. Land	<del> </del>		\$0
2. Building	1		\$0
3. Major Movable Equipment			\$0
4. Minor Movable Equipment			\$0
5. Other (Specify/add rows if needed)	<del>-  </del>		\$0

Complete the Project Budget (Table E) worksheet in the CON Table Package.

<u>Note:</u> Applicant must include a list of all assumptions and specify what is included in all costs, as well the source of cost estimates and the manner in which all cost estimates are derived.

# PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

## PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. List names and addresses of all owners and individuals responsible for the proposed project.

Terry Forde, President and Chief Executive Officer, Adventist HealthCare, Inc. 820 West Diamond Avenue, Gaithersburg, MD 20878

Daniel L. Cochran, President Adventist HealthCare Shady Grove Medical Center, 9901 Medical Center Drive, Rockville, MD 20850

2. Is any applicant, owner, or responsible person listed above now involved, or has any such person ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each such facility, including facility name, address, the relationship(s), and dates of involvement.

#### **Applicant Response**

#### **Terry Forde**

- 5/1992 3/1997 Patient Financial Services, Shawnee Mission Medical Center 9100 West 74th Street, Merriam, KS 66204
- 3/1997 9/1999 Director of Revenue Cycle HCA Independence Regional Health Center 19600 East 39th St S, Independence, MO 64057 Independence, MO
- 9/1999 2/2002)- Chief Financial Officer Avera Holy Family Hospital 826 N. Eighth Street Estherville IA 51334
- 2/2002 6/2003) Chief Financial Officer Truman Medical Center Lakewood 7900 Lee's Summit Road – Kansas City, MO 64139
- 6/2003 6/2011 Adventist Health System/Centura Health Denver, CO -
- 6/2003 2/2007 CFO/COO Porter Adventist Hospital 2525 S Downing St. Denver, Colorado 80210
- 2/2007 6/2011 CEO Parker Adventist Hospital 9395 Crown Crest Blvd, Parker, Colorado 80138
- 6/2011 to Present Adventist HealthCare 820 West Diamond Avenue Gaithersburg, Maryland 20878
- 6/2011 4/2014)Chief Operating Officer
- 4/14- Present President and Chief Executive Officer

#### Daniel L. Cochran

- 1988-1992 Assistant Controller, Renova Center for Special Services, 4950 Wilson Ln, Mechanicsburg, PA 17055
- 1992-1996 Assistant Controller, Mechanicsburg Rehab Hospital, 175 Lancaster Blvd.
  - Mechanicsburg, PA 17055
- 1996-2002 Controller / CFO, HEALTHSOUTH Nittany Valley Rehab Hospital, 550
   W College Ave, Pleasant Gap, PA 16823
- 3/2002-6/2003 Controller/Assistant CFO, Carlisle Regional Medical Center 361 Alexander Spring Rd, Carlisle, PA 17015

- 6/2003-6/2004 Chief Financial Officer, Community Hospital of Lancaster, 1100 East Orange Street, Lancaster, PA 17602
- 6/2004-5/2005 Chief Financial Officer, Lancaster Regional Medical Center, 250 College Ave, Lancaster PA, 17603
- 5/2005-7/2008 Regional Associate Vice President, Quorum Health Resources (QHR), 1573 Mallory Ln, Brentwood, TN 37027
- 8/2008 4/2011 Vice President Finance, The Reading Hospital and Medical Center, 420 S. Fifth Avenue, West Reading, PA 19611
- 4/2011 6/2019 Chief Operating Officer & Chief Financial Officer, Adventist HealthCare
- Shady Grove Medical Center, 9901 Medical Center Dr, Rockville, MD 20850
- 7/2019—Present President, Adventist HealthCare Shady Grove Medical Center,
   9901 Medical Center Dr, Rockville, MD 20850
- 3. In the last 5 years, has the Maryland license or certification of the applicant facility, or the license or certification from any state or the District of Columbia of any of the facilities listed in response to Question 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions)? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant(s), owners, or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

No

4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) ever received inquiries from a federal or any state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with Maryland, another state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

No

5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

No

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

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

Date	Signature of Owner or Board-designated Official
	President and Chief Executive Officer Adventist HealthCare, Inc.
	Position/Title
	Terry Forde
	Printed Name
D. (	
Date	Signature of Owner or Board-designated Official
	President, Adventist HealthCare Shady Grove Medical Center
	Position/Title
	Daniel L. Cochran
	Printed Name

Please see Exhibit 28 Affirmations.

# PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3)

PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3): INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

#### 10.24.01.08G(3)(a). The State Health Plan.

To respond adequately to this criterion, the applicant must address each applicable standard from each chapter of the State Health Plan that governs the services being proposed or affected, and provide a direct, concise response explaining the project's consistency with each standard. In cases where demonstrating compliance with a standard requires the provision of specific documentation, documentation must be included as a part of the application.

Every acute care hospital applicant must address the standards in **COMAR 10.24.10: Acute Care Hospital Services**. A Microsoft Word version is available for the applicant's convenience on the Commission's website. Use of the *CON Project Review Checklist for Acute Care Hospitals General Standards* is encouraged. This document can be provided by staff.

Other State Health Plan chapters that may apply to a project proposed by an acute care hospital are listed in the table below. A pre-application conference will be scheduled by Commission Staff to cover this and other topics. It is highly advisable to discuss with Staff which State Health Plan chapters and standards will apply to a proposed project before application submission. Applicants are encouraged to contact Staff with any questions regarding an application.

Copies of all applicable State Health Plan chapters are available from the Commission and are available on the Commission's web site here:

#### http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs\_shp/hcfs\_shp

	State Health Plan: an overview					
10.24. 07	<ul> <li>Psychiatric services</li> </ul>					
	o EMS					
10.24. 09	Specialized Health Care Services - Acute Inpatient Rehab Services					
10.24. 11	General Surgical Services					
10.24. 12	Inpatient Obstetrical Services					
10.24. 14	Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services					
10.24. 15	Organ Transplant Services					
10.24. 17	Cardiac Surgery and Percutaneous Coronary Artery Intervention Services					
10.24. 18	Neonatal Intensive Care Services					
Capital	Hospital Capital Projects Exceeding the CON Threshold for Capital					
Projects	Expenditures					

<b>Exceeding</b> the	Hospital projects that require CON review because the capital expenditure exceeds the
CON	CON threshold for capital expenditures but do not involve changes in bed capacity,
Threshold for	the addition of new services, and otherwise have no elements that are categorically
Capital	regulated should address all applicable standards in COMAR 10.24.10: Acute Care
Expenditures	<b>Hospital Services</b> in their CON application. Applicants should consult with staff in a
	pre-application conference about any other SHP chapters containing standards that
	should be addressed, based on the nature of the project.

#### **Applicant Response**

Please see responses to this standard in Part V of this application, beginning on page 51, addressing standards contained in the Acute Care Hospital Services section of the State Health Plan.

#### 10.24.01.08G(3)(b). Need.

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

**INSTRUCTIONS:** Please identify the need that will be addressed by the proposed project, quantifying the need, to the extent possible, for each facility and service capacity proposed for development, relocation, or renovation in the project. The analysis of need for the project should be population-based, applying utilization rates based on historic trends and expected future changes to those trends. This need analysis should be aimed at demonstrating needs of the population served or to be served by the hospital. The existing and/or intended service area population of the applicant should be clearly defined.

Fully address the way in which the proposed project is consistent with each applicable need standard or need projection methodology in the State Health Plan.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population of the hospital. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified. Fully explain all assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), the relevant population considered in the analysis, and the service capacity of buildings and equipment included in the project, with information that supports the validity of these assumptions.

Explain how the applicant considered the unmet needs of the population to be served in arriving at a determination that the proposed project is needed. Detail the applicant's consideration of the provision of services in non-hospital settings and/or through population-based health activities in determining the need for the project.

Complete the Statistical Projections (Tables F and I, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package.

#### **Applicant Response**

Shady Grove proposes the development and construction of a six-floor patient care tower along with renovation of 25,696 square feet of existing space. The project is needed to:

- Enhance patient safety, patient experience and clinical efficiency;
- Create all-private medical surgical inpatient rooms;
- Construct appropriately sized ICU space to replace the currently undersized unit;
- Provide a modern ED with private treatment bays; and
- Create a CDU for safe, efficient care for patients in transition from the ED to inpatient care, observation, or discharge.

The project does not propose to increase the number of medical/surgical/gynecological/addiction (MSGA) beds in Montgomery County. To accommodate the growing number of observation patients at Shady Grove, the project will create a new 20 private bed CDU replacing the existing 18 semi-private observation beds currently located on an inpatient floor.

#### **Shady Grove Historical Utilization**

Utilization of Shady Grove's adult MSGA beds for the most recent five full years of data is presented in the following table. There has been a small decline in inpatient discharges and patient days over this period, which is primarily attributable to Shady Grove's shift of inpatients to observation beds in order to treat the patient at the most appropriate level of care.

Shady Grove Medical Center										
Historical Utilization, Years ended December 31,										
Adult MSGA Beds										
	2015	2016	2017	2018	2019					
Discharges	11,431	12,043	11,608	10,956	10,572					
Patient Days 55,237 56,113 53,062 51,917 5										
ADC	151	153	145	142	140					
ALOS	4.83	4.66	4.57	4.74	4.84					
Observation Patients	5,030	4,962	5,711	7,406	7,626					
Source: Hospital Reco	Source: Hospital Records									

The number of licensed MSGA beds was reduced in 2019 from 190 to 156, as a result of the annual adjustment; this has resulted in higher occupancy levels of the reduced bed complement. Shady Grove's occupancy rate for these 156 beds is projected to be 88.5% in 2020 despite the impact of COVID-19, which is above the target occupancy rate for MSGA in the State Health Plan standards. Moreover, the retention of all of Shady Grove's MSGA beds is consistent with the projected needs of Montgomery County residents as demonstrated in the analysis presented below.

MHCC is responsible for calculating the gross and net bed need by jurisdiction for various categories of hospital beds and medical services. The most recent such calculation for MSGA beds, published in the *Maryland Register* on January 20, 2017, is presented in the following table:

	Gross ar	nd Net Bed Need	Projection for MS(	GA Beds: Maryland, 2025	
Jurisdiction	2025 Gros	s Bed Need	Licensed and	2025 Net	Bed Need
			Approved Beds	(Net of Currently Lie	censed and Approved
				Be	ds)
	Minimum	Maximum		Minimum	Maximum
		МО	NTGOMERY COU	NTY	
MONTGOMERY	689	990	975	-286	15
Source: Maryland 1	Register, Volume	44, Issue 2, Frid	day, January 20, 20	17.	

According to the MHCC calculation there is not a surplus of MSGA beds in Montgomery County, and, in fact, it shows a maximum positive net bed need of 15 beds. Shady Grove's proposal is, therefore, consistent with the jurisdictional need for MSGA beds. Moreover, the 156 licensed MSGA beds at Shady Grove are consistent with the most recent determination of licensed bed capacity issued by the MHCC, effective July 1, 2019.

MHCC recently approved an application submitted by Greater Baltimore Medical Center (GBMC) (Docket No. 19-03-2439), which proposed the replacement of inpatient care units and the expansion of space. In its decision, MHCC staff found:

"Staff recommends that this project be approved even though the Commission has not projected a need for additional MSGA beds in Baltimore County. This recommendation is based on staff's belief that modernization of the nursing units at GBMC is needed and because GBMC is adding bed capacity in order to make modernization of fairly dated nursing units (30 to 50 years old) achievable on a more efficient basis, with minimal disruption of operations, and less risk that bed supply shortages will occur during the modernization process. This approach to allowing increases in physical bed capacity to better achieve modernization objectives has been regularly used by MHCC in the past, especially with respect to the transition of hospitals to all private rooms." (page 19)

Unlike Baltimore County, there is a projected maximum positive net bed need in Montgomery County. The same considerations that resulted in approval of GBMC's project are present at Shady Grove in terms of aging facilities, minimal disruption to operations, and the need to transition to all-private rooms.

#### **Service Area of Shady Grove**

Shady Grove has determined its Service Area by examining where Shady Grove inpatients reside. As the information presented in the following table shows, more than 85% of the MSGA patients of Shady Grove during the past two years reside within 28 ZIP Codes, which are located within

Montgomery County and Frederick County. These 28 ZIP Codes define the Service Area of Shady Grove.

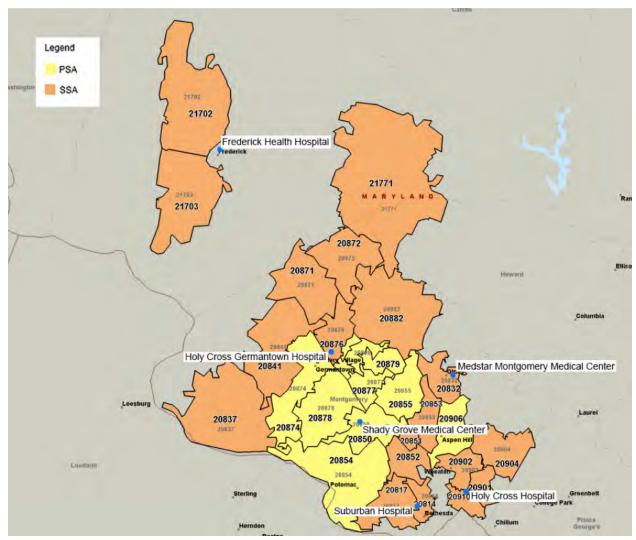
The Service Area is divided further into primary and secondary Service Areas. The primary Service Area, accounting for slightly more than 60% of patient discharges, consists of nine ZIP Codes. The remaining ZIP Codes in the Service Area comprise a Secondary Service Area and account for an additional 25% of discharges. Approximately 14% of Shady Grove's adult MSGA patients resided outside the 28 ZIP Codes of the Service Area during the calendar years 2018 and 2019.

		Sha	ady Grove Me	edical Cent	er		
			MSGA Patie				
		Based	on Discharge	es 2018 and	2019		
		Y	ear ended		•	Year ended	
		Dece	ember 31, 201	18	Dec	ember 31, 20	19
			Perce		_	Perce	
ZIP Code		Discharges	Total	Cum %	Discharges	Total	Cum %
•	ervice Area						
20850	Montgomery	1,206	11.0%	11.0%	1,205	11.4%	11.4%
20878	Montgomery	1,158	10.6%	21.6%	1,080	10.2%	21.6%
20877	Montgomery	1,098	10.0%	31.6%	948	9.0%	30.6%
20874	Montgomery	1,094	10.0%	41.6%	934	8.8%	39.4%
20886	Montgomery	600	5.5%	47.1%	579	5.5%	44.9%
20879	Montgomery	533	4.9%	51.9%	462	4.4%	49.3%
20854	Montgomery	437	4.0%	55.9%	431	4.1%	53.3%
20906	Montgomery	302	2.8%	58.7%	393	3.7%	57.1%
20855	Montgomery	328	3.0%	61.7%	341	3.2%	60.3%
Subtotal		6,756	61.7%		6,373	60.3%	
Secondar	y Service Area						
20852	Montgomery	297	2.7%	64.4%	335	3.2%	63.5%
20876	Montgomery	316	2.9%	67.3%	291	2.8%	66.2%
20853	Montgomery	278	2.5%	69.8%	322	3.0%	69.2%
20851	Montgomery	233	2.1%	71.9%	241	2.3%	71.5%
20882	Montgomery	176	1.6%	73.5%	194	1.8%	73.4%
20871	Montgomery	198	1.8%	75.3%	191	1.8%	75.2%
20872	Montgomery	196	1.8%	77.1%	151	1.4%	76.6%
20837	Montgomery	153	1.4%	78.5%	131	1.2%	77.8%
20832	Montgomery	114	1.0%	79.6%	110	1.0%	78.9%
20841	Montgomery	125	1.1%	80.7%	109	1.0%	79.9%
20904	Montgomery	92	0.8%	81.5%	105	1.0%	80.9%
20902	Montgomery	88	0.8%	82.3%	86	0.8%	81.7%
20817	Montgomery	75	0.7%	83.0%	80	0.8%	82.5%
20814	Montgomery	50	0.5%	83.5%	55	0.5%	83.0%
21771	Frederick	66	0.6%	84.1%	48	0.5%	83.4%
20910	Montgomery	49	0.4%	84.5%	45	0.4%	83.9%
20842	Frederick	44	0.4%	84.9%	43	0.4%	84.3%
20901	Montgomery	47	0.4%	85.4%	41	0.4%	84.7%
21770	Frederick	26	0.2%	85.6%	33	0.3%	85.0%
21754	Frederick	25	0.2%	85.8%	26	0.2%	85.2%
20838	Montgomery	8	0.1%	85.9%	7	0.1%	85.3%
20839	Montgomery	5	0.0%	86.0%	4	0.0%	85.3%
Subtotal		2,661	24.3%		2,648	25.0%	
Total Serv	ice Area	9,417	86.0%		9,021	85.3%	
Other		1,539	14.0%	100.0%	1,551	14.7%	100.0%
Grand Tota	al	10,956	100.0%		10,572	100.0%	

Source: Statewide Data

A map of the Service Area, highlighting the Primary and Secondary Service Areas is presented in the following Figure.

Figure 1 Shady Grove Medical Center Service Area Map



Shady Grove provides an important point of access to a range of inpatient, emergency, and outpatient services within its Service Area. As shown in the following chart, the closest acute care hospital in Montgomery County to Shady Grove is Holy Cross Germantown, with the other area hospitals located more than 20 minutes' drive time away.

Driving Distance and Time from Shady Grove Medical Center to Area Hospitals

	From Shady Grov	e Medical Center
To:	Driving Miles	Driving Minutes
Holy Cross Germantown Hospital	7.7	14
Suburban Hospital	11.2	21
Holy Cross Hospital	13.4	21
Medstar Montgomery Medical Center	13.4	23
White Oak Medical Center	20.7	27

Source: Google Maps

#### **Population**

The Service Area of Shady Grove includes the majority of Montgomery County and, as a result, the population characteristics of the Service Area are approximately the same as those of Montgomery County as a whole. Current estimates and projections of the population of the Service Area and Montgomery County are shown in the table below.

		By Age 0	Cohort		
	Rates	of Increas	se, 2010 - 20	25	
				CA	.GR
	2010	2020	2025	2010-2020	2020-2025
Primary Svc A	ea				
0-14	52,002	54,337	54,117	0.4%	-0.1%
Adult					
15-44	154,895	161,916	163,156	0.4%	0.2%
45-64	108,296	114,637	116,439	0.6%	0.3%
65-74	24,420	39,220	48,398	4.9%	4.3%
75+	21,279	28,558	32,709	3.0%	2.8%
Total Adult	308,890	344,331	360,702	1.1%	0.9%
Total	360,892	398,668	414,819	1.0%	0.8%
Secondary Sv	c Area				
0-14	78,316	82,697	82,797	0.5%	0.0%
Adult					
15-44	219,113	229,999	232,091	0.5%	0.2%
45-64	147,671	160,318	165,223	0.8%	0.6%
65-74	32,229	52,029	64,109	4.9%	4.3%
75+	32,714	38,907	43,169	1.7%	2.1%
Total Adult	431,727	481,253	504,592	1.1%	1.0%
Total	510,043	563,950	587,389	1.0%	0.8%
Total Svc Area	1				
0-14	130,318	137,034	136,914	0.5%	0.0%
Adult					
15-44	374,008	391,915	395,247	0.5%	0.2%
45-64	255,967	274,955	281,662	0.7%	0.5%
65-74	56,649	91,249	112,507	4.9%	4.3%
75+	53,993	67,465	75,878	2.3%	2.4%
Total Adult	740,617	825,584	865,294	1.1%	0.9%
Total	870,935	962,618	1,002,208	1.0%	0.8%
Montgomery C	ounty				
0-14	128,395	134,674	134,935	0.5%	0.0%
Adult					
15-44	386,851	405,142	408,517	0.5%	0.2%
45-64	272,462	286,364	289,987	0.5%	0.3%
65-74	62,541	98,869	121,126	4.7%	4.1%
75+	57,228	70,698	78,860	2.1%	2.2%
Total Adult	779,082	861,073	898,490	1.0%	0.9%
Total	907,477	995,747	1,033,425	0.9%	0.7%

As the table shows, the overall population of the Service Area is increasing at approximately the same rate as that of Montgomery County. In both the Service Area and Montgomery County the populations of the older age cohorts, ages 65-74 and 75 and older, are increasing more rapidly than the population of the younger age cohorts. It is well documented that the medical service needs of an individual increase with age. The greater growth in the older age cohorts of the Service Area suggest the need for health care services in the future will increase more rapidly than the rate that the population will increase as a whole.

The impact of the more rapid increase of the older age cohorts is demonstrated in the following table, which shows the anticipated percentage of the population by age cohort of both the Service Area and Montgomery County. The table shows that the older age cohorts are expected to make up a greater portion of the population in 2025 than in previous years.

		By Age C	ohort						
Percentage of Total Population, 2010- 2025									
					inge				
	2010	2020	2025	2010-2020	2020-2025				
Primary Svc Ar		10.001							
0-14	14.4%	13.6%	13.0%	-0.8%	-0.6%				
Adult	40.00/	10.00/	00.00/	0.00/	1.00/				
15-44	42.9%	40.6%	39.3%	-2.3%	-1.3%				
45-64	30.0%	28.8%	28.1%	-1.3%					
65-74	6.8%	9.8%	11.7%	3.1%	1.8%				
75+	5.9%	7.2%	7.9%	1.3%	0.7%				
Total Adult	85.6%	86.4%	87.0%	0.8%	0.6%				
Total	100.0%	100.0%	100.0%						
Secondary Svo	Area								
0-14	15.4%	14.7%	14.1%	-0.7%	-0.6%				
Adult									
15-44	43.0%	40.8%	39.5%	-2.2%	-1.3%				
45-64	29.0%	28.4%	28.1%	-0.5%	-0.3%				
65-74	6.3%	9.2%	10.9%	2.9%	1.7%				
75+	6.4%	6.9%	7.3%	0.5%	0.5%				
Total Adult	84.6%	85.3%	85.9%	0.7%	0.6%				
Total	100.0%	100.0%	100.0%						
Total Svc Area									
0-14	15.0%	14.2%	13.7%	-0.7%	-0.6%				
Adult									
15-44	42.9%	40.7%	39.4%	-2.2%	-1.3%				
45-64	29.4%	28.6%	28.1%	-0.8%	-0.5%				
65-74	6.5%	9.5%	11.2%	3.0%	1.7%				
75+	6.2%	7.0%	7.6%	0.8%	0.6%				
Total Adult	85.0%	85.8%	86.3%	0.7%					
Total	100.0%	100.0%	100.0%						
Montgomery C	ounty								
0-14	14.1%	13.5%	13.1%	-0.6%	-0.5%				
Adult				0.011					
15-44	42.6%	40.7%	39.5%	-1.9%	-1.2%				
45-64	30.0%	28.8%	28.1%	-1.3%	-0.7%				
65-74	6.9%	9.9%	11.7%	3.0%					
75+	6.3%	7.1%	7.6%	0.8%					
Total Adult	85.9%	86.5%	86.9%	0.6%					
Total	100.0%	100.0%	100.0%	0.076	0.576				
, otal	100.070	100.070	100.070						
Source: Claritas					-				

### **Historical Utilization Rates**

It was observed in the preceding section that while the overall population of the Service Area may increase at a steady rate, individual age cohorts within the population change at separate rates. In the same way, utilization rates of health care services are not static. With more emphasis placed on outpatient care over inpatient admission, the development of new treatment protocols, and the implementation of population health initiatives, hospital admission rates fluctuate. Further, utilization rates are not uniform across age cohorts.

The following table shows the trends in utilization rates in the Shady Grove Service Area during the three years ended December 31, 2016, through 2018. The use rates (cases per 1,000 population) are presented by age cohort and separately by the Primary and Secondary Service Areas. The table shows that use rates in the age cohorts 15-44, 45-64, and 65-74 have generally been declining during the three-year period. The rates for the youngest and oldest cohorts have not changed in consistent directions.

		Historic	al Service Ar			Cohort				
			Years en	ded Decemb	er 31,					
	Estimated Population			Г	ischarges		l Ise Rate	Use Rate (Discharges/1,000)		
Age Cohort	2016	2017	2018	2016	2017	2018	2016	2017	2018	
Primary Service Area										
0-14	53,403	53,637	53,870	8,139	8,583	9,160	152.4	160.0	170.0	
Adult	,		· ·							
15-44	159,108	159,810	160,512	2,862	2,815	2,747	18.0	17.6	17.1	
45-64	112,101	112,735	113,369	5,243	5,160	4,718	46.8	45.8	41.6	
65-74	33,300	34,780	36,260	3,574	3,582	3,620	107.3	103.0	99.8	
75+	25,646	26,374	27,102	6,443	6,652	6,866	251.2	252.2	253.3	
Subtotal	330,155	333,699	337,243	18,122	18,209	17,951	54.9	54.6	53.2	
Total	383,558	387,335	391,113	26,261	26,792	27,111	68.5	69.2	69.3	
Secondary Service Area										
0-14	80,945	81,383	81,821	11,362	11,251	11,526	140.4	138.2	140.9	
Adult										
15-44	225,645	226,733	227,822	3,898	3,941	3,653	17.3	17.4	16.0	
45-64	154,366	155,482	156,598	7,563	7,523	7,069	49.0	48.4	45.1	
65-74	44,109	46,089	48,069	5,033	5,202	5,179	114.1	112.9	107.7	
75+	36,430	37,049	37,668	9,131	9,286	9,371	250.6	250.6	248.8	
Subtotal	460,550	465,354	470,157	25,625	25,952	25,272	55.6	55.8	53.8	
Total	541,494	546,736	551,978	36,987	37,203	36,798	68.3	68.0	66.7	
Total Service Area										
0-14	134,348	135,019	135,691	19,501	19,834	20,686	145.2	146.9	152.4	
Adult										
15-44	384,752	386,543	388,334	6,760	6,756	6,400	17.6	17.5	16.5	
45-64	266,467	268,217	269,967	12,806	12,683	11,787	48.1	47.3	43.7	
65-74	77,409	80,869	84,329	8,607	8,784	8,799	111.2	108.6	104.3	
75+	62,076	63,423	64,771	15,574	15,938	16,237	250.9	251.3	250.7	
Subtotal	790,704	799,052	807,400	43,747	44,161	43,223	55.3	55.3	53.5	
Total	925,052	934,072	943,091	63,248	63,995	63,909	68.4	68.5	67.8	

Future utilization trends will be presented in the following section by applying the population growth rates and use rates by age cohort to Shady Grove's market share.

### **Market Share**

Recent hospital market share data for Shady Grove's Service Area show that eight hospital facilities were mainly responsible for serving Service Area residents. The following table displays the relative market share for inpatient services for each hospital from 2015 through 2018, the most recent complete years available. The inpatient services of Adventist HealthCare Washington Adventist Hospital were relocated to Adventist HealthCare White Oak Medical Center in late August 2019. Market shares have been calculated separately for the Primary Service Area and the Secondary Service Area.

		Shady Grov	/e Medical	Center				
		Primary	/Service A	rea				
	M	arket Shar	e of Area P	roviders				
	Α	dult (Age 1	5+) MSGA	Patients				
			Twelve	Months end	ded Decemb	oer 31,		
	20	15	20		20	17	201	18
	Patients	Mkt Shr	Patients	Mkt Shr	Patients	Mkt Shr	Patients	Mkt Shr
Shady Grove Medical Center	7,280	39.7%	7,311	40.3%	7,112	39.1%	6,756	37.6%
Suburban Hospital	2,873	15.7%	2,937	16.2%	3,138	17.2%	3,190	17.8%
Holy Cross Hospital	2,297	12.5%	1,966	10.8%	1,998	11.0%	2,080	11.6%
Medstar Montgomery Medical Center	2,390	13.0%	2,069	11.4%	2,230	12.2%	2,018	11.2%
Holy Cross Germantown Hospital	1,622	8.9%	1,758	9.7%	1,712	9.4%	1,734	9.7%
Johns Hopkins Hospital	512	2.8%	541	3.0%	631	3.5%	617	3.4%
Washington Adventist Hospital	309	1.7%	253	1.4%	302	1.7%	247	1.4%
Frederick Health Hospital	63	0.3%	44	0.2%	63	0.3%	39	0.2%
Subtotal	17,346	94.7%	16,879	93.1%	17,186	94.4%	16,681	92.9%
Other Providers	975	5.3%	1,243	6.9%	1,023	5.6%	1,270	7.1%
Total	18,321	100.0%	18,122	100.0%	18,209	100.0%	17,951	100.0%
	M	Seconda arket Shar	ve Medical ry Service e of Area P 5+) MSGA	Area roviders				
		(2.90	,					
			Twelve	Months end	ded Decemb	per 31,		
	20	15	20	16	20 <sup>-</sup>		20	18
	Patients	Mkt Shr	Patients	Mkt Shr	Patients	Mkt Shr	Patients	Mkt Shr
Suburban Hospital	4,871	19.3%	5,020	19.6%	5,102	19.7%	5,176	20.5%
Holy Cross Hospital	6,272	24.8%	5,412	21.1%	5,433	20.9%	5,157	20.4%
Frederick Health Hospital	3,941	15.6%	4,146	16.2%	4,460	17.2%	4,366	17.3%
Shady Grove Medical Center	2,735	10.8%	3,071	12.0%	2,883	11.1%	2,676	10.6%
Medstar Montgomery Medical Center	1,887	7.5%	1,911	7.5%	2,009	7.7%	1,824	7.2%
Holy Cross Germantown Hospital	928	3.7%	996	3.9%	1,056	4.1%	1,106	4.4%
Washington Adventist Hospital	1,159	4.6%	1,203	4.7%	1,248	4.8%	1,102	4.4%
Johns Hopkins Hospital	853	3.4%	956	3.7%	1,067	4.1%	1,048	4.1%
Subtotal	22,646	89.5%	22,715	88.6%	23,258	89.6%	22,455	88.9%
Other Providers	2,657	10.5%	2,910	11.4%	2,694	10.4%	2,817	11.1%
Total	25,303	100.0%	25,625	100.0%	25,952	100.0%	25,272	100.0%
Source: Statewide Data								

		Shady Grov	e Medical	Center				
			Service Are					
	M	arket Share	of Area P	roviders				
	Α	dult (Age 1	5+) MSGA	Patients				
			,					
			Twelve	Months en	ded Decemi	per 31,		
	20	15	20	16	20	17	20	18
	Patients	Mkt Shr	Patients	Mkt Shr	Patients	Mkt Shr	Patients	Mkt Shr
Shady Grove Medical Center	10,015	23.0%	10,382	23.7%	9,995	22.6%	9,432	21.8%
Holy Cross Hospital	8,569	19.6%	7,378	16.9%	7,431	16.8%	7,237	16.7%
Suburban Hospital	7,744	17.8%	7,957	18.2%	8,240	18.7%	8,366	19.4%
Frederick Health Hospital	4,004	9.2%	4,190	9.6%	4,523	10.2%	4,405	10.2%
Medstar Montgomery Medical Center	4,277	9.8%	3,980	9.1%	4,239	9.6%	3,842	8.9%
Holy Cross Germantown Hospital	2,550	5.8%	2,754	6.3%	2,768	6.3%	2,840	6.6%
Washington Adventist Hospital	1,468	3.4%	1,456	3.3%	1,550	3.5%	1,349	3.1%
Johns Hopkins Hospital	1,365	3.1%	1,497	3.4%	1,698	3.8%	1,665	3.9%
Subtotal	39,992	91.7%	39,594	90.5%	40,444	91.6%	39,136	90.5%
Other Providers	3,632	8.3%	4,153	9.5%	3,717	8.4%	4,087	9.5%
Total	43,624	100.0%	43,747	100.0%	44,161	100.0%	43,223	100.0%
Source: Statewide Data								

Shady Grove's market shares in the Primary and Secondary Service Areas have fluctuated within a small range; however, it remains the largest provider of inpatient services in the Primary Service Area with more than double the market share of the next closest provider. Holy Cross Germantown opened in October 2014, and it has experienced small increases in market share in both the Primary and Secondary Service Areas of Shady Grove between 2015 and 2018.

# **Projected Utilization**

Utilization projections for Shady Grove for the six years ending December 31, 2021, through December 31, 2026, have been prepared using assumptions that are based on the analysis of past utilization trends and Shady Grove's market share in its Service Area. These assumptions will be detailed as the components of the projection methodology are described.

# **Population**

The following table presents projections of population trends for the 28 ZIP Codes that comprise Shady Grove's Service Area for the years 2021 through 2026. Four adult age cohorts have been included: ages 15-44, ages 45-64, ages 65-74, and ages 75 and over. Separate projections of the population for the Primary and Secondary Service Areas have been included.

		Shady Gr	ove Medica	al Center			
	Projected	Service A	rea Popula	ation by Ag	e Cohort		
		Yea	ars ending D	December 3	<u> </u>		CAGR
Age Cohort	2021	2022	2023	2024	2025	2026	2021-2026
Primary Service Area							
0-14	54,293	54,249	54,205	54,161	54,117	54,073	-0.1%
Adult							
15-44	162,164	162,412	162,660	162,908	163,156	163,404	0.2%
45-64	114,997	115,358	115,718	116,079	116,439	116,799	0.3%
65-74	41,056	42,891	44,727	46,562	48,398	50,234	4.1%
75+	29,388	30,218	31,049	31,879	32,709	33,539	2.7%
Subtotal	347,605	350,879	354,154	357,428	360,702	363,976	0.9%
Total	401,898	405,128	408,359	411,589	414,819	418,049	0.8%
Secondary Service Area	ı						
0-14	82,717	82,737	82,757	82,777	82,797	82,817	0.0%
Adult							
15-44	230,417	230,836	231,254	231,673	232,091	232,509	0.2%
45-64	160,109	161,387	162,666	163,944	165,223	166,502	0.8%
65-74	54,445	56,861	59,277	61,693	64,109	66,525	4.1%
75+	39,759	40,612	41,464	42,317	43,169	44,021	2.1%
Subtotal	484,730	489,696	494,661	499,627	504,592	509,557	1.0%
Total	567,447	572,433	577,418	582,404	587,389	592,374	0.9%
Total Service Area							
0-14	137,010	136,986	136,962	136,938	136,914	136,890	0.0%
Adult							
15-44	392,581	393,248	393,914	394,581	395,247	395,913	0.2%
45-64	275,106	276,745	278,384	280,023	281,662	283,301	0.6%
65-74	95,501	99,752	104,004	108,255	112,507	116,759	4.1%
75+	69,148	70,830	72,513	74,195	75,878	77,561	2.3%
Subtotal	832,336	840,575	848,815	857,054	865,294	873,534	1.0%
Total	969,346	977,561	985,777	993,992	1,002,208	1,010,424	0.8%

The adult populations of the Primary and Secondary Service Areas are anticipated to increase steadily at rates of 0.8% and 0.9% per year, respectively. The anticipated growth is not uniform among the age cohorts. The compound annual growth rate ("CAGR") column shows the population of the two older age cohorts in the Total Service Area, ages 65-74 and ages 75 and over, are expected to increase more rapidly than the younger age cohorts at 4.1% per year and 2.3% per year, respectively.

# **Use Rates**

The following table projects use rates (discharges per 1,000 population) for each of the four adult age cohorts of Shady Grove's Service Area. The projected utilization rates in the Service Area are based on recent trends in use rates. It has been noted that the use rates across all age cohorts have been decreasing slightly in recent years. The health care system has increasingly relied on outpatient and ambulatory care instead of hospitalization, and population health initiatives and

outreach have reduced the need for inpatient care. In the following table, the use rates by age cohort were assumed to decline by 1.0% annually over the period 2021 to 2026. The overall use rate is anticipated to decline in the Primary and Secondary Service Areas only slightly over this period because of the more rapid growth in the elderly age cohorts and their higher use rates.

_			edical Cent								
Pro	jected Serv				rt						
	Discha	rges per 1,	,000 Popula	tion							
		Years ending December 31,									
Age Cohort	2021	2022	2023	2024	2025	2026					
Primary Service Area											
15-44	16.6	16.4	16.3	16.1	16.0	15.8					
45-64	40.6	40.2	39.8	39.4	39.0	38.6					
65-74	64.4	63.7	63.1	62.4	61.8	61.2					
75+	247.5	245.0	242.6	240.1	237.7	235.4					
Subtotal	49.7	49.7	49.7	49.7	49.7	49.6					
Secondary Service Area											
15-44	15.6	15.4	15.2	15.1	14.9	14.8					
45-64	40.6	40.2	39.8	39.4	39.0	38.6					
65-74	64.4	63.7	63.1	62.4	61.8	61.2					
75+	247.5	245.0	242.6	240.1	237.7	235.4					
Subtotal	48.3	48.2	48.1	48.0	47.8	47.7					
Total Service Area											
15-44	16.0	15.8	15.7	15.5	15.4	15.2					
45-64	40.6	40.2	39.8	39.4	39.0	38.6					
65-74	64.4	63.7	63.1	62.4	61.8	61.2					
75+	247.5	245.0	242.6	240.1	237.7	235.4					
Total	48.9	48.8	48.8	48.7	48.6	48.5					

Although the projected utilization rates vary by age cohort, the two oldest age cohorts exhibit a substantially greater need for services. In fact, the age 75+ cohort shows a use rate more than 15 times that of the 15-44 age cohort. These projections were developed by first projecting future inpatient discharges.

# Projected Service Area Discharges

Discharges projected for the years 2021 through 2026 for residents of the 28 ZIP Codes in the Shady Grove Service Area are presented in the table below.

		Shady Gr	ove Medic	al Center			
	Projected	Service A	rea Discha	rges by <b>A</b> g	e Cohort		
							0.4.00
			ars ending D				CAGR
Age Cohort	2021	2022	2023	2024	2025	2026	2021-2026
Primary Service Area							
15-44	2,693	2,670	2,647	2,625	2,603	2,580	-0.8%
45-64	4,668	4,636	4,604	4,572	4,540	4,509	-0.7%
65-74	2,642	2,732	2,821	2,907	2,992	3,074	3.1%
75+	7,274	7,404	7,532	7,656	7,776	7,894	1.7%
Subtotal	17,276	17,442	17,603	17,760	17,911	18,057	0.9%
Secondary Service Area							
15-44	3,585	3,555	3,526	3,497	3,469	3,440	-0.8%
45-64	6,499	6,485	6,471	6,457	6,442	6,427	-0.2%
65-74	3,504	3,622	3,739	3,852	3,963	4,071	3.0%
75+	9,840	9,951	10,058	10,162	10,263	10,361	1.0%
Subtotal	23,428	23,614	23,794	23,969	24,137	24,300	0.7%
Total Service Area							
15-44	6,278	6,225	6,174	6,122	6,071	6,021	-0.8%
45-64	11,167	11,121	11,075	11,029	10,982	10,936	-0.4%
65-74	6,145	6,355	6,559	6,759	6,955	7,145	3.1%
75+	17,114	17,355	17,590	17,818	18,040	18,255	1.3%
Total	40,704	41,056	41,398	41,728	42,048	42,357	0.8%

The projections have been prepared by age cohort by applying the relevant age cohort use rate to the appropriate age cohort population. The CAGR column in the table above indicates that any declining use rates will, to a large extent, be offset by the population growth in the older age cohorts. This expected growth in inpatient discharges along with the high occupancy rate of Shady Grove's existing MSGA beds support the retention of all Shady Grove's licensed bed capacity.

### Market Share

Shady Grove's market share has fluctuated between 2015 and 2018<sup>2</sup> within a narrow range in its Primary and Secondary Service Areas. This period followed the opening of Holy Cross Germantown Hospital, which experienced a small increase in its market share and small shifts among other providers. Shady Grove's market share is projected to stabilize during the projection period.

The following table provides the annual market share assumption for inpatient discharges from Shady Grove for the years 2021 through 2026. It has been assumed that the market share of Shady Grove in the individual components of its Primary and Secondary Service Areas will revert to the levels reported for the year ended December 31, 2018, and remain there throughout the projection period.

<sup>&</sup>lt;sup>2</sup> 2018 was the last year for which complete market share data were available.

Shady Grove Medical Center Projected Service Area Market Share										
		Years ending December 31,								
Market Share	2021	2022	2023	2024	2025	2026				
Primary Svc Area	37.6%	37.6%	37.6%	37.6%	37.6%	37.6%				
Secondary Svc Area	10.6%	10.6% 10.6% 10.6% 10.6% 10.6% 10.6%								
Total Svc Area	22.1%	22.2%	22.2%	22.2%	22.3%	22.3%				

Assuming a constant market share indicates that these projections do not rely on Shady Grove redirecting patients from other facilities to achieve its projected volume.

# Shady Grove Discharges

The projected market share applied to the projected Service Area discharge yields the projected discharges for Shady Grove for residents of its Primary and Secondary Service Areas. The projected Shady Grove Service Area discharges are displayed in the following table.

i ojecica sitaay Grove se			edical Cent			
Projected	<b>SGMC Disc</b>	harges by	Age Cohort	from Servi	ice Area	
		Ye	ars ending I	December 3	1,	
Age Cohort	2021	2022	2023	2024	2025	2026
Primary Service Area						
15-44	1,013	1,005	996	988	979	971
45-64	1,757	1,745	1,733	1,721	1,709	1,697
65-74	994	1,028	1,062	1,094	1,126	1,157
75+	2,737	2,787	2,835	2,881	2,927	2,971
Subtotal	6,502	6,565	6,625	6,684	6,741	6,796
Secondary Service Area						
15-44	380	376	373	370	367	364
45-64	688	687	685	684	682	681
65-74	371	384	396	408	420	431
75+	1,042	1,054	1,065	1,076	1,087	1,097
Subtotal	2,481	2,500	2,520	2,538	2,556	2,573
Total Service Area						
15-44	1,393	1,381	1,370	1,358	1,347	1,335
45-64	2,445	2,431	2,418	2,404	2,391	2,377
65-74	1,365	1,412	1,458	1,502	1,546	1,588
75+	3,779	3,840	3,900	3,957	4,014	4,068
Total	8,983	9,065	9,145	9,222	9,297	9,369

Additionally, Shady Grove receives a substantial number of patients from outside its Service Area. These patients originate from ZIP Codes in neighboring counties as well as patients from a broader area of Maryland and other States. As seen in the table below, it was assumed that Out of Area patients represent 14% of the total Shady Grove discharges based on the hospital's experience in 2018 and 2019.

Shady Grove Medical Center									
Out of Area Discharges (Percent of Total)									
	Years ending December 31,								
	2021	2022	2023	2024	2025	2026			
Out of Area	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%			

By holding the Out of Area percentage constant throughout the projection period, the projections assume the current competitive balance will be unchanged among the area providers in future years.

The following table provides the projected combined total of Service Area and Out of Area Discharges.

Shady Grove Medical Center Projected Total Discharges										
		Years ending December 31,								
Source	2021	2022	2023	2024	2025	2026				
Service Area	8,983	9,065	9,145	9,222	9,297	9,369				
Out of Area	1,462	1,462 1,475 1,489 1,501 1,513 1,52								
Total	10,445	10,540	10,633	10,723	10,810	10,894				

# Average Length of Stay

Inpatients in the various age cohorts have varying lengths of stay. Generally, the younger the patient, the shorter the stay. The projected average lengths of stay by age cohort for patients of Shady Grove were assumed to decline by 0.5% annually during the projection period. This assumption reflects Shady Grove's ongoing population health initiatives as well as the expected efficiencies that will be gained by the proposed project. These projected lengths of stay are summarized in the following table.

	Shac	dy Grove M	edical Cen	ter						
Projected Shady Grove Medical Center Average Length of Stay by Age Cohort										
		Years ending December 31,								
Age Cohort	2021	2022	2023	2024	2025	2026				
15-44	3.98	3.96	3.94	3.92	3.90	3.88				
45-64	4.46	4.44	4.42	4.39	4.37	4.35				
65-74	5.03	5.00	4.98	4.95	4.93	4.90				
75+	5.29	5.26	5.23	5.21	5.18	5.16				
Total	4.82	4.80	4.78	4.76	4.74	4.73				

# **Projected Utilization**

The following table presents utilization projections for Shady Grove's MSGA beds for the period 2021 through 2026. This projection period encompasses the construction period required for the proposed patient tower as well as the first three years after completion of the project. The projections have been based on the assumptions detailed in the preceding paragraphs.

	Shad	y Grove M	edical Cen	iter						
Projected Utilization, MSGA										
	Years ending December 31,									
	2021 2022 2023 2024 2025 2026									
Discharges										
Service Area	8,983	9,065	9,145	9,222	9,297	9,369				
Out of Area	1,462	1,475	1,489	1,501	1,513	1,525				
Total	10,445	10,540	10,633	10,723	10,810	10,894				
ALOS	4.82	4.80	4.78	4.76	4.74	4.73				
Patient Days	50,330	50,598	50,847	51,078	51,290	51,484				
ADC	137.9	138.6	139.3	139.6	140.5	141.1				
Beds	156	156 156 156 156 156 156								
Occ (%)	88.4%	88.9%	89.3%	89.5%	90.1%	90.4%				

The utilization projections demonstrate that Shady Grove's MSGA services will continue to be well utilized. Assuming that Shady Grove's MSGA bed complement will remain at 156 beds during the projection period, the occupancy rate of Shady Grove's MSGA beds will increase steadily from 88.4% in 2021 to 90.4% in 2026.

### **Need for Observation Beds**

An important component of Shady Grove's proposal is to replace its existing observation unit with a CDU featuring private treatment space. Generally, patients are brought to the observation unit from the ED where they can then be admitted to another unit of the hospital or discharged as appropriate. There has been a rapid increase in observation patients at Shady Grove with an average annual increase of 11.0% from 2015 through 2019.

Shady Grove Medical Center Observation Patients								
		Years ending December 31,						
	2015	2016	2017	2018	2019	2015-2019		
Observation Patients	5,030	4,962	5,711	7,406	7,626	11.0%		
Observation Days	5,153	5,153 5,151 5,959 8,261 8,760						
Avg Length of Stay	1.02	1.04	1.04	1.12	1.15			

The future need for Observation Beds will be estimated based on the following assumptions:

- The Average Length of Stay for Observation Patients will be the average over the past five years, 1.1 days.
- The need for Observation Beds will be consistent with the target occupancy expressed in the State Health Plan for inpatient acute care beds, 80%.

The following table presents the need for Observation Beds, calculated under the above assumptions, for the years 2021 through 2026. The 20 observation beds in the CDU proposed for this project are justified by these projections.

Shady Grove Medical Center										
Need for Observation Beds										
	Years ending December 31,									
	2021 2022 2023 2024 2025 2026									
Observation Patients	7,694	7,755	7,817	7,880	7,943	8,006				
Avg Length of Stay	1.1	1.1	1.1	1.1	1.1	1.1				
Observation Days	9,029	9,101	9,174	9,247	9,321	9,396				
Observation ADC (a)	25	25	25	25	26	26				
Bed Need @ 80%	31 31 31 32 32 3									
(a) Average Daily Census										

It is important to note that not all observation patients will be placed in the new CDU. Pediatric patients, for example, will continue to be observed in the pediatric unit, which allows them access to specially trained pediatric caregivers. The 20 beds in the CDU will be well utilized with adult patients.

# **Emergency Department**

The following table provides patient origin data for the ED for the years 2017 through 2019, based on the definitions of Shady Grove's Primary and Secondary Service Areas. The data show that over the years reported in the table approximately 66% of the visits to the Shady Grove ED have been residents of the Primary Service Area. At the same time, nearly 88% of visits have been residents of the Shady Grove Service Area as a whole.

4848-9177-7997

			Shady	Grove Med	dical Cente	er				
				D Patient (						
			Based on	Visits 201	7 through	2019				
`	ear ended		Y	ear ended			Y	ear ended		
		mber 31, 2			mber 31, 2	2018	Dece	mber 31, 2	2019	
		Perc	ent		Perc	ent		Perc		
ZIP Code	Visits	Total	Cum %	Visits	Total	Cum %	Visits	Total	Cum %	
Primary Service	Area									
20850	6,654	12.0%	12.0%	6,558	11.9%	11.9%	6,826	11.9%	11.9%	
20878	6,961	12.6%	24.6%	7,141	13.0%	24.9%	7,334	12.8%	24.7%	
20877	6,187	11.2%	35.8%	6,364	11.6%	36.5%	6,849	11.9%	36.6%	
20874	4,161	7.5%	43.3%	4,017	7.3%	43.8%	3,923	6.8%	43.5%	
20886	3,987	7.2%	50.5%	3,823	6.9%	50.7%	3,726	6.5%	50.0%	
20879	3,118	5.6%	56.1%	3,170	5.8%	56.5%	3,153	5.5%	55.5%	
20854	2,231	4.0%	60.1%	2,214	4.0%	60.5%	2,045	3.6%	59.0%	
20906	1,455	2.6%	62.8%	1,467	2.7%	63.2%	1,475	2.6%	61.6%	
20855	1,635	3.0%	65.7%	1,724	3.1%	66.3%	1,716	3.0%	64.6%	
Subtotal	36,389	65.7%		36,478	66.3%		37,047	64.6%		
Secondary Serv				,						
20852	1,597	2.9%	68.6%	1,532	2.8%	69.1%	1,608	2.8%	67.4%	
20876	1,459	2.6%	71.2%	1,475	2.7%	71.8%	1,378	2.4%	69.8%	
20853	1,303	2.4%	73.6%	1,422	2.6%	74.3%	1,517	2.6%	72.4%	
20851	1,361	2.5%	76.0%	1,406	2.6%	76.9%	1,455	2.5%	75.0%	
20882	669	1.2%	77.3%	684	1.2%	78.1%	726	1.3%	76.2%	
20871	1,124	2.0%	79.3%	1,189	2.2%	80.3%	1,122	2.0%	78.2%	
20872	705	1.3%	80.6%	693	1.3%	81.6%	704	1.2%	79.4%	
20837	520	0.9%	81.5%	534	1.0%	82.5%	562	1.0%	80.4%	
20832	374	0.7%	82.2%	361	0.7%	83.2%	411	0.7%	81.1%	
20841	428	0.8%	82.9%	389	0.7%	83.9%	407	0.7%	81.8%	
20904	537	1.0%	83.9%	502	0.9%	84.8%	511	0.9%	82.7%	
20902	567	1.0%	84.9%	599	1.1%	85.9%	589	1.0%	83.7%	
20817	275	0.5%	85.4%	286	0.5%	86.4%	297	0.5%	84.3%	
20814	266	0.5%	85.9%	240	0.4%	86.9%	208	0.4%	84.6%	
21702	193	0.3%	86.3%	188	0.3%	87.2%	204	0.4%	85.0%	
21771	202	0.4%	86.6%	201	0.4%	87.6%	184	0.3%	85.3%	
21703	277	0.5%	87.1%	245	0.4%	88.0%	276	0.5%	85.8%	
20910	329	0.6%	87.7%	267	0.5%	88.5%	260	0.5%	86.2%	
20901	266	0.5%	88.2%	227	0.4%	88.9%	208	0.4%	86.6%	
Subtotal	12,452	22.5%		12,440	22.6%		12,627	22.0%		
Total Svc Area	48,841	88.2%		48,918	88.9%		49,674	86.6%		
Other	6,535	11.8%	100.0%	6,103	11.1%	100.0%	7,694	13.4%	100.0%	
Grand Total	55,376	100.0%		55,021	100.0%		57,368	100.0%		
Source: Statewi	ide Data									

As the relationship between the visits to the ED from within the Service Area to visits from outside the Service Area is steady, it is not unreasonable to project future utilization of the ED by assuming that its utilization will increase at the same rate as that of the Service Area population, which is 0.9% per year through 2026.

The following table presents projected utilization for the Shady Grove ED for the years 2021 through 2026.

Shady Grove Medical Center									
Projected Emergency Department Utilization									
	Years ending December 31,								
	2021	2022	2023	2024	2025	2026			
Visits	56,907	57,362	57,821	58,284	58,750	59,220			

Based on these projections, the proposal to retain 69 ED treatment rooms is justified.

# **Need Assessment Summary**

Shady Grove is the largest provider of inpatient and emergency services in its Service Area. It is essential that Shady Grove's patients receive care in modern, efficient facilities that promote privacy and comfort. Current and projected utilization rates demonstrate that the services provided will be well used by the community. The relative size of the older age cohorts within the Shady Grove Service Area supports this conclusion.

This project addresses several significant deficiencies in Shady Grove's current facility. It will allow the hospital to provide all-private inpatient, emergency and observation rooms, enhance patient privacy, reduce the risk of infections, and optimize clinical workflows. Shady Grove's Service Area population has a need for, and will benefit from, implementation of this project. The project is also consistent with the goals of Shady Grove's population health initiatives, which are detailed in the following section.

### 10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

**INSTRUCTIONS:** Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the proposed project. The applicant should identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including:

- a) the alternative of the services being provided through existing facilities;
- b) or through population-health initiatives that would avoid or lessen hospital admissions.

Describe the hospital's population health initiatives and explain how the projections and proposed capacities take these initiatives into account.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development costs to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective method to reach stated goal(s) and objective(s) or the most effective solution to the identified problem(s) for the

level of costs required to implement the project, when compared to the effectiveness and costs of alternatives, including the alternative of providing the service through existing facilities, including outpatient facilities or population-based planning activities or resources that may lessen hospital admissions, or through an alternative facility that has submitted a competitive application as part of a comparative review.

### **Applicant Response**

Through its strategic facility planning process, Shady Grove identified several challenges the hospital faced with the size, configuration, and condition of its existing facilities. These challenges include:

- Semiprivate rooms on several units for inpatient care;
- Insufficient space in the ICU;
- Outdated and inefficient ED configuration;
- Inadequate space for observation patients;
- Departments with interrelated services located at opposite ends of the building.

# A. The alternatives of the services being provided through existing facilities.

Please see the response to Standard 04.B(5) Cost Effectiveness. As detailed in that response, using existing facilities rather than undertaking the proposed construction project would:

- Fail to eliminate semiprivate inpatient, emergency, and observation rooms, which in addition to being suboptimal for patient experience and providing care, semiprivate rooms limit the use of all MSGA beds due to the need to match patient gender and to address infection control;
- Fail to provide an updated ICU and to achieve clinical efficiencies through care unit consolidation within the new patient tower;
- Fail to provide a modern ED that would promote clinical efficiency, safety and a better patient experience; and
- Fail to provide adequate space for observation beds as the number of observation patients has been increasing at Shady Grove.
- Fail to provide a safe CVIR located adjacent to pre-op, surgery, and recovery areas

# B. Population health initiatives that would avoid or lessen hospital admissions.

Shady Grove, as part of AHC, participates in many population health initiatives that seek to avoid or reduce unnecessary hospital admissions. Central to the healthcare system's Population Health strategy is the design and implementation of an effective Care Navigation department. The core purpose of this department is to navigate patients through an integrated and aligned network of post-acute services, helping to minimize the cost of care and maximize the patient experience and quality of life.

To achieve this purpose, Shady Grove has implemented several strategies that support the care navigation of our patients as well as mitigate the need for acute care hospitalization and rehospitalization.

- Outpatient Care Navigation: Registered nurses and community health workers who support aligned Shady Grove provider practices assess patients' risk of health breakdown, coordinate preventive care, connect patients to community resources and help prevent the need for acute care hospitalization. Through the Wellcentive population health management tool, this team uses data to identify patients at risk for admission and engages them to mitigate this risk. The mitigation strategies may include preventive care, diagnostic testing, specialty care, pharmaceutical management, remote biometric monitoring, home care, and/or telephonic support. Social determinants of health such as access to transportation, the ability to obtain medication, access to medical care, the access to healthy food, access to safe housing, and when needed, the availability of interpretive services are assessed and identified gaps are closed. When prevention of hospitalization is not possible, the outpatient care navigators partner with patients to connect to their primary care provider after discharge and to complete their post hospitalization care.
- ED U-turn Program: Registered nurses, social workers and community health workers staff the ED as much as 20 hours a day, seven days a week. These team members assist with discharge planning and to identify community resources that can eliminate the need for hospitalization. Experts in community resources, the ED U-turn team identifies safe housing through family members, group homes, or residential care programs where patients may receive the necessary care. If needed, patients are discharged from the ED with medication and transportation to their residence.
- Congestive Heart Failure Clinic: Run by a nurse practitioner, the Congestive Heart Failure (CHF) Clinic has greatly reduced the readmission rate of CHF patients. This provider manages the post-acute care of CHF patients to include disease education, home treatment, symptom identification and routine care.
- Nexus Montgomery Regional Partnership: The Nexus Montgomery Regional Partnership represents an historic commitment of all six hospitals in Montgomery County to collaborate on programs that promise a greater benefit for population health through a collective effort. The six hospitals share infrastructure funds, staff resources, and data (both transactional and evaluative), and collectively coordinate with providers, community-based organizations, and public health entities to develop common interventions and projects.
  - o Programs included in the Nexus Montgomery Regional Partnership Include:
    - Wellness and Independence for Seniors at Home (WISH)
      - Target Population: 65+ adults with Medicare
      - Goal: Stabilize health of older adults to reduce hospital admissions

### Hospital Care Transition

- Target Population: High utilizers with high to moderate risk of readmission
- Goal: Improve transitions from hospital-to-home

# Uninsured / Project Access

- Target Population: Uninsured and without coverage eligibility that had prior hospital interaction within 30 days with referral for specialty care
- Goal: Connect uninsured to specialty care

# Severely Mentally III / Behavioral Health

- Target Population: Behavioral health diagnosis and in crisis, or patients with a diagnosis of a Severe Mental Illness, high utilizers with high risk of Potentially Avoidable Utilization
- Goal: Improve community-based resources for severely mentally ill patients

# Community Advance Directives

 Goal: Increase the number of Nexus Service Area residents who have a designated health care agent and have expressed their wishes for end of life care to that agent.

# Skilled Nursing Facility (SNF) Alliance

- Target Population: SNFs in Nexus Montgomery Service Area
- Goal: reduce hospital readmissions and total cost of care by improving quality of care and care transitions with SNFs post discharge

# Medical Respite Care for the Homeless

- Goal: reduce hospital readmissions among high risk homeless individuals by providing staffed medical respite beds
- Integrated Clinical Pathways: To focus on decreasing potentially avoidable utilization (PAU), Shady Grove partnered with other area hospitals to create an integrated clinical pathway for the outpatient management of patients with chronic obstructive pulmonary disease (COPD). The group took a multidisciplinary approach so that the pathway included all factors of care, such as preventive care, disease management, and assessing and addressing social determinants of care. Primary care physicians identify patients with COPD and refer them to RN care navigators who partner with these individuals to improve disease knowledge, increase likelihood of completing preventive screenings and minimize the risk of hospitalization.
- Urgent Care and Adventist Medical Group (AMG): AHC operates four Urgent Care centers across Montgomery County and Prince George's County. Two of these centers are located in the Shady Grove Service Area (Rockville and Germantown) and offer patients a convenient location to receive quality, expedient care. Additionally, AHC has a signed MOU with Montgomery County Fire and Rescue to take ambulance transfers to our Urgent Cares instead of an ED for Emergency Severity Index level 4 and 5 patients. AHC also formed AMG, a robust network of primary care providers and specialists to support community-based care throughout the region. In 2019, AMG physicians had more than

50,000 ambulatory patient encounters, including new patients, and existing patients. Adventist Medical Group strategies are focused on improving value and demonstrating higher levels of quality and safety, optimized patient-centered care, and lower costs. Initiatives include:

- Managing population health
- Optimizing operations in a risk-bearing environment
- o Navigating care processes across the continuum.

# **Admission Mitigation Results:**

**Readmission Reduction Incentive Program**: As a result of the aforementioned initiatives, Shady Grove has decreased the case mix adjusted readmission rate year over year.

Risk Adjusted Readmi	ssion Rate	
<u>Year</u>	<u>Base</u>	<u>Performance</u>
CY 2018	10.00%	9.66%
CY 2019	10.42%	9.37%
YTD June	10.48%	9.25%
Monthly Summary	ig Services > HSCRC Regula	tory Reports > Readmissions > Readmission
% Potentially /	Avoidable Utilization	
	<u>% Cases</u>	% Charges
CY 2015	13.28%	10.39%
CY 2016	12.88%	9.93%
CY 2017	14.27%	10.49%
CY 2018	12.59%	9.61%
CY 2019	11.61%	9.51%
CY 2020 YTD Ju	ne 10.55%	10.39%
Source: CRISP Reporting Ser	vices > HSCRC Regulatory Reports >	PAU Avoidable Utilization (PAU) > PAU Summary

Additional detail about these population health initiatives is included in Exhibit 4.

# C. How Shady Grove's projections and proposed capacities take these initiatives into account.

Shady Grove's projections of utilization and proposed capacities for its various project elements specifically considered these population health initiatives. For example, the projections of inpatient utilization assumed that the rate of discharges per 1,000 population for MSGA services and average lengths of stay would decline in future years as a result of these population health initiatives. Despite these assumptions, the growth and aging of the Service Area population, as

noted in the previous Need section, still support the retention of Shady Grove's existing 156 MSGA beds.

It was assumed that rate of growth of future ED visits would equal the overall population growth rate, recognizing Shady Grove's initiatives to reduce the use of hospital emergency services in favor of other less costly settings.

### 10.24.01.08G(3)(d). Viability of the Proposal.

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

**INSTRUCTIONS:** Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

Complete applicable Revenues & Expenses (Tables G, H, J and K as applicable), and the Work Force information (Table L) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable.

- Describe and document relevant community support for the proposed project.
- Identify the performance requirements applicable to the proposed project and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, contracting and obtaining and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame.

Audited financial statements for the past two years should be provided by all applicant entities and parent companies.

### **Applicant Response**

Audited financial statements for calendar years 2018 and 2019 can be found in Exhibit 5.

AHC intends to pursue traditional tax-exempt bond financing for this project on behalf of Shady Grove. The assumed issue date for the tax-exempt bonds is October 1, 2021. The financing for the proposed project in the anticipated aggregate principal amount of \$154.0 million will be secured pursuant to the Amended and Restated Master Trust Indenture dated as of February 1, 2003, as supplemented and amended (the "Master Indenture") among AHC and Adventist Rehabilitation Hospital of Maryland, Inc. ("Adventist Rehab") (collectively, the "Obligated Group") and Manufacturers and Traders Trust Company (formerly Allfirst Bank), as master trustee (the "Master Trustee"). For purposes of financial disclosures presented in this application all information relates to consolidated performance and not the Obligated Group. As of December

31, 2019, the Obligated Group represented approximately 93% of AHC total revenues, greater than 96% of total assets and more than 100% of total net income. The consolidated operations of AHC are deemed to be an appropriate representation of the Obligated Group.

In planning this project, AHC evaluated multiple financing scenarios, which included different levels of debt issuance with several equity contribution scenarios to cover the total costs of the project. This included a scenario with no debt issuance and all cash. Based on our analysis of key financial ratios under the various financing scenarios, we believe that the appropriate level of borrowing is \$154.0 million. AHC analyzed these scenarios and the impact of the additional debt to key financial ratios and determined the best one is a borrowing of \$154.0 million. This provides the appropriate balance of funding the project, while allowing our financial ratios to remain at levels that are commensurate with our investment grade rating. The ratios of AHC including the proposed project are presented in the table below. Our proforma key financial ratios indicate that AHC will continue to meet the financial covenants, listed below, as required by the Master Indenture and by certain agreements between one or more members of the Obligated Group and financial institutions providing credit support. Based on the proposed structure, AHC does not anticipate that any bondholder consents would be required as it relates to the project.

Debt service coverage: Not less than 1.25 Days cash on hand: Not less than 70 days

Total Liabilities to Unrestricted Net Assets: Not greater than 2.5

Adventist HealthCare- Key Financial Indicators

(dollars in thousands)

Key Financial Indicators									
	2017	2018	2019	2020	2021	2022	2023	2024	2025
Operating Income	\$ 19,612,951	\$ 15,924,546	\$ 18,145,525	5 19,055,746	5 14,117,744	5 15,042,440	\$ 19,576,249	5 10,969,364	\$ 10,325,158
Excess of Revenue Over Expenses	5 25,822,318	\$ 21,353,561	\$ 37,834,556	5 22,577,124	\$ 20,596,353	\$ 22,604,088	\$ 26,223,014	\$ 17,703,372	5 17,148,590
Cash	\$ 235,407,975	5 237,743,153	\$ 252,507,424	\$ 257,967,338	\$ 274,248,493	\$ 294,478,438	\$ 316,308,553	5 342,530,018	\$ 365,879,583
Long Term Debt	\$ 594,278,035	5 587,867,718	\$ 572,612,619	\$ 567,310,874	\$ 567,310,874	\$ 721,690,874	\$ 721,690,874	\$ 721,690,874	5 721,690,874
Net As sets	\$ 414,743,092	\$ 439,571,362	\$ 471,275,985	\$ 479,993,409	\$ 502,570,531	\$ 523,166,884	\$ 545,770,973	\$ 571,993,986	\$ 589,697,358
Maximum Annual DebtService	\$ 40,503,556	\$ 40,735,233	\$ 40,701,719	\$ 40,429,000	\$ 39,270,896	\$ 45,708,997	\$ 45,708,997	\$ 45,708,997	\$ 45,708,997
Debt Service Coverage	1.79	1.75	2.36	2.38	2.41	2.13	2.21	2.32	2.33
Days Cash on Hand	114.55	113.66	114.81	107.2	0 111.9	117.82	124.12	131.66	136.98
Debt to Capitalization	58.9%	57.2%	54.9%	54.29	6 53.09	58.0%	5 56.9%	55.8%	55.0%
Total Liabilities to Unrestricted Net Assets	191	1.82	1.88	1.8	5 1.70	1.99	1.92	1.83	1.79

In addition to the amount financed by tax-exempt debt for the Shady Grove project, AHC will contribute \$25.9 million in equity. This is comprised of \$16 million in fundraising proceeds, and \$9.9 million in cash. Equity contributions will be spread throughout the project and funded by operations. AHC will continue to invest \$25 million to \$40 million of routine capital annually in the other AHC entities. These capital investments can be deferred if necessary, to ensure that cash is available to fund the equity contribution.

The projected financials for AHC were created using the 2019 audited financials as the base year. Following are assumptions used for 2020-2025.

Adventist HealthCare Consolidated Financial Projections

Adventiseries						
	2020	2021	2022	2023	2024	2025
<b>Income Statement Assumptions</b>						
-						
Revenue						
Net Patient Service Revenue (Note A)	9.0%	1.9%	2.1%	2.2%	2.2%	2.2%
-						
Expenses						
Salaries & Wages (Note B)	8.4%	3.1%	2.6%	2.3%	2.4%	2.6%
Employee Benefits (% of Salaries)	19.1%	19.1%	19.0%	19.0%	19.0%	18.9%
Professional Fees (Note B)	16.2%	-8.9%	-1.1%	-1.8%	0.3%	-0.1%
Medical Supplies (Note B)	15.8%	-0.5%	3.2%	3.2%	3.2%	3.2%
Purchased Services	0.7%	2.0%	1.3%	1.2%	1.2%	1.2%
Investment Income	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%

A- Increase in revenue in 2020 is mainly due to the addition of FWMC in October 2019.

B- Cost increases in 2020 related to COVID-19 and expected to normalize in future years.

Table 1 represents the blended assumptions used to prepare the projections for AHC consolidated. Each entity projection was developed using global assumptions and then adjusted as appropriate based on that entity's historical trends. We believe that the net revenue assumptions are consistent with reimbursement methodologies for entities covered under Global Budget Revenue arrangements and expense assumptions are consistent with historical performance.

The COVID-19 pandemic, government programs and restrictions, the economy and related impacts are all continually changing. With the resumption of elective medical procedures and volumes beginning to return to pre-COVID levels and the uncertainty of future impacts of this unprecedented circumstance, the financial projections presented are based on historical financial performance and AHC's long-term plans do not incorporate any significant impact from COVID-19 and its related effects.

AHC has a track record of meeting projected performance. In conjunction with the 2016 bond issue completed by AHC to fund the construction of White Oak Medical Center, an independent feasibility study was completed for the projection periods ending 2016-2020. For audited periods through 2019, AHC met or exceeded the operating margins in each year of the feasibility study. In addition, AHC's cash position has met or exceeded the projected cash for the same periods.

AHC has conducted several successful philanthropy campaigns over the last 15 years. These campaigns include:

Project:	Raised:
Tower Expansion Campaign (Shady Grove)	\$12.30M
CVIR Suite (Shady Grove)	\$ 5.25M
Cancer Services Campaign (Shady Grove)	\$ 6.80M
New Hospital Campaign (White Oak)	\$12.00M

AHC has contracted with Accordant Philanthropy to develop the case for support and to implement a comprehensive Capital Campaign with a goal of raising \$16 million toward the project. Accordant will oversee the implementation of a campaign plan inviting stakeholders to invest in the growth of Shady Grove, ensuring the community has access to high quality, compassionate care.

In addition to the financial resources discussed above, Shady Grove has documented support from the medical community (Exhibit 6), elected officials (Exhibit 7), and the community (Exhibit 8).

Shady Grove has assumed an overall rate increase in the financial projections of 2.35% per year (Exhibit 9). Under the GBR model, in which Shady Grove participates, a 50% variable cost factor for increased market share does not provide hospitals with the ability to fund capital through growth but rather incentivizes hospitals to manage utilization in the most effective and efficient manner leading to overall reductions in the cost of care. Due to the capital investment and financing related to the project, capital costs at Shady Grove will increase. Project related depreciation, amortization, and interest expenses are identified in Tables G and H of Exhibit 1.

Shady Grove does not anticipate an impact on costs or charges for hospital services at other hospitals located in the area as a result of this project.

Current average patient charges for the most common inpatient procedures, outpatient procedures, diagnostic imaging tests and laboratory tests can be found on AHC's website at: <a href="http://adventisthealthcare.com/patients-visitors/estimated-cost">http://adventisthealthcare.com/patients-visitors/estimated-cost</a> as well in Exhibit 10 (SGMC-Billing-Hospital Charges).

# 10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

**INSTRUCTIONS**: List all of the Certificates of Need that have been issued to the applicant or related entities, affiliates, or subsidiaries since 2000, including their terms and conditions, and any changes to approved CONs that were approved. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

### **Applicant Response**

Adventist HealthCare, Inc. was issued a CON by the Commission on February 20, 2003 for 15 of the 20 comprehensive care beds operated at Care-Link at Washington Adventist Hospital to be consolidated and relocated with the existing 82 bed complement at Fairland Nursing and Rehabilitation Center, expanding its bed capacity to 97 beds. The remaining five beds were relinquished.

Adventist HealthCare, Inc. was issued a CON by the Commission on June 19, 2003 for 22 rehabilitation beds.

Adventist HealthCare, Inc. was issued a CON on February 16, 2005 to expand the patient tower at Shady Grove Adventist Hospital.

Washington Adventist Hospital was issued a CON on November 18, 2005 to establish the Washington Adventist Surgery Center. The CON was relinquished on August 18, 2006.

Adventist HealthCare, Inc. was issued a CON on December 17, 2015 to relocate Washington Adventist Hospital from Takoma Park to Silver Spring (Docket No.: 13-15-2349). Compliance with the conditions of this CON have been met.

Adventist Home Health Services, Inc. was issued a CON on January 17, 2019 to expand their home health agency ("HHA") services into Frederick County, Maryland using its existing Rockville branch office (Docket No. 17-R2-2397). Compliance with the conditions of this CON have been met.

Adventist Rehabilitation Hospital of Maryland was issued a CON on March 21, 2019 to relocate 42 inpatient rehabilitation beds to expanded building space within the general hospital being constructed in Silver Spring, MD as a replacement of AHC Washington Adventist Hospital (Docket No.: 18-15-2428). Construction is ongoing.

Adventist HealthCare White Oak Medical Center was issued an Emergency CON (ECON) on April 4, 2020 to establish additional inpatient bed capacity consisting of 63 MSGA beds at a temporary remote location on the former Washington Adventist Hospital. The 63 MSGA beds will be located at the site as follows: 42 in space that is currently licensed as special-hospital rehabilitation by Adventist Rehabilitation Hospital of Maryland, Inc., and the remaining 21 beds will be located in rooms that previously were used by hospital patients on the 5<sup>th</sup> floor. This ECON was superseded by the ECON for the Alternate Care Site of May 20, 2020, listed below.

Adventist HealthCare White Oak Medical Center was issued an ECON on April 4, 2020 to establish additional inpatient bed capacity consisting of 23 MSGA beds that are in existing, nonclinical spaces located on floors 2, 3, 4, 5, 6 and 7.

Adventist HealthCare Fort Washington Medical Center was issued an ECON to establish additional inpatient capacity consisting of 10 MSGA beds to be located in a temporary field hospital inpatient unit at the Hospital and an Emergency CON on April 5, 2020 to establish

additional inpatient bed capacity consisting of 20 MSGA beds to be located in two temporary field hospital inpatient units at the Hospital.

Adventist HealthCare Fort Washington Medical Center was issued an ECON on April 17, 2020 to establish additional inpatient bed capacity consisting of 16 ICU beds to be located in two temporary modular buildings at Fort Washington Medical Center.

Adventist HealthCare White Oak Medical Center was issued an ECON on May 20, 2020 to establish additional inpatient bed capacity consisting of 200 MSGA beds as an Alternate Care Site in a temporary remote location on the first through fifth floors and the lower level 1 floor of the former Washington Adventist Hospital. The construction of the Alternate Care Site space was overseen by the Department of General Services, in coordination with White Oak Medical Center, and the cost of the project will be borne by the State of Maryland. The site currently has all 200 beds with 54 operational. The site is staffed to serve 18 beds but can quickly ramp up to staff 54 beds in 1-2 days and the full 200 beds in 6-7 days. Since opening in May, approximately 70 patients have been admitted.

### 10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System.

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

**INSTRUCTIONS**: Please provide an analysis of the impact of the proposed project:

- a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project<sup>3</sup>;
- b) On access to health care services for the service area population that will be served by the project. (state and support the assumptions used in this analysis of the impact on access);
- c) On costs to the health care delivery system.

If the applicant is an existing hospital, provide a summary description of the impact of the proposed project on costs and charges of the applicant hospital, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

### **Applicant Response**

# a) Impact On The Volume Of Service Provided By All Other Existing Health Care Providers

This proposed project for Shady Grove should have no material impact on other existing health care providers. Shady Grove assumes that its market share of MSGA services will remain unchanged in the future after completion of the project, as reflected in the projections presented in response 10.24.01.08G(3)(b) (Need). This assumption is based on

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<sup>&</sup>lt;sup>3</sup> Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, the relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions.

the fact that Shady Grove proposes no increase in its number of licensed MSGA beds. Shady Grove will continue to provide services from its existing Rockville campus; therefore, the distribution of hospital services within the Service Area will remain unchanged. Shady Grove does not expect a significant change in referral patterns by physicians practicing at other Service Area hospitals.

The modest projected growth in inpatient, emergency, and outpatient services for Shady Grove in the future is the result of the expected growth and aging of residents of its Service Area. As described in response 10.24.01.08G(3)(b) (Need) with respect to inpatient utilization, the adult population growth is projected to be partially offset by assumed declines in discharge rates per 1,000 population and average lengths of stay. This organic growth in volume at Shady Grove does not rely on redirecting patients from other providers.

### b) Impact on Access to Health Care Services for the Service Area Population

While the proposed project does not result in an increase in licensed MSGA beds or a change in the location from which Shady Grove services are provided, it will enhance access for its Service Area residents seeking care at Shady Grove. For example, the reconfigured ED with all-private treatment rooms will enhance efficiency that should result in reduced wait times, greater privacy, and reduced length of stay from initial contact to discharge. The proposed 20-bed CDU with all-private rooms will replace the existing 18-bed observation unit using semiprivate rooms. The CDU will expedite the transition of patients from the ED to begin observation in a setting that is specifically designed for that purpose while affording patients more privacy during their stay. The ability to offer all-private MSGA beds will improve access to inpatient care because Shady Grove currently faces constraints in utilizing its licensed bed capacity given the number of its beds in semiprivate rooms and the attendant problems of infection control and gender matching.

# c) Impact on Costs to the Health Care Delivery System

Shady Grove reserves the right to seek rates for capital funding for this project, but at this time, no rate increase has been included in the projections of revenue and expenses shown in Tables G and H (Exhibit 1).

# PART V - COMAR 10.24.10 – ACUTE CARE HOSPITAL SERVICES SECTION OF THE STATE HEALTH PLAN

# PART V - COMAR 10.24.10 – ACUTE CARE HOSPITAL SERVICES SECTION OF THE STATE HEALTH PLAN

# .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 website:
- (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**

AHC maintains a written policy for provision of information to the public concerning charges for its services quarterly (Exhibit 11– Policy 3.19.2). The policy is in effect for all of the acute care hospitals in the system that are located in Maryland, and outlines the departments responsible for creating, maintaining, posting, and access in Section A. Section B states how individuals may request specific information, and staff training as it relates to the Representative List of Services and Charges is covered in Section C.

The hospital makes a Representative List of Services and Charges available in print at the hospital and on its website, last updated September 10, 2020: <a href="https://www.adventisthealthcare.com/app/files/public/364/SGMC-Billing-HospitalCharges.pdf">https://www.adventisthealthcare.com/app/files/public/364/SGMC-Billing-HospitalCharges.pdf</a>

### (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**

AHC has a written policy for charity care that includes Shady Grove Medical Center, White Oak Medical Center, Fort Washington Medical Center, Adventist Rehabilitation Hospital of Maryland and the Germantown Emergency Center. (Exhibit 12-- Policy 3.19 Financial Assistance, Exhibit 13 Policy 3.19A Financial Assistance – Spanish). The purpose of the policy (page 1) states:

### 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.

The policy provides a determination of probable eligibility for charity care services or medical assistance within 2 business days of receipt of a request and final determination within 10 business days of receipt of the request (Page 8). AHC also maintains a policy AHC 3.19.0 Financial Assistance – Decision Rules/Application to standardize the administration of the financial assistance policy (Exhibit 14).

The financial assistance application form is the uniform application as mandated by COMAR, and is included as Exhibits 15 and 16, this form and the other documents cited in section 2.3 of the policy are also available on the hospital website:

https://www.adventisthealthcare.com/patients-visitors/billing-financial/assistance

#### 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.

Public notice of information regarding the hospital's charity care policy is stated on page 1 of the policy and published annually in both *The Washington Post* and *El Tiempo Latino* (Exhibits 17 and 18 – Notarized publication announcements).

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.

The charity care policy is posted in the admissions office, business office, and ED areas of the hospital as well as on the website: <a href="https://www.adventisthealthcare.com/patients-visitors/billing-financial/assistance/">https://www.adventisthealthcare.com/patients-visitors/billing-financial/assistance/</a>. Notice of the charity care policy is made available to each person seeking services in the hospital at the time of admission or preadmission. Pictures of the posting is included in Exhibit 19. Page 7 of the policy states:

- 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
  - 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)

Shady Grove contributed \$5,786,233 in charity care as reported in the Maryland Hospital Community Benefit Report FY2019, page 45. An amount placing it in the 3rd quartile.

# (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**

Shady Grove is licensed, in good standing, by the Maryland Department of Health (Exhibit 20), accredited by The Joint Commission (Exhibit 21), and in compliance with the conditions of participation of the Medicare and Medicaid programs (Exhibit 22).

Shady Grove has a record of measurable quality outcomes, most notably earning the 5-star designation from CMS in 2020 for its performance in the seven groups of quality measures: mortality, safety, re-admission patient experience, effectiveness of care, efficient use of medical imaging and timeliness of care. Only 9% of hospitals nationwide have achieved CMS 5-star distinction.

Shady Grove offers several vital health services to the community and has earned recognition for delivering quality patient care. Since 2017, several Shady Grove care teams have earned Circle of Honor and Distinguished Achievement awards from the Maryland Patient Safety Center for standout innovations in patient care. Shady Grove teams have been recognized for their work to improve neonatal care, chronic obstructive pulmonary disease (COPD) treatment, colorectal surgery, mental health care and antibiotic stewardship.

The American College of Cardiology (ACC) has recognized Shady Grove for its demonstrated expertise and commitment in treating patients in its cardiac catheterization lab. Shady Grove was the second in the nation to earn cardiac catheterization lab with PCI accreditation from the ACC.

The radiation oncology program is accredited by the American College of Radiology (ACR), which also has awarded Gold Seal of Accreditation to Shady Grove in computed tomography, or CAT scanning, and MRI. The accreditation is given to facilities that provide the highest level of image quality and patient safety.

Shady Grove's Neonatal Intensive Care and Labor & Delivery units earned a Gold Medal award from the Maryland Patient Safety Center Neonatal Collaborative for the quality care the hospital provides to critically ill newborns. These units, along with pediatric and post-partum care teams, also were recognized by the Vermont Oxford Network for an extraordinary commitment to caring for babies impacted by substance abuse and diagnosed with neonatal abstinence syndrome.

Shady Grove has a tradition of providing high quality support for breastfeeding mothers. Shady Grove was the first Maryland hospital to receive the International Board-Certified Lactation Consultants Care Award, which recognizes exceptional education and support to breastfeeding families. Shady Grove also was the first facility in Maryland to earn designation in the Baby-Friendly Hospital Initiative, a program of the World Health Organization and United Nations Children's Fund that recognizes facilities that promote an optimal level of care for best infant feeding practices. In 2019, Shady Grove opened the state's first Milk Depot, to allow nursing mothers a safe way to donate surplus breastmilk to infants in need.

Shady Grove is nationally recognized for excellence in stroke care. It has achieved designation as Primary Stroke Center by the Maryland Institute of Emergency Medical Services and Systems for quality care in the treatment of stroke patients.

In 2020, the American Heart Association/American Stroke Association (AHA/ASA) presented Shady Grove with its top Stroke Gold Plus Quality Achievement Award with Target: Stroke Honor Roll Elite Plus recognition for the sixth consecutive year. The Gold Plus Quality Achievement recognizes an aggressive goal of treating stroke patients with 85 percent or higher compliance to core standard levels of care outlined by the AHA/ASA for 12 consecutive months. Target: Stroke Honor Roll Elite Plus honors door-to-needle times of 60 minutes or less in at least 75 percent of stroke patients and 45 minutes or less in at least 50 percent of stroke patients. This is the time between when a patient arrives at the hospital and when they receive anti-clotting medication. Providing this medication quickly can reduce long-term damage to patients and increase the chances of their full recovery.

In addition, in 2020, Shady Grove earned ASA/AHA Stroke Gold Plus Target: Type 2 Diabetes Honor Roll recognition for consistently meeting the association's high standards set in its diabetes cardiovascular initiative.

Ambulatory Care Electronic Health Records Solution, or ACES, offers electronic health records implementation and expert guidance to affiliated physicians of AHC, which includes Shady Grove. ACES has earned the Maryland Health Care Commission (MHCC) Management Service Organization (MSO) State Designation. It has also achieved full accreditation with the Management Service Organization Accreditation Program (MSOAP) from the Electronic Healthcare Network Accreditation Commission (EHNAC). he MHCC designation recognizes ACES' national accreditation as an MSO. The designation also means that ACES has met many national and state standards intended to ensure high-quality business operations, and the existence of sound privacy and security policies.

As an EHNAC MSOAP-accredited organization, ACES was evaluated in the areas of privacy and security, technical performance, business practices and organizational resources.

The quality standards that have been rated below average and the initiatives for improvement are listed below:

Summary of Hospital II	nformation: Adve	entist HealthCare Shady	Grove Medical Center
Practice Patterns	Rating	Risk-Adjusted Rates	Initiatives to Effect Change
Childbirth			
Percentage of births (deliveries) that are C-sections	Below average	29.4438	Use of "peanut balls" for positioning moms, frequent position changes and wireless monitoring for laboring mom.
How often babies in the hospital are delivered vaginally when the mother previously delivered by cesarean section (no complications)	Below average	15.2632	Use of "peanut balls" for positioning moms, frequent position changes and wireless monitoring for laboring mom.
Communication			
How often did nurses always communicate well with patients?	Below	74%	Focus on purposeful hourly rounding nurses as well as AIDET (Acknowledge, Introduce, Duration, Explanation, Thank You)
How often did doctors always communicate well with patients?	Below	74%	Initiation of scheduled daily rounding with nurses at the patient bedside started in September 2020
How often did staff always explain about medicines before giving them to patients?	Below	54%	Development of packet of frequently seen medication for easy reference education. Partner with pharmacy to identify frequently used medication. Information is located on laminated cards for easy access education
How well do patients understand their care when they leave the hospital?	Below	47%	Increased emphasis on discharge education and planning delivered by the nurses, physicians and care navigation team. Education starts at the point of admission. Updated process started September 2020.
Environment			
How often were the patients' rooms and bathrooms always kept clean?	Below	67%	Validate cleaning procedures followed and perform enhanced inspections
How often did patients always receive help quickly from hospital staff?	Below average	53%	Develop strategic team for responsiveness and revise model of care to include care team of 2 RNs and 1 CNA. This allows more extensive coverage of patient call lights. Update nurse call system to include voicera integration.
How often was the area around patients' rooms always kept quiet at night?	Below average	54%	Institute quiet time, lower unit lights to promote and serve as a reminder to implement a quiet environment, reminders to staff to minimize noise
Patient Safety			
Results of Care - Complications			
Percentage of patients who received appropriate care for severe sepsis and septic shock	Below average	49	Institution of Modifiable Early Warning Score (MEWS) to help identify change in patient condition signaling possible sepsis. Completion of SEP-1 bundle with case review for misses.

# 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**

The proposed project will be implemented on the existing Shady Grove campus; thus, the Service Area population is not impacted from a geographic accessibility perspective. The existing campus resides within a well-developed area master plan with direct access to major roadways and a mature public transportation infrastructure.

### (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 because Shady Grove does not propose the addition of any MSGA or pediatric beds.

# (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**

Not applicable. Shady Grove does not seek to establish a pediatric unit.

### (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**

a) While Shady Grove reserves the right to file a partial rate application for capital to fund the capital costs associated with the project, at this time the financial projections presented in Tables G and H in Exhibit 1 do not assume any rate increase for capital. If the hospital elects to pursue an increase in rates with the HSCRC to fund the incremental depreciation and interest costs of the project, it will be in accordance with the HSCRC's methodology for a partial rate application for capital. Based on this methodology, Shady Grove's incremental capital eligible for funding, prior to applying any positive or negative adjustments to the policy, would be 1.51% as shown below.

Project Size	\$156,001,201
Project Depreciation and Interest	
Actual Depreciation	\$6,251,433
Allowable Interest (70% debt funded , 30 years @ 4.5%)	2,999,627
Total Depreciation and Interest	\$9,251,060
50/50 Blend with Peer Group	
Hospital Capital Cost % (Including Project) (1)	11.58%
Peer Group Average Capital Cost % (1)	9.99%
50/50 Blend	10.78%
Hospital Capital Cost % Prior to Project (1)	9.27%
Incremental Capital Eligible for Funding	1.51%
Hospital Global Budget Revenue - FY 20 Permanent Revenue	\$468,585,979
Incremental Capital Eligible for Funding	\$7,079,412

<sup>(1)</sup> Source: FY 2019 ACS Schedule

As with most hospitals in the state, Shady Grove has unfavorable performance against the standard under the most recently calculated Inter-hospital Cost Comparison ("ICC") provided by the HSCRC. The ICC is not a rate setting methodology that stands alone, but rather one component of the HSCRC's Integrated Efficiency Methodology. As shown in the table below, the Integrated Efficiency Methodology indicates Shady Grove's permanent revenue is 18.55% above the ICC standard but when taken in totality of the methodology, Shady Grove is in the best performing quartile in the state.

4848-9177-7997

HOSP id	Hospital Name	Volume Adjused ICC Result	ICC Rank (50%)	2018 Medicare TCOC Relative to Benchmark	2018 Medic are TCOC Rank (25%)	2018 Commercial TCOC Relative to Benchmark	2017 Commer cial TCOC Rank (25%)	Total Rank Points (Low Score is Better)
210022	Suburban Hospital	-3.67%	5	-10.14%	1	-36.06%	1	6
210023	Anne Arundel Medical Center	-4.72%	8	-1.33%	7	-31.15%	5	14
	Howard County General Hospital	-6.50%	12	-2.22%	5	-32.32%	3	16
990099	Holy Cross Hospitals	-6.54%	13	2.89%	11	-28.02%	8	23
210060	Fort Washington Medical Center	-6.02%	10	-3.80%	4	-21.35%	23	24
210043	University of Maryland Baltimore Washington	0.0270	, 0	0.0070		21.0070		
	Medical Center	-8.54%	15	10.19%	16	-24.27%	15	31
210008	Mercy Medical Center	4.77%	1	17.56%	32	-19.96%	27	31
210024	MedStar Union Memorial Hospital	-2.59%	4	13.87%	21	-13.68%	36	33
210057	Shady Grove Adventist Hospital	-18.55%	27	-2.05%	6	-31.64%	4	32
210017	Garrett County Memorial Hospital	3.82%	2	7.79%	15	3.01%	43	31
210009	Johns Hopkins Hospital	-5.56%	9	14.42%	24	-20.79%	25	34
210034	MedStar Harbor Hospital Center	-4.20%	6	27.59%	42	-25.13%	13	34
210051	Doctors Community Hospital	-19.25%	31	-4.86%	3	-31.06%	6	36
210005	Frederick Memorial Hospital	-12.24%	21	10.22%	17	-25.04%	14	37
210029	Johns Hopkins Bayview Medical Center	-4.63%	7	17.46%	31	-17.82%	30	38
210044	Greater Baltimore Medical Center	-7.42%	14	14.37%	23	-20.28%	26	39
210002	University of Maryland Medical Center	-10.11%	18	16.60%	29	-25.70%	12	39
210061	Atlantic General Hospital	-1.26%	3	29.41%	43	-17.29%	31	40
210035	University of Maryland Charles Regional							
210033	Medical Center	-13.89%	22	6.02%	14	-21.83%	22	40
210028	MedStar St. Mary's Hospital	-9.51%	16	5.28%	12	-13.24%	37	41
210019	Peninsula Regional Medical Center	-6.42%	11	21.47%	38	-21.99%	21	41
210003	Prince Georges Hospital Center	-16.48%	26	5.39%	13	-22.23%	20	43
210011	St. Agnes Hospital	-14.51%	23	14.13%	22	-23.55%	16	42
210016	Washington Adventist Hospital	-20.13%	34	2.03%	8	-26.22%	11	44
210018	MedStar Montgomery Medical Center	-22.75%	39	2.69%	9	-32.46%	2	45
210010	University of Maryland Shore Medical Center at	40.000/	00	44.000/	40	00.040/		
	Dorchester	-18.68%	28	11.60%	18	-23.21%	17	46
210001	Meritus Medical Center	-9.63%	17	14.45%	25	-16.75%	32	46
210049	Upper Chesapeake Medical Center	-11.57%	19	19.30%	35	-22.89%	19	46
210062	MedStar Southern Maryland Hospital Center	-25.79%	42	-6.70%	2	-28.54%	7	47
210039	Calvert Memorial Hospital University of Maryland St. Joseph Medical	-22.62%	38	2.86%	10	-26.77%	9	48
210063	Center	-11.64%	20	16.58%	28	-18.03%	29	49
210033	Carroll Hospital Center	-19.97%	33	15.88%	27	-21.25%	24	59
210015	MedStar Franklin Square Hospital Center	-15.77%	25	19.24%	34	-16.15%	34	59
210058	University of Maryland Rehabilitation & Orthopaedic Institute	-25.70%	41	16.60%	29	-26.77%	9	60
210038	University of Maryland Medical Center Midtown Campus	-22.29%	37	19.01%	33	-23.21%	17	62
210006	Harford Memorial Hospital	-19.03%	29	21.74%	39	-18.97%	28	63
210037	University of Maryland Shore Medical Center at	10.00 /0		21.7170	00	10.07 %		
	Easton	-21.59%	35	11.60%	18	-12.07%	38	63
210027	Western Maryland Regional Medical Center	-14.57%	24	24.36%	41	-12.05%	39	64
210012	Sinai Hospital	-19.31%	32	20.99%	37	-14.56%	35	68
210056	MedStar Good Samaritan Hospital	-19.12%	30	20.32%	36	-9.88%	41	69
210040 210030	Northwest Hospital Center University of Maryland Shore Medical Center at	-21.93%	36	23.86%	40	-16.30%	33	73
	Chestertown Union Hospital of Cecil County	-32.13% -25.11%	43 40	13.29% 15.43%	20 26	-12.02% -3.56%	40 42	73 74

Source: September 15, 2020 HSCRC Efficiency Workgroup materials

Per the requirement, Shady Grove would be able to demonstrate that it has a debt to capitalization ratio below the peer group average as required by the standard if the hospital elects to file a partial rate application under the HSCRC's capital policy. The data for average age of plant is no longer collected for the state and therefore, Shady Grove is unable to provide a comparison of its average age of plant to its peer group or the state.

4848-9177-7997

#### Comparison of FY2019 Debt to Capitalization Ratio to ICC Peer Group In \$000s Source: FY 2019 Audited Financial Statements

	Long Term Debt	Total Liabilities and Net Assets	Debt to Capitalization Ratio
MERITUS MEDICAL CENTER	251,121	620,980	0.4044
FREDERICK MEMORIAL HOSPITAL	168,386	528,028	0.3189
UM-HARFORD MEMORIAL HOSPITAL	23,576	150,320	0.1568
UM-SHORE REGIONAL HEALTH (1)	73,851	420,143	0.1758
WASHINGTON ADVENTIST HOSPITAL	373,101	412,888	0.9036
GARRETT COUNTY MEMORIAL HOSPITAL	12,905	97,484	0.1324
MEDSTAR HEALTH (2)	1,574,400	5,855,800	0.2689
PENINSULA REGIONAL MEDICAL CENTER	131,317	750,488	0.1750
ANNE ARUNDEL MEDICAL CENTER	298,384	950,383	0.3140
WESTERN MARYLAND REGIONAL MEDICAL CENTER	203,661	532,890	0.3822
UM-SHORE REGIONAL HEALTH AT CHESTERTOWN	3,670	80,951	0.0453
UNION HOSPITAL OF CECIL COUNTY	59,963	163,926	0.3658
CARROLL HOSPITAL CENTER	126,832	332,303	0.3817
UM-CHARLES REGIONAL MEDICAL CENTER	46,605	185,203	0.2516
CALVERT MEMORIAL HOSPITAL	57,873	139,239	0.4156
NORTHWEST HOSPITAL CENTER	81,453	193,169	0.4217
JOHNS HOPKINS HEALTHSYSTEM (3)	1,937,937	8,065,945	0.2403
UM-UPPER CHESAPEAKE MEDICAL CENTER	162,344	729,972	0.2224
DOCTORS COMMUNITY HOSPITAL	122,394	310,280	0.3945
FORT WASHINGTON MEDICAL CENTER	6,187	27,566	0.2245
ATLANTIC GENERAL HOSPITAL	34,464	112,143	0.3073
UM-ST. JOSEPH MEDICAL CENTER	210,299	322,037	0.6530
Peer Group Average (straight average)			0.3253
SHADY GROVE ADVENTIST HOSPITAL	158,869	500,696	0.3173

 $<sup>\</sup>textbf{(1)} \ \mathsf{UM} \ \mathsf{Shore} \ \mathsf{Regional} \ \mathsf{does} \ \mathsf{not} \ \mathsf{report} \ \mathsf{Easton} \ \mathsf{and} \ \mathsf{Dorchester} \ \mathsf{separately} \ \mathsf{on} \ \mathsf{its} \ \mathsf{financial} \ \mathsf{statements}$ 

Additionally, for FY 2019, the most recently publicly reported period, Shady Grove's capital costs as a percentage of its total operating costs of 9.27% are below the peer group average of 9.99%.

<sup>(2)</sup> Medstar Health does not report long term debt at an individual hospital level. Amounts here represent the entire MedStar Health System

<sup>(3)</sup> JHHS does not report long term debt at the individual hospital level. Amounts here represent the entire JHH System

### Comparison of FY2019 Capital % for Peer Group In \$000s

Source: FY 2019 Annual Filings - ACS Schedule

			Tot	al Operating	
	Cap	oital Costs (1)		Expenses	Capital %
MERITUS MEDICAL CENTER	\$	35,644.2	\$	297,295.6	11.99%
FREDERICK MEMORIAL HOSPITAL		21,434.5		257,992.1	8.31%
UM-HARFORD MEMORIAL HOSPITAL		5,700.8		84,348.6	6.76%
UM-SHORE REGIONAL HEALTH AT DORCHESTER		3,115.1		33,888.4	9.19%
WASHINGTON ADVENTIST HOSPITAL		20,006.1		228,558.1	8.75%
GARRETT COUNTY MEMORIAL HOSPITAL		4,557.3		45,380.2	10.04%
MEDSTAR MONTGOMERY MEDICAL CENTER		12,249.9		134,120.3	9.13%
PENINSULA REGIONAL MEDICAL CENTER		36,501.9		335,947.3	10.87%
ANNE ARUNDEL MEDICAL CENTER		47,570.4		514,500.7	9.25%
WESTERN MARYLAND REGIONAL MEDICAL CENTER		35,131.7		245,593.4	14.30%
MEDSTAR ST. MARY'S HOSPITAL		9,564.1		138,596.1	6.90%
UM-SHORE REGIONAL HEALTH AT CHESTERTOWN		3,952.8		40,809.1	9.69%
UNION HOSPITAL OF CECIL COUNTY		13,290.9		126,048.6	10.54%
CARROLL HOSPITAL CENTER		23,740.3		186,491.0	12.73%
UM-CHARLES REGIONAL MEDICAL CENTER		9,031.0		115,439.6	7.82%
UM-SHORE REGIONAL HEALTH AT EASTON		17,033.3		157,397.6	10.82%
CALVERT MEMORIAL HOSPITAL		14,811.0		122,254.9	12.11%
NORTHWEST HOSPITAL CENTER		19,739.6		191,172.1	10.33%
HOWARD COUNTY GENERAL HOSPITAL		24,985.1		252,885.9	9.88%
UM-UPPER CHESAPEAKE MEDICAL CENTER		24,916.0		236,923.7	10.52%
DOCTORS COMMUNITY HOSPITAL		14,219.2		190,028.5	7.48%
SHADY GROVE ADVENTIST HOSPITAL	\$	32,848.4	\$	354,233.9	9.27%
FORT WASHINGTON MEDICAL CENTER		2,695.7		45,291.5	5.95%
ATLANTIC GENERAL HOSPITAL		6,442.0		77,085.4	8.36%
MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER		19,723.4		215,090.6	9.17%
UM-ST. JOSEPH MEDICAL CENTER		32,264.2		291,400.7	<u>11.07</u> %
Peer Group Average	\$	491,168.7	\$	4,918,774.1	9.99%

b) The project does not eliminate or downsize any services and therefore will not have any adverse impact on the availability or accessibility of services.

#### (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**

#### **Cost Effectiveness**

#### **Overview**

As evidenced by its 5-star CMS rating, Shady Grove has demonstrated a high level of quality patient care. However, the hospital is challenged with too few private inpatient rooms, an aging and undersized ICU, a need to modernize patient care areas in the ED and an overall need for appropriate space that enhances clinical workflow and operational efficiency. As one example, the last major renovation of the ED occurred nearly 30 years ago, and most bays are separated just by curtains.

#### **Factors to Consider**

The Shady Grove executive team considered how to address these challenges in a manner consistent with Maryland's reimbursement model, which focuses on cost effective, value-based care. Among the criteria the team considered when evaluating how best to solve the space and facility challenges were:

- How do we best enhance clinical patient experience?
- What are the financial considerations?
- What would be the impact on hospital operations?
- What is the positive impact for the community?

With these overarching considerations in mind, the executive team evaluated several options for addressing the challenges of undersized space, inefficiency and the lack of all-private rooms for medical/surgical patients.

#### Option #1

The first option would be to, essentially, do nothing. Clearly this is the least costly solution, but it would not address the current challenges of the undersized and inefficient clinical space in important areas such as the ICU and ED, nor would it address the significant number of medical/surgical beds in semi-private rooms. The COVID-19 pandemic has highlighted the problems with small space ill-equipped to effectively handle infectious patients. The ED has only a few private rooms not separated by a curtain. During the COVID-19 patient surge, temporary walls were built around four treatment areas and a hole was cut into the glass windows to create a negative air pressure environment. Private inpatient hospital rooms have been the standard for some time, and the need for hospitals to adopt this standard is highlighted when there is a surge of infectious patients. Clearly, while doing nothing is an option, it would fail to address any of the challenges or concerns faced by patients or staff related to workflow, safety or patient experience.

#### Option #2

A second option considered the possibility of building up three floors vertically from the hospital's original four-story patient tower, resulting in all-private, inpatient rooms. This would achieve an important objective, but several challenges would remain. When Shady Grove was initially constructed some 40 years ago, the structural design of the late 1970s original building anticipated three floors could be added to the four-story structure. Changes in the structural code since that time, in particular the International Building Code's wind and seismic load requirements, would make this option expensive and disruptive to current operations. This option would necessitate a multi-phased construction approach that would require the hospital to shut down sections of the existing building (including beds) as the structure was reinforced, floor by floor. The existing tower has a column grid that is 25-feet wide. In order to achieve proper clearances at the foot of the bed, the patient rooms would not lay out consistent with the existing columns, windows or plumbing stacks below. While this type of work can be done when renovating an existing floor, it would not be recommended to invest in new construction that would require this sub-optimal approach. Such an effort would impose a disruptive burden on existing operations, would create

infection control risks for patients during construction and would significantly expand the construction schedule. This option, while yielding private rooms, would not include a renovation or upgrade of the ED, or ICU.

#### Option #3

A third option considered the development and construction of a patient care tower along with renovation of existing space to enhance patient safety, patient experience and clinical efficiency. This project would result in all-private MSGA inpatient rooms; appropriately sized, modern ICU space; private ED rooms; a CDU adjacent to the ED for safe, efficient care for patients in transition to inpatient care, observation or discharge. This option also provides a consolidation of services within the new patient tower, such as the CVIR, ED and perioperative units, that will significantly increase clinical efficiency.

This option would also include relocation of the helipad, from its current location to the top of the tower. The project will not increase the number of licensed inpatient beds.

In analyzing its options, the Shady Grove executive team developed a decision matrix, scoring each of these options with the four decision criteria categories referenced earlier, notably a project's impact on:

- Clinical Patient Experience
- Financial Considerations
- Hospital Operations
- Impact for the Community

The scoring grid: Assessment and Rating of Options for Shady Grove, shows the consideration of each of these three options against specific measures under the aforementioned decision criteria categories (Exhibit 23). Option 3, the initiative ultimately proposed by the executive team, scored the highest for clinical patient experience. Option 1, which maintains the status quo, would not result in any improvement in patient safety, private bed capability, modernization of space or improved clinical workflow. Option 2, the vertical addition to the original patient tower, scores well for private bed capability on the inpatient side, but it does not create additional private space in the ED or improvements to the ICU, which is why it scored a 4 versus a 5 for Option 3.

Regarding financial considerations, Option 1 scored the highest because there is no expenditure of capital. As noted in the scoring for other areas, though, it falls well short in meeting any other important criteria. The option proposed by the hospital, Option 3, includes a capital cost structure that is reasonable and affordable. The Financial Consideration category should, and in this case does, consider the long-term challenge for the hospital, its patients, staff and physicians, for not investing in patient care space. Following are the three options and the construction costs <u>without</u> escalation or financing costs:

Option 1, No Renovation: \$0

Option 2, Vertical Build from Original Tower: \$89,300,000 Option 3, New Patient Tower, upgraded ED, etc.: \$97,000,000

While Option 3, the proposed project, does have a higher capital spend, the project is more effective because it delivers a modern ED and ICU and other enhancements with less disruption to ongoing hospital operations than Option 2. The long-term benefit to patient care is greater and the use of resources is more prudent with Option 3.

For Hospital Operations, the third decision criteria category, Option 1 scored the highest because it is the least disruptive to current operations, as nothing would change. As with the Financial Consideration category, the overall benefit of avoiding any changes is offset by the current and future challenges of not modernizing important, aging patient care areas. Option 2 is the most disruptive to current hospital operations with the requirement for structural reinforcement and the need to shut down sections of the existing building, among other issues. Option 3, the recommended approach, has some immediate impact to operations but the interference with ongoing activities is less than Option 2.

Finally, Option 3 scored the highest on the fourth decision criteria category, Impact for the Community, because it would enhance the care experience for patients through private rooms, modernized ICU and ED spaces, and an overall improved benefit to patients. Importantly, Option 3 also provides the best option for future surge capacity needs with private rooms and right-sized clinical space, a material issue given the challenges in caring for COVID-19 patients. All three options score the same for Impact on existing providers because there would not be an increase in the licensed bed count for Shady Grove.

On June 22, 2020, the Shady Grove Governing Board approved a resolution affirming the hospital Executive team's recommendation for Option 3. (Exhibit 24).

Thus, the hospital is moving forward with the most cost-effective option for addressing the patient care challenges presented by its current facility.

#### (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**

The need for the project is demonstrated in the response to 10.24.01.08G(3)(b), presented above.

#### (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**

The new construction at Shady Grove will include a patient tower with one floor below grade and five floors above grade and is estimated to cost approximately \$95.1 million. Shown below are the computations of the Marshall Valuation Service (MVS) factors as applied to this project, which total \$67.7 million. When adjusted for the "extraordinary" costs that will be incurred to implement this project (approximately \$22.0 million), the adjusted Shady Grove new construction budget is shown to be higher than the MVS standard for new construction by approximately \$36.48 / square foot.

New Construction			
Туре	Hospital	Comp	utations
Construction Quality/Class	Good/A		
Stories	6		
Perimeter	4,356		
Average Floor to Floor Height	16.0		
Square Feet	150,352		
Base Costs (11/19)		\$398.00	
Sprinkler Amount	2.97	\$400.97	
Adjustment for Diff Cost Factors	1.00455	\$402.79	
Additions			
Elevator	0		
Other	0		
Perimeter Multiplier	0.92123	\$371.06	
Height per Story Multiplier	1.08871	\$403.98	
Multi-Story Multiplier	1.00214	\$404.85	
Update & Location Multipliers			
Update Multiplier (7/20)	1.02	\$412.94	
Location Multiplier (Bethesda)	1.09	\$450.11	
MVS Cost Standard		\$ 67,674,935	\$ 450.11
<b>Current Construction Costs (TABLE E.)</b>		\$ 95,129,014	\$ 632.71
Extraordinary Costs (TABLE D.)		\$ 21,968,561	<b>\$ 146.11</b>
<b>Adjusted Current Construction Costs</b>		\$ 73,160,453	\$ 486.59
Above/(Below) MVS Standard	_	\$ 5,485,517	\$ 36.48

In making the computations for the MVS standard, and because the Project will house particular hospital departments and functions at Shady Grove, an adjustment is made to the computations of the MVS standard of 1.00455, as shown below:

			MVS Cost	CF X
Department/Function	DGSF*	MVS Name	Factor	DGSF
FIRST FLOOR	1			
CVIR	13,086	Operating Suite	1.59	20,807
Mechanical / Electrical /	5.061	Mechanical Equip. &	0.7	4 102
Telecom	5,861	Shops	0.7	4,103
EVS	135	Administration/Offices	0.96	130
Corridors	2,156	Internal Circulation	0.6	323
Stairs / Elevator Shafts	539	Internal Circulation	0.6	323
SECOND FLOOR				
Emergency Services	26,128	Emergency Suite	1.18	30,831
Radiology	2,857	Radiology	1.22	3,486
Mechanical / Electrical /	498	Mechanical Equip. &	0.7	349
Telecom	498	Shops	0.7	349
EVS	138	Administration/Offices	0.96	132
Corridors	4,374	Internal Circulation	0.6	2624
Lobby / Public Space	2,098	Lobbies / Public Space	0.8	1,678
Stairs / Elevator Shafts	1,129	Internal Circulation	0.6	677
THIRD FLOOR	•			
ICU	18,779	Inpatient Units	1.06	19,906
Lobby / Public Space	364	Lobbies / Public Space	0.8	291
Mechanical / Electrical /	391	Mechanical Equip. &	0.7	274
Telecom	391	Shops	0.7	274
EVS	229	Administration/Offices	0.96	220
Corridors	1,774	Internal Circulation	0.6	1,064
Stairs/Elevator Shafts	1,120	Internal Circulation	0.6	672
FOURTH FLOOR				
PCU	17,239	Inpatient Units	1.06	18,273
Lobby / Public Space	364	Lobbies / Public Space	0.8	291
Mechanical / Electrical /	391	Mechanical Equip. &	0.7	274
Telecom	391	Shops	0.7	274
EVS	229	Administration/Offices	0.96	220
Corridors	2,041	Internal Circulation	0.6	1,225
Stairs / Elevator Shafts	1,120	Internal Circulation	0.6	672
FIFTH FLOOR				
Medical Surgical Unit	17,239	Inpatient Units	1.06	18,273
Lobby / Public Space	364	Lobbies / Public Space	0.8	291
Mechanical / Electrical /	391	Mechanical Equip. &	0.7	274
Telecom		Shops		
EVS	221	Administration/Offices	0.96	212
Corridors	862	Internal Circulation	0.6	517
Stairs/Elevator Shafts	1,112	Internal Circulation	0.6	667
SIXTH FLOOR				

Department/Function	DGSF*	MVS Name	MVS Cost Factor	CF X DGSF
Mechanical Penthouse	16,507	Mechanical Equip. & Shops	0.7	11,555
Stairs/Elevator Shafts	1,112	Internal Circulation	0.6	667
ROOF				
Corridors	1,426	Internal Circulation	0.6	856
Stairs/Elevator Shafts	512	Internal Circulation	0.6	307
TOTAL	142,786		Adjustment Factor: 1.00455	143,435

<sup>\*</sup>Department Gross Square Feet (DGSF)

Because the Project involves a unique plan for demolition and new construction in the space currently occupied by the existing hospital facility, certain costs have been identified as "extraordinary," and are excluded from the comparison to the applicable MVS standard. These extraordinary construction costs, totaling approximately \$22.0 million and included in the Shady Grove construction budget, are shown on Table D (Exhibit 1). Excluding these extraordinary costs reduces the estimated project costs that are comparable to the MVS applicable calculated standard.

An explanation of these extraordinary costs include the following:

Shady Grove Medical Center Bed Tower Project - Explanation of Extraordinary Costs

Project Budget Item	Cost		Requirement of	Scope of Work	Basis of Estimate				
(1) Costs of buying land such as esc drains, rough grading.									
Demolition	\$	101,514	MVS excludes site demolition.	Remove existing paving, curbs, sidewalks & paths.	Quantity take-off from conceptual plans.				
Storm Drains	\$	319,990	MVS excludes storm drains.	New system incl. pipe, excavation, culverts & manholes.	Quantity take-off from conceptual plans.				
Rough Grading	\$	886,247	MVS excludes rough grading in excess of building pads.	Sloping site requires cut and fill to create building pads.	Quantity take-off from conceptual plans.				
Site Utility Relocation	\$	1,472,782	MVS excludes utility relocation.	Relocate exist. elec. & domestic water to new tunnel.	Quantity take-off from conceptual plans.				
Sediment and Erosion Control	\$	73,829	Montgomery County requirement to meet NPDES standards.	Super silt fence, dikes, rip-rap, gravel and baffleboard.	Quantity take-off from conceptual plans.				
(2) Pilings or hillside foundations, soil	l comp	action and vibi	ration, terracing.						
Pilings & Hillside Foundations	\$	3,962,135	MVS excludes pilings. Pilings are required due to existing soils.	104 auger cast piles @ 30' deep and 84 piles @ 46' deep.	Quantity take-off from conceptual plans.				
Sheeting and Shoring	\$	1,306,643	MVS excludes sheeting and shoring.	Sheeting and shoring as required for excavation adjacent to existing building.	Quantity take-off from conceptual plans.				
(3) Cost of land planning, interest/tax & consulting fees.	es on la	and, feasibility	(3) Cost of land planning, interest/taxes on land, feasibility studies, CON, EIS reports, haz mat testing, appraisal						

Explanation

### Shady Grove Medical Center Bed Tower Project - Explanation of Extraordinary Costs $\\ Explanation \qquad of$

Decinat Dudget Item	Cost		Explanation of	Cooms of Work	Dagia of Estimate
Project Budget Item	Cost		Requirement	Scope of Work  County application fees,	Basis of Estimate
Montgomery County Land Use Costs	\$	1,500,000	MVS excludes cost of land planning. Additional site plan approvals req'd.	design & legal consultants, community outreach, recordation costs.	Allowance.
(5) Yard improvements including separecreational facilities.	tic syste	ms, signs, lan	dscaping, paving, walls, y	ard lighting, pools or other	
Paving	\$	1,401,878	MVS excludes site paving.	Site roadways, parking and sidewalks.	Quantity take-off from conceptual plans.
Exterior Signs	\$	82,814	MVS excludes site signage.	Code-required site signage.	Allowance per conceptual plans.
Landscaping	\$	399,995	MVS excludes landscaping.	Ground cover, plants, trees.	Allowance per conceptual plans.
Walls, Stairs, Structures	\$	337,766	MVS excludes site walls.	Site retaining walls, stairs, structures.	Quantity take-off from conceptual plans.
Yard Lighting	\$	369,143	MVS excludes yard lighting.	Site lighting allowance.	Allowance per conceptual plans.
(6) Off-site costs including roads, utili assessments.	ities, pa	rk fees, jurisd	ictional hookup, tap-in, im	pact or entitlement fees and	
Jurisdictional Hook-up Fees	\$	970,846	MVS excludes jurisdictional hook-up fees.	Connection fees for electrical, telecom, water, gas, & cable.	Allowance per conceptual plans.
(7) Furnishings and fixtures, usually 1	ot foun	d in the gener	al contract, that are partic	rular to a definite tenant.	
Helipad	\$	799,810	MVS excludes helipads.	Helipad, lighting, windsock, barricades, striping.	Quantity take-off from conceptual plans.
Pneumatic Tube System	\$	461,429	MVS excludes pneumatic tube systems.	12 stations, blower, tubing, connect to existing system.	Quantity take-off from conceptual plans.
Additional required adjustments.					
Canopies	\$	952,512	MVS excludes exterior canopies.	Canopies at main entrance, ER drop-off & ambulance bays.	Quantity take-off from conceptual plans.
Vegetated Roofs	\$	771,657	MVS excludes vegetated roofs.	Extensive vegetated roof system at low roofs.	Quantity take-off from conceptual plans.
Additional Service Elevator	\$	602,934	MVS includes code- required vertical transportation.	Additional elevator required for public/private separation.	Quantity take-off from conceptual plans.
Enhanced Commissioning	\$	139,040	MVS includes basic commissioning.	Cost for enhanced commissioning req'd for LEED.	Allowance per conceptual plans.
Underground Oxygen Piping	\$	470,657	MVS includes on-site utilities.	Oxygen piping required from remote farm.	Quantity take-off from conceptual plans.
Temporary Construction for Access	\$	246,095	MVS excludes temporary construction costs.	Temporary construction as required to maintain access to existing hospital.	Allowance per conceptual plans.

Shady Grove Medical Center Bed Tower Project - Explanation of Extraordinary Costs

		Explanation of		
Project Budget Item	Cost	Requirement	Scope of Work	Basis of Estimate
Extended General Conditions	\$ 2,890,451	MVS excludes phasing costs.	Extended general conditions due to required phased construction, 24 months of 60-month schedule.	Proportional allocation of estimated GC's.
A/E Fees Associated w/ Extraordinary Costs	\$ 1,452,052	MVS excludes all aspects of extraordinary costs.	A/E and consultant fees associated with extraordinary costs at 7.4%.	Proportional allocation of estimated A/E costs.
Total Adjustments to Cost	\$ 21.972.219			

In addition to the new construction proposed for the Shady Grove project, approximately 25,696 DGSF of renovations are planned in the existing hospital facility. The estimated cost of renovations is approximately \$9.7 Million. Shown below are the computations of the MVS factors as applied to this portion of the Project, which total \$13.2 Million. No adjustment for extraordinary costs were applied to the estimated costs of the Shady Grove renovations. The comparison shows that the renovation costs are well below the MVS standard by \$(134.94)/square foot.

Renovation				
Туре	Hospital		Cor	mputations
Construction Quality/Class	Good/A			
Stories	4			
Perimeter	1,205			
Average Floor to Floor Height	16.0			
Square Feet	25,696			
Base Costs (11/19)		\$398	3.00	
Sprinkler Amount	2.97	\$400	).97	
Adjustment for Diff Cost Factors	1.09006	\$437	.08	
Additions				
Elevator	0			
Other	0			
Perimeter Multiplier	0.96852	\$423	3.32	
Height per Story Multiplier	1.09200	\$462	2.26	
Multi-Story Multiplier	1.00000	\$462	2.26	
Update & Location Multipliers				
Update Multiplier (7/20)	1.02	\$471	.51	
Location Multiplier (Bethesda)	1.09	\$513	3.95	
MVS Cost Standard		\$ 13	3,206,338	\$ 513.95
<b>Current Construction Costs (TABLE E.)</b>			9,783,923	\$ 379.01
<b>Extraordinary Costs (TABLE D.)</b>	\$	0	\$ 0.00	
<b>Adjusted Current Construction Costs</b>			9,783,923	\$ 379.01
Above/(Below) MVS Standard		\$ (3	,467,415)	\$(134.94)

The tables presented above are included in Exhibit 25.

Shady Grove reserves the right to apply for a change in rates and realizes that the amount in excess of the MVS will not be included at the time of request.

#### (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**

The proposed project does not include construction of non-hospital space.

#### (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**

#### **Proposed Bed Distribution**

Unit Name	Unit Description	No. of Beds in the Project	Unit Size (SF)	Sq. Feet/Bed
Floor 3	ICU/CCU	26	12,927	497
Floor 4	Progressive Care Unit	24	11,992	499
Floor 5	Medical Surgical Unit	24	11,992	499
Total Beds		74		

None of the spaces for inpatient units in the project exceeds 500 square feet per bed. The department area was determined by summing the interior room areas for each departmental unit, including all patient rooms, support spaces and family support rooms within that department. The

tabulation excluded corridor circulation, stairs, elevators, shafts, utility rooms, structural columns, shear walls and exterior wall enclosure.

#### (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**

Shady Grove is not considered a high cost hospital. According to the "Final Recommendation on Integrated Efficiency Policy for RY 2020: Withholding Inflation for Relative Efficiency Outliers and Potential Global Budget Revenue Enhancements" published on October 16, 2019, hospitals in the worst performing quintile *and* in excess of one standard deviation of average Volume Adjusted ICC performance (or 1.21 times the ICC standard) could be deemed outliers and subject to a partial withhold of its annual update factor. Based on the RY2020 Integrated Efficiency calculation shown in the Adverse Impact section 10.24.10.04B(4), Shady Grove does not meet the criteria as a high cost hospital requiring a rate reduction or update factor withhold.

#### (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**

The Shady Grove design team has consistently incorporated performance features into the design of the new addition and renovation in order to enhance operational efficiency. The current design promotes the following features:

- The main public and service elevator banks are positioned to be centrally located between the new addition and the existing Hospital.
- Direct connections between the new addition and existing hospital have been located on levels 1 through 4 as to optimize the flow between departments. This optimized movement between patient care departments and critical support amenities or services will result in greater efficiency for staff providing care and patients receiving care.
- Departments with interrelated services are located adjacent to one another. These include the ED and CDU, and CVIR and perioperative services.
- CVIR is being relocated to level 1 of the hospital to be immediately adjacent to the surgery and sterile processing departments. It is also directly below the expanded ED with a direct elevator connection to optimize travel distances. This location also allows support functions to be shared between Surgery and CVIR.
- Separate entrances for ED patients and hospital visitors improve patient safety, security, wayfinding and overall visitor experience.
- Patient bed unit layouts with decentralized team stations, and optimally located clinical support rooms minimize nurse travel distance and reduce noise.

#### (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**

Evidence-based architectural methods have been employed in the hospital design to improve patient outcomes, safety, and satisfaction. Additionally, these design methods also improve staff efficiency, satisfaction, and retention. The design is consistent with national or jurisdictional codes and guidelines established for hospital design and construction.

All-private MSGA, ICU and ED rooms in the hospital addition and renovation will eliminate infection risks inherent in semi-private rooms occupied by two patients. In addition, hand washing stations will be located both directly inside the entry door to each patient room as well as along the corridor to further reduce the risk of infection.

Within each patient room, the risk of patient falls is reduced due to the proximity of the washroom door to the patient's bed and the amount of light provided. Family space is also provided in the room to encourage patient and family involvement in care. Individual computer access is

provided in each room to facilitate the communication of concerns that patients or family members might have.

The proposed nursing unit design will decentralize caregivers and provide them with clear lines of sight into patient rooms. This will allow nurses to more easily see patients who may be attempting to transition from the bed or chair on their own and allow them to assist more quickly. Computer stations will be included in both the alcoves and at the patient bedside for staff access to electronic medical records and medication bar coding, reducing errors. Clinical support rooms will reduce the distances staff must travel for supplies and medications.

The new hospital addition will provide separate and distinct entrances for hospital visitors, walk-in ED patients and ambulance arrivals. In the ED, all exam spaces will be private, enclosed rooms, reducing the risk of infection, improving patient privacy and consistent with HIPAA guidelines. Within the ED, the EPTU beds will be located close to the ambulance entry door, minimizing travel distance and contact with other patient treatment spaces. The EPTU will be secure and separate from the main ED.

The decontamination area will have a separate entry from the exterior to isolate and extract potential contaminants before they can enter the ED.

The proposed CVIR facility at Shady Grove will create a modern, efficient department designed to replace the aging and inefficient existing space. The current CVIR department requires patients to register, prep and recover in two locations on opposite ends of the existing hospital structure. Patients must travel through major corridors and across multiple levels to move between perioperative areas and the CVIR department. This patient flow is disadvantageous for patient safety.

The proposed CVIR department will not have this issue. Patients will remain within a defined CVIR space, directly connected to the pre-surgery and surgical suite and post-anesthesia care unit. Patients will be separated from the public as they travel to and from care.

The hospital addition and renovation will specify finishes that are easily cleaned and maintained, supporting a reduced risk of hospital-acquired infections.

#### (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**

A table detailing the revenue and volume assumptions that were used in the financial projections can be found in Exhibit 9. The expense assumptions used in the financial projections can be found Tables G and H in Exhibit 1.

		Summary of Rev	ove Medio					
		Summary of Nev	FY 2021-2026	•	UIIS			
ates:								
Glo	bal Budget Re	venue Update Assumptions: (1)	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026
	Update Facto	r	2.36%	2.36%	2.36%	2.36%	2.36%	2.369
	Age Adjusted	Population Growth	-0.01%	-0.01%	-0.01%	-0.01%	-0.01%	-0.01
	Population Ir	nfrastructure	0.00%	0.00%	0.00%	0.00%	0.00%	0.00
	Market Share	2	0.00%	0.00%	0.00%	0.00%	0.00%	0.009
	Deferred Rev	venue	0.00%	0.00%	0.00%	0.00%	0.00%	0.009
	Capital in Rat	res	0.00%	0.00%	0.00%	0.00%	0.00%	0.009
	Other Revers	als/One-time Adjustments/Change in MU	0.00%	0.00%	0.00%	0.00%	0.00%	0.009
	Total		2.35%	2.35%	2.35%	2.35%	2.35%	2.359
olume	es:							
Tot	al Inpatient Di	scharges <sup>(2)</sup>	3.84% (3)	0.92%	0.87%	0.85%	0.81%	0.789
Out	tpatient and E	mergency Visits <sup>(4)</sup>	45.07% <sup>(5)</sup>	0.80%	0.80%	0.80%	0.80%	0.809
ootno	tes:							
	Global Budget	Revenue assumptions are based on estimates of c %. Likewise, the Age Adjusted Population Growth a						
(2)	Changes in tot	al inpatient discharges are estimated based on pr	ojected changes	in the populati	on and use rate	es for the total s	ervice area.	
(3)	service area as	al inpatient discharges for FY 2021 from FY 2020 i s well as the normalization of volumes impacted b 2020 by order of the State of Maryland.						
(4)	Changes in out	patient and emergency visits are estimated based	on projected ch	anges in the po	pulation for the	e primary servi	ce area.	
(5)	Changes in out	patient and emergency visits for FY 2021 from FY	2020 is a combi	nation of the pr	ojected change	s in the popula	tion for the prin	nary

The projections of future utilization of the hospital have been based on historical trends in the utilization of these services by the Service Area population of the hospital and compared with the experience of other hospitals in Montgomery County and across the State of Maryland (Exhibit 26). Future utilization of hospital services after opening of the new patient tower have been based on estimated growth of the Service Area population as shown in the need and market share projection in this application under COMAR 10.24.01.08G(3)(f) (Impact on Existing Providers).

## Utilization Trends Summary of Outpatient Emergency Trends All Maryland Hospitals and Freestanding Emergency Rooms FY 2017-2019

		<u>2017</u>	2018	2019	CAGR (1)
		Statewide			
EMG	RVUs	19,503,275	19,292,979	18,978,009	
			-1.08%	-1.63%	-1.36%
EMG	Visits	2,155,221	2,087,070	2,056,078	
			-3.16%	-1.48%	<b>-2.33%</b>
		Montgomery Cou	inty		
EMG	RVUs	2,451,727	2,444,578	2,429,215	
			-0.29%	-0.63%	-0.46%
EMG	Visits	281,465	275,450	276,807	
			-2.14%	0.49%	-0.83%
		Shady Grove Medical	Center		
EMG	RVUs	666,176	672,341	631,007	•
			0.93%	-6.15%	-2.68%
EMG	Visits	81,483	79,798	78,296	
			-2.07%	-1.88%	-1.98%

<sup>(1)</sup> Compound Annual Growth Rate

Source: HSCRC Maryland Hospital Experience Reports (https://hscrc.maryland.gov/Pages/hsp\_Data2.aspx)

# Utilization Trends Summary of Outpatient Obersvation Trends All Maryland Hospitals FY 2017-2019

		2017	2018	2019	CAGR (1)				
	Statewide								
OBV	Hours	4,380,227	4,401,986	4,625,663					
			0.50%	5.08%	2.76%				
OBV	Visits	229,746	241,540	265,122					
			5.13%	9.76%	7.42%				
		Montgomery Cou	inty						
OBV	Hours	636,198	657,060	721,745					
			3.28%	9.84%	6.51%				
OBV	Visits	24,578	25,930	26,291					
			5.50%	1.39%	3.43%				
		Shady Grove Medical	Center						
OBV	Hours	127,544	175,292	206,059					
			37.44%	17.55%	27.11%				
OBV	Visits	5,388	7,131	7,562					
			32.35%	6.04%	18.47%				

<sup>(1)</sup> Compound Annual Growth Rate

Source: HSCRC Maryland Hospital Experience Reports (https://hscrc.maryland.gov/Pages/hsp\_Data2.aspx)

# Utilization Trends Summary of Admission Trends (excluding Births) All Maryland Hospitals FY 2017-2019

		2017	2018	2019	CAGR (1)
		Statewide			
ADM	Admissions	564,644	551,398	532,389	
			-2.35%	-3.45%	-2.90%
		Montgomery Cou	inty		
ADM	Admissions	82,828	81,617	78,755	
			-1.46%	-3.51%	-2.49%
		Shady Grove Medica	Center		
ADM	Admissions	20,359	20,024	18,871	
			-1.65%	-5.76%	-3.72%

<sup>(1)</sup> Compound Annual Growth Rate

Source: HSCRC Maryland Hospital Experience Reports (https://hscrc.maryland.gov/Pages/hsp\_Data2.aspx)

# Utilization Trends Summary of Admission Trends (excluding Births) + Observation Visits All Maryland Hospitals FY 2017-2019

		2017	2018	2019	CAGR (1)
		Statewide			
ADM + OBV	Admissions + OBV Visits	794,390	792,938	797,511	
			-0.18%	0.58%	0.20%
		Montgomery Cou	inty		
ADM + OBV	Admissions + OBV Visits	107,406	107,547	105,046	
			0.13%	-2,33%	-1.10%
	S	hady Grove Medical	Center		
ADM + OBV	Admissions + OBV Visits	25,747	27,155	26,433	
			5.47%	-2.66%	1.32%

<sup>(1)</sup> Compound Annual Growth Rate

Source: HSCRC Maryland Hospital Experience Reports (https://hscrc.maryland.gov/Pages/hsp\_Data2.aspx)

Revenue estimates are based on current allowable charge levels and incorporate the reimbursement methodologies under the HSCRC's Global Budget Revenue model for Shady Grove. Revenue projections assume a base update factor based on historical experience. Because Shady Grove is assuming growth only related to population growth, there are no positive adjustments for market share in any years in the projections. A summary of revenue updates applied in each year of the projection can be found at Exhibit 9 - Summary of Revenue & Volumes, above).

Expense assumptions in the financial projections as shown in Tables G and H of Exhibit 1 are generally based on historical expenditure levels. For FY2021, expenses were assumed to normalize back to historical levels prior to the onset of COVID-19 during FY2020. Inflation assumptions for future years are estimated to be 2%-3% annually through 2026.

Staffing and expenditure levels as shown in Table L of Exhibit 1 are based on current expenditure levels but include adjustments for changes in volumes over time and staff necessary to support the added square footage of the new patient tower when it is completed in 2024. The increase in staff to support the new patient tower includes support teams, such as Environmental Services, Facilities, and Nutritional Services, and clinical unit support staff and leadership for the additional clinical units. It is not anticipated that there will be an increase in staff related to direct patient care other than for the expected change in volumes over time.

As shown in Tables G and H of Exhibit 1, the hospital will generate revenues in excess of expenses in the first year of the project.

Attached as Exhibit 27 is a letter from AHC's investment banker, Ziegler Capital Markets, which endorses the feasibility of the project.

#### (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 nonemergency 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.

#### **Applicant Response**

- (a) Shady Grove has deployed, and continues to refine, many strategies to maximize the existing capacity of our ED. Some of these strategies include:
  - Segmented flow Shady Grove separates ED patients according to needs so that providers can treat them more efficiently. These segments are acute adult, minor adult, pediatric, and psychiatric patient groups. Shady Grove added a results-pending area for minor adult patients to improve its ability to cycle patients through treatment spaces more expeditiously.
  - Executive commitment to throughput Senior hospital executives committed in 2015 to improve efficiency of patient movement though the ED. Since that time, a leadership team has met monthly to review performance and plan interventions. Metrics were established for each service line and are monitored on a weekly and monthly basis. Barriers to patient flow have been reduced or eliminated and ED flow has improved.
  - **Dedicated observation unit added** Shady Grove created a unit dedicated to the admission of observation patients that admits an average of 350 patients per month. Each admission to the unit reduces the length of stay to 20 hours, from an average of 2.5 days on a medical/surgical unit. The observation unit has eliminated more than 575 bed days per month in medical/surgical units and reduced ED boarding time.
  - Clinical Resource Group of US Acute Care Services (USACS) engagement The ED leadership team worked with the USACS, the physician group that serves the department, to assess and recommend improvements to patient flow. The recommendations were implemented and are monitored on an ongoing basis for effectiveness.
  - **Partnering with EMS** Shady Grove is the largest volume destination for Montgomery County EMS and works closely with them to ensure efficient operations. Shady Grove monitors ED diversion times and compares them with other EDs in the county, and monitors EMS turnover times to ensure the needs of EMS colleagues are met.

• Opening of Urgent Care sites – AHC has in recent years opened two urgent care centers within the Shady Grove Service Area. A Rockville Urgent Care center opened in 2015 and a Germantown center in 2016. The centers provide an ED alternative to patients without primary care providers. As part of efforts to promote the sites, Shady Grove leaders have worked with AHC on materials that educate potential patients about conditions for which a visit to Urgent Care would be more appropriate than a visit to the ED. These materials have been widely distributed in publications and at community events in the Shady Grove Service Area.

Shady Grove has worked to improve throughput, but it has also seen a significant jump in the number of behavioral health and substance abuse patients who report through its EDs, both voluntarily and involuntarily. This change has occurred since the Shady Grove ED was last renovated in the early 1990s. These patients are adversely impacted by noise and animated activity that takes place in an ED, especially one that is not optimized for privacy or organized for modern care techniques. The replacement ED at Shady Grove will consider this population in its design and result in a care space that better meets the mental and physical needs of these patients, the other patients in the department and the hospital's caregivers.

Also, it is noteworthy that Shady Grove's ED serves as a front door for patients seeking care from its Forensic Medical Unit (FMU), the only one in Montgomery County. Highly specialized nurses serve county residents who are victims of sexual abuse and assault, child abuse, elder abuse and human trafficking. The nurses treat the medical and emotional needs of these patients, work closely with law enforcement to collect medical evidence, and partner with community agencies that serve the long-term needs of victims. The number of patients that the FMU serves has increased over the last several years. Cases were up 28% in the first six months of 2020 compared with the same time in 2019.

Nurses on the Shady Grove FMU estimate that as many as half of its patients report to the hospital through the ED. The proposed replacement ED with private bays and improved patient flow will provide victims who report to Shady Grove with a more straightforward, discreet path to care through the ED to the dedicated FMU. Forensic patients who cannot wait to travel to the separate FMU for care will have a private, quiet space in the ED that reduces further traumatization and allows nurses to ask highly sensitive questions essential to the patient's ongoing health and personal safety.

Shady Grove proposes a replacement ED to be located on the ground level of the new patient tower. The proposal is based on analysis of the projected changes to the adjusted Service Area and market share, current utilization rates and trends, the projected population for the Service Area, and the existing ED's utilization trends.

The current Shady Grove ED houses 58 treatment bays and 11 behavioral health evaluation rooms, which do not provide a desirable level of privacy or dignity for patients and caregivers. The proposed ED will contain the same number of treatment rooms, and 13 behavioral health evaluation rooms.

Comparing the proposed ED with the ACEP standards and parameters, the project meets the projected volumes and allows for expansion should volumes increase. The current design, 69 treatment bays in 49,436 DGSF, is within the high range parameters (see table below). In addition, the current design is appropriately sized to the projected volumes with improvements in efficiency or minor changes in room mix. The current design includes a radiology program within the ED to provide direct access to a CT, general radiology rooms and ultrasound.

Shady Grove considered the ACEP guidelines for determining the number of treatment spaces and the total program area for the design of the ED in the proposed project. The table below provides Shady Grove's responses to the ACEP parameters.

#### **Parameters Determining Size for Emergency Department**

Low Range Parameter	SGMC		
	(Yes or No Response)		
ALOS for all ED patients <2.5 hours	No		
Observation /Evaluation Beds located outside ED	Yes		
Time to admit <60 minutes after disposition	No		
Average turnaround time for diagnostic test results <30 minutes	No		
Less than 18% of patients are admitted to the Hospital	No		
Non-urgent patients outnumber urgent patients by more than 10 %	No		
Less than 20% of patients are age 65+	Yes		
Minimal Need for offices or teaching spaces	No		
Imaging studies are not performed within the department	No		
No specialty components or departments	No		
Flight/trauma services support areas not included	Yes		

High Range Parameter	SGMC
	(Yes or No Response)
ALOS for all ED patients >3.5 hours	Yes
Observation/evaluation beds will be located within the ED	Yes
Time to admit >90 minutes after disposition	No
Average turnaround time for diagnostic test results in >60 minutes	Yes
More than 23% of patients are admitted to the Hospital	**
	16% if counting inpatient status only 26% if counting inpatient and observation status
Need for offices or teaching spaces, such as a university teaching hospital	Yes
Imaging studies are performed within the department	Yes
Specialty components or departments (pediatric ED, large number of psychiatric patients)	Yes
Flight/trauma services support areas included	No

Shown below are the low and high ranges of ED areas and bed quantities, including patient spaces for observation/clinical decision. The high range includes beds for "observation/clinical decision."

Projected Annual Visits	Departmo Area	ental Gross		Bed Quantities						
	Low Range	High Range	Low Range	Low Range Visits/bed	High Range	High Range Visits/Bed		Estimated Observation/ Clinical Decision		
20,000	13,500	17,100	15	1,333	19	1,053	900	3-4 spaces		
30,000	17,500	22,750	20	1,500	26	1,154	875	4-6 spaces		
40,000	21,875	28,875	25	1,600	33	1,212	875	6-8 spaces		
50,000	25,500	34,000	30	1,677	40	1,277	850	8-10 spaces		
60,000	29,750	39,950	35	1,714	47	1,296	850	9-12 spaces		
70,000	33,000	44,550	40	1,750	54	1,296	825	11-14 spaces		

Source: Emergency Department Design, A Practical Guide to Planning for the Future

- (b) (i) There are two providers with emergency departments located within the Primary Service Area of Shady Grove.
  - Shady Grove Medical Center (Shady Grove)
  - Adventist HealthCare Germantown Emergency Center (AHC Germantown EC)

As the information in the following table shows, seven facilities serve the majority of residents of the Primary Service Area. In fact, for the calendar years 2017 and 2018 these facilities accounted for nearly 97% of emergency visits by Primary Service Area residents. The emergency centers within AHC provided approximately 54% of the visits in those two years.

Emergency Department Visits								
Residents of Primary Service Area								
		Year ended D	ecember 31,					
	20	17	20	18				
Hospital	Visits	Pct Total	Visits	Pct Total				
Shady Grove	36,589	37.3%	36,036	37.4%				
AHC Germantown EC	16,202	16.5%	14,891	15.5%				
Holy Cross Germantown	13,801	14.1%	14,648	15.2%				
Medstar Montgomery	10,662	10.9%	10,243	10.6%				
Holy Cross Hospital	8,861	9.0%	8,696	9.0%				
Suburban Hospital	8,058	8.2%	8,089	8.4%				
Washington Adventist Hospital	918	0.9%	821	0.9%				
Subtotal	95,091	96.9%	93,424	96.9%				
Others	3,052	3.1%	2,950	3.1%				
Total	98,143	100.0%	96,374	100.0%				
Source: Statewide Data								

Recent trends in the utilization of emergency services at Shady Grove have been presented in response to Subsection (a) of this criterion. Anticipated future utilization of Shady Grove's ED has been assumed to follow trends in population growth of the Service Area.

(ii) Shady Grove treats all patients who present to its ED consistent with the EMTALA requirements. Moreover, Shady Grove follows AHC's Financial Assistance Policy (FAP, Exhibits 12 and 13) that ensures the availability of health care services for patients who are uninsured, underinsured, or lack adequate resources to pay for services. The FAP applies to all services provided by AHC hospitals, including, in particular, Shady Grove, the AHC Germantown Emergency Center, and White Oak.

The FAP ensures that ability to pay is not a barrier to emergency care so that the volume of uninsured, underserved, and otherwise medically indigent emergency patients at Shady Grove is commensurate with the Service Area at large.

The following table shows the number of patients whose services are paid for through Medicaid, charity patients for whom no payment is expected, and self-pay patients. These financial categories include most patients who are considered to be uninsured, underinsured, or lacking sufficient resources to pay for their care.

As the table shows, Shady Grove's charitable commitment is commensurate with the other providers of emergency services. In 2017 and 2018 41.3% and 41.2%, respectively, of emergency patients at Shady Grove were Medicaid beneficiaries or charity or self-pay patients. For the three AHC facilities together more than 46% of emergency patients from the Primary Service Area were included in these categories in both 2017 and 2018.

		Year ended December 31, 2017						
	Medi	caid	Charity/S	Charity/Self Pay		Subtotal		
Hospital	Visits	Pct Total	Visits	Pct Total	Visits	Pct Total	Total Visits	
Shady Grove	10,760	29.4%	4,355	11.9%	15,115	41.3%	36,589	
AHC Germantown EC	6,915	42.7%	2,367	14.6%	9,282	57.3%	16,202	
Washington Adventist Hospital	318	34.6%	195	21.2%	513	55.9%	918	
Subtotal, AHC	17,993	33.5%	6,917	12.9%	24,910	46.4%	53,709	
Holy Cross Germantown	3,705	26.8%	2,819	20.4%	6,524	47.3%	13,801	
Medstar Montgomery	3,243	30.4%	800	7.5%	4,043	37.9%	10,662	
Holy Cross Hospital	2,931	33.1%	2,158	24.4%	5,089	57.4%	8,861	
Suburban Hospital	1,101	13.7%	542	6.7%	1,643	20.4%	8,058	
Total	28,973	30.5%	13,236	13.9%	42,209	44.4%	95,091	
			Year ende	ed December	31, 2018			
	Medi	caid	Charity/\$	Charity/Self Pay Subt		otal		
Hospital	Visits	Pct Total	Visits	Pct Total	Visits	Pct Total	Total Visits	
Shady Grove	10,437	29.0%	4,395	12.2%	14,832	41.2%	36,036	
AHC Germantown EC	6,451	43.3%	2,115	14.2%	8,566	57.5%	14,891	
Washington Adventist Hospital	249	30.3%	217	26.4%	466	56.8%	821	
Subtotal, AHC	17,137	33.1%	6,727	13.0%	23,864	46.1%	51,748	
Holy Cross Germantown	3,765	25.7%	3,117	21.3%	6,882	47.0%	14,648	
Medstar Montgomery	3,036	29.6%	812	7.9%	3,848	37.6%	10,243	
Holy Cross Hospital	2,742	31.5%	2,073	23.8%	4,815	55.4%	8,696	
Suburban Hospital	1,182	14.6%	618	7.6%	1,800	22.3%	8,089	
Total	27,862	29.8%	13,347	14.3%	41,209	44.1%	93,424	
Source: Statewide Data								

(iii) Projected future utilization of emergency services depends on a combination of the use rate for emergency services and population growth. Shady Grove, as described above, has undertaken a number of initiatives to make primary care urgent care services available to the Service Area population in order that patients do not utilize the ED as a substitute for less intensive services. The population of the Service Area continues to increase, and the need for emergency services will necessarily increase with the population.

The proposed project is intended also to make emergency services at Shady Grove more efficient and more clinically effective through design features, including better separation of patients and improved patient flow to other inpatient areas. These features will improve the throughput of the ED and the capability of the department to respond to the needs of emergent patients. The improvements to the ED that are incorporated into the proposed project are described elsewhere in the application in substantial detail.

(iv) As noted above, Shady Grove, through AHC, is affiliated with two urgent care centers in hospital's Service Area. These urgent care centers provide an alternative to the ED for patients who lack a primary care physician. AHC has also reached an agreement with the Montgomery County Fire and Rescue to transport medically appropriate patients to an AHC urgent care center instead of a hospital-based ED. AHC has reached out to the local community through the provision of educational material and through the Adventist Medical Group, a network of primary care providers, to increase awareness of the availability of urgent care centers for non-emergent services.

(v) The current ED at Shady Grove has not had a significant renovation for 30 years and needs to be upgraded to support the range of services it provides and to increase its capacity to meet the needs of a growing Service Area population. Shady Grove has placed a greater emphasis on behavioral health services than was the case when the current ED was established. The design of the new and renovated ED space will create separate pathways for behavioral health patients, pediatric patients, and other emergency patients. The treatment bays will afford more privacy, as they will be separated by walls rather than curtains and will also become multifunctional. The improvements to Shady Grove's ED will meet the current and future needs of the emergent population it serves.

#### (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**

The project does not include expansion of the ED.

#### (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;

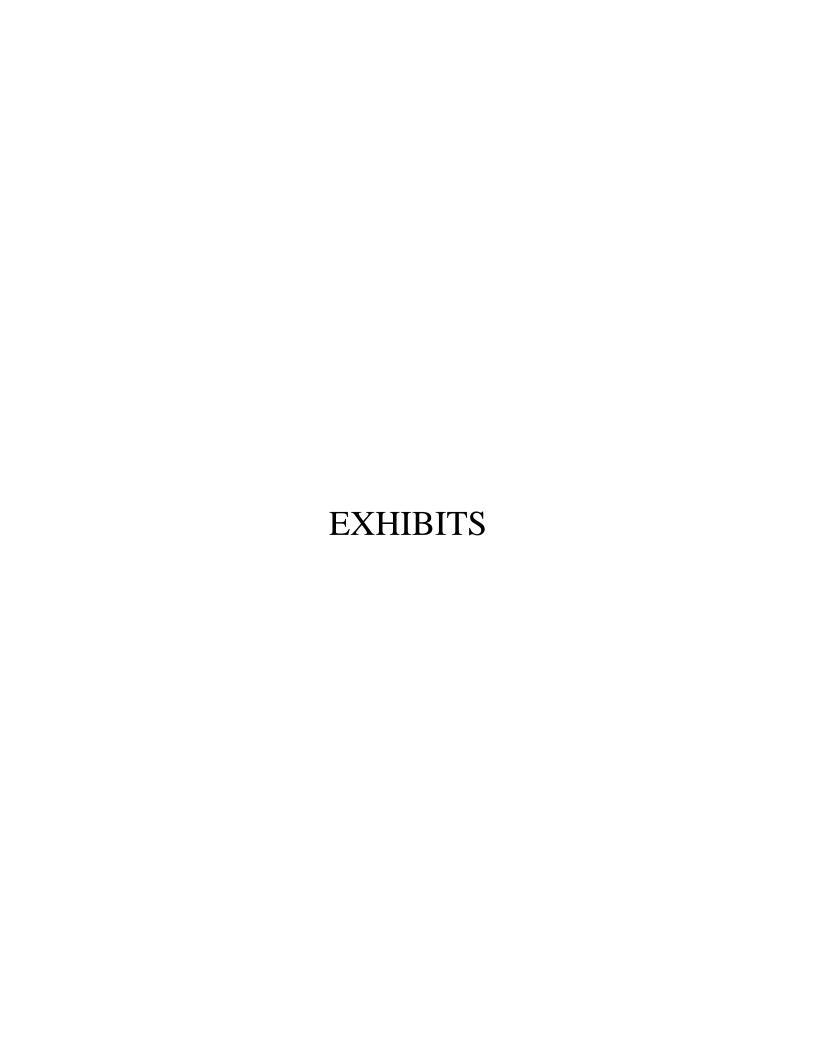
- (ii) Considers the time frame projected for finishing the space; and
- (iii) Demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.
- (c) Shell space being constructed on lower floors of a building addition that supports finished building 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**

Not applicable in this project.

#### **List of Exhibits**

Exhibit	Title
1	Hospital CON Tables
2	Shady Grove Medical Center Deed
3	Project Drawings
4	Adventist HealthCare Shady Grove Medical Center Admission Mitigation
5	Audited Financial Statements for Adventist HealthCare, Inc 2018 and 2019
6	Support from Medical Community
7	Support from Elected Officials
8	Support from Community
9	Summary of Revenue & Volumes
10	Adventist Health Care Shady Grove Medical Center List of Representative
	Hospital Charges September 10, 2020
11	Policy AHC 3.19.2 Public Disclosure of Charges
12	Policy AHC 3.19 Financial Assistance Policy
13	Policy 3.19A Financial Assistance – Spanish
14	Policy AHC 3.19.0 Financial Assistance – Decision Rules/Application
15	Financial Assistance Application Form
16	Financial Assistance Application Form - Spanish
17	Public Notice of Charity Care Policy—Washington Post
18	Public Notice of Charity Care Policy – El Tiempo Latino
19	Photographs of Hospital Postings of Charity Care Policy
20	Maryland Hospital License and OHCQ Letters
21	TJC Accreditations
22	CMS Compliance Letter
23	Assessment and Rating of Options for SGMC
24	Shady Grove Medical Center Board Resolution
25	Marshall Valuation Service Tables
26	Utilization Trends
27	Ziegler Letter
28	Affirmations



## EXHIBIT 1: Hospital CON Tables

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

#### TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTIONS: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.

Before the Project							After Project Completion					
	Location Licensed		Based on Physical Capacity				Location	Based on Physical Capacity				
Hospital Service	(Floor/	Beds:		Room Count	i	Bed Count	Hospital Service	(Floor/	Room Count			Bed Count
Hospital Service	Wing)*	8/25/2019	Private	Semi-Private	Total Rooms	Physical Capacity	Hospital Service	Wing)*	Private	Semi- Private	Total Rooms	Physical Capacity
ACUTE CARE	_						ACUTE CARE	-				
General Medical/ Surgical*	2A	24	24	0	24	24	General Medical/ Surgical*	2A	24	0	24	24
General Medical/ Surgical*	2B	24	24	0	24	24	General Medical/ Surgical*	2B	24	0	24	24
PCU	2D	16	11	13	24	37	General Medical/ Surgical*	2D	0	0	0	0
General Medical/ Surgical*	4A	24	24	0	24	24	ICU	3rd	26	0	26	26
General Medical/ Surgical*	4B	24	24	0	24	24	General Medical/ Surgical*	4A	24	0	24	24
General Medical/ Surgical*	4C	10	12	10	22	32	General Medical/ Surgical*	4B	24	0	24	24
General Medical/ Surgical*	4D	12	14	10	24	34	General Medical/ Surgical*	4C	10	0	10	10
ICU	3E	22	26	0	26	26	General Medical/ Surgical*	4D	12	0	12	12
							PCU	4th	24	0	24	24
							General Medical/ Surgical*	5th	24	0	24	24
SUB-TOTAL MSGA		156	159	33	192	225	SUB-TOTAL MSGA		192	0	192	192
Obstetric - Post partum	3A	23	24	0	24	24	Obstetric Post partum	3A	24	0	24	24
Obstetric - Post partum	3B	23	24	0	24	24	Obstetric Post partum	3B	24	0	24	24
Pediatrics	3D	10	9	8	17	25	Pediatrics	3D	10	0	10	10
Psychiatric	Broschart	133	6	75	81	156	Psychiatric	Broschart	6	64	70	133
TOTAL ACUTE		345	222	116	338	454	TOTAL ACUTE		256	64	320	383
Dedicated Observation**	2C		0	9	9	18	Dedicated Observation** (CDU)	2nd	20	0	20	20
TOTAL NON-ACUTE		0	0	9	9	18	TOTAL NON-ACUTE		20	0	20	20
HOSPITAL TOTAL		345	222	125	347	472	HOSPITAL TOTAL		276	64	340	403

<sup>\*</sup> Include beds dedicated to gynecology and addictions, if unit(s) is separate for acute psychiatric unit

<sup>\*\*</sup> Include services included in the reporting of the "Observation Center". Service furnished by the hospital on the hospital's promise, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient; Must be ordered and documented in writing, given by a medical practitioner.

INSTRUCTION: Add or delete rows if necessary. See additional instruction in the column to the right of the table. **DEPARTMENTAL GROSS SQUARE FEET DEPARTMENT/FUNCTIONAL AREA** To be Added Thru **Total After Project** To Remain As Is Current To Be Renovated **New Construction** Completion FIRST FLOOR **CVIR** 13,086 13,086 Mechanical / Electrical 5,859 5,859 Stairs / Elevator Shaft 539 539 Circulation - Horizontal 2,156 400 2,556 **EVS** 135 135 Mechanical Shaft 76 76 SECOND FLOOR **Emergency Department** 34,831 28,985 11,635 8,816 49,436 9,971 5,089 9,971 Observation Progressive Care Unit 9,535 Medical/Surgical 30,352 30,352 30,352 Conference 1,357 1,357 2,098 2,167 Public / Lobby 69 Stairs / Elevator Shaft 1,129 1,129 4,374 5,799 Circulation - Horizontal 1,425 99 Room Expansion (maintain natural light) 99 **EVS** 138 50 188 247 IT / Electrical Rooms 498 745 Mechanical Shaft 243 142 385 THIRD FLOOR 29,947 29,947 29,947 Medical/Surgical ICU 11,666 18,779 18,779 **CVIR** 9,789 Public / Lobby 364 364 Stairs / Elevator Shaft 1,120 1,120 Circulation - Horizontal 1,774 200 1,974 97 97 Room Expansion (maintan natural light) **EVS** 229 229 IT / Electrical Rooms 391 391 Mechanical Shaft 444 444 FOURTH FLOOR Medical/Surgical 48,503 48,503 48,503

Progressive Care Unit		17,239			17,239
Public / Lobby		364			364
Stairs / Elevator Shaft		1,120			1,120
Circulation - Horizontal		2,041	200		2,241
Room Expansion (maintan natural light)		120			120
EVS		229			229
IT / Electrical Rooms		391			391
Mechanical Shaft		444			444
FIFTH FLOOR					
Medical/Surgical		17,239			17,239
Public / Lobby		364			364
Stairs / Elevator Shaft		1,112			1,112
Circulation - Horizontal		862			862
EVS		221			221
IT / Electrical Rooms		391			391
Mechanical Shaft		438			438
PENTHOUSE					
Mechanical / Electrical		16,507			16,507
Stairs / Elevator Shaft		1,112			1,112
ROOF					
Stairs / Elevator Shaft		512			512
Circulation - Horizontal		1,426			1,426
Exterior Wall Thickness		5,607			5,607
Current Department Vacated, Not Used				38,644	38,644
Total	179,712	150,352	25,696	156,262	332,310

#### TABLE C. CONSTRUCTION CHARACTERISTICS

<u>INSTRUCTION</u>: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.

	NEW CONSTRUCTION	RENOVATION		
BASE BUILDING CHARACTERISTICS	Check if applicable			
Class of Construction (for renovations the class of the				
building being renovated)*				
Class A				
Class B				
Class C				
Class D				
Type of Construction/Renovation*				
Low				
Average				
Good				
Excellent				
Number of Stories	7	4		

\*As defined by Marshall Valuation Service

PROJECT SPACE	List Number of Feet, if applicable		
Total Square Footage	Total Squ	Total Square Feet	
First Floor	22,502	400	
Second Floor	38,560	24,896	
Third Floor	24,193	200	
Fourth Floor	22,978	200	
Fifth Floor	21,486		
Penthouse	18,457		
Roof	2,176		
Total Square Footage	150,352	25,696	
Average Square Feet	21,479		
Perimeter in Linear Feet	Linear	Linear Feet	
First Floor	375		
Second Floor	810		
Third Floor	764		
Fourth Floor	821		
Fifth Floor	695		
Penthouse	695		
Roof	196		
Total Linear Feet	4,356		
Average Linear Feet	622		
Wall Height (floor to eaves)	Feet		
First Floor	16		
Second Floor	16		
Third Floor	16		
Fourth Floor	16		
Fifth Floor	15		
Penthouse	17		
Roof	15		
Average Wall Height	15.86		
OTHER COMPONENTS	•		
Elevators	List Number		
Passenger	2		
Freight	2		
Sprinklers	Square Fee	t Covered	
Wet System	150,352		

Dry System		
Other	Describe Type	
Type of HVAC System for proposed project	VAV / Reheat	VAV / Reheat
	Precast concrete and brick	
	with glass and metal panel	
Type of Exterior Walls for proposed project	curtain wall system	

#### TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS

<u>INSTRUCTION</u>: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table D for each structure.

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation	\$1,696,406	\$0
Utilities from Structure to Lot Line	\$1,230,477	\$0
Subtotal included in Marshall Valuation Costs	\$2,926,883	\$0
Site Demolition Costs	\$101,514	\$0
Storm Drains	\$319,990	\$0
Rough Grading	\$886,247	\$0
Pilings & Hillside Foundation	\$3,962,135	\$0
Paving	\$1,401,878	\$0
Exterior Signs	\$82,814	\$0
Landscaping	\$399,995	\$0
Walls, Stairs, Structures	\$337,766	\$0
Yard Lighting	\$369,143	\$0
Other (Specify/add rows if needed)		
Sheeting & Shoring for Excavation Adjacent to Existing Bldg.	\$1,306,643	\$0
Relocate Existing Utilities to New Tunnel	\$1,472,782	\$0
Sediment and Erosion Control	\$73,829	\$0
Montgomery County Land Use Costs	\$1,500,000	\$0
New Helipad	\$799,810	\$0
Pneumatic Tube System	\$461,429	\$0
Exterior Canopies	\$952,512	\$0
Vegetated Roofs	\$771,657	\$0
Additional Service Elevator	\$602,934	\$0
Enhanced Commissioning	\$139,040	\$0
Underground Oxygen Piping	\$470,657	\$0
Temporary Construction for Access	\$246,095	\$0
Extended General Conditions for Phased Construction	\$2,890,451	\$0
A/E Fees Associated wih Extraordinary Costs	\$1,452,052	\$0

Subtotal On-Site excluded from Marshall Valuation Costs	\$21,001,373	\$0
OFFSITE COSTS		
Jurisdictional Hook-up Fees	\$970,846	\$0
Other (Specify/add rows if needed)	\$0	\$0
Subtotal Off-Site excluded from Marshall Valuation Costs	\$970,846	\$0
TOTAL Estimated On-Site and Off-Site Costs <u>not</u> included in Marshall Valuation Costs	\$21,972,219	\$0
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	\$24,899,102	\$0

<sup>\*</sup>The combined total site and offsite cost included and excluded from Marshall Valuation Service should typically equal the estimated site preparation cost reported in Application Part II, Project Budget (see Table E. Project Budget). If these numbers are not equal, please reconcile the numbers in an explanation in an attachment to the application.

The combined total site and offsite costs do not equal the estimated site preparation costs identified in the project budget because various costs are distributed throughout other budget line items. Certain extraordinary costs are included in budget categories a.(1) Building, a.(2) Fixed Equipment, a.(4) Architect/Engineering Fees and/or a.(5) Permits (Building, Utilities) in lieu of a.(3) Site and Infrastructure. For example, the pilings, helipad, exterior canopies, vegetated roofs, service elevator, enhanced commissioning, temporary construction for access and extended general conditions are in the Building line item. The pneumatic tube system is in the Fixed Equipment. The A/E fees associated with extraordinary costs are carried with A/E fees. The Montgomery County land use costs are partly within Permits and partly within A/E Fees. The jurisdictional hook-up fees are in Permits. See Exhibit 25.

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

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

ne B.8 as a source of funds	Hoonital Duildin	CUD Up areada	Total
A. USE OF FUNDS	Hospital Building	CUP Upgrade	Total
1. CAPITAL COSTS			
a. New Construction			
(1) Building	\$73,458,451	\$6,752,441	\$80,210,89
(2) Fixed Equipment	\$3,525,375	\$301,922	\$3,827,29
(3) Site and Infrastructure	\$10.150.141	\$408,005	\$10,558,14
(4) Architect/Engineering Fees	\$5,856,282	\$501,546	\$6,357,82
(5) Permits (Building, Utilities, Etc.)	\$2,158,953	\$184,898	\$2,343,85
SUBTOTAL	\$95,149,202	\$8,148,812	\$103,298,01
b. Renovations			
(1) Building	\$8,840,236	\$0	\$8,840,23
(2) Fixed Equipment (not included in construction)	\$0	\$0	
(3) Architect/Engineering Fees	\$656,620	\$0	\$656,62
(4) Permits (Building, Utilities, Etc.)	\$242,067	\$0	\$242,06
SUBTOTAL	\$9,738,923	\$0	\$9,738,92
c. Other Capital Costs			
(1) Movable Equipment	\$3,629,400	\$200,000	\$3,829,40
(2) Contingency Allowance	\$11,997,789	\$849,381	\$12,847,17
(3) Gross interest during construction period	\$13,653,795	\$957,801	\$14,611,59
(4) Other (Specify/add rows if needed)	40.007.000	405.000	***
a. Furniture	\$2,367,000	\$25,000	\$2,392,00
b. Interior & Exterior Signage c. IS/Comm	\$723,400 \$6,615,000	\$15,000 \$50,000	\$738,40
d. Security system	\$1,250,000	\$15,000	\$6,665,00 \$1,265,00
e. Relocation expense	\$315,600	\$15,000	\$330,60
f. Certifications, inspections, etc.	\$189,360	\$25,000	\$214,36
SUBTOTAL	\$40,741,344	\$2,152,182	\$42,893,52
TOTAL CURRENT CAPITAL COSTS	\$145,629,469	\$10,300,994	\$155,930,46
d. Land Purchase	\$1.10,020,100	\$10,000,004	<b>\$100,000,10</b>
e. Inflation Allowance	\$13,799,530	\$882,804	\$14,682,33
TOTAL CAPITAL COSTS	\$159,428,999	\$11,183,798	\$170,612,79
2. Financing Cost and Other Cash Requirements	¥ 100, 120,000	¥11,100,100	¥ 11 0,0 1 <u>2</u> ,10
a. Loan Placement Fees	\$1,798,990	\$126,197	\$1,925,18
b. Bond Discount		. ,	. , ,
c CON Application Assistance			
c1. Legal Fees			
c2. Other (Specify/add rows if needed)			
d. Non-CON Consulting Fees			
d1. Legal Fees			9
d2. Other (Specify/add rows if needed)			97.470.00
e. Debt Service Reserve Fund	\$6,986,996	\$486,379	\$7,473,37
f Other (Specify/add rows if needed)	40.707.000	4040 550	\$
SUBTOTAL	\$8,785,986	\$612,576	\$9,398,50
3. Working Capital Startup Costs	0400.044.005	\$44.700.074	\$100.011.05
TOTAL USES OF FUNDS	\$168,214,985	\$11,796,374	\$180,011,35
Sources of Funds 1. Cash	\$9,337,090	\$659,269	\$9,996,35
2. Philanthropy (to date and expected)	\$9,337,090 \$14,958,694	\$1,041,306	\$16,000,00
3. Authorized Bonds	\$143,919,200	\$10,095,800	\$154,015,00
Interest Income from bond proceeds listed in #3	\$524,068	\$36,763	\$560,83
5. Mortgage	Ψ024,000	Ψ00,100	φοσο,σο
6. Working Capital Loans			
7. Grants or Appropriations	<u> </u>		<u> </u>
a. Federal			,
b. State			,
c. Local			
8. Other (Specify/add rows if needed)			;
TOTAL SOURCES OF FUNDS	\$168,214,984	\$11,796,375	\$180,011,3
	Hospital Building	CUP Upgrade	Total
nnual Lease Costs (if applicable)			
1. Land			
2. Building			Ç

5. Other (Specify/add rows if needed)

\$0

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

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

	Two Most R		Current Year Projected			at least two y tional years, if Tables (	needed in or		
Indicate CY	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026
1. DISCHARGES									
a. General Medical/Surgical*	10,381	10,007	9,516	10,037	10,129	10,217	10,304	10,388	10,468
b. ICU/CCU	436	401	404	408	412	415	419	422	426
Total MSGA	10,817	10,408	9,920	10,445	10,541	10,633	10,723	10,810	10,894
c. Pediatric	594	579	402	523	527	532	537	541	545
d. Obstetric	4,644	4,509	4,522	4,567	4,609	4,649	4,689	4,727	4,764
e. Acute Psychiatric	3,501	3,303	3,358	3,492	3,524	3,555	3,585	3,614	3,642
Total Acute	19,556	18,799	18,202	19,027	19,202	19,369	19,533	19,692	19,845
f. Rehabilitation									
g. Comprehensive Care									
h. Other - Newborn and NICU	4,523	4,402	4,436	4,480	4,522	4,561	4,600	4,637	4,673
TOTAL DISCHARGES	24,079	23,201	22,638	23,507	23,723	23,930	24,133	24,329	24,518
2. PATIENT DAYS									
a. General Medical/Surgical*	46,038	44,959	44,224	44,187	44,523	44,842	45,143	45,426	45,692
b. ICU/CCU	5,517	5,935	6,270	6,143	6,075	6,006	5,935	5,864	5,791
Total MSGA	51,555	50,894	50,494	50,330	50,598	50,847	51,078	51,290	51,484
c. Pediatric	1,320	1,290	988	1,284	1,296	1,308	1,319	1,329	1,340
d. Obstetric	11,283	11,239	10,376	10,480	10,576	10,668	10,759	10,846	10,930
e. Acute Psychiatric	32,903	32,638	33,138	33,947	33,745	33,529	33,305	33,072	32,829
Total Acute	97,061	96,061	94,996	96,041	96,215	96,352	96,461	96,537	96,582
f. Rehabilitation				0	0	0	0	0	0
g. Comprehensive Care				0	0	0	0	0	0
h. Other - Newborn and NICU	16,615	16,136	16,576	16,742	16,896	17,043	17,187	17,327	17,461
TOTAL PATIENT DAYS	113,676	112,197	111,572	112,783	113,110	113,395	113,648	113,864	114,044

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

	Two Most R (Act		Current Year Projected	•	Years (ending ) Include addi		needed in or	•	
Indicate CY	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026
3. AVERAGE LENGTH OF STAY (	patient days di	vided by disc	harges)						
a. General Medical/Surgical*	4.4	4.5	4.6	4.4	4.4	4.4	4.4	4.4	4.4
b. ICU/CCU	12.7	14.8	15.5	15.1	14.8	14.5	14.2	13.9	13.6
Total MSGA	4.8	4.9	5.1	4.8	4.8	4.8	4.8	4.7	4.7
c. Pediatric	2.2	2.2	2.5	2.5	2.5	2.5	2.5	2.5	2.5
d. Obstetric	2.4	2.5	2.3	2.3	2.3	2.3	2.3	2.3	2.3
e. Acute Psychiatric	9.4	9.9	9.9	9.7	9.6	9.4	9.3	9.2	9.0
Total Acute	5.0	5.1	5.2	5.0	5.0	5.0	4.9	4.9	4.9
f. Rehabilitation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
h. Other - Newborn and NICU	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7
TOTAL AVERAGE LENGTH OF									
STAY	4.7	4.8	4.9	4.8	4.8	4.7	4.7	4.7	4.7
4. NUMBER OF LICENSED BEDS									
a. General Medical/Surgical*	157	165	134	134	134	134	134	134	134
b. ICU/CCU	28	25	22	22	22	22	22	22	22
Total MSGA	185	190	156	156	156	156	156	156	156
c. Pediatric	25	12	10	10	10	10	10	10	10
d. Obstetric	56	46	46	46	46	46	46	46	46
e. Acute Psychiatric	117	133	133	133	133	133	133	133	133
Total Acute	383	381	345	345	345	345	345	345	345
f. Rehabilitation									
g. Comprehensive Care									
h. Other - Newborn and NICU	79	79	79	79	79	79	79	79	79
TOTAL LICENSED BEDS	462	460	424	424	424	424	424	424	424

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

	Two Most R (Act		Current Year Projected			at least two y tional years, it Tables (			
Indicate CY	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026
5. OCCUPANCY PERCENTAGE *III	MPORTANT N	OTE: Leap yea	ar formulas sho	ould be change	ed by applicant	to reflect 366	days per year.		
a. General Medical/Surgical*	80.3%	74.7%	90.2%	90.3%	91.0%	91.7%	92.0%	92.9%	93.4%
b. ICU/CCU	54.0%	65.0%	77.9%	76.5%	75.7%	74.8%	73.7%	73.0%	72.1%
Total MSGA	76.3%	73.4%	88.4%	88.4%	88.9%	89.3%	89.5%	90.1%	90.4%
c. Pediatric	14.5%	29.5%	27.0%	35.2%	35.5%	35.8%	36.0%	36.4%	36.7%
d. Obstetric	55.2%	66.9%	61.6%	62.4%	63.0%	63.5%	63.9%	64.6%	65.1%
e. Acute Psychiatric	77.0%	67.2%	68.1%	69.9%	69.5%	69.1%	68.4%	68.1%	67.6%
Total Acute	69.4%	69.1%	75.2%	76.3%	76.4%	76.5%	76.4%	76.7%	76.7%
f. Rehabilitation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
g. Comprehensive Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
h. Other (Specify/add rows of needed)	57.6%	56.0%	57.3%	58.1%	58.6%	59.1%	59.4%	60.1%	60.6%
TOTAL OCCUPANCY %	67.4%	66.8%	71.9%	72.9%	73.1%	73.3%	73.2%	73.6%	73.7%
6. OUTPATIENT VISITS									
a. Emergency Department	55,021	57,368	40,648	56,907	57,362	57,821	58,284	58,750	59,220
Emergency Department -     Inpatient visits converted to     Admissions	10,497	11,684	9,090	11,628	11,721	11,815	11,910	12,005	12,101
Total ED Visits	65,518	69,052	49,738	68,535	69,084	69,636	70,193	70,755	71,321
b. Same-day Surgery	9,844	9,863	5,722	9,899	9,978	10,058	10,139	10,220	10,301
c. Laboratory	6,255	5,691	4,076	5,625	5,670	5,715	5,761	5,807	5,854
d. Imaging	2,753	2,009	1,078	2,048	2,065	2,081	2,098	2,115	2,131
e. Other - Germantown Emergency Center	24,211	23,418	16,920	23,688	23,878	24,069	24,261	24,455	24,651
e. Other - Partial Hospitalization									
Program	5,390	4,549	2,976	4,762	4,800	4,838	4,877	4,916	4,955
e. Other - Clinic	31,751	41,332	23,486	39,926	40,246	40,568	40,892	41,219	41,549
TOTAL OUTPATIENT VISITS	211,240	224,966	153,734	223,019	224,803	226,601	228,414	230,241	232,083

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

		ecent Years ual)	Current Year Projected	Projected Years (ending at least two years after project completion and occupancy) Include additional years, if needed in order to be consistent Tables G and H.										
Indicate CY	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026					
7. Outpatient OBSERVATIONS**														
a. Number of Patients	7,406	7,626	5,476	7,694	7,755	7,817	7,880	7,943	8,006					
b. Hours	198,260	210,249	169,070	216,685	218,418	220,165	221,927	223,702	225,492					

<sup>\*</sup> Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

(1.) Patients with both an ED and Observation visit are included in both counts.

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

#### TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F 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.

	Tv	vo Most Recer	nt Y	ears (Actual)	ď	Current Year Projected	F	Projected Years needed in or	•	to document t	hat	•	ill g	enerate exces	s re	venues over to	
Indicate CY		CY 2018		CY 2019		CY 2020		CY 2021		CY 2022		CY 2023		CY 2024		CY 2025	CY 2026
1. REVENUE																	
a. Inpatient Services	\$	276,338,352	_	285,811,383	_	- ,- ,	\$	, , -	\$	303,055,312	\$	303,055,312	\$	303,055,312	·	303,055,312	\$ 303,055,312
b. Outpatient Services	\$	216,294,577	\$	221,454,634	\$	215,643,711	\$	229,858,241	\$	229,858,241	\$	229,858,241	\$	229,858,241	\$	229,858,241	\$ 229,858,241
2020 COVID Stimulus Funds	\$	-	\$	-	\$	29,961,247	\$	-	\$	-	\$	-	\$	-	\$	-	\$ -
Gross Patient Service Revenues	\$	492,632,928	\$	507,266,017	\$	0_0,,	\$	,,	\$	532,913,553	_	532,913,553	\$	,,	\$	532,913,553	\$ 532,913,553
c. Allowance For Bad Debt	\$	20,131,873	_	18,167,576	\$	,,	\$	18,815,036	\$	18,815,036	<u> </u>	18,815,036	\$	18,815,036	<del>-</del>	18,815,036	\$ 18,815,036
d. Contractual Allowance	\$	61,288,049	Ė	60,553,149	Ė	62,096,039	_	62,553,234	\$	62,553,234	_	62,553,234	\$	62,553,234	_	62,553,234	\$ 62,553,234
e. Charity Care	\$	5,659,157	·	9,599,449	·	10,016,173	i i		\$	10,095,871	·	10,095,871	\$	10,095,871	<u> </u>	10,095,871	\$ 10,095,871
Net Patient Services Revenue	\$	405,553,850	\$	418,945,842	\$	437,481,128	\$	441,449,412	\$	441,449,412	\$	441,449,412	\$	441,449,412	\$	441,449,412	\$ 441,449,412
f. Other Operating Revenues (Specify/add rows if needed)	\$	27,567,441	\$	27,956,963	\$	30,064,718	\$	-, - ,	\$	26,757,599	\$	26,757,599	\$	23,957,599	\$	23,957,599	\$ 23,957,599
NET OPERATING REVENUE	\$	433,121,290	\$	446,902,805	\$	467,545,846	\$	468,207,011	\$	468,207,011	\$	468,207,011	\$	465,407,011	\$	465,407,011	\$ 465,407,011
2. EXPENSES																	
a. Salaries & Wages (including benefits)	\$	188,017,064	\$	193,009,561	\$	198,572,363	\$	204,482,281	\$	205,076,638	\$	205,592,352	\$	207,912,386	\$	210,164,782	\$ 210,490,569
b. Contractual Services	\$	7,820,499	\$	9,951,244	\$	17,508,312	\$	12,387,131	\$	11,148,418	\$	9,810,608	\$	9,320,077	\$	8,714,272	\$ 8,017,130
c. Interest on Current Debt	\$	6,317,210	\$	6,206,678	\$	6,066,904	\$	6,127,573	\$	6,127,573	\$	6,127,573	\$	6,127,573	\$	6,127,573	\$ 6,127,573
d. Interest on Project Debt					\$	-	\$	-	\$	-	\$	-	\$	6,947,100	\$	6,947,100	\$ 6,947,100
e. Current Depreciation	\$	23,657,629	\$	22,964,509	\$	21,817,427	\$	22,035,601	\$	22,035,601	\$	22,035,601	\$	22,035,601	\$	22,035,601	\$ 22,035,601
f. Project Depreciation					\$	-	\$	-	\$	-	\$	-	\$	5,730,480	\$	6,251,433	\$ 6,251,433
g. Current Amortization																	
h. Project Amortization																	
i. Supplies	\$	54,771,090	\$	56,114,400	\$	63,900,817	\$	60,492,417	\$	60,668,247	\$	60,820,812	\$	60,956,646	\$	61,072,470	\$ 61,168,849
j. Other Expenses - General & Administrative	\$	9,570,164	\$	11,063,980	\$	9,836,615	\$	10,969,473	\$	10,969,473	\$	10,969,473	\$	10,969,473	\$	10,969,473	\$ 10,969,473
j. Other Expenses - Professional Fees	\$	13,463,556	\$	13,175,566	\$	11,356,931	\$	12,038,347	\$	12,038,347	\$	12,038,347	\$	12,038,347	\$	12,038,347	\$ 12,038,347
j. Other Expenses - Purchased Services	\$	29,456,617	\$	30,408,254	\$	30,206,310	\$	30,583,889	\$	30,583,889	\$	30,583,889	\$	30,583,889	\$	30,583,889	\$ 30,583,889
j. Other Expenses - Building & Maintenance	\$	25,591,807	\$	26,407,365	\$	28,870,964	\$	28,582,254	\$	28,582,254	\$	28,582,254	\$	23,950,254	\$	25,650,254	\$ 25,650,254
j. Other Expenses	\$	53,927,675	\$	54,561,653	\$	55,154,770			\$	55,706,318	\$	55,706,318	\$	55,706,318	\$	55,706,318	\$ 55,706,318
TOTAL OPERATING EXPENSES	\$	412,593,313	\$	423,863,210	\$	443,291,413	\$	443,405,285	\$	442,936,759	\$	442,267,227	\$	452,278,144	\$	456,261,512	\$ 455,986,537

SGMC Tower CON Exhibit 1 Table G

#### TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F 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.

	Two Most Rec			P	rrent Year rojected	Projected Years (ending at least two years after project completion and full occupancy) Add colur needed in order to document that the hospital will generate excess revenues over total expens consistent with the Financial Feasibility standard.											expenses
Indicate CY	CY 2018		CY 2019		CY 2020		CY 2021		CY 2022		CY 2023		CY 2024		CY 2025		CY 2026
3. INCOME																	
a. Income From Operation	\$ 20,527,978		23,039,594		24,254,433		24,801,726	_	25,270,252		25,939,784		13,128,866		9,145,499		9,420,474
b. Non-Operating Income	\$ 775,313	_	6,301,524	•	1,566,002	·	3,321,587	\$	3,321,587		- / - /	\$	3,321,587	_	3,321,587	_	3,321,587
SUBTOTAL	\$ 21,303,29	1 \$	29,341,118	\$	25,820,435	\$	28,123,313	\$	28,591,839	\$	29,261,371	\$	16,450,453	\$	12,467,086	\$	12,742,061
c. Income Taxes	4 04 000 00		00.044.440	•	25 222 425	•	00 100 010	•	00 504 000	•	00 004 074	_	10 150 150		10 107 000	•	10 7 10 001
NET INCOME (LOSS) 4. PATIENT MIX	\$ 21,303,29	7   \$	29,341,118	\$	25,820,435	\$	28,123,313	\$	28,591,839	\$	29,261,371	\$	16,450,453	\$	12,467,086	\$	12,742,061
a. Percent of Total Revenue																	
1) Medicare	34.4	%	34.5%		34.5%		34.5%		34.5%		34.5%		34.5%		34.5%		34.5%
2) Medicaid	19.3	%	19.8%		20.2%		20.2%		20.2%		20.2%		20.2%		20.2%		20.2%
3) Blue Cross	20.5	%	19.9%		20.0%		20.0%		20.0%		20.0%		20.0%		20.0%		20.0%
4) Commercial Insurance	20.89	%	20.8%		20.7%		20.7%		20.7%		20.7%		20.7%		20.7%		20.7%
5) Self-pay	4.0	%	3.9%		3.4%		3.4%		3.4%		3.4%		3.4%		3.4%		3.4%
6) Other	1.0	%	1.0%		1.1%		1.1%		1.1%		1.1%		1.1%		1.1%		1.1%
TOTAL	100.09	%	100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%
b. Percent of Equivalent Inpatient Days																	
1) Medicare	33.1	%	33.8%		33.8%		33.8%		33.8%		33.8%		33.8%		33.8%		33.8%
2) Medicaid	28.5	%	27.9%		27.9%		27.9%		27.9%		27.9%		27.9%		27.9%		27.9%
3) Blue Cross	17.89	%	16.7%		17.0%		17.0%		17.0%		17.0%		17.0%		17.0%		17.0%
4) Commercial Insurance	18.39	%	19.1%		17.4%		17.4%		17.4%		17.4%		17.4%		17.4%		17.4%
5) Self-pay	2.19	%	2.4%		3.4%		3.4%		3.4%		3.4%		3.4%		3.4%		3.4%
6) Other	0.20	%	0.2%		0.5%		0.5%		0.5%		0.5%		0.5%		0.5%		0.5%
TOTAL	100.09	%	100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%

#### Shady Grove Medical Center Assumptions & Drivers Current State - No Inflation (Table G1)

				Current St	ate - N	lo Inflation (Table	G1)						
			orical					Pro	ojection				
		CY 2018	CY 2019	CY 2020		CY 2021	CY 2022		CY 2023	CY 2024		CY 2025	CY 2026
IP Hospital Revenue		276,338,352	285,811,383	282,671,660	)	303,055,312	303,055,312		303,055,312	303,055,31	12	303,055,312	303,055,312
OP Hospital + GEC Revenue		192,329,870	199,698,415	197,120,936	5	211,335,465	211,335,465		211,335,465	211,335,46	55	211,335,465	211,335,465
SGMC & GEC													
Gross GBR				475,472,635	5	509,931,215	509,931,215		509,931,215	509,931,21	15	509,931,215	509,931,215
Stimulus Funds				29,961,247	7	-	-		-	-		-	-
UCC Payments/Receipts				4,319,961		4,459,562	4,459,562		4,459,562	4,459,56	52	4,459,562	4,459,562
				509,753,843		514,390,777	514,390,777		514,390,777	514,390,77		514,390,777	514,390,777
Total Gross				528,276,618		532,913,553	532,913,553		532,913,553	532,913,55		532,913,553	532,913,553
Deductions:				520,270,01	•	332,323,333	332,313,333		552,515,555	332,323,33		302,313,333	552,515,555
Contractual Allowances				35,234,205		35,539,589	35,539,589		35,539,589	35,539,58	20	35,539,589	35,539,589
HSCRC Assessments				16,056,56		16,208,377	16,208,377		16,208,377	16,208,37		16,208,377	16,208,377
Bad Debt				18,097,550		18,229,307	18,229,307		18,229,307	18,229,30		18,229,307	18,229,307
Charity Care				10,013,946		10,093,644	10,093,644		10,093,644	10,093,64		10,093,644	10,093,644
Net Patient Service Revenue				430,351,575	5	434,319,859	434,319,859		434,319,859	434,319,85	59	434,319,859	434,319,859
Other Revenue													
	115	1,102,253	1,272,103	1,404,686	5	1,404,686	1,404,686		1,404,686	1,404,68		1,404,686	1,404,686
Inflation						0.0%	0.0%		0.0%	0.0		0.0%	0.0%
Contractual Allowances				22.8		22.8%	22.89		22.8%	22.8		22.8%	22.8%
Charity				0.0	%	0.0%	0.09	6	0.0%	0.0	0%	0.0%	0.0%
Bad Debt				4.8	%	4.8%	4.89	6	4.8%	4.8	3%	4.8%	4.8%
Net Revenue				1,016,993	3	1,016,993	1,016,993		1,016,993	1,016,99	93	1,016,993	1,016,993
	131	6,345,164	6,412,277	6,119,669	)	6,119,669	6,119,669		6,119,669	6,119,66	59	6,119,669	6,119,669
Inflation						0.0%	0.0%	6	0.0%	0.0	1%	0.0%	0.0%
Contractual Allowances				69.0	%	69.0%	69.09	6	69.0%	69.0	0%	69.0%	69.0%
Charity				0.0		0.0%	0.09		0.0%	0.0		0.0%	0.0%
Bad Debt				0.0		0.0%	0.09		0.0%	0.0		0.0%	0.0%
Net Revenue				1,898,933		1,898,933	1,898,933		1,898,933	1,898,93		1,898,933	1,898,933
Net nevenue	401	6,665,743	5,898,712	3,839,532		3,839,532	3,839,532		3,839,532	3,839,53		3,839,532	3,839,532
Inflation	401	0,003,743	3,030,712	3,033,33		0.0%	0.0%		0.0%	0.0		0.0%	0.0%
Contractual Allowances				69.6	·	69.6%			69.6%	69.6		69.6%	69.6%
Charity				0.1		0.1%	0.19		0.1%	0.:		0.1%	0.1%
Bad Debt				3.1		3.1%	3.19		3.1%	3.:		3.1%	3.1%
Net Revenue				1,045,389		1,045,389	1,045,389		1,045,389	1,045,38		1,045,389	1,045,389
	405	9,851,457	8,173,127	7,158,888	3	7,158,888	7,158,888		7,158,888	7,158,88		7,158,888	7,158,888
Inflation						0.0%	0.0%		0.0%	0.0		0.0%	0.0%
Contractual Allowances				50.2		50.2%	50.29		50.2%	50.2		50.2%	50.2%
Charity				0.0	%	0.0%	0.09	6	0.0%	0.0	0%	0.0%	0.0%
Bad Debt				5.69	%	5.6%	5.69	6	5.6%	5.6	5%	5.6%	5.6%
Net Revenue				3,168,238	3	3,168,238	3,168,238		3,168,238	3,168,23	88	3,168,238	3,168,238
Total Contractuals				46,039,472	2	46,344,856	46,344,856		46,344,856	46,344,85	6	46,344,856	46,344,856
Total Charity				10,016,173	3	10,095,871	10,095,871		10,095,871	10,095,87	71	10,095,871	10,095,871
Total Bad Debt				18,683,279	)	18,815,036	18,815,036		18,815,036	18,815,03	36	18,815,036	18,815,036
Total Passthroughs				16,056,56		16,208,377	16,208,377		16,208,377	16,208,37		16,208,377	16,208,377
Net Patient Service Revenue				437,481,128		441,449,412	441,449,412		441,449,412	441,449,41		441,449,412	441,449,412
EIPA Factor ("Equivalent IP Admission")		1.6960	1.6987	1.697	3	1.6973	1.6973		1.6973	1.697	73	1.6973	1.6973
IP Revenue per Admission		\$ 11,476				12,892			12,664		8 \$	12,457 \$	
OP Revenue per EIPD ("Equivalent IP Day") Physician Revenue per EIPD		2,430.93	2,547.41	2,533.54	1	2,687.08	2,679.29		2,672.57	2,666.6	51	2,661.56	2,657.36
Other Operating Revenue		\$ 27,567,441	\$ 27,956,963	\$ 30,064,718	\$ \$	26,757,599	\$ 26,757,599		26,757,599	\$ 23,957,59		23,957,599 \$	
Other Operating Revenue Growth						-11.00%	0.00%	5	0.00%	0.00		0.00%	0.00%
Other Operating Revenue Growth \$										(2,800,00	00)		
Non Operating Revenue				1 500 000	, =	2 224 567	2 224 527		2 224 507	2 224 = 1	7	2 224 507	2 224 507
Non-Operating Revenue				1,566,002	4	3,321,587	3,321,587		3,321,587	3,321,58		3,321,587	3,321,587
Inflation						0.00%	0.00%	)	0.00%	0.00	76	0.00%	0.00%
								,	0.00				
Revenue Inflation Update						0.00%	0.00%	,	0.00%	0.00	1%	0.00%	0.00%

SGMC Tower CON Exhibit 1

Table G Assumptions Uninflated

#### Shady Grove Medical Center Assumptions & Drivers Current State - No Inflation (Table G1)

	Histo	orical				Projection				
	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026	Notes
SGMC Discharges	24,079	23,201	22,638	23,507	23,723	23,930	24,133	24,329	24,518	
SGMC Days	113,676	112,197	111,572	112,783	113,110	113,395	113,648	113,864	114,044	
SGMC ADC	311.44	306.55	304.84	308.99	309.89	310.67	310.51	311.96	312.45	
SGMC ALOS	4.72	4.84	4.93	4.80	4.77	4.74	4.71	4.68	4.65	
EIPA	40,838	39,412	38,425	39,900	40,267	40,618	40,962	41,294	41,615	
EIPD	192,794	190,590	189,377	191,431	191,988	192,471	192,900	193,267	193,572	
Adjusted Occupied Bed	528.2	522.2	517.4	524.5	526.0	527.3	528.5	529.5	530.3	
,										
Total Paid FTEs excluding new tower	2,224.39	2,274.72	2,263.92	2,267.98	2,266.03	2,262.57	2,263.95	2,264.31	2,263.12	
Staff FTEs	2,173.62	2,207.64	2,149.91	2,184.94	2,191.29	2,196.80	2,201.71	2,205.89	2,209,37	
Contract Labor FTEs	50.77	67.08	114.01	83.04	74.73	65.76	62.24	58.42	53.74	
FTEs per AOB	4.12	4.23	4.16	4.17	4.17	4.17	4.17	4.17	4.17	
Total Salaries	154,567,541	161,156,153	164,513,011	169,409,254	169,901,666	170,328,924	172,251,023	174,117,085	174,386,994	
Salary per FTE	69,488	70,847	76,521	77,535	77,535	77,535	77,535	77,535	77,535	
Salary per 1 12	05,400	70,047	70,321	77,555	77,555	77,555	77,555	77,555	77,555	
										2021 includes a 1/2 year of expense inflation due to the C
Salary Inflation %				1.33%	0.00%	0.00%	0.00%	0.00%	0.00%	which includes inflation for January - June 2021 from the S
New Tower FTEs				1.55/0	0.00%	0.0070	48.8	48.8	48.8	which includes inhadon for sandary state 2021 from the s
New Tower Salary \$							1,541,696	3,083,392	3,083,392	
New Tower Salary 5							1,341,050	3,063,392	3,063,392	
Benefit %	21.6%	19.8%	20.7%	20.7%	20.7%	20.7%	20.7%	20.7%	20.7%	
Beriefit 76	21.0%	19.6%	20.7%	20.776	20.776	20.776	20.776	20.7%	20.7%	
Cumply nor FIDD	\$ 284	ć 204 ć	227	ć 216 ć	216 ¢	216 ¢	216 ¢	216 ¢	216	
Supply per EIPD	\$ 284	\$ 294 \$	337	\$ 316 \$	316 \$	316 \$	316 \$	316 \$	316	
										2021 includes a 1/2 year of avenue inflation due to the Ci
I-B-4'				3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	2021 includes a 1/2 year of expense inflation due to the C
Inflation	ć 7.000 400	¢ 0.054.244 ¢	47 500 343							which includes inflation for January - June 2021 from the S
Contract Labor	\$ 7,820,499	\$ 9,951,244 \$	17,508,312	\$ 12,387,131 \$	11,148,418 \$	9,810,608 \$	9,320,077 \$	8,714,272 \$	8,017,130	
										2004
										2021 includes a 1/2 year of expense inflation due to the C
Inflation				-29.25%	-10.00%	-12.00%	-5.00%	-6.50%	-8.00%	which includes inflation for January - June 2021 from the S
General & Administrative	\$ 9,570,164	\$ 11,063,980 \$	9,836,615	\$ 10,969,473 \$	10,969,473 \$	10,969,473 \$	10,969,473 \$	10,969,473 \$	10,969,473	
										2021 includes a 1/2 year of expense inflation due to the C
Inflation				8.00%	0.00%	0.00%	0.00%	0.00%	0.00%	which includes inflation for January - June 2021 from the S
Professional Fees	\$ 13,463,556	\$ 13,175,566 \$	11,356,931	\$ 12,038,347 \$	12,038,347 \$	12,038,347 \$	12,038,347 \$	12,038,347 \$	12,038,347	
										2021 includes a 1/2 year of expense inflation due to the C
Inflation				6.00%	0.00%	0.00%	0.00%	0.00%	0.00%	which includes inflation for January - June 2021 from the S
Building and Maintenance	\$ 25,591,807	\$ 26,407,365 \$	28,870,964	\$ 28,582,254 \$	28,582,254 \$	28,582,254 \$	23,950,254 \$	25,650,254 \$	25,650,254	
										2021 includes a 1/2 year of expense inflation due to the C
Inflation				-1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	which includes inflation for January - June 2021 from the S
Inflation \$							(4,632,000)	1,700,000		
Insurance	\$ 3,157,536	\$ 3,261,789 \$	3,285,659	\$ 3,318,516 \$	3,318,516 \$	3,318,516 \$	3,318,516 \$	3,318,516 \$	3,318,516	
										2021 includes a 1/2 year of expense inflation due to the C
Inflation				1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	which includes inflation for January - June 2021 from the S
Depreciation and Amortization	\$ 17,310,935	\$ 16,617,815 \$	16,187,681	\$ 16,349,558 \$	16,349,558 \$	16,349,558 \$	16,349,558 \$	16,349,558 \$	16,349,558	
										2021 includes a 1/2 year of expense inflation due to the C
Inflation				1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	which includes inflation for January - June 2021 from the S
IT Depreciation	\$ 6,346,694	\$ 6,346,694 \$	5,629,746	\$ 5,686,043 \$	5,686,043 \$	5,686,043 \$	5,686,043 \$	5,686,043 \$	5,686,043	
										2021 includes a 1/2 year of expense inflation due to the C
Inflation				1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	which includes inflation for January - June 2021 from the S
IT Services	\$ 21,497,046	\$ 21,497,051 \$	21,457,719		21,672,296 \$	21,672,296 \$	21,672,296 \$	21,672,296 \$		,,,,,,,,,,,
	+,, 0.10	,,	, ,. 13	,,,	-,, 7	-,, 4	-,, 9	-,,	,_,_,_	
										2021 includes a 1/2 year of expense inflation due to the C
Inflation				1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	which includes inflation for January - June 2021 from the S
Interest Expense	\$ 6317.210	\$ 6,206,678 \$	6,066,904		6,127,573 \$	6,127,573 \$	6,127,573 \$	6,127,573 \$		Anien melades milator for sandary safet 2021 from the
merest expense	9 0,517,210	y 0,200,070 y	0,000,504	y 0,121,313 3	3,121,313 3	3,121,313 3	0,121,515 \$	0,121,313 3	0,127,373	
										2021 includes a 1/2 year of expense inflation due to the C
Inflation				1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	which includes inflation for January - June 2021 from the S
триноп				1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	which includes illiation for January - June 2021 from the S

e CY 2021 revenue calculation, he SFY 2021 rate order.

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e CY 2021 revenue calculation, he SFY 2021 rate order.

#### Shady Grove Medical Center Assumptions & Drivers Current State - No Inflation (Table G1)

		_			_							
	Historical						Pr	rojection				
	CY 2018 CY 2019		CY 2020	CY 2021		CY 2022		CY 2023	CY 2	024	CY 2025	CY 2026
Other - Overhead Allocation	\$ 29,273,093 \$ 29,802,813	\$	30,411,392	\$ 30,715,506	\$	30,715,506 \$	5	30,715,506 \$	30,	715,506	\$ 30,715,506	\$ 30,715,506
Inflation				1.00%		0.00%		0.00%		0.00%	0.00%	0.00%
Purchased Services	\$ 29,456,617 \$ 30,408,254	\$	30,206,310	\$ 30,583,889	\$	30,583,889 \$	5	30,583,889 \$	30,	583,889	\$ 30,583,889	\$ 30,583,889
Inflation				1.25%		0.00%		0.00%		0.00%	0.00%	0.00%
Project Interest Expense				\$ -	\$	- \$	5	- \$	6,	947,100	\$ 6,947,100	\$ 6,947,100
Inflation				0.00%		0.00%		0.00%		0.00%	0.00%	0.00%
Inflation \$									6,	947,100		
Project Depreciation								\$	5,	730,480	\$ 6,251,433	\$ 6,251,433
Inflation				0.00%		0.00%		0.00%		0.00%	0.00%	0.00%

#### Notes

2021 includes a 1/2 year of expense inflation due to the CY 2021 revenue calculation, which includes inflation for January - June 2021 from the SFY 2021 rate order.

2021 includes a 1/2 year of expense inflation due to the CY 2021 revenue calculation, which includes inflation for January - June 2021 from the SFY 2021 rate order.

SGMC Tower CON Exhibit 1

#### Adventist HealthCare Shady Grove Medical Center - SGMC Consolidated Historical and Projected P&L - Tower Project

CY 2018 through CY 2026 Projected - UNINFLATED

		Histor	rical	Ι	Projection						Proje	ectio	on				
		CY 2018	CY 2019		CY 2020		CY 2021		CY 2022		CY 2023		CY 2024		CY 2025		CY 2026
Inpatient Revenue Outpatient Revenue 2020 COVID Stimulus Funds	\$	276,338,352 216,294,577	\$ 285,811,383 221,454,634	\$	282,671,660 215,643,711 29,961,247	\$	303,055,312 229,858,241 -		303,055,312 229,858,241 -		303,055,312 229,858,241 -	\$	303,055,312 229,858,241 -	•	303,055,312 229,858,241 -		303,055,312 229,858,241
Gross Patient Revenue	\$	492,632,928	\$ 507,266,017	\$	528,276,618	\$	532,913,553	\$	532,913,553	\$	532,913,553	\$	532,913,553	\$	532,913,553	\$	532,913,553
HSCRC Assessments/Pass-thrus Contractual Allowances Charity Care	\$	- 61,288,049 5,659,157	\$ - 60,553,149 9,599,449	\$	16,056,567 46,039,472 10,016,173	\$	16,208,377 46,344,856 10,095,871	\$	16,208,377 46,344,856 10,095,871	\$	16,208,377 46,344,856 10,095,871	\$	16,208,377 46,344,856 10,095,871	\$	16,208,377 46,344,856 10,095,871	\$	16,208,377 46,344,856 10,095,871
Deductions from Revenue	\$	66,947,206	\$ 70,152,598	\$	72,112,211	\$	72,649,105	\$	72,649,105	\$	72,649,105	\$	72,649,105	\$	72,649,105	\$	72,649,105
Net Patient Revenue before Bad Debt	\$	425,685,723	\$ 437,113,418	\$	456,164,407	\$	460,264,448	\$	460,264,448	\$	460,264,448	\$	460,264,448	\$	460,264,448	\$	460,264,448
Bad Debt	_	20,131,873	18,167,576	_	18,683,279		18,815,036	_	18,815,036	_	18,815,036	_	18,815,036	_	18,815,036		18,815,036
Net Patient Revenue	\$	405,553,850	\$ 418,945,842	\$	437,481,128	\$	441,449,412	\$	441,449,412	\$	441,449,412	\$	441,449,412	\$	441,449,412	\$	441,449,412
Other Operating Revenue	l	27,567,441	27,956,963		30,064,718		26,757,599		26,757,599		26,757,599		23,957,599		23,957,599		23,957,599
Total Operating Revenue	Ś	433.121.290	\$ 446,902,805	\$	467,545,846	\$	468,207,011	Ś	468,207,011	Ś	468,207,011	Ś	465,407,011	Ś	465,407,011	Ś	465,407,011
. com operaning necessary	,	100,222,200	·	ľ	101,5 15,6 16	*	100,207,022	•	.00,201,022	*	,,	*	100,107,022	•	100,107,022	*	100,107,022
Salaries and Wages	\$	154,567,541	\$ 161,156,153	\$	164,513,011	\$	169,409,254	\$	169,901,666	\$	170,328,924	\$	172,251,023	\$	174,117,085	\$	174,386,994
Employee Benefits		33,449,523	31,853,408		34,059,352		35,073,028		35,174,972		35,263,428		35,661,363		36,047,696		36,103,576
Supplies		54,771,090	56,114,400		63,900,817		60,492,417		60,668,247		60,820,812		60,956,646		61,072,470		61,168,849
Contract Labor		7,820,499	9,951,244		17,508,312		12,387,131		11,148,418		9,810,608		9,320,077		8,714,272		8,017,130
General & Administrative		9,570,164	11,063,980		9,836,615		10,969,473		10,969,473		10,969,473		10,969,473		10,969,473		10,969,473
Professional Fees		13,463,556	13,175,566		11,356,931		12,038,347		12,038,347		12,038,347		12,038,347		12,038,347		12,038,347
Purchased Services		29,456,617	30,408,254		30,206,310		30,583,889		30,583,889		30,583,889		30,583,889		30,583,889		30,583,889
Building and Maintenance		25,591,807	26,407,365		28,870,964		28,582,254		28,582,254		28,582,254		23,950,254		25,650,254		25,650,254
Insurance		3,157,536	3,261,789		3,285,659		3,318,516		3,318,516		3,318,516		3,318,516		3,318,516		3,318,516
Depreciation and Amortization		17,310,935	16,617,815		16,187,681		16,349,558		16,349,558		16,349,558		22,080,038		22,600,991		22,600,991
IT Depreciation		6,346,694	6,346,694		5,629,746		5,686,043		5,686,043		5,686,043		5,686,043		5,686,043		5,686,043
IT Services		21,497,046	21,497,051		21,457,719		21,672,296		21,672,296		21,672,296		21,672,296		21,672,296		21,672,296
Interest Expense		6,317,210	6,206,678		6,066,904		6,127,573		6,127,573		6,127,573		13,074,673		13,074,673		13,074,673
Other - Overhead Allocation	-	29,273,093	29,802,813	_	30,411,392		30,715,506	_	30,715,506	_	30,715,506	_	30,715,506	_	30,715,506	_	30,715,506
<b>Total Operating Expenses</b>	<u>\$</u>	412,593,313	\$ 423,863,210	<u>\$</u>	443,291,413	\$	443,405,285	\$	442,936,759	\$	442,267,227	\$	452,278,144	\$	456,261,512	\$	455,986,537
Income (loss) from operations	\$	20,527,978	\$ 23,039,594	\$	24,254,433	\$	24,801,726	\$	25,270,252	\$	25,939,784	\$	13,128,866	\$	9,145,499	\$	9,420,474
Non-Operating Income		775,313	6,301,524		1,566,002		3,321,587		3,321,587		3,321,587		3,321,587		3,321,587		3,321,587
Net Income	\$	21,303,291	\$ 29,341,118	<u>\$</u>	25,820,435	\$	28,123,313	\$	28,591,839	\$	29,261,371	\$	16,450,453	\$	12,467,086	\$	12,742,061

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#### TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. 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.

	Τ\	vo Most Rece	nt Y	ears (Actual)	c	Current Year Projected	Projected needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.											
Indicate CY		CY 2018		CY 2019		CY 2020		CY 2021		CY 2022		CY 2023		CY 2024		CY 2025		CY 2026
1. REVENUE																		
a. Inpatient Services	\$	276,338,352		,	\$	282,671,660	\$	306,618,524	\$	313,809,684	\$	321,169,518	\$	328,701,982	\$	336,411,125	\$	344,301,092
b. Outpatient Services	\$	216,294,577	\$	221,454,634	\$	215,643,711	\$	232,528,272	\$	237,730,104	\$	243,051,431	\$	248,495,031	\$	254,063,747	\$	259,760,487
2020 COVID Stimulus Funds	\$	-	\$	-	\$	29,961,247	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Gross Patient Service Revenues	\$	492,632,928	\$	507,266,017	\$\$	528,276,618	\$	539,146,795	\$	551,539,788	\$	564,220,950	\$	577,197,013	\$	590,474,872	\$	604,061,579
c. Allowance For Bad Debt	\$	20,131,873	\$	18,167,576	\$	18,683,279	\$	19,034,133	\$	19,470,379	\$	19,916,728	\$	20,373,417	\$	20,840,685	\$	21,318,779
d. Contractual Allowance	\$	61,288,049	\$	60,553,149	\$	62,096,039	\$	63,269,740	\$	64,606,836	\$	65,973,827	\$	,,	\$	68,800,255	\$	70,261,115
e. Charity Care	\$	5,659,157	\$	9,599,449	\$	10,016,173	\$	10,214,219	\$	10,453,034	\$	10,697,434	\$	10,947,550	\$	11,203,517	\$	11,465,470
Net Patient Services Revenue	\$	405,553,850	\$	418,945,842	\$\$	437,481,128	\$	446,628,703	\$	457,009,540	\$	467,632,961	\$\$	478,504,647	\$	489,630,415	\$	501,016,215
f. Other Operating Revenues (Specify/add rows if needed)	\$	27,567,441	\$	27,956,963	\$	30,064,718	\$	27,058,246	\$	27,599,411	\$	28,151,399	\$	25,914,427	\$	26,432,716	\$	26,961,370
NET OPERATING REVENUE	\$	433,121,290	\$	446,902,805	\$	467,545,846	\$	473,686,949	\$	484,608,951	\$	495,784,360	\$	504,419,074	\$	516,063,131	\$	527,977,585
2. EXPENSES																		
a. Salaries & Wages (including benefits)	\$	188,017,064	\$	193,009,561	\$	198,572,363	\$	207,156,241	\$	212,329,055	\$	217,545,993	\$	224,080,603	\$	231,885,241	\$	237,272,824
b. Contractual Services	\$	7,820,499	\$	9,951,244	\$	17,508,312	\$	12,518,443	\$	11,454,375	\$	10,251,666	\$	9,892,858	\$	9,398,215	\$	8,787,331
c. Interest on Current Debt	\$	6,317,210	\$	6,206,678	\$	6,066,904	\$	6,188,242	\$	6,312,007	\$	6,438,247	\$	6,567,012	\$	6,698,352	\$	6,832,319
d. Interest on Project Debt	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	6,947,100	\$	6,947,100	\$	6,947,100
e. Current Depreciation	\$	23,657,629	\$	22,964,509	\$	21,817,427	\$	22,253,776	\$	22,698,851	\$	23,152,828	\$	23,615,885	\$	24,088,202	\$	24,569,966
f. Project Depreciation	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	5,730,480	\$	6,251,433	\$	6,251,433
g. Current Amortization																		
h. Project Amortization																		
i. Supplies	\$	54,771,090	\$	56,114,400	\$	63,900,817	\$	61,369,119	\$	63,393,922	\$	65,459,941	\$	67,574,320	\$	69,733,800	\$	71,939,163
j. Other Expenses - General & Administrative	\$	9,570,164	\$	11,063,980	\$	9,836,615	\$	11,071,043	\$	11,292,463	\$	11,518,313	\$	11,748,679	\$	11,983,652	\$	12,223,326
j. Other Expenses - Professional Fees	\$	13,463,556	\$	13,175,566	\$	11,356,931	\$	12,151,916	\$	12,394,954	\$	12,642,854	\$	12,895,711	\$	13,153,625	\$	13,416,697
j. Other Expenses - Purchased Services	\$	29,456,617	\$	30,408,254	\$	30,206,310	\$	30,961,468		31,735,504	\$	32,528,892	\$	33,342,114	\$	34,175,667	\$	35,030,059
j. Other Expenses - Building & Maintenance	\$	25,591,807	\$	26,407,365	\$	28,870,964	\$	28,870,964	\$	29,448,383	\$	30,037,351	\$	26,006,098	\$	28,226,220	\$	28,790,744
j. Other Expenses	\$	53,927,675	\$	54,561,653	\$	55,154,770	\$	56,257,865	\$	57,383,023	\$	58,530,683	\$	59,701,297	\$	60,895,323	\$	62,113,229
TOTAL OPERATING EXPENSES	\$	412,593,313	\$	423,863,210	\$	443,291,413	\$	448,799,077	\$	458,442,539	\$	468,106,768	\$	488,102,156	\$	503,436,830	\$	514,174,191

#### TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. 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.

	Two Most Recer	nt Years (Actual)	Current Year Projected		der to document	two years after pro that the hospital w stent with the Finar	ill generate excess	s revenues over to	
Indicate CY	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026
3. INCOME									
a. Income From Operation	\$ 20,527,978	\$ 23,039,594	\$ 24,254,433	\$ 24,887,872	\$ 26,166,412			\$ 12,626,300	\$ 13,803,394
b. Non-Operating Income	\$ 775,313	\$ 6,301,524	\$ 1,566,002	\$ 3,321,587	\$ 3,404,627	\$ 3,489,742	\$ 3,576,986	\$ 3,666,411	\$ 3,758,071
SUBTOTAL	\$ 21,303,291	\$ 29,341,118	\$ 25,820,435	\$ 28,209,459	\$ 29,571,039	\$ 31,167,335	\$ 19,893,904	\$ 16,292,711	\$ 17,561,465
c. Income Taxes									
NET INCOME (LOSS)	\$ 21,303,291	\$ 29,341,118	\$ 25,820,435	\$ 28,209,459	\$ 29,571,039	\$ 31,167,335	\$ 19,893,904	\$ 16,292,711	\$ 17,561,465
4. PATIENT MIX									
a. Percent of Total Revenue									
1) Medicare	34.4%	34.5%	34.5%	34.5%	34.5%	34.5%	34.5%	34.5%	34.5%
2) Medicaid	19.3%	19.8%	20.2%	20.2%	20.2%	20.2%	20.2%	20.2%	20.2%
3) Blue Cross	20.5%	19.9%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%
4) Commercial Insurance	20.8%	20.8%	20.7%	20.7%	20.7%	20.7%	20.7%	20.7%	20.7%
5) Self-pay	4.0%	3.9%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%
6) Other	1.0%	1.0%	1.1%	1.1%	1.19	1.1%	1.1%	1.1%	1.1%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
b. Percent of Equivalent Inpatient Days									
Total Patient Days									
1) Medicare	33.1%	33.8%	33.8%	33.8%	33.8%	33.8%	33.8%	33.8%	33.8%
2) Medicaid	28.5%	27.9%	27.9%	27.9%	27.9%	27.9%	27.9%	27.9%	27.9%
3) Blue Cross	17.8%	16.7%	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%
4) Commercial Insurance	18.3%	19.1%	17.4%	17.4%	17.4%	17.4%	17.4%	17.4%	17.4%
5) Self-pay	2.1%	2.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%
6) Other	0.2%	0.2%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

SGMC Tower CON Exhibit 1 Table H

#### Shady Grove Medical Center Assumptions & Drivers Current State - Inflation (Table H1)

	Г	Histor	ical		,		Projection			
	L	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026
IP Hospital Revenue	-	276,338,352	285,811,383	282,671,660	306,618,524	313,809,684	321,169,518	328,701,982	336,411,125	344,301,092
OP Hospital Revenue		192,329,870	199,698,415	197,120,936	213,820,268	218,835,021	223,967,397	229,220,157	234,596,124	240,098,188
or nospital nevenue		132,323,070	155,050,415	137,120,330	213,020,200	210,033,021	223,307,337	223,220,137	234,330,124	240,030,100
SGMC & GEC										
Gross GBR				475,472,635	515,926,701	528,026,598	540,410,302	553,084,470	566,055,914	579,331,609
Stimulus Funds				29,961,247	-	-	-	-	-	-
UCC Payments/Receipts				4,319,961	4,512,091	4,618,107	4,726,613	4,837,669	4,951,334	5,067,670
				509,753,843	520,438,792	532,644,705	545,136,915	557,922,139	571,007,249	584,399,280
Total Gross				528,276,618	539,146,795	551,539,788	564,220,950	577,197,013	590,474,872	604,061,579
Deductions:										
Contractual Allowances				35,234,205	35,957,141	36,799,824	37,662,259	38,544,909	39,448,248	40,372,760
HSCRC Assessments				16,056,567	16,399,279	16,784,559	17,178,890	17,582,486	17,995,564	18,418,346
Bad Debt				18,097,550	18,442,547	18,872,877	19,313,251	19,763,905	20,225,078	20,697,016
Charity Care				10,013,946	10,211,970	10,450,762	10,695,140	10,945,233	11,201,176	11,463,106
Net Patient Service Revenue				430,351,575	439,427,855	449,736,683	460,287,375	471,085,606	482,137,183	493,448,051
				, , , , , , , , , , , , , , , , , , , ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.,,		,,	. , . ,	, . , . , . ,
Other Revenue	445	4 402 252	4 272 402	4 404 505	4 440 700	4 422 020	4 447 240	4 454 722	4 476 220	4 404 401
1.00	115	1,102,253	1,272,103	1,404,686	1,418,733	1,432,920	1,447,249	1,461,722	1,476,339	1,491,102
Inflation					1.0%	1.0%	1.0%	1.0%	1.0%	1.09
Contractual Allowances				22.8%	22.8%	22.8%	22.8%	22.8%	22.8%	22.89
Charity				0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.09
Bad Debt				4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.89
Net Revenue				1,016,993	1,027,163	1,037,434	1,047,809	1,058,287	1,068,869	1,079,558
	131	6,345,164	6,412,277	6,119,669	6,180,866	6,242,675	6,305,101	6,368,152	6,431,834	6,496,152
Inflation					1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Contractual Allowances				69.0%	69.0%	69.0%	69.0%	69.0%	69.0%	69.09
Charity				0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.09
Bad Debt				0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.09
Net Revenue				1,898,933	1,917,923	1,937,102	1,956,473	1,976,038	1,995,798	2,015,756
	401	6,665,743	5,898,712	3,839,532	3,877,927	3,916,707	3,955,874	3,995,432	4,035,387	4,075,741
Inflation					1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Contractual Allowances				69.6%	69.6%	69.6%	69.6%	69.6%	69.6%	69.69
Charity				0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.19
Bad Debt				3.1%	3.1%	3.1%	3.1%	3.1%	3.1%	3.19
Net Revenue				1,045,389	1,055,843	1,066,402	1,077,066	1,087,836	1,098,715	1,109,702
	405	9,851,457	8,173,127	7,158,888	7,230,477	7,302,782	7,375,810	7,449,568	7,524,063	7,599,304
Inflation	105	3,031,137	0,1,0,12,	7,130,000	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Contractual Allowances				50.2%	50.2%	50.2%	50.2%	50.2%	50.2%	50.29
Charity				0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.09
Bad Debt				5.6%	5.6%	5.6%	5.6%		5.6%	5.69
Net Revenue				3,168,238	3,199,920	3,231,919	3,264,238	5.6% 3,296,881	3,329,850	3,363,148
Nethevende				3,100,230	3,133,320	3,231,313	3,204,230	3,230,001	3,323,630	3,303,140
Total Contractuals				46,039,472	46,870,461	47,822,277	48,794,936	49,788,913	50,804,692	51,842,769
Total Charity				10,016,173	10,214,219	10,453,034	10,697,434	10,947,550	11,203,517	11,465,470
Total Bad Debt				18,683,279	19,034,133	19,470,379	19,916,728	20,373,417	20,840,685	21,318,779
Total Passthroughs				16,056,567	16,399,279	16,784,559	17,178,890	17,582,486	17,995,564	18,418,346
Net Patient Service Revenue				437,481,128	446,628,703	457,009,540	467,632,961	478,504,647	489,630,415	501,016,215
EIPA Factor ("Equivalent IP Admission")		1.6960	1.6987	1.6973	1.6973	1.6973	1.6973	1.6973	1.6973	1.6973
IP Revenue per Admission				\$ 12,487			\$ 12,487			
OP Revenue per EIPD ("Equivalent IP Day")				2,533.54	2,718.67	2,774.37	2,832.31	2,892.28	2,954.50	3,019.03
Physician Revenue per EIPD										
				2,534	2,719	2,774	2,832	2,892	2,954	3,019
Other Operating Revenue		\$ 27,567,441 \$	27,956,963	\$ 30,064,718		\$ 27,599,411	\$ 28,151,399	\$ 25,914,427		\$ 26,961,370
Other Operating Revenue Growth Other Operating Revenue Growth \$					-10.00%	2.00%	2.00%	2.00% (2,800,000)	2.00%	2.009
Non-Operating Revenue				1,566,002	3,321,587	3,404,627	3,489,742	3,576,986	3,666,411	3,758,071
Inflation				1,300,002	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%
Injudioli					2.50%	2.50%	2.50%	2.50%	2.50%	2.50%
Revenue Inflation Update					0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

#### Shady Grove Medical Center Assumptions & Drivers Current State - Inflation (Table H1)

	Historical								F	Projection		_		
	 CY 2018		CY 2019	CY 2	020	CY 2021		CY 2022		CY 2023	CY 2024		CY 2025	CY 2026
SGMC Discharges	24,079		23,201		22,638	23,507		23,723		23,930	24,133		24,329	24,518
SGMC Days	113,676		112,197		111,572	112,783		113,110		113,395	113,648		113,864	114,044
SGMC ADC	311.44		306.55		304.84	308.99		309.89		310.67	310.51		311.96	312.45
SGMC ALOS	4.72		4.84		4.93	4.80		4.77		4.74	4.71		4.68	4.65
EIPA	40,838		39,412		38,425	39,900	)	40,267		40,618	40,962		41,294	41,615
EIPD	192,794		190,590		189,377	191,431		191,988		192,471	192,900		193,267	193,572
Adjusted Occupied Bed	528.2		522.2		517.4	524.5		526.0		527.3	527.1		529.5	530.3
Total Paid FTEs excluding new tower	2,224.39		2,274.72	2	2,263.92	2,268.86		2,268.08		2,265.52	2,261.76		2,268.89	2,268.28
Staff FTEs	2,173.62		2,207.64	2	2,149.91	2,184.94		2,191.29		2,196.80	2,195.69		2,205.89	2,209.37
Contract Labor FTEs (Included in Total Paid)	50.77		67.08		114.01	83.92		76.78		68.72	66.06		63.00	58.91
FTEs per AOB	4.12		4.23		4.16	4.17		4.17		4.17	4.17		4.17	4.17
Total Salaries	154,567,541		161,156,153	164,	513,011	171,624,573		175,910,140		180,232,263	185,646,049	1	192,112,027	196,575,526
Salary per FTE	69,488		70,847		76,521	78,549		80,277		82,043	83,848		85,693	87,578
Salary Inflation %						2.65%	6	2.20%		2.20%	2.20%		2.20%	2.20%
New Tower FTEs											48.8		48.8	48.8
New Tower Salary \$											1,541,696		3,083,392	3,083,392
Benefit %	21.6%		19.8%		20.7%	20.79	6	20.7%		20.7%	20.7%		20.7%	20.7%
Supply per EIPD	\$ 284	\$	294	\$	337		. \$	330	\$	340	\$ 350	\$	361	\$ 372
Inflation						5.00%		3.00%		3.00%	3.00%		3.00%	3.00%
Contract Labor	\$ 7,820,499	\$	9,951,244	\$ 17,	508,312	\$ 12,518,443			\$	10,251,666	\$ 9,892,858	\$	9,398,215	\$ 8,787,331
Inflation						-28.50%		-8.50%		-10.50%	-3.50%		-5.00%	-6.50%
General & Administrative	\$ 9,570,164	\$	11,063,980	\$ 9,	836,615	\$ 11,071,043			\$	11,518,313	\$	\$	11,983,652	\$ 12,223,326
Inflation						9.00%		2.00%		2.00%	2.00%		2.00%	2.00%
Professional Fees	\$ 13,463,556	\$	13,175,566	\$ 11,	356,931	\$ 12,151,916			\$	12,642,854	\$	\$		\$ 13,416,697
Inflation						7.00%		2.00%		2.00%	2.00%		2.00%	2.00%
Building and Maintenance	\$ 25,591,807	\$	26,407,365	\$ 28,	870,964	\$ 28,870,964			\$	30,037,351	\$	\$		\$ 28,790,744
Inflation						0.00%	6	2.00%		2.00%	2.00%		2.00%	2.00%
Inflation \$											(4,632,000)		1,700,000	
Insurance	\$ 3,157,536	\$	3,261,789	\$ 3,	285,659	\$ 3,351,372			\$		\$ 3,556,503	\$	3,627,633	\$ 3,700,186
Inflation						2.00%		2.00%		2.00%	2.00%		2.00%	2.00%
Depreciation and Amortization	\$ 17,310,935	\$	16,617,815	\$ 16,	187,681	\$ 16,511,435			\$	17,178,497	\$	\$	17,872,508	\$ 18,229,958
Inflation						2.00%	6	2.00%		2.00%	2.00%		2.00%	2.00%
IT Depreciation	\$ 6,346,694	\$	6,346,694	\$ 5,	629,746	\$ 5,742,341			\$		\$ -,,-	\$	6,215,694	\$ 6,340,008
Inflation						2.00%		2.00%		2.00%	2.00%		2.00%	2.00%
IT Services	\$ 21,497,046	\$	21,497,051	\$ 21,	457,719	\$ 21,886,873	\$	22,324,611	\$	22,771,103	\$ 23,226,525	\$	23,691,056	\$ 24,164,877
Inflation						2.00%		2.00%		2.00%	2.00%		2.00%	2.00%
Interest Expense	\$ 6,317,210	\$	6,206,678	\$ 6,	066,904	\$ 6,188,242			\$	6,438,247	\$ 6,567,012	\$	6,698,352	\$ 6,832,319
Inflation						2.00%	6	2.00%		2.00%	2.00%		2.00%	2.00%

Exhibit 1

SGMC Tower CON Table H Assumptions Current Inflated

Notes

#### Shady Grove Medical Center Assumptions & Drivers Current State - Inflation (Table H1)

		His	toric	al				Projection			
	_	CY 2018		CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026
Other - Overhead Allocation	\$	29,273,093	\$	29,802,813	\$ 30,411,392	\$ 31,019,620	\$ 31,640,012	\$ 32,272,812	\$ 32,918,269	\$ 33,576,634	\$ 34,248,167
Inflation						2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
Purchased Services	\$	29,456,617	\$	30,408,254	\$ 30,206,310	\$ 30,961,468	\$ 31,735,504	\$ 32,528,892	\$ 33,342,114	\$ 34,175,667	\$ 35,030,059
Inflation						2.50%	2.50%	2.50%	2.50%	2.50%	2.50%
Project Interest Expense						\$ -	\$ -	\$ -	\$ 6,947,100	\$ 6,947,100	\$ 6,947,100
Inflation						0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Inflation \$									6,947,100		
Project Depreciation									\$ 5,730,480	\$ 6,251,433	\$ 6,251,433
Inflation						0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Notes

#### Adventist HealthCare Shady Grove Medical Center - SGMC Consolidated Historical and Projected P&L - Tower Project

CY 2018 through CY 2026 Projected - INFLATED

		Histo	rica	ıl		Projection						Projec	tion					
		CY 2018		CY 2019		CY 2020		CY 2021		CY 2022		CY 2023		CY 2024		CY 2025		CY 2026
Inpatient Revenue Outpatient Revenue	\$	276,338,352 216,294,577	\$	285,811,383 221,454,634	\$	282,671,660 215,643,711	\$	306,618,524 232,528,272		313,809,684 237,730,104	•	321,169,518 243,051,431	•	328,701,982 248,495,031		336,411,125 254,063,747		344,301,092 259,760,487
2020 COVID Stimulus Funds		-		-		29,961,247	7	-	Y	-	Y	-	7	-	7	-	Y	-
Gross Patient Revenue	\$	492,632,928	\$	507,266,017	\$	528,276,618	\$	539,146,795	\$	551,539,788	\$	564,220,950	\$	577,197,013	\$	590,474,872	\$	604,061,579
HSCRC Assessments/Pass-thrus	\$	-	\$	-	\$	16,056,567	\$	16,399,279	\$	16,784,559	\$	17,178,890	\$	17,582,486	\$	17,995,564	\$	18,418,346
Contractual Allowances		61,288,049		60,553,149		46,039,472		46,870,461		47,822,277		48,794,936		49,788,913		50,804,692		51,842,769
Charity Care	_	5,659,157		9,599,449		10,016,173		10,214,219		10,453,034		10,697,434		10,947,550		11,203,517		11,465,470
Deductions from Revenue	\$	66,947,206		70,152,598	\$	72,112,211	\$	73,483,959	\$	75,059,870	\$	76,671,261	\$	78,318,950		80,003,772	\$	81,726,585
Net Patient Revenue before Bad Debt	\$	425,685,723	\$	437,113,418	\$	456,164,407	\$	465,662,836	\$	476,479,919	\$	487,549,689	\$	498,878,064	\$	510,471,100	\$	522,334,994
Bad Debt	_	20,131,873	_	18,167,576	_	18,683,279	_	19,034,133		19,470,379		19,916,728		20,373,417	_	20,840,685		21,318,779
Net Patient Revenue	\$	405,553,850	\$	418,945,842	\$	437,481,128	\$	446,628,703	\$	457,009,540	\$	467,632,961	\$	478,504,647	\$	489,630,415	\$	501,016,215
Other Operating Revenue	_	27,567,441		27,956,963		30,064,718		27,058,246	_	27,599,411	_	28,151,399		25,914,427	_	26,432,716		26,961,370
Total Operating Revenue	\$	433,121,290	Ś	446,902,805	ļ ģ	467,545,846	Ś	473,686,949	Ś	484,608,951	Ś	495,784,360	Ś	504,419,074	Ś	516,063,131	Ś	527,977,585
	"	,,_	•	, ,		,,	*	,,.	•	,,	•	,,	•		•	,,	*	
Salaries and Wages	Ś	154,567,541	۲	161,156,153	\$	164,513,011	۲	171,624,573	۲.	175,910,140	ć	180,232,263	,	185,646,049	Ļ	192,112,027	Ļ	196,575,526
Employee Benefits	٦	33,449,523	Ş	31,853,408	٦	34,059,352	Ş	35,531,668	Ş	36,418,915	Ş	37,313,730	Ş	38,434,553	Ş	39,773,214	Ş	40,697,298
Supplies		54,771,090		56,114,400		63,900,817		61,369,119		63,393,922		65,459,941		67,574,320		69,733,800		71,939,163
Contract Labor		7,820,499		9,951,244		17,508,312		12,518,443		11,454,375		10,251,666		9,892,858		9,398,215		8,787,331
General & Administrative		9,570,164		11,063,980		9,836,615		11,071,043		11,292,463		11,518,313		11,748,679		11,983,652		12,223,326
Professional Fees		13,463,556		13,175,566		11,356,931		12,151,916		12,394,954		12,642,854		12,895,711		13,153,625		13,416,697
Purchased Services		29,456,617		30,408,254		30,206,310		30,961,468		31,735,504		32,528,892		33,342,114		34,175,667		35,030,059
Building and Maintenance		25,591,807		26,407,365		28,870,964		28,870,964		29,448,383		30,037,351		26,006,098		28,226,220		28,790,744
Insurance		3,157,536		3,261,789		3,285,659		3,351,372		3,418,400		3,486,768		3,556,503		3,627,633		3,700,186
Depreciation and Amortization		17,310,935		16,617,815		16,187,681		16,511,435		16,841,663		17,178,497		23,252,547		24,123,941		24,481,391
IT Depreciation		6,346,694		6,346,694		5,629,746		5,742,341		5,857,188		5,974,331		6,093,818		6,215,694		6,340,008
IT Services		21,497,046		21,497,051		21,457,719		21,886,873		22,324,611		22,771,103		23,226,525		23,691,056		24,164,877
Interest Expense		6,317,210		6,206,678		6,066,904		6,188,242		6,312,007		6,438,247		13,514,112		13,645,452		13,779,419
Other - Overhead Allocation		29,273,093		29,802,813		30,411,392		31,019,620		31,640,012		32,272,812		32,918,269		33,576,634		34,248,167
	1-		_		—		_		_		_		_		_	_	_	
Total Operating Expenses	\$	412,593,313	\$	423,863,210	<u>\$</u>	443,291,413	\$	448,799,077	\$	458,442,539	\$	468,106,768	\$	488,102,156	\$	503,436,830	\$	514,174,191
Income (loss) from operations	\$	20,527,978	\$	23,039,594	\$	24,254,433	\$	24,887,872	\$	26,166,412	\$	27,677,593	\$	16,316,919	\$	12,626,300	\$	13,803,394
			_		L				_		_		_					
Non-Operating Income		775,313		6,301,524		1,566,002		3,321,587		3,404,627		3,489,742		3,576,986		3,666,411		3,758,071
Net Income	\$	21,303,291	\$	29,341,118	\$	25,820,435	\$	28,209,459	\$	29,571,039	\$	31,167,335	\$	19,893,904	\$	16,292,711	\$	17,561,465

## **Shady Grove Medical Center Tower CON Additional Costs**

#### **Salaries**

Description	FTE	Rate	Salary
EVS Staff	10.00	\$ 18.00	374,400
EVS Managers	1.00	\$ 33.00	68,640
Facilties	3.00	\$ 35.00	218,400
Nurse Manager	2.00	\$ 64.00	266,240
ANM	9.40	\$ 53.00	1,036,256
USC	9.40	\$ 23.00	449,696
Dietary	5.00	\$ 20.00	208,000
Security/Other	6.00	\$ 28.00	349,440
Transporters	3.00	\$ 18.00	112,320
Total	48.80		3,083,392

#### **Other Expenses**

Description		Expense
Maintenance and EVS Expense	-	1,700,000

#### **TABLE L. WORKFORCE INFORMATION**

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

Indicate CY	cu	RRENT ENTIRE	FACILITY	OF THRO	TED CHANGES HE PROPOSED DUGH THE LAS CTION (CURREI	PROJECT T YEAR OF	OPERATION		CHANGES IN THE LAST YEAR ENT DOLLARS)	FACILITY LAS	CTED ENTIRE THROUGH THE TYEAR OF TION (CURRENT
Job Category	Current Year FTEs	Average Salary per FTE	Current Year Total Cost	FTEs	Average Salary per FTE	Total Cost (should be consistent with projections in Table G, if submitted).	FTEs	Average Salary per FTE	Total Cost	FTEs	Total Cost (should be consistent with projections in Table G)
1. Regular Employees											
Administration (List general											
categories, add rows if needed)		407.700	4 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			•			**	20.0	<b>*</b> 4 • 6 • 7 • 7 • 7
Hospital Leadership	38.6	\$ 127,798			100 100	\$0		105.000	\$0		. , ,
Other Administrative Leadership	45.9	105,296	4,833,126	2.0	133,120	\$266,240	4.9	105,296	515,950	52.8	5,615,316
Senior Leadership	7.8	275,388	2,134,501			\$0			\$0	7.8	2,134,501
<del>-</del>	00.0	<b>A</b> 100 000	<b>A</b> 44 004 000	0.0	<b>*</b> 100 100	\$0	4.0	<b>*</b> 105 000	\$0	0.0	
Total Administration	92.3	\$ 129,002	\$ 11,904,903	2.0	\$ 133,120	\$ 266,240	4.9	\$ 105,296	\$ 515,950	99.2	\$12,687,093
Direct Care Staff (List general categories, add rows if needed)											
Ancillary	46.2	\$ 89,694	\$ 4,146,305							46.2	\$4,146,305
Behavioral Health	254.4	61,641	15,680,863			\$0	5.3	61,641	329,164	259.7	16,010,027
Imaging Services	55.7	87,070	4,850,446			\$0				55.7	4,850,446
Nursing	851.7	84,176	71,694,307	9.4	110,240	\$1,036,256	34.5	84,176	2,906,583	895.7	75,637,146
Physician and Physician Extender	37.4	173,247	6,481,896			\$0				37.4	6,481,896
Surgical and Cardiovascular Services	89.9	88,666	7,969,575			\$0				89.9	7,969,575
			-			\$0			-	0.0	\$0
Total Direct Care	1,335.3	\$ 82,992	\$ 110,823,392	9.4	\$ 110,240	\$ 1,036,256	39.9	\$ 81,157	\$ 3,235,747	1,384.6	\$115,095,395

#### **TABLE L. WORKFORCE INFORMATION**

24890168, add rows In needed)   18.8   \$ 62.818   \$ 1,181.096	TABLE L. WORKFORCE INFORM	ATION											
Administrative Support   18.8   \$ 6.2818   \$ 1.181.096     3.0   \$ 6.2818   \$ 188.453   21.8   \$ 1.389.546   Care Navigation   74.5   71.998   5.366.792     2.6   71.998   131.916   77.1   5.553.987     1.0   4.0276   443.040   2.1   44.529   94.615   105.2   13.01.173   Environmental Services   93.5   45.592   4.293.785   11.0   40.276   443.040   2.1   44.529   94.615   105.6   4.831.433   4.838   4.839.67   1.0   4.945   4.945   4.945   5.758.976   9.0   63.093   567.840   2.3   49.945   116.871   126.2   6.423.687   1.0   4.945   4.	Support Staff (List general												
Care Navigation	categories, add rows if needed)												
Clinical Support   182.8   70,243   12.839,157   12.4   45,324   562,016     195.2   13.01,173   Environmental Services   33.5   45,529   4.293,188   11.0   40,276   443,040   2.1   45,929   94,615   106.5   4.831,439   4.29,867   4.29,867   4.29,867   4.29,867   4.29,867   4.29,867   4.29,867   4.29,867   4.29,867   4.29,965   4.29,867   4.29,965   4.29,867   4.29,965   4.29,965   4.29,867   4.29,965   4.29,867   4.29,965   4.29,867   4.29,965	Administrative Support		\$ 62	2,818	\$ 1,181,096				3.0	\$ 62,818	\$ 188,453	21.8	\$1,369,549
Environmental Services 93.5   45.929   4.293.765   11.0   40.276   443.040   2.1   45.929   94.615   106.5   4.831.438   Facility Support 114.9   49.945   5.738.976   90   63.093   567.40   2.3   49.945   116.871   176.2   62.43.878   Nutrition Services   75.3   45.512   3.425.019   5.0   41.600   208.000   2.1   45.512   93.300   82.3   3.726.319   Nutrition Services   74.0   42.9   56.995   2.444.016   2.7   54.186   143.592   Revenue Cycle   74.0   54.186   4.010.380   2.7   54.186   143.592   Rate Change for FTEs due to 1/2   2.7   54.186   143.592   Rate Change for FTEs due to 1/2   2.7   57.845   4.1784.716   37.4   47.618   1.780.896   14.7   5.206.728   5.3038.994   777.3   546.604.506   Revenue Cycle   74.0   72.2   5.78.84   4.1784.716   37.4   47.618   1.780.896   14.7   5.206.728   5.3038.994   777.3   546.604.506   Rate Change for FTEs due to 1/2   2.2   5.78.84   4.1784.716   37.4   47.618   1.780.896   14.7   5.206.728   5.3038.994   777.3   546.604.506   REVERUAR EMPLOYEES TOTAL   2.499   5.76.522   5.64.513.011   48.8   5.31.84   3.083.392   59.47   5.114.185   6.799.591   2.258.1   3174.386.994   Revenue Cycle   74.0   72.2   5.78.84   4.1784.716   37.4   47.618   1.780.896   14.7   5.206.728   5.3038.994   777.3   546.604.506   Revenue Cycle   74.0   72.2   5.78.84   4.1784.716   37.4   47.618   1.780.896   14.7   5.206.728   5.3038.994   777.3   546.604.506   Revenue Cycle   74.0   72.2   5.78.84   4.1784.716   37.4   47.618   1.780.896   14.7   5.206.728   5.3038.994   777.3   546.604.506   Revenue Cycle   74.0   72.2   5.78.84   4.1784.716   37.4   4.7618   1.780.896   14.7   5.206.728   5.3038.994   777.3   546.604.506   Revenue Cycle   74.0   72.2   5.78.84   4.1784.716   37.4   4.7618   1.780.896   14.7   5.206.728   5.3038.994   777.3   546.604.506   Revenue Cycle   74.0   72.2   5.78.84   4.1784.716   37.4   4.7618   1.780.896   14.7   5.206.728   5.3038.994   777.3   546.604.506   Revenue Cycle   74.0   72.2   5.78.84   4.1784.716   37.4   4.7618   1.780.896   14.7   5.206.728   5.00	Care Navigation	74.5							2.6	71,998	187,196	77.1	5,553,987
Facility Support   114.9	Clinical Support	182.8	70	),243	12,839,157	12.4	45,324	562,016				195.2	13,401,173
Nutrition Services   75.3   45,512   3.425,019   5.0   41,600   208,000   2.1   45,512   93,300   82.3   3.726,319     Chier	Environmental Services		45	,929		11.0	40,276		2.1	45,929	94,615	106.5	4,831,439
Other	Facility Support	114.9	49	9,945	5,738,976	9.0	63,093	567,840	2.3	49,945	116,871	126.2	6,423,687
Revenue Cycle	Nutrition Services	75.3	45	5,512		5.0	41,600	208,000	2.1	45,512	93,300	82.3	3,726,319
Support Staff	Other		56	3,985	2,444,016							42.9	2,444,016
Rate Change for FTEs due to 1/2 year of inflation in FY2021  Rate Change for FTEs due to 1/2 year of inflation in FY2021  REGULAR EMPLOYEES TOTAL  2,149,9 \$ 76,522 \$ 164,513,011	Revenue Cycle	74.0			4,010,380				2.7	54,186	143,592		
Rate Change for FTEs due to 1/2 year of inflation in FY2021  Total Support 722.2 \$ 57,854 \$ 41,784,716 37.4 \$ 47,618 \$ 1,780,896 14.7 \$ 206,728 \$ 3,038,894 77.4.3 \$ 46,604,506	Support Staff	45.6	54	1,543	2,485,495							45.6	2,485,495
year of inflation in FY2021  Total Support  Total S												0.0	-
Total Support   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general categories, add rows if needed)   Total Support Staff (List general ca	Rate Change for FTEs due to 1/2										¢2 214 969		
REGULAR EMPLOYEES TOTAL 2. Contractual Employees Administration (List general categories, add rows if needed)	year of inflation in FY2021												
2. Contractual Employees Administration (List general categories, add rows if needed)	Total Support	722.2	\$ 57	7,854	\$ 41,784,716	37.4	\$ 47,618	\$ 1,780,896	14.7	\$ 206,728	\$ 3,038,894		
Administration (List general categories, add rows if needed)  \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$	REGULAR EMPLOYEES TOTAL	2,149.9	\$ 76	5,522	\$ 164,513,011	48.8	\$ 63,184	\$ 3,083,392	59.47	\$ 114,185	\$ 6,790,591	2,258.1	\$174,386,994
categories, add rows if needed)         \$0	2. Contractual Employees												
SO   SO   SO   SO   SO   SO   SO   SO	Administration (List general												
So	categories, add rows if needed)												
SO   SO   SO   SO   SO   SO   SO   SO												0.0	
Total Administration Direct Care Staff (List general categories, add rows if needed)  Clinical Staff  Total Direct Care Staff (List general categories, add rows if needed)  Clinical Staff  114.0 \$153,582 \$17,508,312 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0					\$0			\$0			\$0	0.0	
Total Administration   So   So   So   So   So   So   So												0.0	
Direct Care Staff (List general categories, add rows if needed)   Clinical Staff											\$0	0.0	
categories, add rows if needed)         114.0         \$153,582         \$17,508,312         \$0         -60.3         157,478         (9,491,182)         53.7         \$8,017,130           Clinical Staff         114.0         \$153,582         \$17,508,312         \$0         -60.3         157,478         (9,491,182)         53.7         \$8,017,130           Support Staff (List general categories, add rows if needed)         \$0         \$0         -60.3         \$157,478         (9,491,182)         53.7         \$8,017,130           Support Staff (List general categories, add rows if needed)         \$0	Total Administration				\$0			\$0			\$0	0.0	\$0
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Support Staff (List general categories, add rows if needed)   Support Staff (List general categories, add rows if needed)	Clinical Staff	114.0	\$15	3,582	\$17,508,312			\$0	-60.3	157,478	(9,491,182)	53.7	\$8,017,130
Total Direct Care Staff Support Staff (List general categories, add rows if needed)  \$\begin{array}{cccccccccccccccccccccccccccccccccccc													
Total Direct Care Staff         114.0         \$ 153,582         \$ 17,508,312         \$0         -60.3         \$ 157,478         \$ (9,491,182)         53.7         \$ 8,017,130           Support Staff (List general categories, add rows if needed)         \$0													
Support Staff (List general categories, add rows if needed)  \$\begin{array}{c} \\$0 &													
categories, add rows if needed)       \$0 <td></td> <td>114.0</td> <td>\$ 153</td> <td>3,582</td> <td>\$ 17,508,312</td> <td></td> <td></td> <td>\$0</td> <td>-60.3</td> <td>\$ 157,478</td> <td>\$ (9,491,182)</td> <td>53.7</td> <td>\$8,017,130</td>		114.0	\$ 153	3,582	\$ 17,508,312			\$0	-60.3	\$ 157,478	\$ (9,491,182)	53.7	\$8,017,130
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CONTRACTUAL EMPLOYEES TO         114.0         \$ 153,582         \$ 17,508,312         0.0         \$ -         \$ -         -60.3         \$ 157,478         \$ (9,491,182)         53.7         \$8,017,130           Benefits (State method of calculating benefits below):         \$34,059,352         \$ 34,059,352         \$ 36,103,576           % of Total Salaries         \$ 34,059,352         \$ 36,103,576												0.0	~~
Benefits (State method of calculating benefits below): % of Total Salaries  \$34,059,352  \$36,103,576								\$0					
calculating benefits below):  % of Total Salaries  \$34,059,352  \$36,103,576		114.0	\$ 153	3,582	\$ 17,508,312	0.0	\$ -	\$ -	-60.3	\$ 157,478	\$ (9,491,182)	53.7	\$8,017,130
% of Total Salaries	Benefits (State method of				¢34.050.353								¢26 102 576
	calculating benefits below):				φ3 <del>4</del> ,039,332								φου, 100,570
TOTAL COST 2.263.9 \$216.080.675 48.8 \$3.083.392 -0.8 \$ (2.700.591) \$218.507.700	% of Total Salaries												
-,510	TOTAL COST	2,263.9			\$216,080,675	48.8		\$3,083,392	-0.8		\$ (2,700,591)		\$218,507,700

## EXHIBIT 2: Shady Grove Medical Center Deed

**Parcel Identification Numbers:** 

Parcel 1 09-001-03259837 Parcel 2 09-001-03095180

Parcel 3 09-001-03095134

Parcel 4 09-001-03095191

Title Insurer: Lawyers Title Insurance Corporation

PLEASE RETURN TO:
LERCH, EARLY & BREWER
3 Bethesda Metro Center, Suite 380
Bethesda Maryland 20814-5367:

File 76926 001/CEC

IMP FD SURE

RECORDING PEE

#### **DEED**

THIS **DEED** ("Deed"), is made this 30th day of August, 2004, by and between **MONTGOMERY COUNTY, MARYLAND**, a political subdivision of the State of Maryland, having a mailing address of 101 Monroe Street, Rockville, Maryland 20850 (the "Grantor"), and **ADVENTIST HEALTHCARE, INC.**, a Maryland corporation, having a mailing address of 1801 Research Boulevard, Suite 200, Rockville, Maryland 20850 (the "Grantee").

#### **RECITALS**

- The Property is currently subject to the following Ground Leases (a) that certain Lease between Montgomery County, Maryland and Washington Adventist Hospital, Incorporated (predecessor to Adventist HealthCare, Inc.) dated May 10, 1977, recorded October 10, 1978 in Liber 5219 at folio 168 among the Land Records of Montgomery County, Maryland ("Land Records"), as amended pursuant to Lease Amendment No. 1 dated October 19 Applicand 6.63 recorded October 10, 1978 among the Land Records in Liber 5219 at folio 21 CCRNI or ther 9.00 amended by Lease Amendment No. 2 dated September 19, 1979 and recorded September 25, 9.86 1979 among the Land Records in Liber 5402 at folio 809, as further amended by Lease Amendment No. 3 dated April 8, 1991 and recorded September 5, 1991 among the Land Records in Liber 5402 at folio 809, as further amended by Lease 399 Amendment No. 3 dated April 8, 1991 and recorded September 5, 1991 among the Land Records in Liber 5402 at folio 809, as further amended by Lease 399 Amendment No. 3 dated April 8, 1991 and recorded September 5, 1991 among the Land Records in Liber 5402 at folio 809, as further amended by Lease 399 Amendment No. 3 dated April 8, 1991 and recorded September 5, 1991 among the Land Records in Liber 5402 at folio 809, as further amended by Lease 399 Amendment No. 3 dated April 8, 1991 and recorded September 5, 1991 among the Land Records in Liber 5402 at folio 809, as further amended by Lease 399 Amendment No. 3 dated April 8, 1991 and recorded September 5, 1991 among the Land Records in Liber 5402 at folio 809, as further amended by Lease 399 Amendment No. 3 dated April 8, 1991 and recorded September 5, 1991 among the Land Records in Liber 5402 at folio 809, as further amended by Lease 399 Amendment No. 3 dated April 8, 1991 and recorded September 5, 1991 among the Land Records in Liber 5402 at folio 809 Amendment No. 3 dated April 8, 1991 and recorded September 5, 1991 among the Land Records in Liber 5402 at folio 809 Amendment No. 3 dated April 8, 1991 and recorded September 5, 1991 among the Land Records in Liber 5402 at folio 809 Amendment No. 3 dated April 8, 1991 among the Land Records in Liber 5402 at folio 809 Amendment No. 3 dated April 8, 1991 among the Land Records in Liber 5402 at folio 809 Amendment No. 3 dated April 8, 1991 among the Land Records in Liber 5402 at folio 809 Amendment No. 3 dated April 8, 1991 among the Land Records in Liber 5402 at folio 809 Amendment No. 3 dated April 8, 1991 among the Land Records in Liber 5402 Amendment No. 3 dated April 8, 1991 among the Land Records in Liber 5402 Amendment No. 3 dated April 8, 1991 Among the Land Records in Liber 540 9.0 in Liber 9920 at folio 753, as further amended by Lease Amendment No. 4 dated April 8 2429 [69:53 am and recorded September 5, 1991 among the Land Records in Liber 9920 at folio 757, and as further amended by Lease Amendment No. 5 dated June 21, 1995 and recorded among the Land Records on June 29, 1995, in Liber 13475 at folio 309, and as further amended by Lease Amendment No. 6 dated March 17, 1998 and recorded among the Land Records on October 27, 1998, in Liber 16385 at folio 740 (collectively, the "Hospital Ground Lease"); (b) that certain Lease between Montgomery County, Maryland and Jeff Weidig and Juliana Weidig (predecessor), 31 in interest to Adventist HealthCare, Inc.) dated March 29, 1985, and recorded in the Land 121 in Records on September 27, 1985 in Liber 6871, at folio 388, as assigned by Decitor 1985 in Liber 6871, at folio 388, as assigned by Decitor 1985 in Liber 6871, at folio 388, as assigned by Decitor 1985 in Liber 6871, at folio 388, as assigned by Decitor 1985 in Liber 6871, at folio 388, as assigned by Decitor 1985 in Liber 6871, at folio 388, as assigned by Decitor 1985 in Liber 6871, at folio 388, as assigned by Decitor 1985 in Liber 6871, at folio 388, as assigned by Decitor 1985 in Liber 6871, at folio 388, as assigned by Decitor 1985 in Liber 6871, at folio 388, as assigned by Decitor 1985 in Liber 6871, at folio 388, as assigned by Decitor 1985 in Liber 6871, at folio 388, as assigned by Decitor 1985 in Liber 6871, at folio 388, as assigned by Decitor 1985 in Liber 6871, at folio 388, as assigned by Decitor 1985 in Liber 6871, at folio 388, as a second 1985 in Liber 6871, at folio 388, as a second 1985 in Liber 6871, at folio 388, as a second 1985 in Liber 6871, at folio 388, a dated September 29, 1988 and recorded among the Land Records in Liber 8488 at folio 371111 2371 amended by Deed of Assignment and Lease Modification Agreement dated Anal 20,200994 and 35 at recorded among the Land Records on June 20, 1994 in Liber 12709 at folio 113, as further amended by Second Lease Modification Agreement dated March 17, 1998 and recorded among the Land Records on October 27, 1998 in Liber 16385 at folio 736 (collectively, the "Office

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Building Ground Lease"); (c) that certain Lease between Montgomery County, Maryland and Shady Grove Adventist Nursing Center, Inc., dated October 25, 1985, and recorded among the Land Records on December 26, 1985 in Liber 6967, at folio 312, as assigned by Assignment of Lease dated December 23, 1985 and recorded among the Land Records on December 26, 1995 in Liber 6976 at folio 405, as amended by Lease Amendment No. 1 dated June 21, 1995 and recorded among the Land Records on June 29, 1995 in Liber 13475 at folio 314, as further amended by Lease Amendment No. 2 dated March 17, 1998 and recorded among the Land Records on October 27, 1998 in Liber 16385 at folio 725 (collectively, the "Nursing Center Ground Lease"); and (d) that certain Lease between Montgomery County, Maryland and Psychiatric Institute of Montgomery County, Incorporated, dated December 15, 1977, and recorded among the Land Records on September 28, 1979 in Liber 5406, at folio 127, as amended by Memorandum of Exercise of Option to Lease dated June 21, 1994 and recorded among the Land Records on July 6, 1994 in Liber 12746 at folio 317, as assigned to Charter Behavioral Health System at Potomac Ridge, Inc. and Charter Fairbridge Behavioral Health System, Inc. by Assignment and Assumption of Real Property Lease dated June 30, 1994 and recorded among the Land Records on July 6, 1994 in Liber 12746 at folio 327, as further assigned to Charter Behavioral Health System of Maryland at Potomac Ridge, LLC by Assignment of Real Property Lease dated June 13, 1997 and recorded among the Land Records on July 25, 1997 in Liber 15038 a folio 692, as further assigned to Adventist Healthcare, Inc. by unrecorded Second Agreement and Consent of Lessor to Assignment dated effective July 20, 2000, a copy of which is attached hereto as Exhibit B (collectively, the "Psychiatric Hospital Ground Lease").

- R-3. The Grantor intends, by this Deed, to convey Grantors' fee simple reversionary interest in the Property to Grantee, and it is the intention of the parties that the leasehold interests of Grantee pursuant to the Hospital Ground Lease, the Office Building Ground Lease and the Psychiatric Hospital Ground Lease merge into the fee simple estate and the Hospital Ground Lease, the Office Building Ground Lease and the Psychiatric Hospital Ground Lease shall be hereby terminated.
- R-4. The Grantor's interest in the Nursing Center Ground Lease is being assigned by Assignment of Lease recorded subsequent hereto.

WITNESSETH, that in consideration of NINE MILLION TWO HUNDRED TWENTY-FOUR THOUSAND TWO HUNDRED TWO AND NO/100 DOLLARS (\$9,224,202.00), the Grantor does grant and convey, assign and transfer unto the Grantee, its successors and assigns, all of the Grantor's reversionary and fee simple interests in that certain real property situate, lying and being in Montgomery County, Maryland, and as more fully described in Exhibit A attached hereto and incorporated herein by this reference together with all improvements thereupon, and the rights, alleys, ways, waters, easements, privileges, appurtenances and advantages belonging or appertaining thereto;

AND, the by virtue of the Grantee now being the owner of the leasehold estate and the underlying fee simple estate, the Hospital Ground Lease, the Office Building Ground Lease and the Psychiatric Hospital Ground Lease hereby merge into the fee simple estate by operation of law:

#### 28157 454

SUBJECT TO covenants and restrictions of record;

TO HAVE AND TO HOLD the said Property unto and to the use of the Grantee, its successors and assigns, in fee simple, forever;

AND, the undersigned hereby certifies under the penalties of perjury that the actual consideration paid or to be paid for the aforegoing conveyance, including the amount of any mortgage or deed of trust assumed by the Grantee is in the amount of \$9,202,224.00.

WITNESS our hands and seals the day and year first above written.

#### **GRANTOR**:

MONTGOMERY COUNTY, MARYLAND, a political subdivision of the State of Maryland

BY: Douglas M. Dunc

County Executive

APPROVED AS TO FORM AND LEGALITY BY THE OFFICE OF THE COUNTY ATTORNEY

Associate County Attorney

Date: 8 ab aux

711905

\$9.2241.02 TRANSPER TAX PAID

#### 28157 455

STATE OF MARYLAND :

SS:

COUNTY OF MONTGOMERY

I HEREBY CERTIFY THAT on this 27th day of August , 2004, before the undersigned, a Notary Public of the State and County aforesaid, personally appeared Douglas M. Duncan, who acknowledged himself to be County Executive of Montgomery County, Maryland, a political subdivision of the State of Maryland, and that he, as such officer, being authorized so to do, executed the foregoing instrument for the purposes therein contained.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

(SEAL)

Notary Public

MY COMMISSION EXPIRES:

I HEREBY CERTIFY that this instrument was prepared by or under the supervision of the undersigned, an attorney duly admitted to practice before the Court of Appeals of Maryland

Cindi E. Cohen, Attorney

#### After Recordation, Please Return To:

Judith A. Hill, Paralegal Lerch, Early & Brewer, Chartered 3 Bethesda Metro Center, Suite 380 Bethesda, Maryland 20814 301-986-1300 [File No. 76926.001\JAH]

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#### EXHIBIT A

#### LEGAL DESCRIPTION

Parcel 1:

Parcel Identification Number: 09-001-03259837

Parcel 4A, as per Plat of Correction of Parcel 1A, Shady Grove Life Science Center, recorded among the Land Records of Montgomery County, Maryland, in Plat Book 193 at Plat 21086.

Parcel 2:

Parcel Identification Number: 09-001-03095180

Parcel 3A/3B, as per plat, **Shady Grove Life Science Center**, recorded among the Land Records of Montgomery County, Maryland, in Plat Book 175 at Plat 19643.

Parcel 3:

Parcel Identification Number: 09-001-03095134

Parcel L, as per plat, **Shady Grove Life Science Center**, recorded among the Land Records of Montgomery County, Maryland, in Plat Book 175 at Plat 19638.

Parcel 4:

Parcel Identification Number: 09-001-03095191

Parcel K, as per plat, **Shady Grove Life Science Center**, recorded among the Land Records of Montgomery County, Maryland, in Plat Book 175 at Plat 19644.

#### **Parcel Identification Numbers:**

Parcel 1 09-001-03259837 Parcel 2 09-001-03095180 Parcel 3 09-001-03095134 Parcel 4 09-001-03095191

#### TRANSFEROR AFFIDAVIT AND CERTIFICATION AS TO TOTAL PAYMENT

Doualas M. Duncan (the "Affiant"), duly authorized by Montgomery County, Maryland (the County"), makes oath, in due form of law and under the penalties of perjury, that the following is true to the best of the Affiant's knowledge, information and belief, in accordance with Section 10-912(b)(2) of the Tax-General Article of the Annotated Code of Maryland (the "withholding law") as follows:

- 1. That the County is the transferor of that real property described in the accompanying Deed (the "Property");
- That the Affiant has examined the settlement statement prepared in connection with the transfer of the 2. property, including both the gross amounts due to the Affiant and the listing of expenses and adjustments which result in a reduction in the net proceeds due to the Affiant;
- The Affiant understands that, for purposes of the tax withholding law, the calculation of a "total payment" 3. is determined as follows:
  - a. Total payment includes the fair market value of any property transferred to the Affiant as part of
  - Ь. In calculating the deductions from gross proceeds, only the Affiant's expenses arising out of the sale or exchange of the property have been deducted; and
  - Debts incurred in contemplation of sale (i.e., debts secured by the property that were incurred c. within 120 days of the sale, including loan funds received from financing or refinancing, as well as advances received on new or existing lines of credit) were not deducted from the gross proceeds in calculating the total payment.
- 4. The Affiant declares that the amount of "total payment" for the purpose of the above-cited statute is \$4,612,011.00.

The Affiant hereby affirms under penalty of law that the above statements and representations are true and correct to the best of their information, knowledge and belief.

SUBSCRIBED and SWORN to before me by Vouslas M. Duncay this 27 day of

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8/25/2004

Sammanna WERY CO.

#### Parcel Identification Numbers:

Parcel 1 09-001-03259837 Parcel 2 09-001-03095180 Parcel 3 09-001-03095134 Parcel 4 09-001-03095191

## Certification of Exemption from Withholding Upon Disposition of Maryland Real Estate Affidavit of Residence or Principal Residence

Based on the certification below, the Transferor claims exemption from the tax withholding requirements of §10-912 of Maryland's Tax General Article. Section 10-912 states that certain tax payments must be withheld when a deed or other instrument that affects a change in ownership of real property is recorded. The requirements of § 10-912 do not apply when a transferor provides a certification of Maryland residence or certification that the transferred property is the transferor's principal residence.

1. Transferor Information	
Name of Transferor	
Montgomery County, Maryland	

	2. Reason for Exemptica
Resident Status	<ul> <li>I, Transferor, am a resident of the State of Maryland.</li> <li>Transferor is a resident entity under § 10-912(A)(4) of Maryland's Tax General Article, I am an agent of Transferor, and I have authority to sign this document on Transferor's behalf.</li> </ul>
Principal Residence	□ Although I am no longer a resident of the State of Maryland, the Property is my principal residence as defined in IRC § 121.

Under penalty of perjury, I certify that I have examined this declaration and that, to the best of my knowledge, it is true, correct, and complete.

	3a. Individual Transferors
Witness	Name
	Signature
Appropriate Control of the Control o	3b, Entity Transferors
Witness Attest	Montgomery County, Maryland  Name of Entity  By: Douglas M. Dancan
	Name

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## 28157 459

State of 1	Marylaı	nd Land II			e Sheet							
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Information provided is for the use of the Clerk's Office and State Department of Assessments and Taxation, and the County Finance Office only.												
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Real Property Article	Partial Conveyance?     Yes   X   No   Description/Amt. of SqFt/Acreage Transferred:											
Section 3-104(g)(3)(i).								'				
	If Partial Co	nveyance, List Im	provements Co	onveyed:								
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#### OFFICE OF THE COUNTY ATTORNEY

Douglas M. Duncan County Executive

Charles W. Thompson, Jr. County Attorney

August 27, 2004

Molly Q. Ruhl, Clerk of the Circuit Court Circuit Court for Montgomery County, Maryland Montgomery County Judicial Center 50 Maryland Avenue Rockville, MD 20850

Dear Madame Clerk:

Please record the attached document on behalf of Montgomery County, Maryland, and waive the recording fee.

Thank you for your attention to this matter.

Very truly yours,

Eileen T. Basaman

Associate County Attorney

ETB:s

I:\AF\basame\waiver of fees=l=ruhl

## EXHIBIT 3:

**Project Drawings** 

18310 MONTGOMERY VILLAGE AVENUE • SUITE 300 GAITHERSBURG, MD 20879 301.590.2900 • WWW.WILMOTSANZ.COM

Architect/Engineer Seal:

#### MEP ENGINEER

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### STRUCTURAL ENGINEER **WALTER P. MOORE**

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## **CIVIL ENGINEER**

## **SOLTESZ**

2 RESEARCH PLACE, SUITE 100 ROCKVILLE, MARYLAND 20850 301.948.2750

# ADVENTIST HEALTHCARE

# SHADY GROVE MEDICAL CENTER **TOWER EXPANSION**

9901 Medical Center Drive Rockville, MD 20850

## CERTIFICATE OF NEEDED (C.O.N.) DRAWING SUBMITTAL

SEPTEMBER 29, 2020 PROJECT #8903.79

ARCHITECTS / PLANNERS **WILMOT SANZ** Gaithersburg, MD

MEP ENGINEERS TLC ENGINEERING SOLUTIONS

Philadelphia, PA

STRUCTURAL ENGINEERS WALTER P. MOORE Washington, DC

CIVIL ENGINEERS SOLTESZ Rockville, MD

## **DRAWING LIST**

CIVIL

EXISTING CONDTIONS PLAN (SITE) SCHEMATIC DESIGN PLAN (SITE)

## ARCHITECTURAL

AG-1 COVER SHEET

A1-1 FIRST FLOOR PLAN

A1-2 SECOND FLOOR PLAN

A1-3 THIRD FLOOR PLAN

A1-4 FOURTH FLOOR PLAN

A1-5 FIFTH FLOOR PLAN

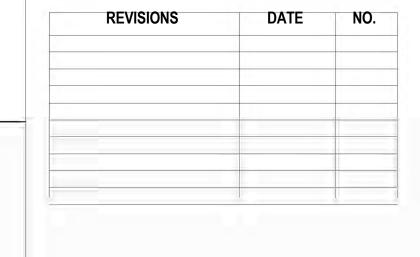
A1-6 PENTHOUSE PLAN

A1-7 ROOF PLAN

A2-1 ELEVATIONS

A2-2 ELEVATIONS

A2-3 STACKING DIAGRAMS





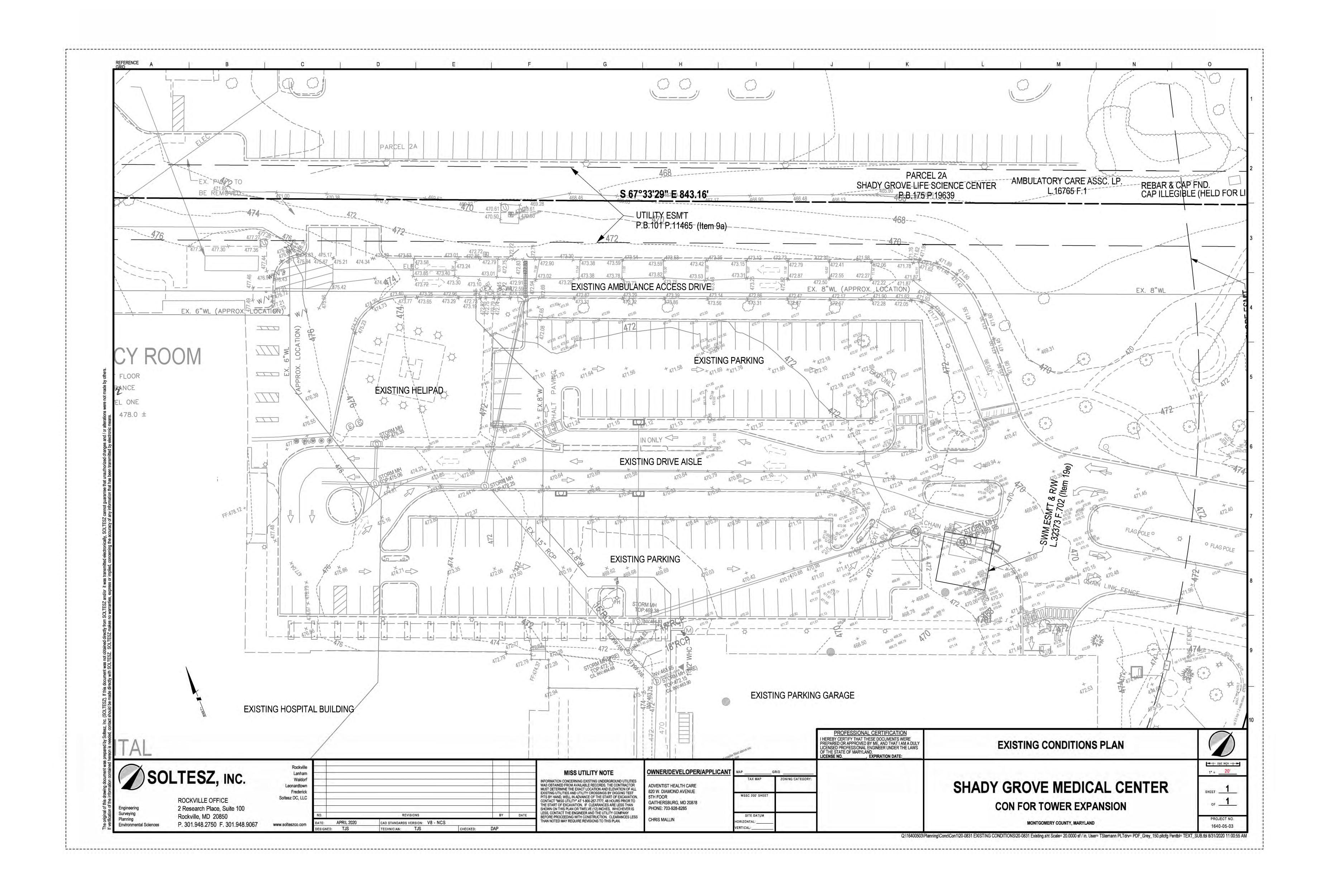
SHADY GROVE MEDICAL CENTER CON 9901 MEDICAL CENTER DRIVE ROCKVILLE, MD 20850

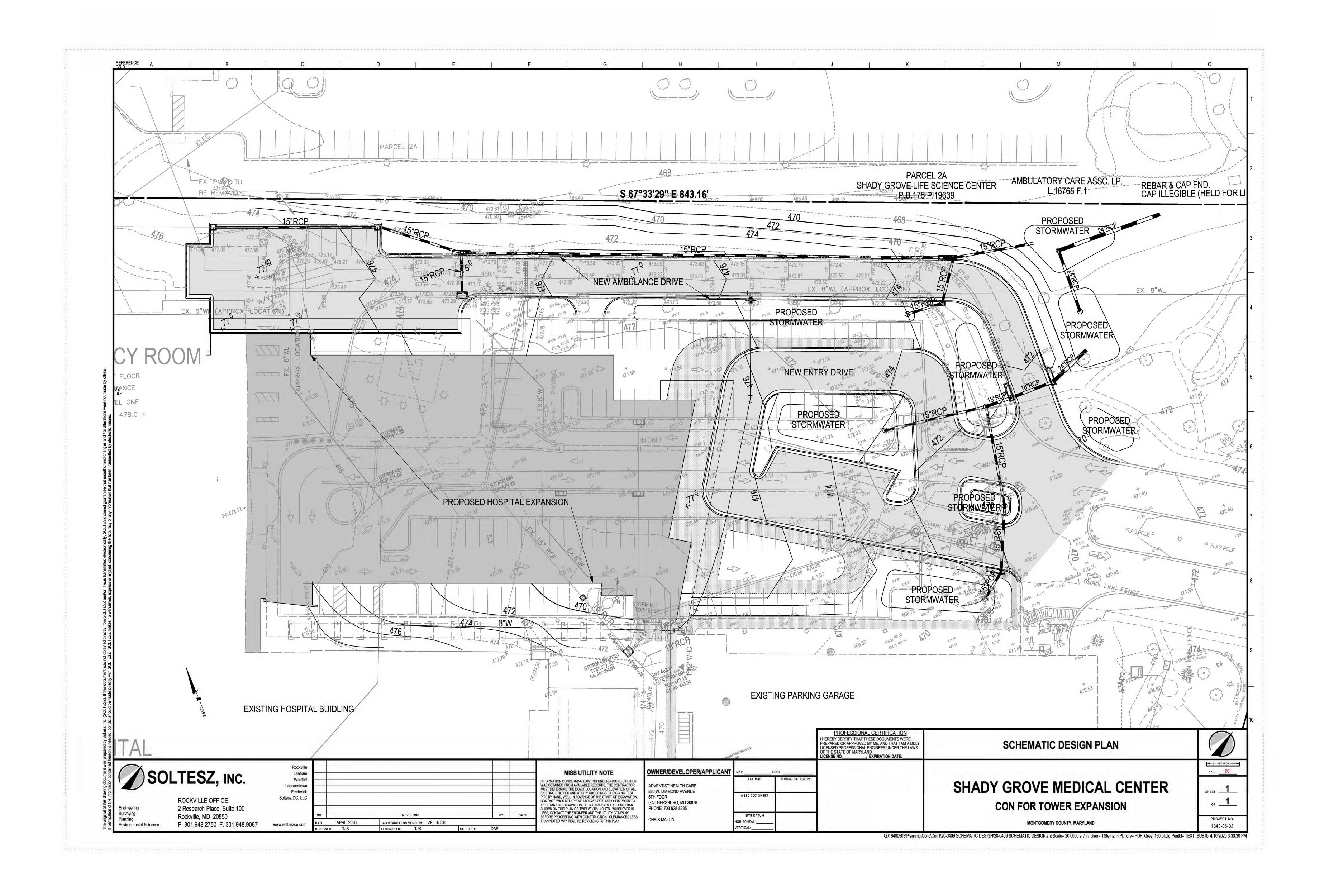
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## **FIRST FLOOR PLAN**

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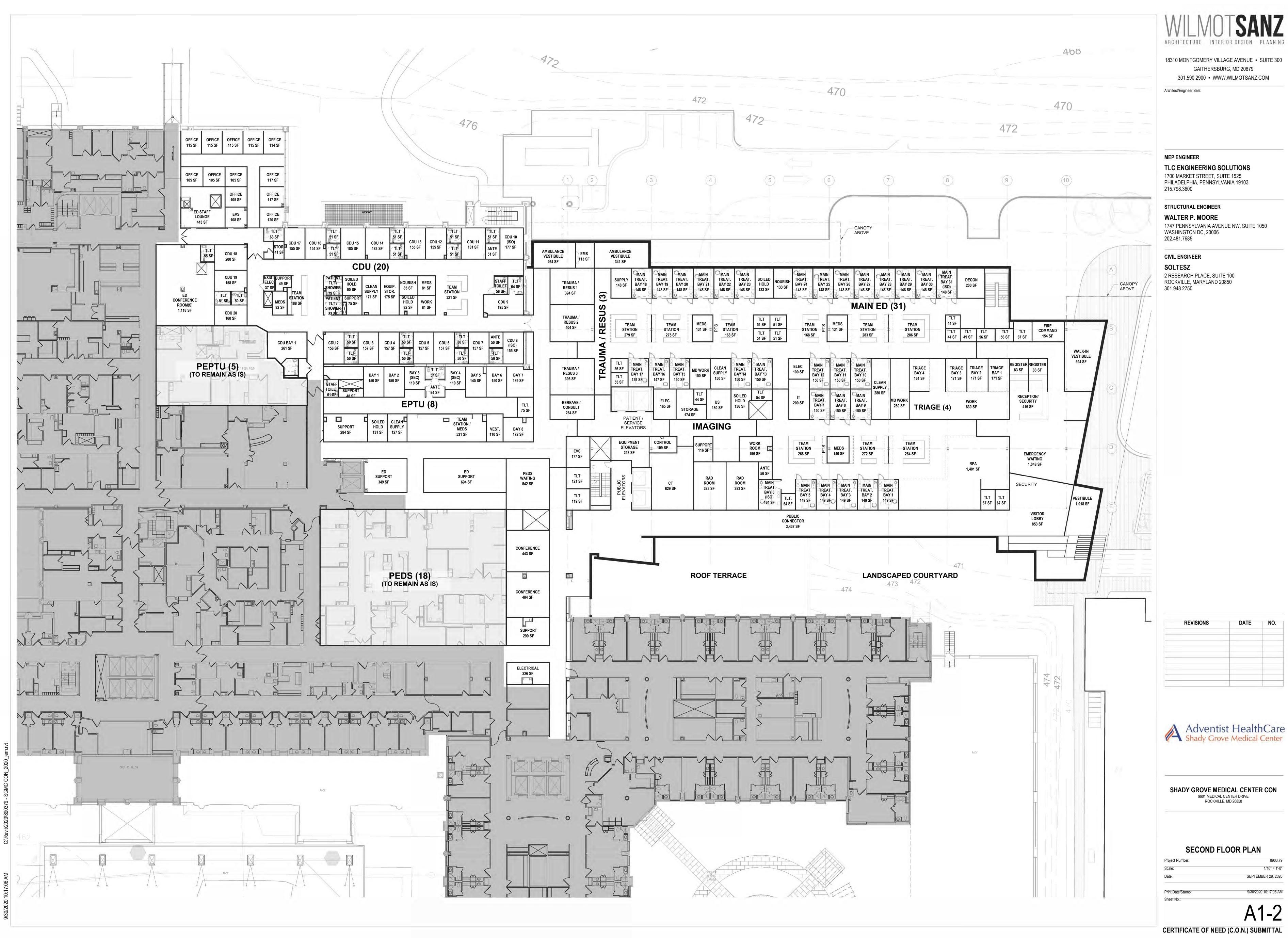
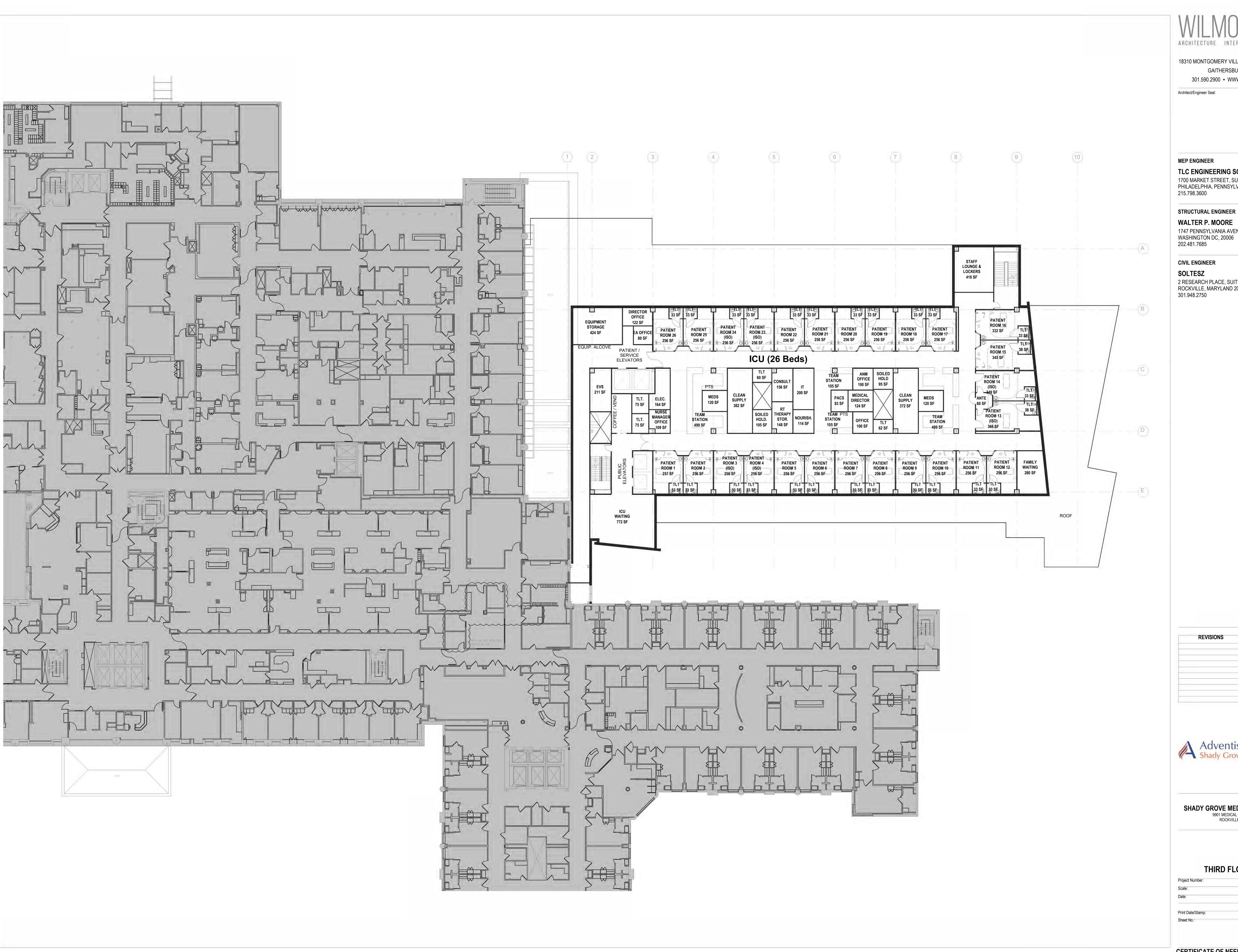


Exhibit 3, Page 5 of 13



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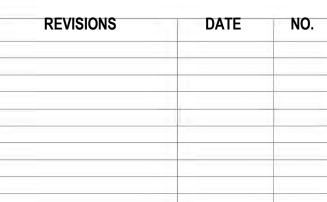
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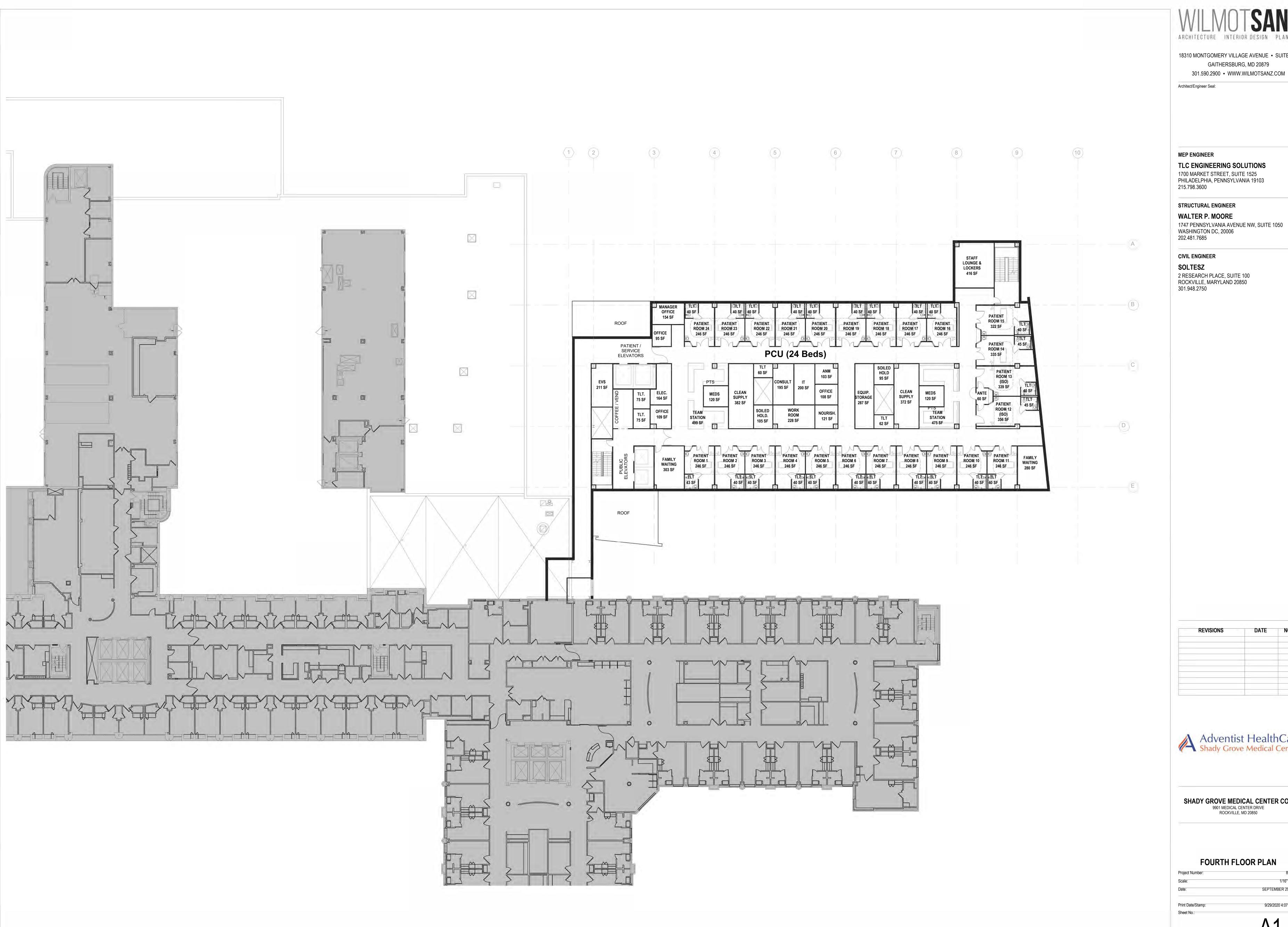




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**WALTER P. MOORE** 

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## **CIVIL ENGINEER**

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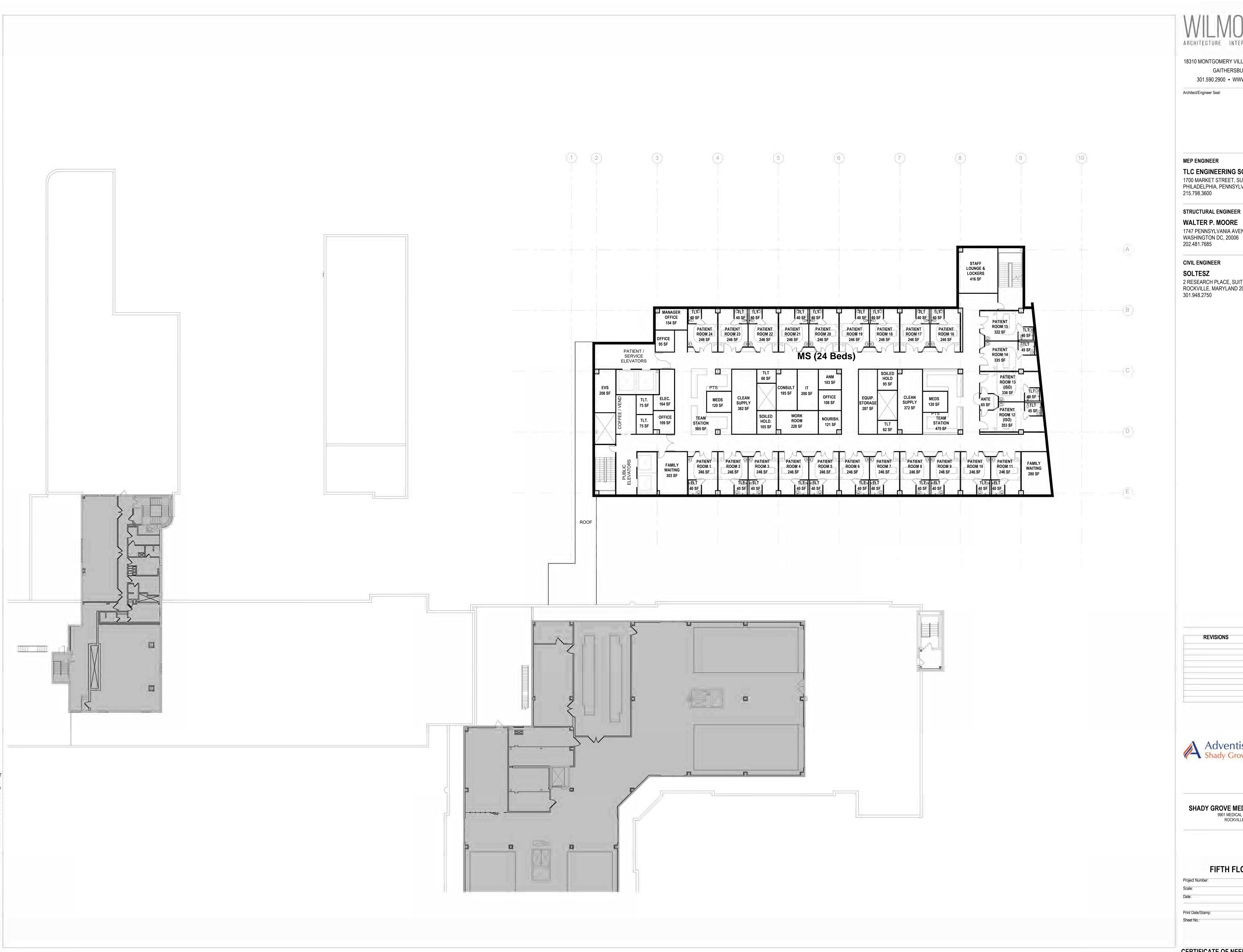
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# STRUCTURAL ENGINEER

**WALTER P. MOORE** 1747 PENNSYLVANIA AVENUE NW, SUITE 1050

## **CIVIL ENGINEER**

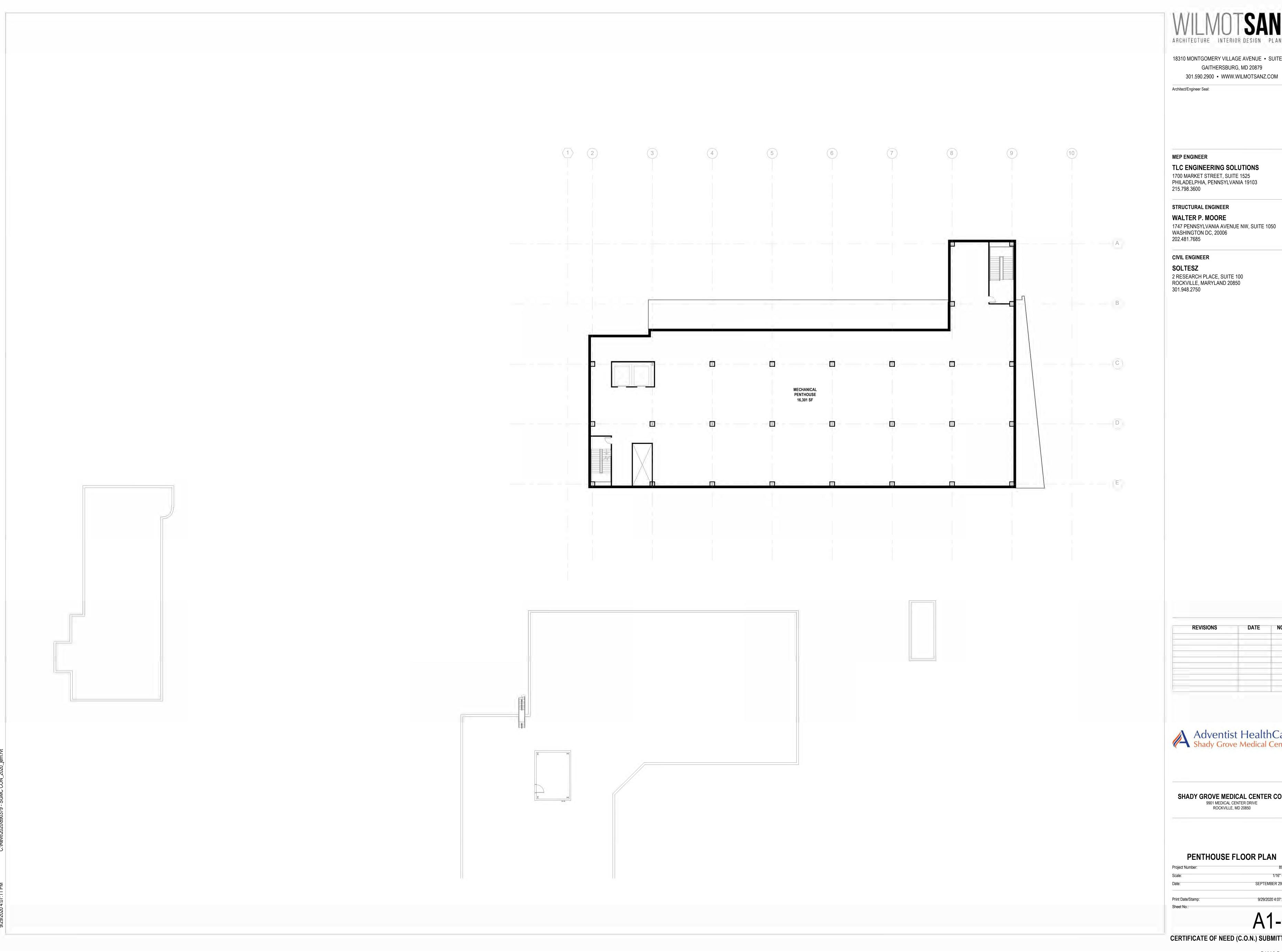
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## **WALTER P. MOORE**

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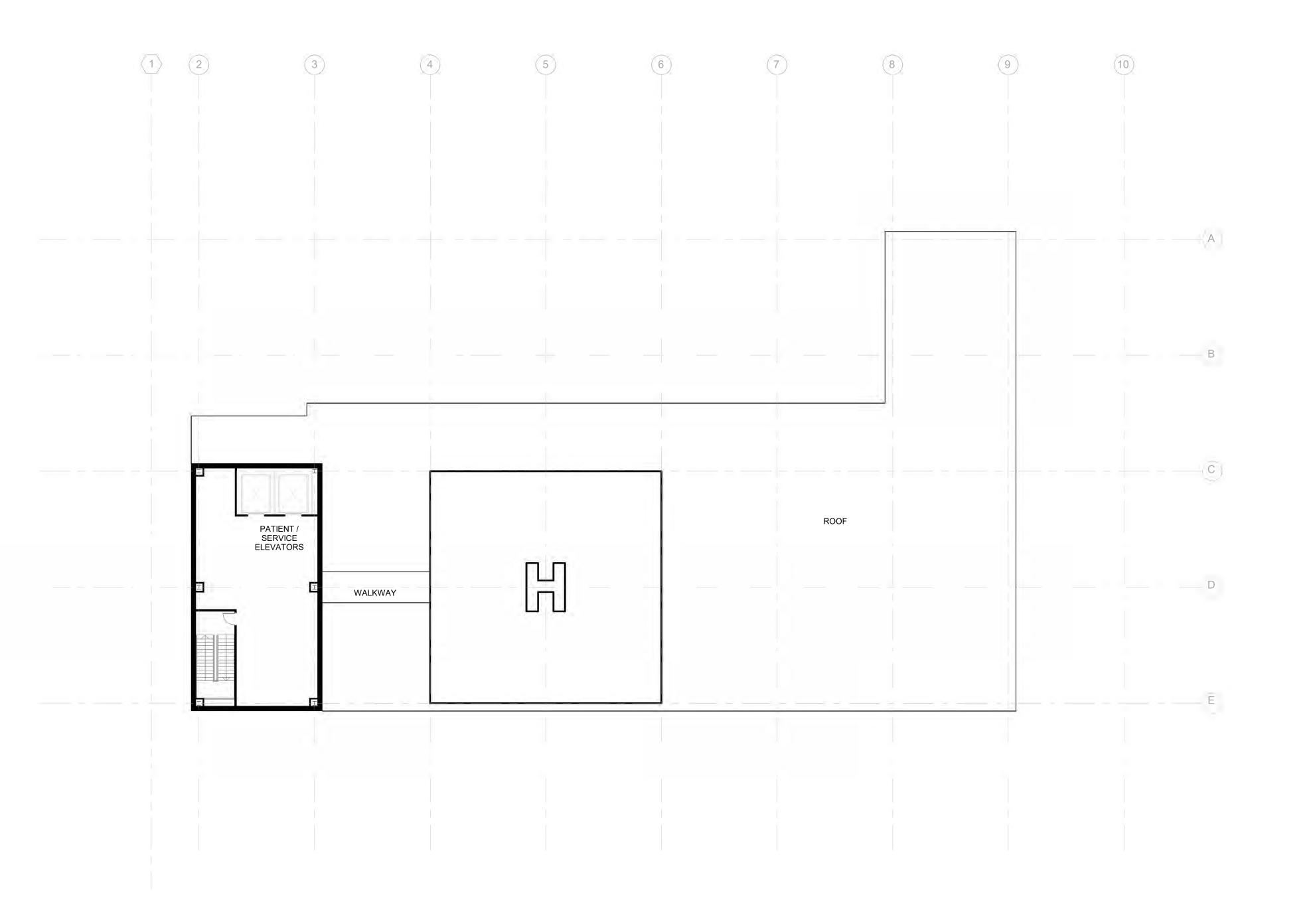


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## PENTHOUSE FLOOR PLAN

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Exhibit 3, Page 9 of 13





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215.798.3600

# STRUCTURAL ENGINEER WALTER P. MOORE

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# CIVIL ENGINEER SOLTESZ

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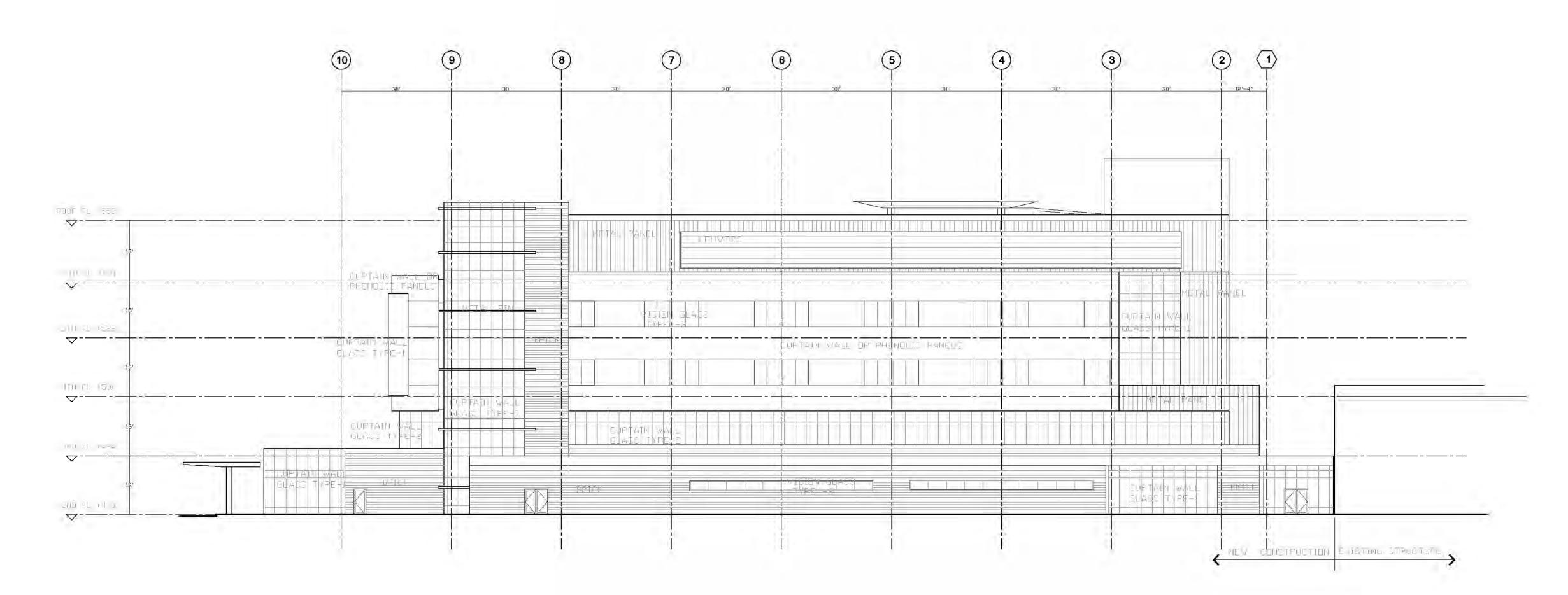
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## **ROOF PLAN**

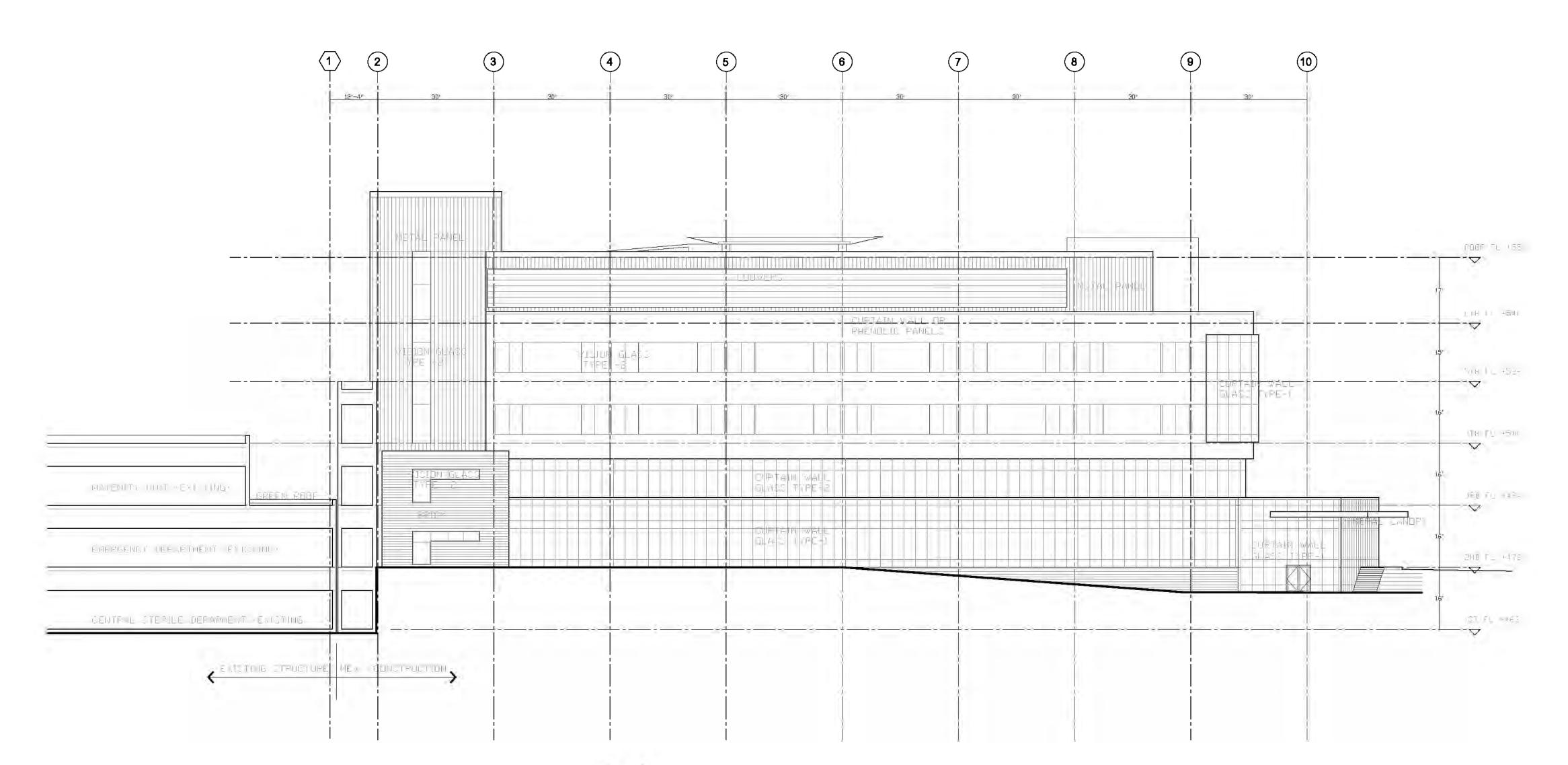
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Exhibit 3, Page 10 of 13



# NORTH ELEVATION



SOUTH ELEVATION

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License Number:

Expiration Date:

MEP ENGINEER

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WALTER P. MOORE

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WASHINGTON DC, 20006
202.481.7685

REVISIONS DATE NO.

Adventist HealthCare

SHADY GROVE MEDICAL CENTER CON 9901 MEDICAL CENTER DRIVE ROCKVILLE, MD 20850

ELEVATION

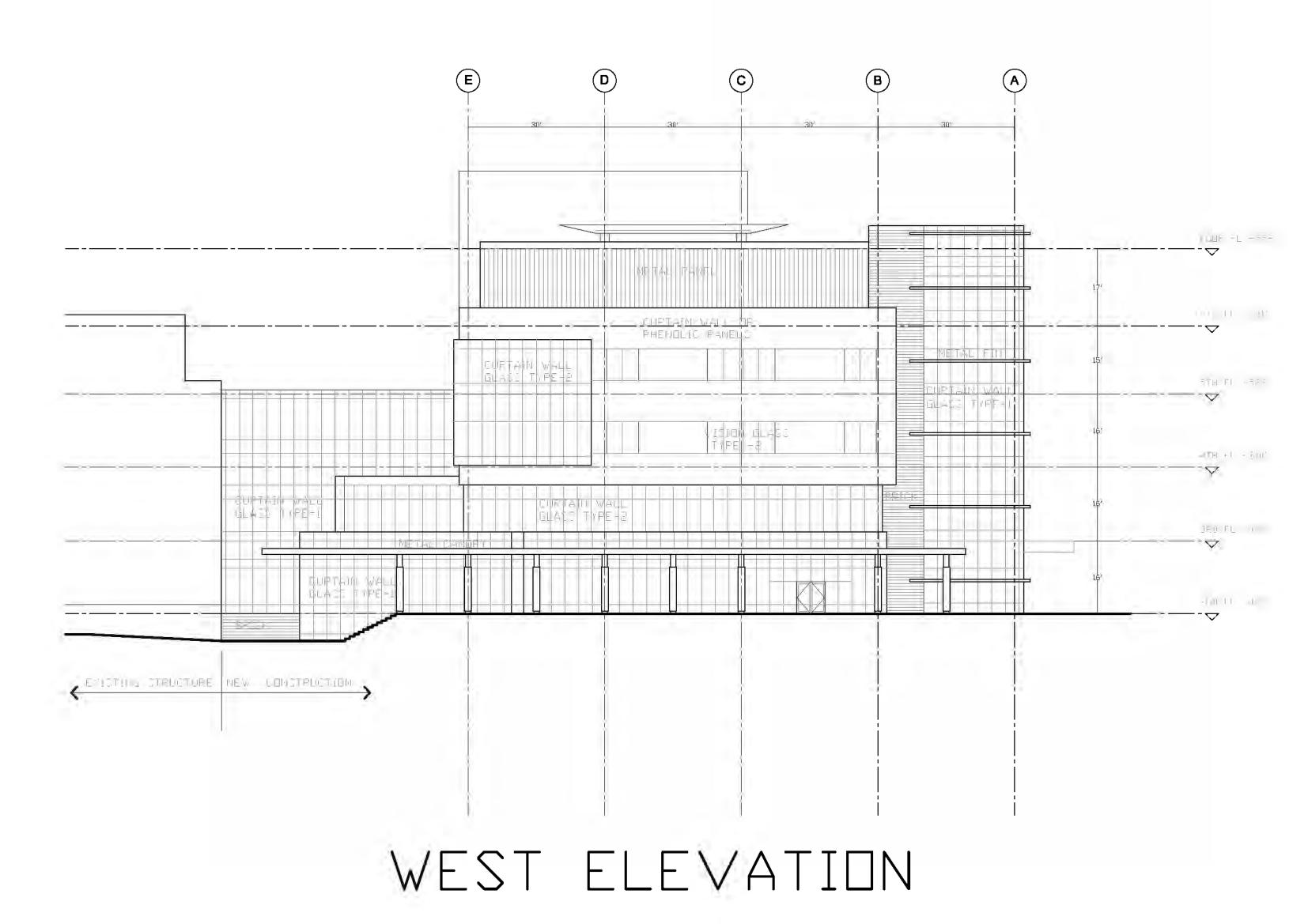
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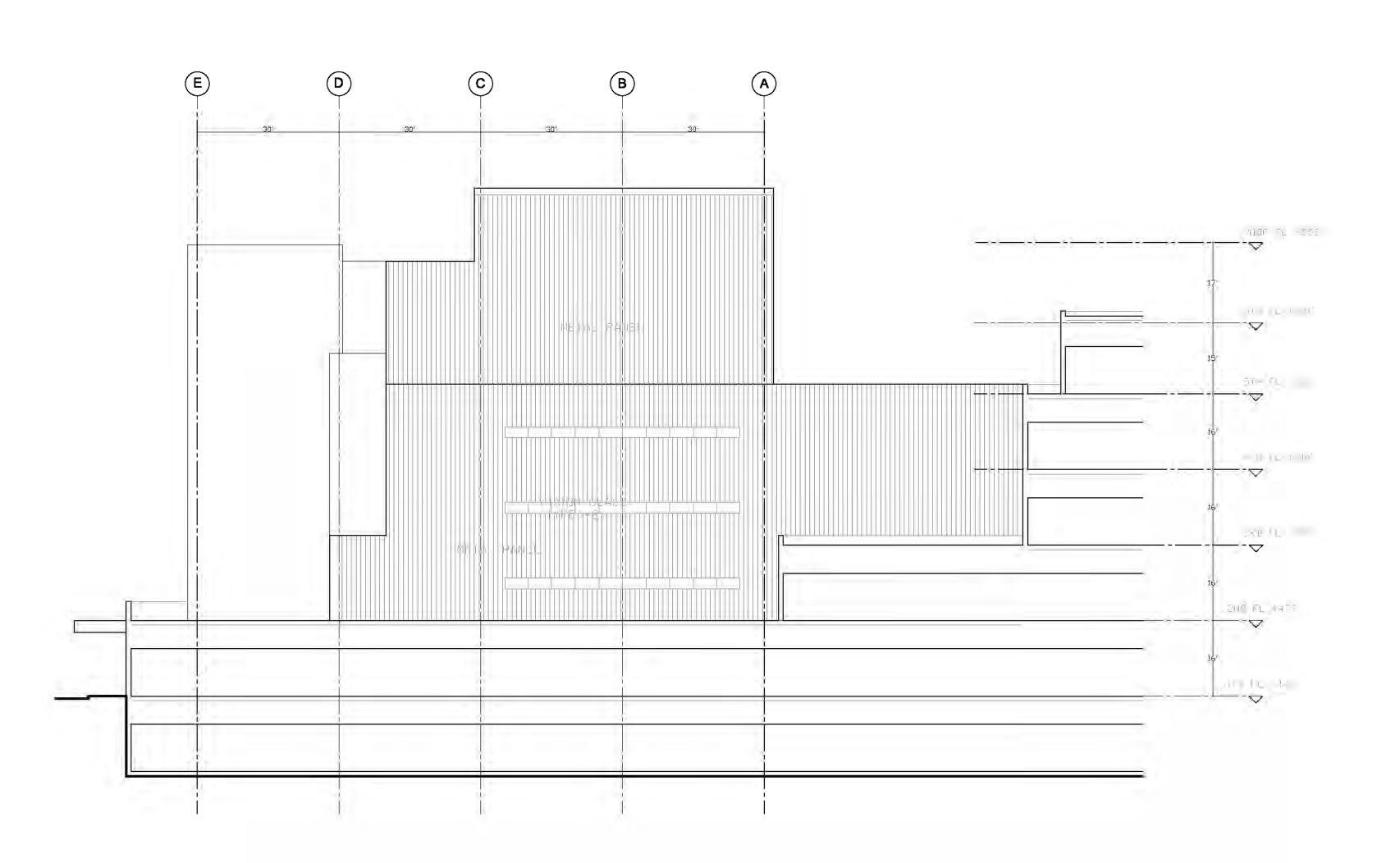
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EAST ELEVATION

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STRUCTURAL ENGINEER
WALTER P. MOORE

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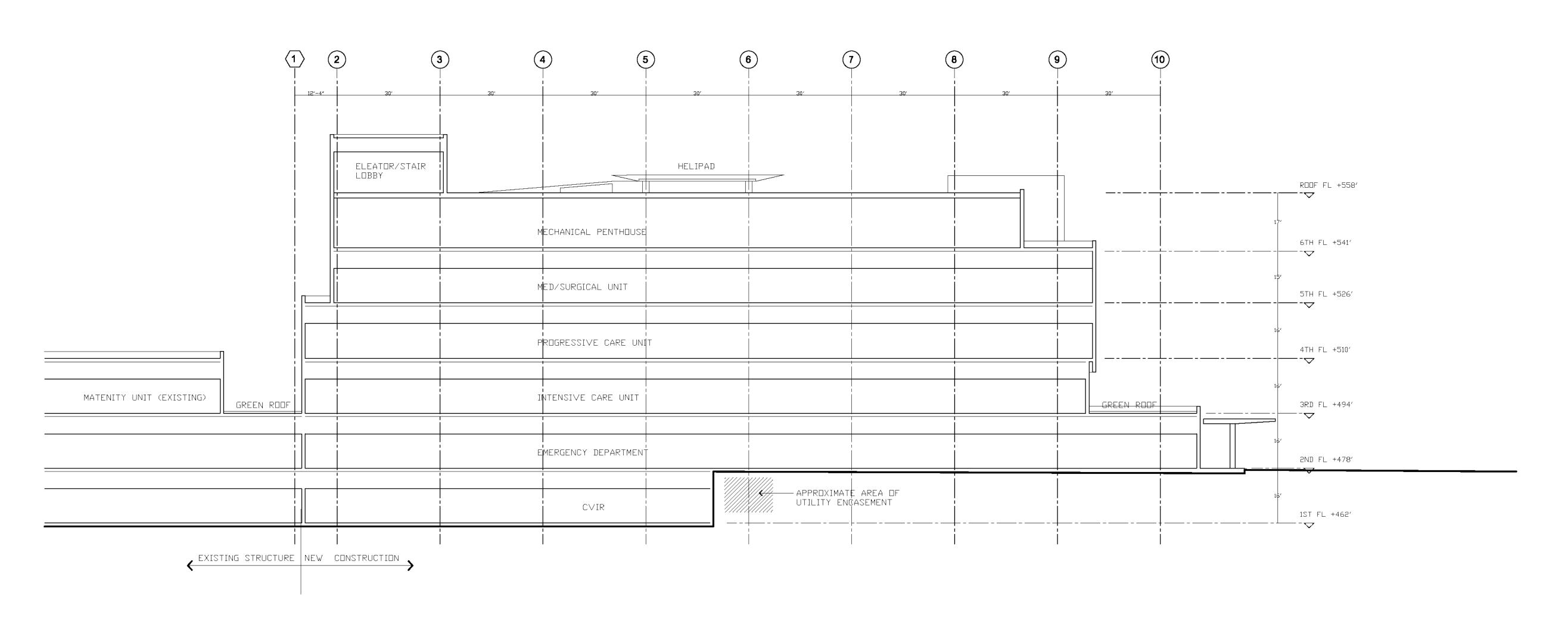
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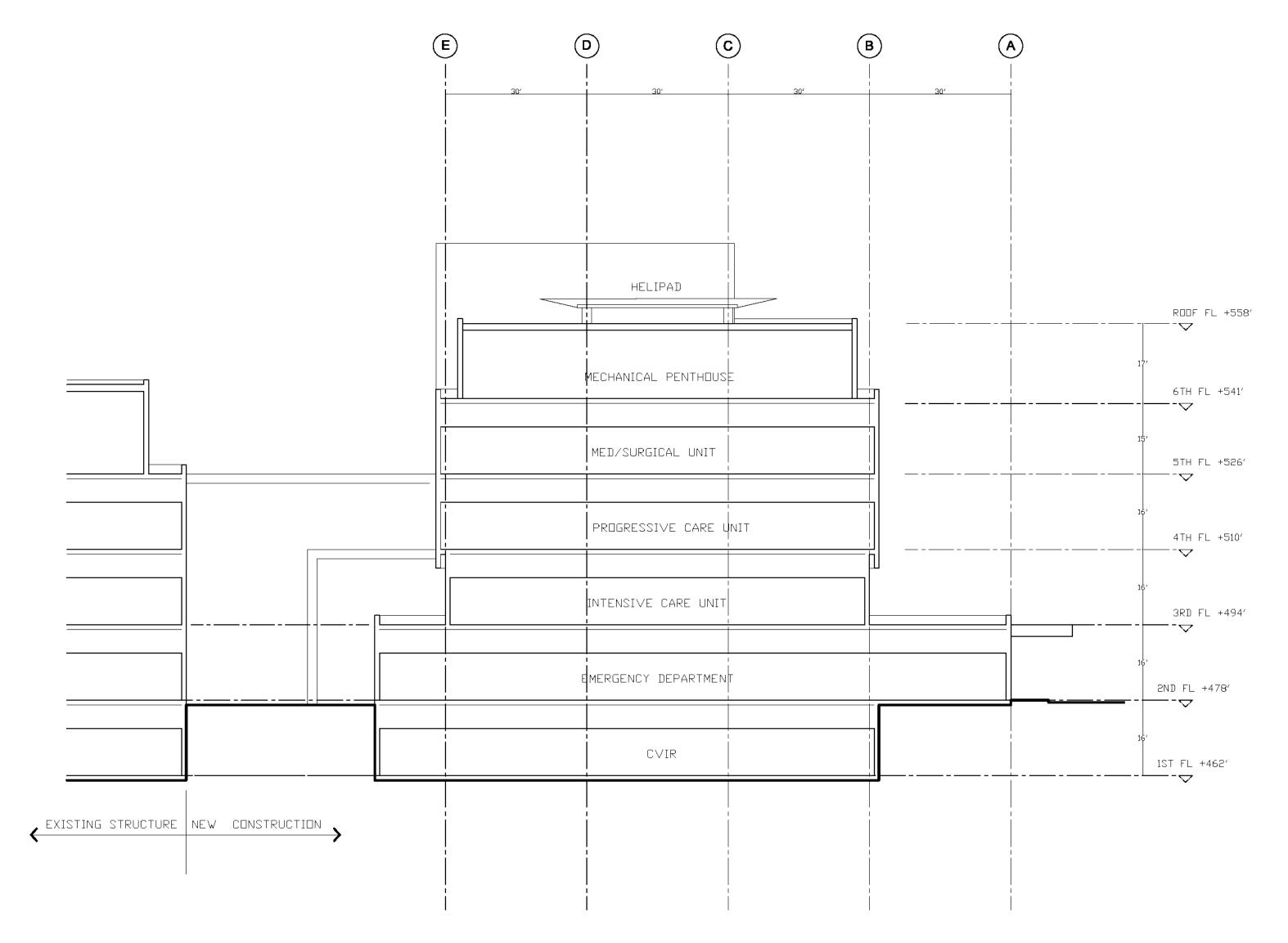
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# EAST-WEST SECTION



NORTH-SOUTH SECTION



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STRUCTURAL ENGINEER

WALTER P. MOORE

1747 PENNSYLVANIA AVENUE NW, SUITE 1050
WASHINGTON DC, 20006

REVISIONS DATE NO.

Adventist HealthCare
Shady Grove Medical Center

SHADY GROVE MEDICAL CENTER CON 9901 MEDICAL CENTER DRIVE ROCKVILLE, MD 20850

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## **EXHIBIT 4:**

Adventist HealthCare Shady Grove Medical Center Admission Mitigation



#### **Adventist HealthCare Shady Grove Medical Center Admission Mitigation**

Central to the Population Health Division strategy is to design and implement an effective Care
Navigation department. The core purpose of this department is to *Navigate patients through an integrated and aligned network of post-acute services designed to carry out a patient-centered plan of care spanning the care continuum, helping to minimize the cost of care and maximize the patient experience and quality of life.* 

To achieve this core purpose, the Shady Grove Medical Center team has implemented several strategies that support the care navigation of our patients as well as mitigate the need for acute care hospitalization and rehospitalization.

- Outpatient Care Navigation: Team of Registered Nurses and Community Health Workers who support aligned SGMC provider practices to assess risk of health breakdown, coordinate preventative care, connect to community resources and prevent the need for acute care hospitalization. Through the Wellcentive population health management tool, this team uses data to identify the patients at risk for admission and engages them to mitigate this risk. The mitigation strategies may include preventive care, diagnostic testing, specialty care, pharmaceutical management, remote biometric monitoring, home care, and/or telephonic support. Social determinants of health such as access to transportation, ability to obtain medication, to obtain medical care, access to health food, access to safe housing, with interpretive services when needed are assessed and identified gaps are closed. When prevention of hospitalization is not possible, the Outpatient Care Navigators partner with patients to connect to their Primary Care Provider after discharge and to complete their post hospitalization care.
- ED U-turn Program: Team of Registered Nurses, Social Workers and Community Health Workers
  work in the Emergency Department as much as 20 hours a day, seven days a week. These team
  members assist with discharge planning and to identify community resources that can eliminate
  the need for a hospitalization. Expert in community resources, the ED U-turn team identifies
  safe housing through family, group homes, residential care programs where patients may
  receive the necessary care. If needed, patients are discharged from the ED with medication and
  transportation to their residence.
- Congestive Heart Failure Clinic: Run by a Nurse Practitioner, the CHF Clinic has greatly reduced
  the readmission rate of Congestive Heart Failure (CHF) patients. This provider manages the postacute care of CHF patients to include disease education, home treatment, symptom
  identification and routine care.
- Nexus Montgomery Regional Partnership: The Nexus Montgomery Regional Partnership represents an historic commitment of all six hospitals in Montgomery County to collaborate on



efforts that promise greater return on investment and benefit for population health through joint effort than from efforts of hospitals individually. The six hospitals will share infrastructure funds and staff resources, share data (both transactional and evaluative), and collectively coordinate with providers, community-based organizations, and public health entities to develop common interventions and projects.

- o Programs included in the Nexus Montgomery Regional Partnership Include:
  - Wellness and Independence for Seniors at Home (WISH)
    - Target Population: 65+ adults with Medicare
    - Goal: Stabilize health of older adults to reduce hospital admissions
  - Hospital Care Transition
    - Target Population: High utilizers with high to moderate risk of readmission
    - Goal: Improve transitions from hospital-to-home
  - Uninsured / Project Access
    - Target Population: Uninsured and without coverage eligibility that had prior hospital interaction within 30 days with referral for specialty care
    - Goal: Connect uninsured to specialty care
  - Severely Mentally III / Behavioral Health
    - Target Population: Behavioral health diagnosis and in crisis, or Severe Mental Illness diagnosis, high utilizers with high risk of Potentially Avoidable Utilization
    - Goal: Improve community-based resources for severely mentally ill
  - Community Advanced Directives
    - Target Population: Grass roots initiative throughout Montgomery County
    - Goal: Increase the number of Nexus service area residents who have a
      designated health care agent and have expressed their wishes for end of
      life care to that agent so that Individual's wishes followed at end of life
  - Skilled Nursing Facility (SNF) Alliance
    - Target Population: SNFs in Nexus Montgomery Service Area
    - Goal: reduce readmissions and TOCO by improving quality of care and care transitions with SNFs post discharge
  - Medical Respite Care for the Homeless
    - Goal: reduce readmissions among high risk homeless individuals by providing staffed medical respite beds
- Integrated Clinical Pathways: In focus on decreasing Potentially Avoidable Utilization (PAU),
   Adventist HealthCare Shady Grove Medical Center partnered with other area hospitals to create
   an Integrated Clinical Pathway for the outpatient management of patients with COPD. A
   multidisciplinary approach to Pathway creation was employed so that all factors of care are
   included such as preventive care, disease management, and assessing and addressing social



determinants of care. Patients with COPD are identified by Primary Care Physicians and referred to RN Care Navigators who partner with these individuals to improve disease knowledge, increase likelihood of completing preventive screenings and minimize risk of an exacerbation resulting in a hospitalization. Patients who are admitted for COPD exacerbations are also screened for Pathway inclusion and encouraged to welcome this support.

 Diabetes and Congestive Heart Failure Pathways are currently in development and will be implemented once done.

#### **Admission Mitigation Results:**

**Readmission Reduction Incentive Program**: As a result of the initiatives demonstrated above, Adventist HealthCare Shady Grove Medical Center has decreased the case mix adjusted readmission rate year over year.

Case Mix Adjusted Readmission Rate							
Base Period Performance Period Improvement							
Rate Year 2020 - Final	10.00%	9.66%	0.34%				
Rate Year 2021 - Final	10.42%	9.37%	1.05%				
Rate Year 2022 - YTD April 2020	9.73%	9.04%	0.69%				

#### **Potentially Avoidable Utilization:**

% Potentially Avoidable Utilization (PQI + Readmission Rate)				
2015	16.77%			
2016	15.43%			
2017	16.36%			
2018	15.62%			
2019	14.20%			
2020 YTD May	13.60%			

Attachments:

**COPD Integrated Clinical Pathway** 





#### COPD EBP GUIDELINES FOR AHC II INTEGRATED CLINICAL DELIVERY NETWORK

The purpose of this guideline is to provide interdisciplinary care teams standardized, evidence-based practice pathways, which enable the delivery of high-value, high-quality, patient-focused care to AHC II Integrated Clinical Delivery Network members across the care continuum.

The COPD Collaborative Care Pathway focuses on the following key areas:

- 1) Screening/Prevention & Risk Reduction
- 2) Diagnosis & Treatment
- 3) Patient Self-Management
- 4) Care Coordination
- 5) Health-related Outcomes, Cost & Quality

The Pathways are not intended to replace a clinician's judgment, or to establish a protocol for all patients with a particular condition.

#### COPD Collaborative Care Pathway

COPD is an umbrella term used to describe progressive lung diseases including emphysema, chronic bronchitis, refractory (non-reversible) asthma, and some forms of bronchiectasis<sup>1</sup>.

#### Screening and Prevention

Screening for COPD in the asymptomatic general population is not recommended.

At-Risk Adults - Conduct a risk assessment via a formal prescreening questionnaire to evaluate for exposure to:

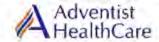
- c An estimated 80% to 90% of COPD is due to cigarette smoking. Tobacco use or exposure to cigarette smoke, dust, industrial chemicals, and/or environmental pollutants.
- Non-modifiable risk factors for COPD: history of asthma or childhood respiratory tract infections; α<sub>1</sub>-antitrypsin deficiency is the best-described genetic risk factor to consider, especially when patients develop COPD before age 50.<sup>2,1</sup>.

#### Clinical Considerations:

- Patients who smoke, or are exposed to pollutants and have cough, sputum or dyspnea or have family history of
  respiratory disease, are at risk for COPD. Patients with positive risk assessment consider follow-up with diagnostic
  spirometry testing or screening spirometry administered without a bronchodilator and, if positive, follow-up with
  diagnostic spirometry testing.
- Patients Identified high risk by a prescreening questionnaire or screening spirometry are referred for diagnostic spirometry testing.

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#### COPD EBB GUIDELINES FOR AHO II INTERNATED CUNICAL DELIVERY NETWOR

#### Diagnosis

The Global Initiative for Chronic Obstructive Lung Disease (GOLD) classifications are used to determine the severity of the disease. These classifications can help guide appropriate treatments to relieve symptoms and reduce risk.

Confirm the diagnosis by spirometry with a FEV<sub>1</sub>-FVC ratio < 0.70 measured after administration of a bronchodilator. Consider measuring the  $\alpha$ 1-antrypsin level in patients who present with early-onset COPD or in those with a compatible family history<sup>3</sup>.

	SEVERIT	OF COPD BASED ON SPIROMETRY <sup>3</sup>	1
Stage	Severity	Post bronchodilator FEV1/FVC	FEV1 % predicted
XI	At-Risk	2 0.7	≥ 80
-1	Mild	€ 0.7	≥80
2	Moderate	∉ 0.7	50 - 79.9
3	Severe	< 0.7	30 - 49.9
4	Very Severe	< 0.7	< 30

FEV1: forced expiratory volume in one second; FVC: forced vital capacity

		SEVERITY OF COPD BASED ON DYSPNEAS
Severity	Score	Degree of Breathlessness Related to Activities
None	0	Not troubled with breathlessness except with strenuous exercise
Mild	1	Troubled by shortness of breath when hurrying or walking up a slight hill
Moderate	1	Walks slower than people of the same age due to breathlessness or has to stop for breath when walking at own pace on the level
Severe	3	Stops for breath after walking approximately 100 meters or after a few minutes on the level
Very Severe	4	Too breathless to leave the house or breathless when dressing or undressing

Breathlessness and functional limitation can be rated numerically with the simple Modified Medical Research Council (mMRC) dyspnea scale<sup>5</sup>.

#### Treatment Strategy/Collaborative Management Plan

- Follow the flow diagrams detailed on pages 4-6 which provide the following guidelines segmented by severity based on dyspnea and/or spirometry results:
  - Module A: Diagnosis, considerations and referrals, page 4. ABCD assessment tool, page 5.
  - GOLD pharmacologic treatment pathways, page 5.
  - Module B: Treatment of stable COPD, page 6.
  - Module C: Treatment of COPD acute exacerbation, page 6.
- 2. Encourage patients to participate in their own care by encouraging;
  - Exercise
  - Those who smoke, to stop and to enter a smoking cessation program.
- 3. Encourage influenza vaccine every year and pneumococcal vaccine.

2 J P a g a 7/8/2020





#### COPD EBP GUIDELINES FOR AHC II INTEGRATED CLINICAL DELIVERY NETWORK

#### 4. Considerations:

- For at -risk adults, consider lung cancer screening followed by low-dose CT of chest if indicated
- Differential diagnoses and co-morbid conditions
- Sleep apnea evaluation
- Refer to pulmonary rehabilitation for help with reducing dyspnea, anxiety, and depression; improves
  exercise capacity and quality of life; and may reduce hospitalizations.
- COPD patients should be considered ideal candidates for Transitional Care Management (TCM)
  and Chronic Care Management (CCM) outreach. Providers can receive additional reimbursements
  for both TCM and CCM services. TCM requires an interactive patient contact within two business days
  post-discharge and an office visit within 7 to 14 days post-discharge. The TCM timeline is designed to
  better accommodate the patient's transition needs and prevent 30-day readmission.
- ALL patients with a diagnosis of COPD should be referred to Care Coordination for appropriate follow up and connection to wrap-around services
- 5. When to consider referral to a pulmonary specialist:

#### Referral Considerations'

#### Table 3. When to Consider Referral to a Pairnonary Specialist\*

Ultrasta possit perfore 40 years of as-

Frequent exacercatives (7 or more per year) despite acceptate trestment

Republy progressive course of classics (decline to TEV), progressive dyappen, decreased exercise to course, annitentional weight loss)

Severe COPD (FEV. <50% predicted) respite optimal treasment

Need for oxygen therapy

Orace of comprisis condition (extenporous, heart failure, oranchickless, Aung concer)

Diagnostic uncertainty (for mample, concisting CDPO and actions)

Symptoms disproportionate to the seventy of the arrhow obstruction

Continued or suspected we amorrypsin deficiency

Patient requests a second aphilon

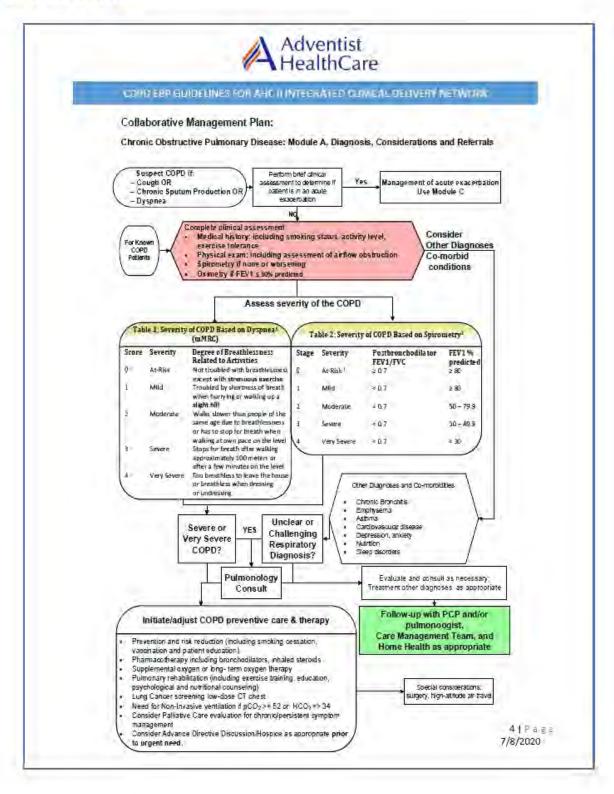
Patient is a potential condicate for lung transplantation or line-volume reduction surpery Patient.

has very severe displace and requires elective surgery that may know respiratory function

"depred and monifold from American Thologic Society European Reshinatory Society and Veteratin' Affair (Department of Defence yurderines (2, 3), CVD = clarities abstractive pulmorary crease.

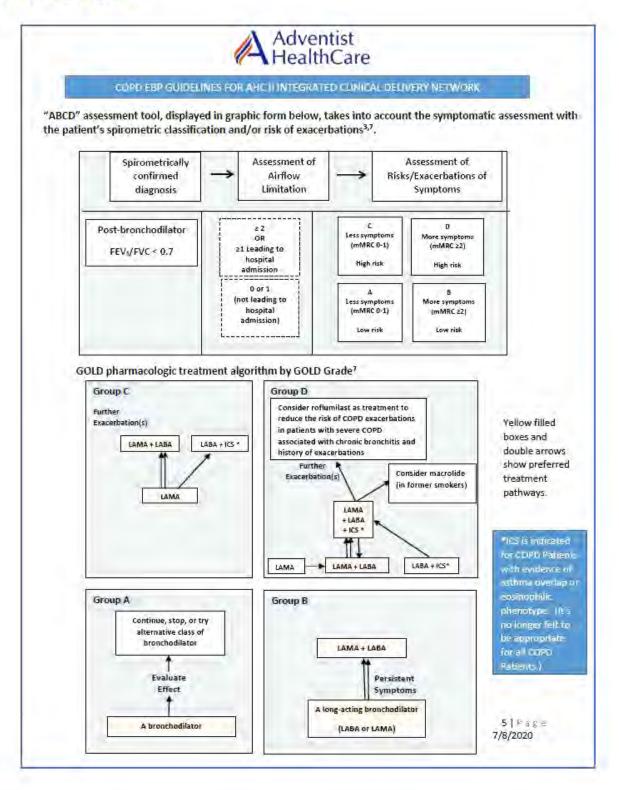
> 3 | Page 7/8/2020





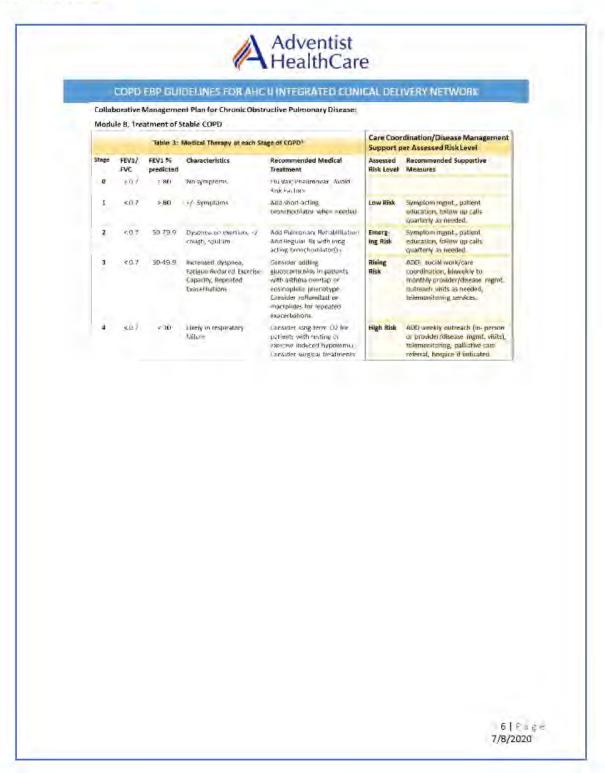
Page 7 of 12 7/26/2020



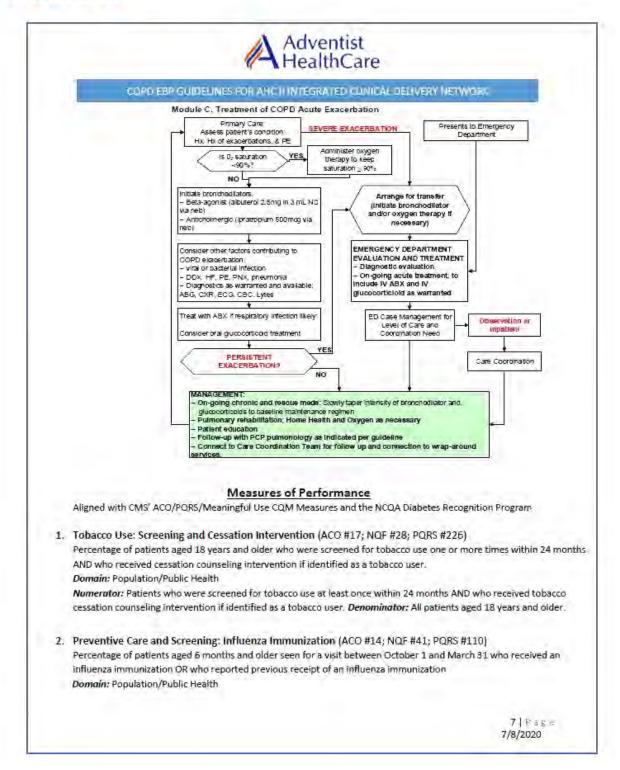


Page 8 of 12 7/26/2020













#### CORD EBP GUIDELINES FOR AHC II INTEGRATED CLINICAL DELIVERY NETWORK

**Numerator:** Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization.

Denominator: All patients aged 6 months and older seen for a visit between October 1 and March 31.

3. Pneumonia Vaccination Status for Older Adults (ACO #15; NQF #43; PQRS #111)

Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.

Domain: Clinical Process/Effectiveness

Numerator: Patients who have ever received a pneumococcal vaccination.

Denominator: Patients 65 years of age and older with a visit during the measurement period

#### 4. HEDIS Measures:

- · Use of Spirometry for COPD
  - Assesses adults 40 years of age and older who have a new diagnosis of chronic obstructive pulmonary disease (COPD) or newly active COPD, who received spirometry testing to confirm the diagnosis.
- Pharmacotherapy Management of COPD Exacerbation
   Assesses Chronic Obstructive Pulmonary Disease (COPD) exacerbations for adults 40 years and older who had appropriate medication therapy to manage an exacerbation. A COPD exacerbation is defined as an inpatient or ED visit with a primary discharge diagnosis of COPD.
- 5. COPD Mortality Rate (definition, numerotor and denominator to follow for 4-7)
- 6. Inpatient Utilization Rate
- 7. Emergency Department Utilization
- 8. Quality of Life Score

#### Other Measures to consider:

- 1 Spirometry Evaluation (NQF #0091, PQRS #51)
  - Person has documentation of Spirometry testing during the current measurement period
- Bronchodilator Therapy (NQF #0102, PQRS #52)

Person who was prescribed one or more of the following 1) inhaled Bronchodilator during the current measurement period OR 2) Inhaled Bronchodilator prescribed during the current measurement period

3. Corticosteroid Therapy (NQF # 2865)

Person was prescribed a Systemic Corticosteroid or Systemic Corticosteroid Prescribed CPTF overlapping the 14 days from date of discharge, from one of the following:

- •Inpatient Visit with a primary condition of COPD during the current measurement period
- •OR an Emergency Department visit with a primary condition of COPD during the current measurement period
- 4. Corticosteroid Therapy on Admission

8 | Page 7/8/2020





#### COPP EBP GUIDELINES FOR AHC II INTEGRATED CUNICAL DELIVERY NETWORK

Person was prescribed a

Systemic Corticosteroid or Systemic Corticosteroid Prescribed CPTF overlapping the 5 days from date of admission, from one of the following:

- •Inpatient visit with a primary condition of COPD during the current measurement period.
- •OR an Emergency Department visit with a primary condition of COPD during the current measurement period

#### References/Key Tools

- <sup>4</sup> COPD Foundation http://www.copdfoundation.org/
- <sup>2</sup> Littner MR, In the clinic, Chronic obstructive pulmonary disease. Ann Intern med. 2011;154:ITC4-1. Doi: 10.7326/0003-4819-154-7-2001104050-01004
- <sup>3</sup> Global Initiative for Chronic Obstructive Lung Disease (GOLD) Updated 2017 http://www.goldcopd.org/uploads/users/files/GOLD\_Report\_2014\_Jan23.pdf
- <sup>4</sup> American Lung Association COPD http://www.lung.org/lungdisease/copd/?referrer=https://www.google.com/
- Bestall, J. C., Paul, E. A., Garrod, R., Garnham, R., Jones, P.W., & Wedzicha, J. A. (1999). Usefulness of the medical research council (MRC) dyspnea scale as a measure of disability in patients with chronic abstructive pulmonary disease. Thorax, 54(7), 581-586. 10.1136/thx.54.7.581
- <sup>6</sup> Adopted and modified from American Thoracic Society/European Respiratory Society and Veterans' Affairs/ Department of Defense Guidelines (2, 3). COPD = chronic obstructive pulmonary disease.

  <sup>7</sup> Clobal Initiative for Change Obstructive Lung Disease (COLD) 2018 Report Base 35: pdf case 30.
- <sup>7</sup> Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2018 Report; Page 25; pdf page 29 http://goldcood.org/wo-content/uploads/2018/02/WMS-GOLD-2018-Feb-Final-to-print-v2.pdf
- s Centers for Disease Control COPD http://www.cdc.gov/copd/index.html

9 | Page 7/8/2020

## EXHIBIT 5:

Audited Financial Statements for Adventist HealthCare, Inc 2018 and 2019

Consolidated Financial Statements and Supplementary Information

December 31, 2018 and 2017



	<u>Page</u>
Independent Auditors' Report	1
Financial Statements	
Consolidated Balance Sheets	3
Consolidated Statements of Operations	5
Consolidated Statements of Changes in Net Assets	6
Consolidated Statements of Cash Flows	7
Notes to Consolidated Financial Statements	9
Supplementary Information	
Adventist HealthCare, Inc. and Controlled Entities:	
Consolidating Schedule, Balance Sheet	38
Consolidating Schedule, Statement of Operations	40
Adventist HealthCare, Inc Foundations:	
Combining Schedule, Balance Sheet	41
Combining Schedule, Statement of Operations and Changes in Net Assets	42



#### **Independent Auditors' Report**

To the Board of Trustees of Adventist HealthCare, Inc. and Controlled Entities

#### **Report on the Consolidated Financial Statements**

We have audited the accompanying consolidated financial statements of Adventist HealthCare, Inc. and controlled entities (collectively, the "Corporation"), which comprise the consolidated balance sheets as of December 31, 2018 and 2017, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

#### Management's Responsibility for the Consolidated Financial Statements

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

#### **Auditors' Responsibility**

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

#### **Opinion**

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Adventist HealthCare, Inc. and controlled entities as of December 31, 2018 and 2017, and the results of their operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

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#### **Report on Supplementary Information**

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating and combining information presented on pages 38 to 42 is presented for purposes of additional analysis rather than to present the financial position, results of operations, and cash flows of the individual companies and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Wilkes-Barre, Pennsylvania April 30, 2019

Baker Tilly Virchaw Krause, UP

Consolidated Balance Sheets December 31, 2018 and 2017

	2018			2017
Assets				
Current Assets				
Cash and cash equivalents	\$	41,673,365	\$	40,714,884
Short-term investments		196,069,788		197,803,029
Assets whose use is limited		3,573,229		2,923,796
Patient accounts receivable		94,756,571		93,209,946
Other receivables		12,096,855		16,070,981
Inventories		8,611,875		9,410,777
Prepaid expenses and other current assets		8,337,954		7,653,048
Total current assets		365,119,637		367,786,461
Property and Equipment, Net		652,882,719		511,609,795
Assets Whose Use is Limited				
Under trust indentures and capital lease purchase				
financing facilities, held by trustees and banks		139,004,400		244,332,570
Professional liability trust fund		11,128,261		11,878,591
Deferred compensation fund		1,300,086		1,403,371
Cash and Cash Equivalents Temporarily Restricted				
for Capital Acquisitions		1,512,793		2,322,753
Investments and Investments in				
Unconsolidated Subsidiaries		17,057,997		15,665,245
Land Held for Healthcare Development		45,404,765		47,660,070
Intangible Assets, Net		8,127,689		8,343,130
Deposits and Other Noncurrent Assets		4,592,743		5,610,693
Total assets	\$	1,246,131,090	\$	1,216,612,679

Consolidated Balance Sheets December 31, 2018 and 2017

		2018	2017
Liabilities and Net Assets			
Current Liabilities			
Accounts payable and accrued expenses	\$	86,631,393	\$ 86,818,184
Accrued compensation and related items		37,155,567	37,260,446
Interest payable		9,775,665	9,747,294
Due to third party payors		19,981,019	17,818,402
Estimated self-insured professional liability		1,795,731	1,179,664
Current maturities of long-term obligations		9,151,220	13,019,860
Total current liabilities	1	64,490,595	165,843,850
Construction Payable		33,038,715	14,828,539
Long-Term Obligations, Net			
Bonds payable	5	46,699,908	551,211,489
Notes payable		21,295,957	22,089,282
Capital lease obligations		10,096,187	11,229,970
Derivative Financial Instrument		503,251	1,145,303
Other Liabilities		10,257,050	11,963,765
Estimated Self-Insured Professional Liability		14,929,354	13,082,881
Total liabilities	8	01,311,017	791,395,079
Net Assets			
Net assets without donor restrictions	4	39,571,362	417,328,975
Net assets with donor restrictions		5,248,711	7,888,625
Total net assets	4	44,820,073	425,217,600
Total liabilities and net assets	\$ 1,2	46,131,090	\$ 1,216,612,679

Consolidated Statements of Operations Years Ended December 31, 2018 and 2017

		2018		2017
Revenues				
Patient service revenue	\$	779,303,420	\$	801,836,667
Provision for doubtful collections	•	-	•	(31,782,541)
				(-,-,-,-,
Net patient service revenue		779,303,420		770,054,126
Other revenues		41,246,589		38,064,322
Total revenues		820,550,009		808,118,448
Expenses				
Salaries and wages		366,176,376		360,720,746
Employee benefits		72,221,612		68,630,252
Contract labor		35,754,655		39,039,683
Medical supplies		104,580,658		103,013,363
General and administrative		122,362,912		122,036,220
Building and maintenance		41,344,766		41,922,317
Insurance		9,113,009		5,674,763
Interest		11,951,282		10,353,452
Depreciation and amortization		38,120,194		36,463,353
Total expenses		801,625,464		787,854,149
Income from operations		18,924,545		20,264,299
Other Income (Expense)				
Investment income		2,284,965		8,232,502
Other income (expense)		143,382		(1,994,397)
Total other income		2,428,347		6,238,105
Revenues in excess of expenses from				
continuing operations		21,352,892		26,502,404
Change in net unrealized (losses) gains on investments				
other than trading securities		(3,582,832)		2,582,625
Change in net unrealized gain on derivative financial instrument Net assets released from restriction for purchase of		700,697		700,697
property and equipment		2,656,339		1,152,590
Deferred compensation plan liability adjustment		1,609,635		(512,305)
Other unrestricted net asset activity		(494,344)		(1,762,971)
Increase in net assets without donor restrictions from				
continuing operations		22,242,387		28,663,040
Loss from discontinued operations				(2,661,722)
Increase in net assets without donor restrictions	\$	22,242,387	\$	26,001,318

Adventist HealthCare, Inc. and Controlled Entities
Consolidated Statements of Changes in Net Assets
Years Ended December 31, 2018 and 2017

	2018			2017
Net Assets Without Donor Restrictions				
Revenues in excess of expenses from continuing operations	\$	21,352,892	\$	26,502,404
Change in net unrealized (losses) gains on investments other than trading securities		(3,582,832)		2,582,625
Change in net unrealized gain on derivative financial instrument		700,697		700,697
Net assets released from restriction for purchase of property and equipment		2,656,339		1,152,590
Deferred compensation plan liability adjustment		1,609,635		(512,305)
Other unrestricted net asset activity		(494,344)		(1,762,971)
Increase in net assets without donor restrictions from				
continuing operations		22,242,387		28,663,040
Loss from discontinued operations				(2,661,722)
Increase in net assets without donor restrictions		22,242,387		26,001,318
Net Assets With Donor Restrictions				
Restricted gifts and donations		4,077,505		4,933,934
Net assets released from restriction for purchase of property and equipment		(2,656,339)		(1,152,590)
Net assets released from restriction used for operations		(3,519,841)		(2,480,828)
Change in value of beneficial interest in trusts and charitable gift annuity obligation		(69,836)		18,397
Change in discount of pledges receivable and provision for doubtful pledges		(508,987)		11,309
Donor restricted investment income		37,584		10,234
(Decrease) increase in net assets with donor restrictions		(2,639,914)		1,340,456
Increase in net assets		19,602,473		27,341,774
Net Assets, Beginning		425,217,600	_	397,875,826
Net Assets, Ending	\$	444,820,073	\$	425,217,600

Consolidated Statements of Cash Flows Years Ended December 31, 2018 and 2017

		2018		2017
Cash Flows from Operating Activities				
Increase in net assets	\$	19,602,473	\$	27,341,774
Adjustments to reconcile increase in net assets to net cash	Ψ	13,002,473	Ψ	21,041,114
provided by operating activities:				
Provision for doubtful collections		_		31,782,541
Depreciation and amortization		38,120,194		36,453,533
Amortization of deferred financing costs		212,496		200,349
Deferred compensation plan liability adjustment		(1,609,635)		512,305
Restricted contributions and grants		(1,151,766)		(3,782,795)
Earnings recognized from unconsolidated subsidiaries		(1,101,100)		(0,: 02,: 00)
and affiliates		(1,943,590)		(2,040,340)
Amortization of physician income guarantees		26,348		9,105
Net realized loss (gain) on investments		3,128,140		(3,628,355)
Change in net unrealized losses (gains) on investments		5,125,115		(0,020,000)
other than trading securities		3,582,832		(2,582,625)
Change in net unrealized gain on derivative financial instrument		(700,697)		(700,697)
Change in value of beneficial interest in trusts and charitable gift annuity		69,836		(18,397)
Change in discount on pledges receivable and provision for		•		, , ,
doubtful pledges		508,987		(11,309)
Loss on disposal of BH&WS Eastern Shore		· -		2,911,706
Changes in assets and liabilities:				, ,
Patient accounts receivable		(1,546,625)		(33,960,881)
Other receivables		3,947,778		(836,069)
Inventories, prepaid expenses and other current assets		113,996		514,096
Accounts payable and accrued expenses		(186,791)		2,880,926
Accrued compensation and related items		(104,879)		2,408,992
Interest payable		28,371		7,725,904
Estimated self-insured professional liability		2,462,540		1,397,042
Due to third party payors		2,162,617		(846,625)
Other noncurrent assets and liabilities		397,341		(3,415,492)
Net cash provided by operating activities		67,119,966		62,314,688

Consolidated Statements of Cash Flows Years Ended December 31, 2018 and 2017

		2018		2017
Cash Flows from Investing Activities				
Purchase of property and equipment	\$	(159,276,923)	\$	(105,592,446)
Increase in investments and investments in unconsolidated subsidiaries	Ψ	(4,779,492)	Ψ	(3,959,138)
Additions to land held for healthcare development		(2,309,960)		(6,675,741)
Proceeds from sale of land for healthcare development		4,565,265		7,721,976
Distributions from investments in unconsolidated subsidiaries		2,524,000		321,113
Purchase of investment in unconsolidated subsidiary		(1,182,000)		(674,626)
Decrease in trustee held funds and restricted cash		106,506,583		26,520,312
Net cash used in investing activities		(53,952,527)		(82,338,550)
Cash Flows from Financing Activities				
Payment of financing costs		-		(423,227)
Proceeds from issuance of bonds		-		40,000,000
Repayments on long-term obligations, net		(13,360,724)		(12,818,901)
Proceeds from restricted contributions and grants		1,151,766		3,782,795
Net cash (used in) provided by financing activities		(12,208,958)		30,540,667
Net increase in cash and cash equivalents		958,481		10,516,805
Cash and Cash Equivalents, Beginning		40,714,884		30,198,079
Cash and Cash Equivalents, Ending	\$	41,673,365	\$	40,714,884
Supplemental Disclosure of Cash Flow Information				
Interest paid	\$	12,464,520	\$	4,138,018
Supplemental Disclosure of Noncash Investing and Financing Activities				
Capital lease obligation incurred for equipment	\$	3,203,212	\$	469,249
Land contributed to investment in unconsolidated subsidiary	\$	1,153,672	\$	-
Construction payable for property and equipment	\$	33,038,715	\$	14,828,539

### 1. Nature of Operations and Summary of Significant Accounting Policies

#### **Nature of Operations**

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

Shady Grove Medical Center ("SGMC") is a 266-bed acute care hospital located in Rockville, Maryland. Effective August 1, 2018, Behavioral Health & Wellness Services ("BH&WS") became a department of SGMC and as a result is reimbursed under SGMC's global budget revenue agreement. BH&WS is comprised of BH&WS - Rockville, a 117-bed psychiatric hospital. BH&WS - Eastern Shore was an acute care and residential mental health resource for children and adolescents, which had 15 acute care psychiatric beds and 59 residential treatment rooms. In November 2016, AHC made the decision to discontinue the operations of the BH&WS - Eastern Shore location. See Note 3 for further details.

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

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

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

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

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

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

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

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

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

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

The Foundations operating division is comprised of Washington Adventist Hospital Foundation, Inc., Shady Grove Medical Center Foundation, Inc., and Adventist Behavioral Health & Wellness Services Foundation, Inc. (collectively, the "Foundations"). Each are separate nonstock corporations that operate for the furtherance of each named hospital's health care objectives primarily through the solicitation of contributions, gifts and bequests. The Foundations also exist to help fund new equipment purchases and capital improvement projects for their respective hospitals. The Adventist Behavioral Health & Wellness Services Foundation, Inc. (BH&WS Foundation) was dissolved in 2018 and its assets were transferred to Shady Grove Medical Center Foundation, Inc. The transfer had no impact on net assets with donor restriction as the amounts will be used in accordance with the donors intended restriction.

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

# **Principles of Consolidation**

The consolidated financial statements for 2018 and 2017 include the accounts of AHC, the controlling parent, SGMC, WAH, Rehab, Imaging, CIS, LWS, CCPL, the Support Center, the Lourie Center, AHCS, Urgent Care, OHQA, ACO and the Foundations, which include their majority-owned subsidiaries and controlled affiliates (collectively, the "Corporation"). All significant intercompany balances and transactions have been eliminated in the consolidated financial statements of the Corporation.

# **Subsequent Events**

The Corporation evaluated subsequent events for recognition or disclosure through April 30, 2019, the date the consolidated financial statements were issued.

#### **Use of Estimates**

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

#### **Maryland Health Services Cost Review Commission**

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

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

As a result of the waiver, the HSCRC introduced revenue arrangements, including the Global Budget Revenue ("GBR") model. The GBR methodology encourages hospitals to focus on population health strategies by establishing a fixed annual revenue cap for each GBR hospital. The agreement establishes a fixed amount of charging authority (i.e. revenue) at the beginning of the rate year. It is evergreen in nature and covers both regulated inpatient and outpatient revenues. Annual revenue is calculated from a base year and is adjusted annually for inflation, infrastructure requirements, population changes, performance in quality-based programs and changes in levels of uncompensated care. Revenue may also be adjusted annually for market levels and shifts of services from one health system to another and from a regulated setting to an unregulated setting (or vice versa).

In 2014, AHC entered into Global Budget Revenue Agreements with the HSCRC for SGMC, WAH and Shady Grove Germantown Emergency Center. The agreements set a fixed amount of revenue for each entity for the period July 1, 2013 through June 30, 2014 and is subsequently updated on an annual basis every July 1.

The HSCRC requires rate-regulated hospitals under its jurisdiction to calculate the amount of revenue lost or gained due to variances from approved rates. Revenue lost due to undercharges in rates is recouped through increases in prospective rates. Similarly, revenue gained due to overcharges in rates is paid back, wholly or in part, through reductions in prospective rates. The Corporation reported net undercharges of \$1,289,841 and \$3,043,105 as of December 31, 2018 and 2017, respectively. These price variances reflect the variance between actual patient charges and the pro-rata share of approved rate orders. The net amounts are reported as a component of net patient service revenue and patient accounts receivable in the accompanying consolidated financial statements. Since the HSCRC's rate year extends from July 1 through June 30, these amounts will continue to fluctuate until the end of the rate year as actual patient charges deviate from the total approved charging authority. At the conclusion of the rate year, any over/under charges are amortized on the straight-line basis over the following rate year when the price variance adjustments are actually built into each entity's rate order.

Under Maryland law, charges of specialty hospitals such as Rehab are subject to review and approval by the HSCRC. HSCRC regulations also include a provision whereby a hospital may apply for an exemption from the requirements to charge for services in accordance with HSCRC regulations. Certain conditions regarding the percentage of revenue related to Medicare and Medicaid patients and total revenues must be met to receive the initial exemption and must be met each year thereafter. Reporting requirements as established by the HSCRC continue even if an exemption regarding charging for services is received. The Corporation's management believes Rehab met the conditions for exemption during 2018 and 2017.

BH&WS-Rockville is subject to HSCRC rate setting. For 2017 and the period January 1, 2018 through July 31, 2018, BH&WS-Rockville did not enter into a Global Budget Revenue Agreement. Instead, BH&WS-Rockville continues to generate charging authority based on the volume of services it provides to patients. Unit rates are set for all payors, however Medicare and Medicaid are not required to reimburse at HSCRC rates. Services provided to Medicare beneficiaries are reimbursed under the Inpatient Psychiatric Facility Prospective Payment System. Services provided to Medicaid patients are cost-settled for outpatient services and reimbursed for inpatient services at a rate of 94 percent of charges (as set forth in the Code of Maryland Regulations 10.09.06.09). Effective August 1, 2018, BH&WS became a department of SGMC and is reimbursed under their Global Budget Revenue Agreement.

# **Cash and Cash Equivalents**

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

#### **Patient Accounts Receivable**

The Corporation assesses collectability on patient contracts prior to the recognition of net patient service revenues. Patient accounts receivable are reported at their net realizable value. Accounts are written off through bad debt expense when the Corporation has exhausted all collection efforts and determines accounts are impaired based on changes in patient credit worthiness. Patient accounts receivable also includes management's estimate of the impact of certain undercharges to be recouped or overcharges to be paid back for inpatient and outpatient services in subsequent years rates as discussed earlier.

#### Other Receivables

Other receivables represent amounts due to the Corporation for charges other than providing health care services to patients and pledges from donors and are reported at their net realizable value. These services include, but are not limited to, fees from educational programs, rental of health care facility space, interest earned, and management services provided to unconsolidated subsidiaries. Other receivables are written off when they are determined to be uncollectible based on management's assessment of individual accounts.

### **Assets Whose Use Is Limited**

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

#### Investments and Investment Risk

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

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

# **Inventories**

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

### **Property and Equipment**

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

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

Impairment losses are recognized in the consolidated statements of operations as a component of revenues in excess of expenses from continuing operations as they are determined. The Corporation reviews its long-lived assets whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. In that event, the Corporation calculates the estimated future net cash flows to be generated by the asset. If those future net cash flows are less than the carrying value of the asset, an impairment loss is recognized for the difference between the estimated fair value and the carrying value of the asset. There were no impairment losses reported in 2018 or 2017.

# **Intangible Assets**

The Corporation's intangible assets primarily include costs in excess of net assets acquired related to certain business acquisitions. The Corporation is amortizing certain intangible assets over a period not to exceed 40 years. Amortization of these intangible assets was \$218,792 in 2018 and \$221,457 in 2017. Accumulated amortization of intangible assets was \$3,826,808 and \$3,608,016 as of December 31, 2018 and 2017, respectively.

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

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

# **Deferred Financing Costs**

Costs incurred in connection with the issuance of long-term obligations have been deferred and are being amortized over the term of the related obligation using the straight-line method. Deferred financing costs remaining as of December 31, 2018 and 2017 totaled \$4,850,301 and \$5,062,797, respectively, and are included in the consolidated balance sheets as a reduction of bonds payable.

Amortization expense was \$212,496 and \$200,349 in 2018 and 2017, respectively, and is included as a component of interest expense in the consolidated statements of operations. Accumulated amortization of deferred financing costs was \$3,074,318 and \$2,861,822 at December 31, 2018 and 2017, respectively, and is included as a component of bonds payable in the consolidated balance sheets.

# **Due to Third Party Payors**

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

Settlements with third party payors for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence with the payor and the Corporation's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information become available), or as years are settled or no longer subject to such audits, reviews and investigations. Adjustments arising from a change in in the transaction price, were not significant in 2018 or 2017.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result, health care entities, may from time to time and in the ordinary course of business, receive requests for information and notices from government agencies regarding alleged noncompliance with those laws and regulations, some of which may result in settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. Management is not aware of any material incidents of noncompliance; however, there can be no assurance that regulatory authorities will not challenge the Corporation's compliance in the future.

#### **Derivative Financial Instruments**

The Corporation has an interest rate swap agreement, which is considered a derivative financial instrument, to manage its interest rate exposure on certain long-term obligations (Note 12). The interest rate swap agreement is reported at fair value in the accompanying consolidated balance sheets. The interest rate swap agreement is not designated as a cash flow hedge. Changes in fair value are reported as a component of other non-operating income (expense).

#### **Estimated Self-Insured Professional Liability**

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

#### **Net Assets**

Net assets, revenues, gains, and losses are classified based on the existence or absence of donor imposed restrictions. Accordingly, net assets and changes therein are classified and reported as follows:

Net assets without donor restrictions includes amounts available for use in general operations and not subject to donor restrictions. All revenue not restricted by donors and donor restricted contributions whose restrictions are met in the same period in which they are received are accounted for in net assets without donor restrictions.

Net assets with donor restrictions includes amounts subjected to donor imposed restrictions which are temporary in nature, such as those that will be met by the passage of time or other events specified by the donor. Other donor-imposed restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity. All revenues restricted by donors as to either timing or purpose of the related expenditures or required to be maintained in perpetuity as a source of investment income are accounted for in net assets with donor restrictions. When a donor restriction expires, that is when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified to net assets without donor restrictions. Net assets were released from donor restriction by satisfying their restricted purposes in the amount of \$6,176,180 in 2018 and \$3,633,418 in 2017.

Net assets with donor restrictions includes those whose use by the Corporation has been limited by donors to specific purposes in the amount of \$4,907,290 and \$7,547,204 as of December 31, 2018 and 2017, respectively. Net assets with donor restrictions that have been restricted by donors to investments to be held in perpetuity was \$341,421 as of December 31, 2018 and 2017.

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received or when the underlying conditions have been substantially met. The gifts are reported as net assets with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. Restricted funds to be used for capital acquisitions have been reported as noncurrent assets in the accompanying consolidated balance sheets, while other restricted cash and investments are included with the cash and cash equivalents of net assets without donor restrictions.

### Measure of Operations

The consolidated statements of operations reflects all changes in net assets without donor restrictions, including changes from both operating and non-operating activities. Operating revenues and expenses consist of those items that are an integral part of the Corporation's provision of healthcare and related supporting activities. Non-operating activities are limited to resources that generate return from investments and other activities considered to be of a more unusual or nonrecurring nature.

#### Revenues in Excess of Expenses from Continuing Operations

The consolidated statements of operations include the determination of revenues in excess of expenses from continuing operations. Revenues in excess of expenses from continuing operations is the Corporation's performance indicator. Changes in net assets without donor restriction which are excluded from the determination of revenues in excess of expenses from continuing operations, consistent with industry practice, include the loss from discontinued operations, the change in net unrealized gains and losses on investments other than trading securities, the effective portion of the net unrealized gain (loss) on derivative financial instruments, the deferred compensation plan liability adjustment, contributions of long-lived assets (including contributions which by donor restriction were to be used for the purpose of acquiring such long-lived assets), and other unrestricted net asset activity.

# **Net Patient Service Revenue**

Net patient service revenues are recognized at the amount that reflects the consideration to which the Corporation expects to be entitled in exchange for providing patient care. These amounts are due from patients, third party payors (including commercial and governmental programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews and investigations. Generally, the Corporation bills the patients and third party payors after the services are performed and/or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the Corporation. Revenues for performance obligations satisfied over time are recognized based on actual charges incurred in relation to total expected (or actual) charges. The Corporation believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in our hospitals receiving services over multiple days. The Corporation measures the performance obligation from admission into the hospital to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge. Revenue for performance obligations satisfied at a point in time are generally recognized when goods or services are provided and the Corporation does not believe it is required to provide additional services to the patient. Generally, performance obligations satisfied at a point in time relate to patients receiving outpatient services in a single day. The Corporation measures the performance obligation from the commencement of the outpatient service, to the point when it is no longer required to provide services to that patient, which is generally the completion of the outpatient service.

All of the Corporation's performance obligations generally relate to contracts with a duration of less than one year, therefore the Corporation has elected to apply the optional exemptions provided in FASB ASC 606-10-50-14(a) and as a result is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

The Corporation determines the transaction price based on standard charges for services provided, reduced by contractual adjustments provided to third party payors, financial assistance provided to uninsured or underinsured patients in accordance with the Corporation's policies, and/or implicit price concessions provided to uninsured or underinsured patients. The Corporation determines its estimates of contractual adjustments based on contractual agreements, its financial assistance policies, and historical experience. The Corporation determines its estimates of implicit price concessions based on its historical collection experience with a respective class of patient. Certain amounts categorized as implicit price concessions under ASC 606 were previously categorized as provision for doubtful accounts. The Corporation pursues collection of amounts defined as implicit price concessions.

The Corporation has elected the practical expedient allowed under FASB ASC 606-10-32-18 and does not adjust the promised amount of consideration from patients and third party payors for the effects of a significant financing component due to the Corporation's expectation that the period between the time the service is provided to a patient and the time that the patient or a third party payor pays for that service will be one year or less.

#### **Income Taxes**

The Corporation accounts for uncertainty in income taxes using a recognition threshold of more-likely-than-not to be sustained upon examination by the appropriate taxing authority. Measurement of the tax uncertainty occurs if the recognition threshold is met. Management determined there were no tax uncertainties that met the recognition threshold in 2018 or 2017.

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

# **Charity Care**

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

The Corporation maintains records to identify and monitor the level of charity care it provides. The costs associated with the charity care services provided are estimated by applying a cost-to-charge ratio to the amount of gross uncompensated charges for the patients receiving charity care. The level of charity care provided by the Corporation amounted to approximately \$8,958,000 in 2018 and \$7,748,000 in 2017.

#### **Advertising Costs**

The Corporation expenses advertising costs as they are incurred.

#### Reclassifications

Certain amounts relating to 2017 have been reclassified to conform to the 2018 reporting format.

#### 2. Adoption of Accounting Standards

# **Revenue Recognition**

In 2018, the Corporation adopted the Financial Accounting Standards Board ("FASB") Accounting Standards Update ("ASU") No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*, using the modified retrospective approach. ASU No. 2014-09 supersedes the revenue recognition requirements in *Topic 605, Revenue Recognition*, and most industry specific guidance. The core principle under ASU No. 2014-09 is that revenues are recognized to depict the transfer of promised goods or services to customers (patients) in an amount that reflects the consideration at which the entity expects to be entitled in exchange for those goods or services. Additionally, ASU No. 2014-09 requires enhanced disclosures of revenue arrangements.

The Corporation applied the modified retrospective approach to all contracts when adopting ASU No. 2014-09. As a result of the adoption, what was previously classified as the provision for doubtful collections in the consolidated statements of operations is now reflected as implicit price concessions, as defined in Topic 606, and therefore included as a reduction of net patient service revenues. For changes in transaction price related to changes in patient circumstances, the Corporation will prospectively recognize those amounts as a provision for bad debts within operating expenses on the consolidated statements of operations. For periods prior to January 1, 2018, the provision for doubtful collections has been presented consistent with the previous revenue recognition standards that required separate presentation of these amounts as a component of net patient service revenue. Additionally, as a result of the adoption of ASU No. 2014-09, the allowance for doubtful collections of approximately \$22,487,000 as of January 1, 2018 became a component of patient accounts receivable.

### **Not-for-Profit Financial Statement Presentation**

In August 2016, FASB issued ASU No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities*. In 2018, the Corporation adopted ASU No. 2016-14, and has applied the changes retrospectively to all periods presented, except for the disclosures around liquidity and availability of resources and analysis of expenses by nature and function. These disclosures have been presented for 2018 only, as allowed by ASU No. 2016-14. The new standard changes the following aspects of the consolidated financial statements:

- The unrestricted net assets class has been renamed Net Assets Without Donor Restrictions;
- The temporarily and permanently restricted net asset classes have been combined into a single net asset class called Net Assets With Donor Restrictions;
- The financial statements include a disclosure about liquidity and availability of resources at December 31, 2018 (Note 17); and
- The functional expense disclosure for 2018 includes expenses reported both by nature and function (Note 18).

#### **Financial Instruments**

During January 2016, the FASB issued ASU No. 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities*. ASU No. 2016-01 was issued to enhance the reporting model for financial instruments in financial statements. The provisions of ASU No. 2016-01 require marketable equity securities to be reported at fair value with changes in fair value recognized within the performance indicator, establishes a qualitative factor in evaluating impairment on equity investments without readily determinable fair values, and eliminates the requirement to disclose the fair value on financial instruments measured at amortized cost. The Corporation will be required to adopt the guidance in ASU No. 2016-01 for the year ending December 31, 2019. The Corporation is currently assessing the impact that ASU No. 2016-01 will have on its consolidated financial statements.

#### **Statement of Cash Flows**

During August 2016, the FASB issued ASU No. 2016-15, Classification of Certain Cash Receipts and Cash Payments. ASU No. 2016-15 addresses eight cash flow issues with specific guidance on how certain cash receipts and cash payments should be presented on the statement of cash flows. The Corporation will be required to adopt the guidance in ASU No. 2016-15 for the year ending December 31, 2019. The Corporation is currently assessing the impact that ASU No. 2016-15 will have on its consolidated statements of cash flows.

# **Restricted Cash**

During November 2016, the FASB issued ASU No. 2016-18, *Statement of Cash Flows (Topic 30)*, *Restricted Cash*. ASU No. 2016-18 requires that a statement of cash flows explain the change during the period in the total cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. Amounts generally described as restricted cash and restricted cash equivalents should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts showing on the statement of cash flows. The Corporation will be required to retroactively adopt the guidance in ASU No. 2016-18, with transition provisions, for the year ending December 31, 2019. The Corporation is currently assessing the impact that ASU No. 2016-18 will have on its consolidated financial statements.

# **Lease Accounting**

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)*. ASU No. 2016-02 was issued to increase transparency and comparability among organizations by recognizing lease assets and lease liabilities on the balance sheet and disclosing key information about leasing arrangements. Under the provisions of ASU No. 2016-02, a lessee is required to recognize a right-to-use asset and lease liability, initially measured at the present value of the lease payments, in the balance sheet. In addition, lessees are required to provide qualitative and quantitative disclosures that enable users to understand more about the nature of the Corporation's leasing activities. The Corporation will be required to retrospectively adopt the guidance in ASU No. 2016-02 for the year ending December 31, 2019. The Corporation is currently assessing the impact that ASU No. 2016-02 will have on its consolidated financial statements.

# Goodwill

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

#### 3. Discontinued Operations

On March 31, 2016, the Corporation sold the operating assets of Hackettstown Regional Medical Center ("HRMC") and HRMC Foundation to an unrelated third party, and discontinued the operations of the facility. The Corporation received net proceeds from the sale of approximately \$44,500,000, which was net of a contribution paid by the Corporation of \$2,500,000 to the HRMC Foundation. During 2017, the Corporation recorded a gain from discontinued operations of \$249,984 related to the final settlement of receivables and payables that existed at the time of sale. The amount is included in the net loss from discontinued operations in the accompanying consolidated statements of operations.

During 2016, AHC discontinued operations at the BH&WS - Eastern Shore facility and made the decision to no longer provide services on Maryland's eastern shore. During 2017, the Corporation recorded a loss from discontinued operations of \$2,911,706, which is included in the net loss from discontinued operations in the accompanying consolidated statements of operations. The majority of the property and equipment was disposed of as a result of the closure and a loss of approximately \$1,611,000 was recognized in 2017 and included in the loss from discontinued operations in the accompanying consolidated statements of operations. In addition, goodwill of approximately \$412,000 related to BH&WS Eastern Shore was written off and included in the loss from discontinued operations in the accompanying consolidated statements of operations in 2017.

# 4. Net Patient Service Revenues

The Corporation routinely obtains assignments of (or is otherwise entitled to receive) patient benefits receivable under their health insurance programs, plans or policies (i.e. third party payors). Third party payors include both government payors, which include Medicare, Medicaid, and Management Care Organizations, and commercial insurance carriers. Agreements with third party payors typically provide for payments at amounts less than established charges. A summary of payment arrangements with third party payors, by service type, is as follows:

- Global budget revenue SGMC and WAH have entered into agreements by which the third party
  payors pay a percentage of approved HSCRC charges. A reduced percentage can be obtained if
  the payor advances a certain amount of working capital.
- Rehabilitation services Rehab has entered into agreements by which the third party payors pay at a contract rate per day or visit.
- Physician practice services AMG has entered into agreements by which the third party payors
  pay negotiated rates per procedures as defined in the term sheet of the agreements.
- Imaging services Imaging has entered into agreements by which the third party payors pay
  negotiated rates per procedures as defined in the term sheet of the agreements.
- Home health services AHCS has entered into agreements by which the third party payors pay negotiated rates on a per visit basis.

Generally, patients who are covered by third party payors are responsible for related deductibles and coinsurance, which vary in amount. The Corporation also provides services to uninsured patients, and offers those uninsured or underinsured patients financial assistance, by either policy or law, from standard charges. The Corporation estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charges by any contractual adjustment, financial assistance, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustment to net patient service revenues in the period of the change. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense.

Consistent with the Corporation's mission, care is provided to patients regardless of their ability to pay. Therefore, the Corporation has determined it has provided implicit price concessions to uninsured patients and other patient balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Corporation expects to collect based on its collection history with those patients.

The Corporation disaggregates revenue from contracts with customers by type of service and payor source as this depicts the nature, amount, timing and uncertainty of its revenue and cash flows as affected by economic factors. Tables providing details of these factors are presented below.

Net patient service revenues disaggregated by service type for the year ended December 31, 2018 are as follows:

Global budget revenue	\$ 636,611,309
Rehabilitation services	46,385,493
Physician practice services	30,529,693
Imaging services	29,948,092
Home health services	28,779,161
Other health services	7,049,672
Total	\$ 779,303,420

Net patient service revenues disaggregated by payor for the years ended December 31, 2018 and 2017 are as follows:

	Medicare	Medicaid	Other Third Party Payors	Self-Pay and Other	Total
December 31, 2018	\$ 292,876,720	\$ 85,066,955	\$ 368,341,417	\$ 33,018,328	\$ 779,303,420
December 31, 2017	\$ 287,729,217	\$ 80,722,260	\$ 371,203,570	\$ 30,399,079	\$ 770,054,126

# 5. Investments

#### **Short-Term Investments**

The Corporation's short-term investments at December 31, 2018 and 2017 are comprised of the following:

	2018		2017	
Cash and cash equivalents Fixed income:	\$	4,671,466	\$	827,792
Corporate bonds		70,694,426		72,558,705
Asset backed securities U.S. government securities,		58,864,628		34,501,068
U.S. treasury notes Mutual funds:		36,563,482		61,937,170
Equity, balanced		16,628,693		17,575,243
Equity, growth		8,647,093		10,403,051
Total	\$	196,069,788	\$_	197,803,029

# **Assets Whose Use is Limited**

The composition of assets whose use is limited at December 31, 2018 and 2017 is set forth in the following tables:

	2018	2017
Under trust indentures and capital lease purchase financing facilities, held by trustees and banks:  Cash and cash equivalents  U.S. government securities:  U.S. treasury notes  U.S. government agency notes	\$ 55,754,102 82,672,276 2,355,520	\$ 56,604,016 166,238,057 23,234,629
Total	140,781,898	246,076,702
Less funds held for current liabilities	1,777,498	1,744,132
Noncurrent portion of assets held under trust indentures and capital lease purchase financing facilities	\$ 139,004,400	\$ 244,332,570
Professional liability trust fund: Cash and cash equivalents Mutual funds:	\$ 1,133,693	\$ 228,643
Equity, balanced Equity, large value Equity, growth Fixed income, intermediate Fixed income, multi-sector	3,618,514 1,179,972 3,907,005 921,591	801,545 3,869,027 1,137,927 3,912,844 960,543
Fixed income, short-term  Total	2,163,217	2,147,726 13,058,255
Less funds held for current liabilities	1,795,731	1,179,664
Noncurrent portion of professional liability trust fund	\$ 11,128,261	\$ 11,878,591
Deferred compensation fund: Mutual funds: Equity, growth Equity, large value Equity, midcap value Equity, other Fixed income, intermediate	\$ 203,128 226,707 111,635 313,022 445,594 \$ 1,300,086	\$ 1,403,371 - - - - - \$ 1,403,371

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

The composition of trustee held and escrow funds at December 31, 2018 and 2017 is as follows:

	2018	2017
Debt service reserve funds	\$ 28,401,140	\$ 28,224,212
Principal and interest funds	17,902,335	29,448,690
Project fund	94,478,423	188,403,800
Total	\$ 140,781,898	\$ 246,076,702

Unrestricted investment income and gains and losses for investments, assets whose use is limited, and cash and cash equivalents are comprised of the following in 2018 and 2017:

	2018		2017	
Investment income: Interest and dividends, net Interest on trustee held funds	\$	5,292,594 120,511	\$	4,555,234 48,913
Net realized (losses) gains on sale of investments		(3,128,140)		3,628,355
Total	\$_	2,284,965	\$	8,232,502
Other changes in net assets without donor restriction, Change in net unrealized gains and losses on investments other than trading securities	\$	(3,582,832)	\$	2,582,625

#### 6. Fair Value Measurements and Financial Instruments

#### **Fair Value Measurements**

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

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

The levels of the fair value hierarchy are as follows:

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

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

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

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

	2018				
	Carrying Value	Fair Value	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
Reported at Fair Value					
Assets:					
Cash and cash equivalents	\$ 62,449,848	\$ 62,449,848	\$ 62,449,848	\$ -	\$ -
Mutual funds:					
Fixed income, intermediate	4 252 500	4 252 500	4 252 500		
Fixed income,	4,352,599	4,352,599	4,352,599	-	-
multi -sector	921,591	921,591	921,591	-	<u>-</u>
Fixed income, short-term	2,163,217	2,163,217	2,163,217	-	_
Equity, growth	10,030,193	10,030,193	10,030,193	_	_
Equity, large value	3,845,221	3,845,221	3,845,221	_	_
Equity, balanced	16,628,693	16,628,693	16,628,693	-	-
Equity, mid value	111,635	111,635	111,635	-	-
Equity, other	313,022	313,022	313,022	-	-
U.S. government securities:					
U.S. treasury notes	119,235,758	119,235,758	-	119,235,758	-
U.S. government agency					
notes	2,355,520	2,355,520	-	2,355,520	=
Asset backed securities	58,864,628	58,864,628	-	58,864,628	-
Corporate bonds and other	70.004.400	70.004.400		70.004.400	
debt securities Beneficial interest in trusts	70,694,426	70,694,426	-	70,694,426	- 077 024
beneficial interest in trusts	977,231	977,231	· <del></del>		977,231
	\$ 352,943,582	\$ 352,943,582	\$ 100,816,019	\$ 251,150,332	\$ 977,231
Liabilities,					
Derivative financial					
instrument	\$ 503,251	\$ 503,251	\$ -	\$ 503,251	\$ -
	<del>*</del> 555,251	<del>*</del>	<u>*</u>	<del>*</del>	<del>-</del>
Disclosed at Fair Value					
Cash and cash equivalents	\$ 41,673,363	\$ 41,673,363	\$ 41,673,363	\$	\$
Pledges receivable	3,219,172	3,219,172	· · · · · -	-	<u>-</u>
Long-term debt, excluding					
capital leases (Note 11):					
Fixed rate revenue	500 700 004	F70 4F0 007		F70 4F0 007	
bonds Variable rate revenue	523,782,204	576,452,087	-	576,452,087	-
bonds	21,985,000	21,985,000	_	21,985,000	_
Note payable	22,089,282	22,089,282	_	- 1,000,000	22,089,282
4,460	,000,202	,555,252			,500,_02

			2017		
	Carrying Value	Fair Value	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
Reported at Fair Value					
Assets:					
Cash and cash equivalents	\$ 58,471,764	\$ 58,471,764	\$ 58,471,764	\$ -	\$ -
Mutual funds:					
Fixed income,					
intermediate	3,970,702	3,970,702	3,970,702	-	-
Fixed income,					
multi -sector	960,543	960,543	960,543	-	-
Fixed income, short-term	2,147,726	2,147,726	2,147,726	-	-
Equity, growth	12,960,164	12,960,164	12,960,164	-	-
Equity, large value	3,887,685	3,887,685	3,887,685	-	-
Equity, balanced	18,376,788	18,376,788	18,376,788	-	-
U.S. government securities:					
U.S. treasury notes U.S. government agency	228,175,227	228,175,227	-	228,175,227	-
notes	23,234,629	23,234,629	-	23,234,629	-
Asset backed securities	34,501,068	34,501,068	-	34,501,068	-
Corporate bonds and other					
debt securities	72,558,705	72,558,705	-	72,558,705	-
Beneficial interest in trusts	1,052,891	1,052,891			1,052,891
	\$ 460,297,892	\$ 460,297,892	\$ 100,775,372	\$ 358,469,629	\$ 1,052,891
Liabilities.					
Derivative financial					
instrument	\$ 1,145,303	\$ 1,145,303	\$ -	\$ 1,145,303	\$ -
			-		-
Disclosed at Fair Value					
Cash and cash equivalents	\$ 40,714,884	\$ 40,714,884	\$ 40,714,884	\$ -	\$ -
Pledges receivable	4,333,990	4,181,880	-	· -	· -
Long-term debt, excluding					
capital leases (Note 11):					
Fixed rate revenue					
bonds	526,076,559	578,746,439	-	578,746,439	-
Variable rate revenue	00 005 000	00 005 000		00 005 000	
bonds	22,985,000	22,985,000	-	22,985,000	-
Note payable	22,861,750	22,861,750	-	-	22,861,750
Secured line of credit	3,500,000	3,500,000	-	-	3,500,000

The following table presents the fair value measurements for beneficial interest in trusts that have unobservable inputs at December 31, 2018 and 2017:

Balance, December 31, 2016 Distributions	\$ 1,310,686 (276,192)
Increase in value, included in changes in net assets with donor restrictions	18,397
Balance, December 31, 2017 Distributions Decrease in value, included in changes in net assets with	1,052,891 (5,824)
donor restrictions	(69,836)
Balance, December 31, 2018	\$ 977,231

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

	2018	2017
Short-term investments (Note 4) Assets whose use is limited (Note 4):	\$ 196,069,788	\$ 197,803,029
Current portion Under trust indentures and capital lease purchase	3,573,229	2,923,796
financing facilities, held by trustees and banks	139,004,400	244,332,570
Professional liability trust fund	11,128,261	11,878,591
Deferred compensation fund	1,300,086	1,403,371
Investments held by foundations	890,587	903,644
Beneficial interest in trusts	977,231	1,052,891
	\$ 352,943,582	\$ 460,297,892

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

The following is a description of the valuation methodologies used for assets and liabilities measured at fair value and for financial instruments disclosed at fair value. There have been no changes in methodologies used at December 31, 2018 and 2017.

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

Mutual funds: Valued based on quoted market prices.

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

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

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

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

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

# 7. Property and Equipment and Accumulated Depreciation and Amortization

Property and equipment and accumulated depreciation and amortization at December 31, 2018 and 2017 consist of the following:

	2018	2017
Land and improvements Buildings and improvements Office furniture and equipment Computer software and hardware Equipment under capital leases	\$ 31,408,104 469,717,964 201,151,320 137,906,569 27,952,929	\$ 32,566,971 457,474,313 194,126,065 133,864,945 24,749,717
Total	868,136,886	842,782,011
Less accumulated depreciation and amortization	(512,122,004)	(474,343,085)
Total	356,014,882	368,438,926
Construction in progress	296,867,837	143,170,869
	\$ 652,882,719	\$ 511,609,795

Interest incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. During 2018 and 2017, the Corporation incurred interest expense, including amortization expense related to deferred financing costs, of approximately \$12,679,000 and \$12,064,000, respectively, of which approximately \$727,400 was capitalized in 2018 and \$1,711,000 was capitalized in 2017. Investment earnings of approximately \$13,000 and \$12,000 were offset against capitalized interest in 2018 and 2017, respectively.

Depreciation expense, including amortization of equipment under capital leases, was approximately \$38,264,000 in 2018 and \$36,604,000 in 2017. Accumulated amortization of equipment under capital lease as of December 31, 2018 and 2017 was approximately \$21,515,000 and \$20,314,000, respectively.

Construction in progress as of December 31, 2018 consists primarily of major renovation and expansion projects of clinical facilities. Purchase commitments related to these and other miscellaneous projects were approximately \$90,487,000 at December 31, 2018. The cost of these projects is expected to be funded through the project fund established through bond proceeds as well as transfers from the Corporation's related foundations and operations.

#### 8. Investments and Investments in Unconsolidated Subsidiaries

The Corporation's investments and investments in unconsolidated subsidiaries include the following at December 31, 2018 and 2017:

	 2018	 2017
Investment in healthcare entities Investment in Premier Investments held by foundations	\$ 6,417,119 9,831,206 809,672	\$ 6,447,367 8,409,290 808,588
Total	\$ 17,057,997	\$ 15,665,245

#### Investment in Healthcare Entities

The Corporation recognized earnings of \$521,675 and \$258,193 during 2018 and 2017, respectively, related to its ownership interest in the healthcare entities accounted for under the equity method. A brief description of these investments is presented below:

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

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

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

White-Oak AHF-1 Manager, LLC ("White-Oak") – White-Oak was organized for the purpose of developing and constructing a medical office building on the White Oak campus of WAH. The Corporation has a 50 percent ownership in White-Oak.

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

The Corporation has invested \$3,884,672 in Advanced Health Collaborative II, LLC ("AHC II") for a 25 percent interest. AHC II was formed to hold a 24 percent interest in Maryland Health Advantage, LLC which is a Medicare preferred provider network providing health services to its members.

Summarized financial information related to these entities is presented below:

	 2018	 2017
Net revenue	\$ 18,786,903	\$ 17,682,566
Revenues in excess of expenses	1,919,276	958,934
Total assets	49,884,592	30,265,624
Total liabilities	24,630,109	15,478,915

#### Investment in Premier

The Corporation is a partner in Premier, Inc. ("Premier"), a health care system group purchasing organization. In 2013, the Corporation recorded its Premier investment under the cost method of accounting. In October 2013, Premier converted from a privately held company to a public company through the issuance of an Initial Public Offering. At the time of conversion, the Corporation was issued 493.810 Class B common units of which 78,946 units were sold.

The remaining 414,864 Class B common units held by the Corporation are exchangeable for Class A common stock over a 7-year quarterly vesting period. The Corporation recognized a gain of \$1,421,915 and \$1,782,147 during 2018 and 2017, respectively, based on the market value of the units available for exchange. In addition, the Corporation recognized earnings of \$669,776 and \$707,426 during 2018 and 2017, respectively, related to distributions. Both the gain and the distributions are included in other revenue in the accompanying consolidated statements of operations.

#### **Investments Held by Foundations**

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

### 9. Land Held for Healthcare Development

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

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

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

In April 2017, the Corporation entered into a purchase and sale agreement with an unrelated third party to sell 9.95 acres of the land located in Clarksburg at a purchase price of \$7,250,792. The Corporation's share of \$4,565,265 was received in November and December of 2018.

The total proceeds received related to the parcels of land sold by the Corporation through December 31, 2018 was \$30,997,245. No gain or loss was recognized on the sale of the parcels of land as of December 31, 2018 and 2017. Total remaining land held for healthcare development in Clarksburg as of December 31, 2018 and 2017, was \$45,404,765 and \$47,660,070, respectively.

# 10. Short-Term Financing

The Corporation has a \$3,000,000 unsecured line of credit with a commercial bank, with interest at LIBOR plus 1.50 percent (4 percent at December 31, 2018). There were no borrowings outstanding under this line of credit as of December 31, 2018 or 2017.

# 11. Long-Term Obligations

Long-term obligations as of December 31, 2018 and 2017 are comprised of the following:

	2018	2017
Fixed rate revenue bonds	\$ 523,782,204	\$ 526,076,559
Variable rate revenue bonds	21,985,000	22,985,000
Secured lines of credit	-	3,500,000
Note payable	22,089,282	22,861,750
Other long-term liabilities	14,092,321	16,683,010
Total obligations	581,948,807	592,106,319
Plus bond premium Less:	10,144,766	10,507,079
Current maturities	(9,151,220)	(13,019,860)
Deferred financing costs	(4,850,301)	(5,062,797)
Noncurrent portion of long-term obligations, net	\$ 578,092,052	\$ 584,530,741

#### **Fixed Rate Revenue Bonds**

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

	P	ar Amounts	Interest Rates		2018		2017
Adventist Healthcare, Inc.:							
Series 2011A	\$	57,205,000	5-6.25%	\$	57,205,000	\$	57,205,000
Series 2013		15,623,500	3.21%		8,342,204		9,886,559
Series 2014A		24,280,000	3.56%		22,090,000		22,840,000
Series 2016A		269,750,000	5.00%		269,750,000		269,750,000
Series 2016B		126,395,000	3.23%		126,395,000		126,395,000
Series 2017		40,000,000	2.77%		40,000,000		40,000,000
Total				Φ.	500 700 004	Φ.	F00 070 FF0
Total					523,782,204	\$_	526,076,559

The above bond issues are subject to trust indentures which impose various covenants on SGMC, WAH, Rehab, Imaging, CIS, Other Health Services and the Support Center (collectively, the "Obligated Group") which include restrictions on the transfer or disposition of property, the incurrence of additional liabilities, and the achievement of certain pre-established financial indicators. Management believes it has complied with these required financial covenants for the years ended December 31, 2018 and 2017. Debt service reserve funds are required on the Series 2011A, Series 2016A and Series 2017 bonds.

#### Variable Rate Revenue Bonds

The variable rate revenue bonds consist of the Maryland Health and Higher Educational Facilities Authority Revenue Refunding Bonds, Series 2014B, Adventist HealthCare, Inc. which had an outstanding balance of \$21,985,000 and \$22,985,000 as of December 31, 2018 and 2017, respectively. The Series 2014B Bonds bear interest at a variable rate of one month LIBOR plus 2.3 percent (4.8 percent at December 31, 2018). The Series 2014B bonds are subject to an Amended and Restated Master Trust Indenture that imposes various covenants on the Obligated Group which include restrictions on the transfer or disposition of property, the incurrence of additional liabilities, and the achievement of certain pre-established financial indicators. Management believes it has complied with these required financial covenants for the years ended December 31, 2018 and 2017.

The bonds subject to the Amended and Restated Master Trust Indenture are secured by the unrestricted revenues of the Obligated Group as well as a mortgage interest in the facilities of SGMC, WAH, HRMC, BH&WS and Rehab.

#### **Secured Lines of Credit**

The Corporation had a secured line of credit for \$16,000,000 that bore interest at LIBOR plus 2.00 percent and expired on June 30, 2018. The balance on the line of credit was \$3,500,000 at December 31, 2017.

# **Note Payable**

In December 2014, the corporation entered into a taxable term note for \$25,000,000 with a commercial bank, which is secured by a Master Note issued under the Amended and Restated Master Trust Indenture dated as of February 1, 2003. The note bears interest at one month LIBOR plus 2.45 percent (4.95 percent as of December 31, 2018). The amortization on the note extends to December 18, 2034, however, the note matures on December 18, 2024. As of December 31, 2018 and 2017, the outstanding balance was \$22,089,282 and \$22,861,750, respectively.

# Other Long-Term Liabilities

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

Scheduled principal repayments of long-term obligations at December 31, 2018 are as follows:

Years ending December 31:	
2019	\$ 9,151,220
2020	14,996,059
2021	13,934,044
2022	14,354,419
2023	13,271,324
Thereafter	516,241,741_
Total	\$ 581,948,807

#### 12. Derivative Financial Instrument

The Corporation has an interest rate swap agreement, which is considered a derivative financial instrument. The agreement is for a notional amount of \$50,880,000 and requires the Corporation to pay a fixed interest rate of 3.457 percent while receiving variable interest rates based upon 67 percent of LIBOR, maturing January 2021. The agreement was entered into in order to manage interest rate exposure. The principal objective of the swap agreement is to minimize the risks associated with financing activities by reducing the impact of changes in interest rates on its debt portfolio. The notional amount of the swap agreement is used to measure the interest to be paid or received and does not represent the amount of exposure to credit loss. Exposure to credit loss is limited to the receivable, if any, which may be generated as a result of the swap agreement. The interest rate swap agreement is reported at fair value in the consolidated balance sheets. At December 31, 2018 and 2017, the fair value of the Corporation's derivative financial instrument was \$503,251 and \$1,145,303, respectively.

During 2016, the Corporation terminated one of its interest rate swap agreements with a notional amount of \$78,000,000 that was designated as a cash flow hedge with the counterparty for \$16,875,000. The Corporation borrowed the termination fee, which was included as a component of the proceeds for the 2016B bonds. No gain or loss was recognized on the termination of the swap. As of December 31, 2018 and 2017, \$11,606,149 and \$12,288,864, respectively, remained in net assets without donor restriction and is being amortized over the remaining term of the hedge, or through January 2035.

The net cash paid or received under the swap agreement is recognized as either an adjustment to interest expense or other income. The net cash paid under the interest rate swap agreement was \$582,142 in 2018 and \$928,616 in 2017. The remaining amounts for 2018 and 2017 are reported as a component of other income (expense) in the accompanying consolidated statements of operations, which is related to the swap agreement that does not qualify for hedge accounting.

The fair value of the interest rate swap agreement is estimated to be the amount the Corporation would receive or pay to terminate the swap agreements at the reporting date and was based on information supplied by an independent third party valuation agent (Note 5). Additionally, the fair value reflects a credit risk adjustment required under accounting principles generally accepted in the United States of America. Gains or losses resulting from the interest rate swap agreement are entirely recognized as a component of revenues in excess of expenses from continuing operations. The impact on the consolidated statements of operations were gains of \$642,052 in 2018 and \$964,909 in 2017.

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

On October 16, 2008, the Corporation terminated this agreement and concurrently entered into an agreement with a new counterparty that assumed all existing terms and conditions of the original agreement. The termination of the original swap agreement resulted in a loss of \$472,023 which is included in net assets without donor restriction in the consolidated balance sheets. This loss is being amortized over the remaining term of the designated period of the hedge, or through January 2035. As of December 31, 2018 and 2017, accumulated amortization of \$201,632 and \$161,837, respectively, is included in other changes in net assets without donor restriction and interest expense in the consolidated statements of operations and changes in net assets.

#### 13. Leases

The Corporation has entered into various operating leases primarily for office space as well as certain equipment items. Rental expense for operating leases was \$21,065,136 in 2018 and \$20,924,709 in 2017. Future minimum payments under non-cancelable operating leases with initial terms of one year or more consist of the following during the years ending December 31:

Years ending December 31:	
2019	\$ 16,591,264
2020	16,374,128
2021	16,279,959
2022	14,556,651
2023	13,288,887
Thereafter	 27,120,705
Total	\$ 104,211,594

The Corporation has also entered into various sub-lease agreements with tenants that occupy space in the Corporation's buildings. The terms of these sub-leases vary and extend through 2030. Rental income was \$4,119,236 in 2018 and \$3,303,484 in 2017, which has been reported as a component of other operating revenue in the consolidated statements of operations. Future rent payments expected to be received by the Corporation during the years ending December 31, are as follows:

Years ending December 31:	
2019	\$ 4,069,884
2020	3,803,687
2021	3,497,826
2022	2,853,887
2023	2,543,956
Thereafter	1,221,807
Total	\$ 17,991,047

#### 14. Retirement, Health Plan and Life Insurance

#### **Defined Contribution Retirement Plan**

The Corporation sponsors a 401(a) defined contribution retirement plan, which covers substantially all full-time employees. After twelve months of full-time or regular part-time employment of at least 1,000 base hours, the Corporation will contribute a total of 2 percent of eligible employees' compensation, plus a matching employer contribution equal to 50 percent of employee contributions (to the 403(b) plan) up to 6 percent of base salary. The Corporation also has a 403(b) retirement savings plan for employees. Employee contributions are made to the 403(b) retirement savings plan. Retirement plan expense was \$10,101,533 in 2018 and \$7,983,472 in 2017.

#### **Supplemental Executive Retirement Plan**

The Corporation also has a Supplemental Executive Retirement Plan ("SERP") that became effective in 2015 and covers a group of key executives. SERP expense was \$236,635 in 2018 and \$404,894 in 2017. In addition, a SERP liability adjustment was recorded for \$(1,609,635) in 2018 and \$512,305 in 2017, which was recognized in net assets without donor restriction in the consolidated statements of changes in net assets. At December 31, 2018 and 2017, the Corporation's liability for the SERP was \$2,418,405 and \$3,811,232, respectively, which is included in other liabilities in the consolidated balance sheets.

#### Executive Retention 457(F) Plan

Effective January 1, 2015, the Corporation established the Executive Retention 457(F) Plan (the "457(F) Plan"). The 457(F) Plan is a tax-deferred plan offered to key executives, whereby annual employer contributions are made to the Plan. Plan participants become vested in the contributions and receive plan payments in the second calendar year after the contribution is made, if the participant is still employed. The final contribution will be made to the Plan for the year in which the plan participant becomes 62. The 457(F) plan expense was \$1,305,693 in 2018 and \$1,451,249 in 2017. The Corporation's liability for the 457(F) plan at December 31, 2018 and 2017 was \$2,549,173 and \$2,792,809, respectively, which is included in other liabilities in the consolidated balance sheets.

#### Salary Deferral (457(b)) Plan

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

#### **Health Plan**

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

### Life Insurance

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

#### 15. Commitments and Contingencies

# Litigation and Claims

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

#### Insurance

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

It is the Corporation's policy to accrue for the ultimate cost of uninsured asserted and unasserted malpractice claims, if any, when incidents occur. Based on a review of the Corporation's prior experience and incidents occurring through December 31, 2018, management determined that the fully-funded professional liability reserve reported at December 31, 2018 and 2017 is adequate in light of the program's excess umbrella policy currently in force and historical claims experience. The estimated professional liability for both asserted and unasserted claims was \$16,725,085 and \$14,262,545 at December 31, 2018 and 2017, respectively. The discount rate used in determining these liabilities was 2.5 percent at both December 31, 2018 and 2017.

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

#### Remediation

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

#### 16. Business and Credit Concentrations

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

At December 31, 2018 and 2017, concentrations of gross receivables from third party payors and others are as follows:

	2018	2017
Medicare	22 %	22 %
Medicaid	12	11
Other third party payors	41	39
Self-pay and others	25	28
	100 %	100 %

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

# 17. Liquidity and Availability

The Corporation's financial assets available for general expenditure within one year of the consolidated balance sheet date, consist of the following at December 31, 2018:

Cash and cash equivalents	\$ 41,673,363
Short-term investments	196,069,788
Patient accounts receivable, net	94,756,571
Other receivables, net	12,096,855
Assets whose use is limited,	
Professional liability trust fund	 11,128,261
Total	\$ 355,724,838

The Corporation has designated certain assets as available for settling professional liability claims however these assets could be used for general expenditure if necessary and therefore have been included in the information above.

As part of the Corporation's liquidity management plan, it has a policy to structure its financial assets to be available as its general expenditures, liabilities and other obligations come due. In addition, the Corporation invests excess cash in short-term investments.

# 18. Functional Expenses

A summary of the Corporation's operating expenses by function for the year ended December 31, 2018 is as follows:

	Hospital Acute and Ambulatory Services		Home Care Services			ındraising	Total			
Salaries and wages Employee benefits and	\$ 220,718,693	\$	18,731,190	\$	,,	\$	38,100,836	\$	-	\$ 366,176,376
payroll taxes	47,966,466		3,553,383		13,110,485		7,591,278		-	72,221,612
Contract labor	32,343,445		245,199		2,963,787		202,224		-	35,754,655
Medical supplies	98,202,724		458,492		5,875,860		43,582		-	104,580,658
General and administrative	55,707,950		1,215,423		17,182,465		48,146,794		110,280	122,362,912
Building and maintenance	30,686,995		704,542		7,821,497		2,131,732		-	41,344,766
Insurance	4,741,326		105,956		1,861,698		2,404,029		-	9,113,009
Interest Depreciation and	8,724,197		-		530,114		2,696,971		-	11,951,282
amortization	22,503,068	_	314,415	_	4,087,192	_	11,215,519	_	-	38,120,194
Total	\$ 521,594,864	\$	25,328,600	\$	142,058,755	\$	112,532,965	\$	110,280	\$ 801,625,464

A summary of the Corporation's operating expenses by function for the year ended December 31, 2017 is as follows:

Hospital acute and ambulatory services Home care services Other health care services Other, including general and administrative	\$ 477,985,379 24,328,504 181,539,007 103,568,758
Fundraising  Total	\$ 432,501 787,854,149

# Adventist HealthCare, Inc. and Controlled Entities Consolidating Schedule, Balance Sheet December 31, 2018

	Shady Grove Medical Center	Washington Adventist Hospital	Rehabilitation	Imaging Services	Clinical Integration Services	Other Health Services	Support Center	Eliminating Entries	Total Combined Obligated Group	Lourie Center	Adventist Home Care Services	Urgent Care Centers	One Health Quality Alliance	Adventist HealthCare, Inc. Foundations	Eliminating Entries	Consolidated Adventist HealthCare, Inc.
Assets																
Current Assets																
Cash and cash equivalents	\$ 182,612,390	\$ (82,157,324)	\$ 20,072,440	\$ (24,230,924)	\$ (29,940,781)	\$ 1,685,186	\$ (21,382,805)	\$ -	\$ 46,658,182	\$ (451,313)	\$ 7,191,925	\$ (11,901,913)	\$ (2,487,527)	\$ 2,664,011	\$ -	\$ 41,673,365
Short-term investments	-	-	-	-	-	-	196,069,788	-	196,069,788	-	-	-	-	-	-	196,069,788
Assets whose use is limited	-	-	-	-	-	-	3,573,229	-	3,573,229	-	-	-	-	-	-	3,573,229
Patient accounts receivable	48,097,132	35,284,511	4,262,325	2,696,448	546,306	(14,875)	150	-	90,871,997	-	4,193,208	(308,634)	-	-	-	94,756,571
Other receivables	2,083,734	2,510,501	166,744	1,003,076	34,022	798,858	3,492,336	(683,262)	9,406,009	1,918,131	18,652	(312)	-	754,375	-	12,096,855
Inventories	4,432,488	3,967,065	93,906	619	112	117,172	-	-	8,611,362	-	-	513	-	-	-	8,611,875
Prepaid expenses and other current assets	687,700	854,188	118,300	44,066	171,330	230,077	6,147,365		8,253,026	1,764	67,425	59,288	(43,549)			8,337,954
Total current assets	237,913,444	(39,541,059)	24,713,715	(20,486,715)	(29,189,011)	2,816,418	187,900,063	(683,262)	363,443,593	1,468,582	11,471,210	(12,151,058)	(2,531,076)	3,418,386	-	365,119,637
Property and Equipment, Net	181,704,217	338,552,541	10,085,146	13,206,429	1,233,186	173,563	98,603,604	-	643,558,686	1,495,807	1,366,009	6,462,217	-	-	-	652,882,719
Assets Whose Use is Limited Under trust indentures and capital lease purchase																
financing facilities, held by trustees and banks	1,344,871	133,753,946	448,290	100,731	-	-	3,350,382	-	138,998,220	6,180	-	-	-	-	-	139,004,400
Professional liability trust fund	-	-	-	-	-	-	11,128,261	-	11,128,261	-	-	-	-	-	-	11,128,261
Deferred compensation fund	-	-	-	-	-	-	1,300,086	-	1,300,086	-	-	-	-	-	-	1,300,086
Cash and Cash Equivalents Temporarily Restricted for Capital Acquisitions	332,232	_	57,408	_	_	_	_	_	389,640	777,092	_	_	_	346,061	_	1,512,793
	,		,						222,212	,						1,012,120
Investments and Investments in Unconsolidated Subsidiaries	(1,943,527)	1,175,657	-	-	-	-	17,016,195	-	16,248,325	-	-	-	-	809,672	-	17,057,997
Land Held for Healthcare Development	-	-	-	-	-	-	45,404,765	-	45,404,765	-	-	-	-	-	-	45,404,765
Intangible Assets, Net	1,704,030	-	813,286	5,435,091	-	22,732	-	-	7,975,139	-	152,550	-	-	-	-	8,127,689
Deposits and Other Noncurrent Assets	1,615,718	31,351	43,000	15,687	46,717	32,756	789,965		2,575,194	5,052	30,828	200,582		1,781,087		4,592,743
Total assets	\$ 422,670,985	\$ 433,972,436	\$ 36,160,845	\$ (1,728,777)	\$ (27,909,108)	\$ 3,045,469	\$ 365,493,321	\$ (683,262)	\$ 1,231,021,909	\$ 3,752,713	\$ 13,020,597	\$ (5,488,259)	\$ (2,531,076)	\$ 6,355,206	\$ -	\$ 1,246,131,090

# Adventist HealthCare, Inc. and Controlled Entities Consolidating Schedule, Balance Sheet December 31, 2018

	Shady Grove Medical Center	Washington Adventist Hospital	Rehabilitation	Imaging Services	Clinical Integration Services	Other Health Services	Support Center	Eliminating Entries	Total Combined Obligated Group	Lourie Center	Adventist Home Care Services	Urgent Care Centers	One Health Quality Alliance	Adventist HealthCare, Inc. Foundations	Eliminating Entries	Consolidated Adventist HealthCare, Inc.
Liabilities and Net Assets																
Current Liabilities																
Accounts payable and accrued expenses	\$ 32,130,575	\$ 17,384,711	\$ 1,893,421	\$ 1,282,761	\$ 869,924	\$ 886,261	\$ 29,922,155	\$ -	\$ 84,369,808	\$ 499,577	\$ 1,066,116	\$ 341,694	\$ 340,710	\$ 13,488	\$ -	86,631,393
Accrued compensation and related items	14,117,306	8,383,654	2,614,517	199,308	437,812	208,569	9,415,433	(683,262)	34,693,337	490,232	1,647,869	313,819	10,310	-	-	37,155,567
Interest payable	-	-	-	-	-	-	9,775,665	-	9,775,665	-	-	-	-	-	-	9,775,665
Due to third party payors	11,780,733	8,258,811	(126,072)	-	-	-	67,547	-	19,981,019	-	-	-	-	-	-	19,981,019
Estimated self-insured professional liability	-	-	-	-	-	-	1,795,731	-	1,795,731	-	-	-	-	-	-	1,795,731
Current maturities of long-term obligations	1,612,067	3,960,463		1,206,459			2,195,074		8,974,063			177,157				9,151,220
Total current liabilities	59,640,681	37,987,639	4,381,866	2,688,528	1,307,736	1,094,830	53,171,605	(683,262)	159,589,623	989,809	2,713,985	832,670	351,020	13,488	-	164,490,595
Construction Payable	353,406	32,424,036	209,217	813	-	-	51,243	-	33,038,715	-	-	-	-	-	-	33,038,715
Long-Term Obligations, Net																
Bonds payable	129,026,027	375,417,868	4,296,188	-	-	-	37,974,168	-	546,714,251	-	-	(14,343)	-	-	-	546,699,908
Notes payable	-	-	-	-	-	-	17,053,821	-	17,053,821	-	-	4,242,136	-	-	-	21,295,957
Capital lease obligations	2,457,686	943,513	-	2,946,866	-	-	3,655,614	-	10,003,679	-	-	92,508	-	-	-	10,096,187
Derivative Financial Instrument	-	-	-	-	-	-	503,251	-	503,251	-	-	-	-	-	-	503,251
Other Liabilities	1,595,969	-	277,920	-	528,057	-	7,807,506	-	10,209,452	-	-	-	-	47,598	-	10,257,050
Estimated Self-Insured Professional Liability							14,929,354		14,929,354							14,929,354
Total liabilities	193,073,769	446,773,056	9,165,191	5,636,207	1,835,793	1,094,830	135,146,562	(683,262)	792,042,146	989,809	2,713,985	5,152,971	351,020	61,086	-	801,311,017
Net Assets (Deficit)																
Net assets (deficit) without donor restrictions	229,814,202	(13,534,110)	26,964,989	(7,364,984)	(29,744,901)	1,950,639	229,614,802	-	437,700,637	2,467,142	10,306,612	(10,641,230)	(2,882,096)	2,620,297	-	439,571,362
Net assets (deficit) with donor restrictions	(216,986)	733,490	30,665				731,957		1,279,126	295,762				3,673,823		5,248,711
Total net assets (deficit)	229,597,216	(12,800,620)	26,995,654	(7,364,984)	(29,744,901)	1,950,639	230,346,759		438,979,763	2,762,904	10,306,612	(10,641,230)	(2,882,096)	6,294,120		444,820,073
Total liabilities and net assets (deficit)	\$ 422,670,985	\$ 433,972,436	\$ 36,160,845	\$ (1,728,777)	\$ (27,909,108)	\$ 3,045,469	\$ 365,493,321	\$ (683,262)	\$ 1,231,021,909	\$ 3,752,713	\$ 13,020,597	\$ (5,488,259)	\$ (2,531,076)	\$ 6,355,206	\$ -	\$ 1,246,131,090

# Adventist Healthcare, Inc. and Controlled Entities Consolidating Schedule, Statement of Operations Year Ended December 31, 2018

	Shady Grove Medical Center	Washington Adventist Hospital	Rehabilitation	Imaging Services	Clinical Integration Services	Other Health Services	Support Center	Eliminating Entries	Total Combined Obligated Group	Lourie Center	Adventist Home Care Services	Urgent Care Centers	One Health Quality Alliance	Adventist HealthCare, Inc. Foundations	Eliminating Entries	Consolidated Adventist HealthCare, Inc.
Revenues																
Net patient service revenue	\$ 404,818,916	\$ 253,697,595	\$ 48,666,804	\$ 29,948,092	\$ 7,886,017	\$ (41,535)	\$ -	\$ (65,406)	\$ 744,910,483	\$ 717,277	\$ 28,779,161	\$ 5,182,835	\$ -	\$ -	\$ (286,336)	\$ 779,303,420
Other revenues	15,008,872	4,695,223	3,119,495	1,854,609	233,699	7,168,688	7,819,392	(11,135,186)	28,764,792	12,710,970	215,965		85,500	2,777,792	(3,308,430)	41,246,589
Total revenues	419,827,788	258,392,818	51,786,299	31,802,701	8,119,716	7,127,153	7,819,392	(11,200,592)	773,675,275	13,428,247	28,995,126	5,182,835	85,500	2,777,792	(3,594,766)	820,550,009
Expenses																
Salaries and wages	148,110,347	97,872,374	29,028,695	16,287,966	7,776,511	2,295,400	38,100,836	(2,048,427)	337,423,702	6,548,261	18,731,190	3,262,553	210.670	_	_	366,176,376
Employee benefits	31,921,792	17,437,143	5,804,010	3,009,470	685,153	450,746	7,591,278	(382,511)	66,517,081	1,527,731	3,553,383	585,438	37.979	_	_	72,221,612
Contract labor	20,980,936	15,115,343	322,674	(2,248,878)	81,394	694,156	202,224	(2,843)	35,145,006	285,461	245,199	10,452	114,583	_	(46,046)	35,754,655
Medical supplies	54,490,762	44,537,216	1,639,077	1,416,802	605,702	809,118	43,582	(79,042)	103,463,217	280,328	458,492	379,621	(1,000)	_	-	104,580,658
General and administrative	35,842,391	26,915,696	3,331,841	4,429,747	2.889.252	1,358,564	48,223,224	(6,048,123)	116,942,592	3,245,725	1,254,129	1,213,774	183.718	3,044,385	(3,521,411)	122,362,912
Building and maintenance	25,234,406	7,849,674	1,542,810	3,549,330	1,021,547	512,106	2,131,732	(2,639,646)	39,201,959	357,401	704,542	1,103,591	300	-	(23,027)	41,344,766
Insurance	3,147,493	2,432,553	160,885	605,410	134,214	5,292	2,404,029	-	8,889,876	10,043	105,956	107,134	-	_	-	9,113,009
Interest	6,351,767	2,372,430	189,289	137,882		_	2,696,971	_	11,748,339	-	-	202,943	-	_	_	11,951,282
Depreciation and amortization	17,110,236	5,575,038	1,029,626	2,160,536	133,962	68,495	11,215,519	_	37,293,412	166,142	314,415	346,225	_	_	_	38,120,194
IT depreciation	6,346,694	3,800,194	504,704	93,264	-	29,937	(10,856,857)	_	(82,064)		82,064	-	-	_	_	-
IT services	21,497,046	12,668,073	2,174,818	1,214,810	123,200	139,121	(38,533,220)	_	(716,152)	_	716,152	-	-	_	_	-
Shared services	18,691,906	10,391,475	1,590,376	483,451	736,414	71,502	(32,714,132)	_	(749,008)	301,934	399,334	52,022	_	_	(4,282)	_
Management fees	9,940,544	5,716,347	1,417,193	494,120	492,538	145,592	(19,571,018)		(1,364,684)	338,708	875,479	150,497				
Total expenses	399,666,320	252,683,556	48,735,998	31,633,910	14,679,887	6,580,029	10,934,168	(11,200,592)	753,713,276	13,061,734	27,440,335	7,414,250	546,250	3,044,385	(3,594,766)	801,625,464
Income (loss) from operations	20,161,468	5,709,262	3,050,301	168,791	(6,560,171)	547,124	(3,114,776)		19,961,999	366,513	1,554,791	(2,231,415)	(460,750)	(266,593)		18,924,545
Other Income (Expense)																
Investment income	1,006,301	8,338	94,453	-	_	6,048	1,114,259	-	2,229,399	11,086	35,454	-	_	9,026	-	2,284,965
Other income (expense)	(242,074)	(154,218)	(9,628)				549,302		143,382	<u> </u>				<u> </u>		143,382
Total other income (expense)	764,227	(145,880)	84,825		<u> </u>	6,048	1,663,561		2,372,781	11,086	35,454			9,026		2,428,347
Revenues in excess of (less than)																
expenses from continuing operations	20,925,695	5,563,382	3,135,126	168,791	(6,560,171)	553,172	(1,451,215)	-	22,334,780	377,599	1,590,245	(2,231,415)	(460,750)	(257,567)	-	21,352,892
Change in net unrealized (losses) gains on investments																
other than trading securities	(1,980,445)	345,649	(174,375)	-	-	(10,573)	(1,980,322)	-	(3,800,066)	(7,250)	(67,497)	-	-	291,981	-	(3,582,832)
Change in net unrealized gain on derivative financial instrument	-	-	-	-	-	-	700,697	-	700,697	-	-	-	-	-	-	700,697
Transfers from (to) subsidiaries	(1,170,945)	-	4,243	-	-	-	(59,028)	-	(1,225,730)	-	-	-	-	-	1,225,730	-
Net assets released from restriction for purchase of																
property and equipment	1,025,625	1,600,817	28,535	-	-	-	-	-	2,654,977	1,362	-	-	-	-	-	2,656,339
Deferred compensation plan liability adjustment	-	-	-	-	-	-	1,609,635	-	1,609,635	-	-	-	-	-	-	1,609,635
Other unrestricted net asset activity		(55)	(619,155)				2,381,444		1,762,234	-	(1,030,848)				(1,225,730)	(494,344)
Increase (decrease) in net assets (deficit) without donor restrictions	\$ 18,799,930	\$ 7,509,793	\$ 2,374,374	\$ 168,791	\$ (6,560,171)	\$ 542,599	\$ 1,201,211	\$ -	\$ 24,036,527	\$ 371,711	\$ 491,900	\$ (2,231,415)	\$ (460,750)	\$ 34,414	\$ -	\$ 22,242,387

Adventist HealthCare, Inc. - Foundations
Combining Schedule, Balance Sheet
December 31, 2018

	Shady Grove Medical Center Foundation, Inc.		Adventist Hospital		Behavioral Health & Wellness Services Foundation, Inc.		Eliminating Entries		<i>H</i> Hea	ombined dventist hCare, Inc. ndations	
Assets											
Current Assets Cash and cash equivalents Current portion of pledges receivable, less allowance for	\$	2,006,674	\$	657,337	\$	-	\$	-	\$	2,664,011	
doubtful pledges		234,283		520,092						754,375	
Total current assets		2,240,957		1,177,429		-		-		3,418,386	
Cash and Cash Equivalents Temporarily Restricted for Capital Acquisitions		-		346,061		-		-		346,061	
Investments		809,672		-		-		-		809,672	
Beneficial Interest in Trusts		130,915		424,287		-		-		555,202	
Noncurrent Portion of Pledges Receivable		224,777		1,001,108						1,225,885	
Total assets	\$	3,406,321	\$	2,948,885	\$		\$		\$	6,355,206	
Liabilities and Net Assets											
Current Liabilities Accounts payable and accrued expenses	\$	13,488	\$	-	\$	-	\$	-	\$	13,488	
Liability to Charitable Gift Annuitants		47,598								47,598	
Total liabilities		61,086					-			61,086	
Net Assets Net assets without donor restrictions Net assets with donor restrictions		2,403,339 941,896		216,958 2,731,927		- -		- -		2,620,297 3,673,823	
Total net assets		3,345,235		2,948,885						6,294,120	
Total liabilities and net assets	\$	3,406,321	\$	2,948,885	\$		\$		\$	6,355,206	

Adventist HealthCare, Inc. - Foundations

Combining Schedule, Statement of Operations and Changes in Net Assets
Year Ended December 31, 2018

	Shady Grove Medical Center Foundation, Inc.	Washington Adventist Hospital Foundation, Inc.	Behavioral Health & Wellness Services Foundation, Inc.	Eliminating Entries	Combined Adventist HealthCare, Inc. Foundations	
Changes in Net Assets Without Donor Restrictions				'		
Revenues, Gains, And Other Support						
Contributions, net	\$ 251,989	\$ 82,531	\$ -	\$ -	\$ 334,520	
Investment income	9,026	-	-	-	9,026	
Net assets released from restrictions	870,665	1,572,607			2,443,272	
Total revenues, gains, and other support	1,131,680	1,655,138			2,786,818	
Expenses						
General and administrative expenses	35,471	55,848	-	-	91,319	
In-kind gifts expended	<del>-</del>	18,961			18,961	
Total expenses before transfers to the hospitals	35,471	74,809	-	-	110,280	
Transfers to the hospitals	1,329,873	1,604,232			2,934,105	
Total expenses	1,365,344	1,679,041			3,044,385	
Revenues less than expenses	(233,664	(23,903)	-	-	(257,567)	
Transfer from (to) Foundations	147,510	-	(147,510)	-	-	
Change in net unrealized gains (losses) on investments						
other than trading securities	327,405	(35,424)			291,981	
Increase (decrease) in net assets without donor restrictions	241,251	(59,327)	(147,510)	-	34,414	
Net assets without donor restrictions, beginning	2,162,088	276,285	147,510		2,585,883	
Net assets without donor restrictions, ending	\$ 2,403,339	\$ 216,958	\$ -	\$ -	\$ 2,620,297	
Changes in Net Assets With Donor Restrictions						
Contributions, net	\$ 253,325	\$ 514,370	\$ -	\$ -	767,695	
Net assets released from restrictions	(870,665	(1,572,607)	_	· .	(2,443,272)	
Change in value of beneficial interest in tusts	5,824		_	_	(1,051)	
Change in discount of pledges receivable and provision for doubtful pledges	(522,186	( ' '	_	_	(508,987)	
Transfer from (to) Foundations	181,781	, ., .,	(181,781)	_	-	
Investment income (loss) and unrealized gains (losses) on investments	(2,069	39,653			37,584	
Decrease in net assets with donor restrictions	(953,990	(1,012,260)	(181,781)	-	(2,148,031)	
Net assets with donor restrictions, beginning	1,895,886	3,744,187	181,781		5,821,854	
Net assets with donor restrictions, ending	\$ 941,896	\$ 2,731,927	\$ -	\$ -	\$ 3,673,823	



# Adventist HealthCare, Inc. and Controlled Entities

Consolidated Financial Statements and Supplementary Information

December 31, 2019 and 2018

# Adventist HealthCare, Inc. and Controlled Entities

Table of Contents
December 31, 2019 and 2018

	<u>Page</u>				
Independent Auditors' Report					
Financial Statements					
Consolidated Balance Sheets	3				
Consolidated Statements of Operations	5				
Consolidated Statements of Changes in Net Assets	6				
Consolidated Statements of Cash Flows	7				
Notes to Consolidated Financial Statements	9				
Supplementary Information					
Adventist HealthCare, Inc. and Controlled Entities:					
Consolidating Schedule, Balance Sheet	42				
Consolidating Schedule, Statement of Operations	44				
Adventist HealthCare, Inc Foundations:					
Combining Schedule, Balance Sheet	45				
Combining Schedule, Statement of Operations and Changes in Net Assets	46				



### **Independent Auditors' Report**

To the Board of Trustees of Adventist HealthCare, Inc. and Controlled Entities

#### **Report on the Financial Statements**

We have audited the accompanying consolidated financial statements of Adventist HealthCare, Inc. and Controlled Entities (collectively, the Corporation), which comprise the consolidated balance sheets as of December 31, 2019 and 2018, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

### Management's Responsibility for the Financial Statements

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

#### **Auditors' Responsibility**

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

#### **Opinion**

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Adventist HealthCare, Inc. and Controlled Entities as of December 31, 2019 and 2018, and the results of their operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

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#### **Emphasis of Matters**

As discussed in Note 2 to the consolidated financial statements, in 2019, the Corporation adopted new accounting guidance related to the accounting for leases and the presentation of amounts generally described as restricted cash and restricted cash equivalents in the consolidated statement of cash flows. Our opinion is not modified with respect to these matters.

#### **Report on Required Supplementary Information**

Accounting principles generally accepted in the United States of America require that the supplemental pro forma information for the acquisition of Fort Washington Medical Center for the years ended December 31, 2019 and 2018 on page 21 be presented to supplement the basic consolidated financial statements. Such information, although not a part of the basis consolidated financial statements, is required by the Financial Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic consolidated financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's response to our inquiries, the basic consolidated financial statements, and other knowledge we obtained during our audit of the basic consolidated financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

### **Report on Supplementary Information**

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

Wilkes-Barre, Pennsylvania

Baker Tilly Virchaw & rause, LP

April 30, 2020

Consolidated Balance Sheets December 31, 2019 and 2018

	2019	2018
Assets		
Current Assets		
Cash and cash equivalents	\$ 25,807,370	\$ 41,673,365
Short-term investments	226,700,054	196,069,788
Assets whose use is limited	3,716,230	3,573,229
Patient accounts receivable	117,498,048	94,756,571
Other receivables	13,764,346	12,096,855
Inventories	12,418,380	8,611,875
Prepaid expenses and other current assets	8,074,200	8,337,954
Total current assets	407,978,628	365,119,637
Property and Equipment, Net	724,843,830	652,882,719
Financing Lease Right-of-Use Asset	2,965,826	-
Operating Lease Right-of-Use Asset	73,138,407	-
Assets Whose Use is Limited		
Under trust indentures and capital lease purchase	40.000.040	400 004 400
financing facilities, held by trustees and banks	40,290,848	139,004,400
Professional liability trust fund	13,948,336	11,128,261
Deferred compensation fund	1,537,921	1,300,086
Cash and Cash Equivalents Restricted for Capital Acquisitions	922,325	1,512,793
Investments and Investments in		
Unconsolidated Subsidiaries	22,555,200	17,057,997
Land Held for Healthcare Development	48,091,039	45,404,765
Intangible Assets, Net	7,918,711	8,127,689
Deposits and Other Noncurrent Assets	3,677,673	4,592,743
Assets Held for Sale	15,939,824	
Total assets	\$ 1,363,808,568	\$ 1,246,131,090

Consolidated Balance Sheets December 31, 2019 and 2018

	2019			2018
Liabilities and Net Assets				
Current Liabilities				
Accounts payable and accrued expenses	\$	110,337,646	\$	86,631,393
Accrued compensation and related items		45,674,609		37,155,567
Interest payable		9,916,230		9,775,665
Due to third party payors		19,589,154		19,981,019
Estimated self-insured professional liability		1,929,261		1,795,731
Current maturities of:				
Long-term obligations		14,070,657		9,151,220
Financing lease obligations		1,053,932		-
Operating lease obligations		13,242,576		
Total current liabilities		215,814,065		164,490,595
Construction Payable		10,894,297		33,038,715
Long-Term Obligations, Net				
Bonds payable		536,331,645		546,699,908
Notes payable		30,888,657		21,295,957
Capital lease obligations		-		10,096,187
Suprial rouse obligations				10,000,107
Financing Lease Obligations		1,747,777		-
Operating Lease Obligations		60,968,875		-
Derivative Financial Instrument		236,291		503,251
Other Liabilities		13,552,593		10,257,050
Estimated Self-Insured Professional Liability		16,138,921		14,929,354
Total liabilities		886,573,121		801,311,017
Net Assets				
Net assets without donor restrictions		471,275,984		439,571,362
Net assets with donor restrictions		5,959,463		5,248,711
Total net assets		477,235,447		444,820,073
Total liabilities and net assets	\$	1,363,808,568	\$	1,246,131,090

Adventist HealthCare, Inc. and Controlled Entities
Consolidated Statements of Operations
Years Ended December 31, 2019 and 2018

	2019	2018
Revenues		
Net patient service revenue	\$ 821,575,609	\$ 779,303,420
Other revenues	40,928,213	41,246,589
Total revenues	862,503,822	820,550,009
Expenses		
Salaries and wages	384,439,065	366,176,376
Employee benefits	73,675,888	72,221,612
Contract labor	38,699,033	35,754,655
Medical supplies	107,737,246	104,580,658
General and administrative	127,423,342	122,362,912
Building and maintenance	44,000,964	41,344,766
Insurance	6,950,972	9,113,009
Interest	16,586,180	11,951,282
Depreciation and amortization	41,582,280	38,120,194
Loss on disposal of property and equipment	3,265,295	
Total expenses	844,360,265	801,625,464
Income from operations	18,143,557	18,924,545
Other Income (Expense)		
Investment income	14,156,295	2,284,965
Other (loss) income	(1,510,714)	143,382
Inherent contribution on business combination	7,045,520	_
interest contribution on business combination	7,040,320	
Total other income	19,691,101	2,428,347
Revenues in excess of expenses from		
continuing operations	37,834,658	21,352,892
Change in net unrealized gains and losses on investments in debt securities	8,144,221	(3,582,832)
Change in net unrealized gain on derivative financial instrument	700,697	700,697
Net assets released from restriction for purchase of	4 === 004	0.050.000
property and equipment	1,777,624	2,656,339
Deferred compensation plan liability adjustment	(789,431)	1,609,635
Other net asset activity	(24,248)	(494,344)
Increase in net assets without donor restrictions from		
continuing operations	47,643,521	22,242,387
Loss from discontinued operations	(14,841,272)	
Increase in net assets without donor restrictions	\$ 32,802,249	\$ 22,242,387

Adventist HealthCare, Inc. and Controlled Entities
Consolidated Statements of Changes in Net Assets
Years Ended December 31, 2019 and 2018

No. A control Million A Decomposition of the Control				
Net Assets Without Donor Restrictions	_		_	
Revenues in excess of expenses from continuing operations	\$	37,834,658	\$	21,352,892
Change in net unrealized gains and losses on investments in debt securities		8,144,221		(3,582,832)
Change in net unrealized gain on derivative financial instrument		700,697		700,697
Net assets released from restriction for purchase of property and equipment		1,777,624		2,656,339
Deferred compensation plan liability adjustment		(789,431)		1,609,635
Other net asset activity		(24,248)		(494,344)
Increase in net assets without donor restrictions				
from continuing operations		47,643,521		22,242,387
Loss from discontinued operations		(14,841,272)		_
2000 Hoff Glocoffandou oportations		(11,011,272)		
Increase in net assets without donor restrictions		32,802,249		22,242,387
Net Assets With Donor Restrictions				
Restricted gifts and donations		6,174,849		4,077,505
Net assets released from restriction for purchase of property and equipment		(1,777,624)		(2,656,339)
Net assets released from restriction used for operations		(3,516,369)		(3,519,841)
Change in value of beneficial interest in trusts and charitable gift annuity obligation		(204,626)		(69,836)
Change in discount of pledges receivable and provision for doubtful pledges		25,622		(508,987)
Donor restricted investment income		8,900		37,584
Increase (decrease) in net assets with donor restrictions		710,752		(2,639,914)
Increase in net assets		33,513,001		19,602,473
Net Assets, Beginning		444,820,073		425,217,600
Cumulative Effect of Change in Accounting Principle		(1,097,627)		
Net Assets, Ending	\$	477,235,447	\$	444,820,073

Consolidated Statements of Cash Flows Years Ended December 31, 2019 and 2018

	2019		2018	
			(A	s Adjusted)
Cash Flows From Operating Activities				
Increase in net assets	\$	33,513,001	\$	19,602,473
Adjustments to reconcile increase in net assets to net cash				
provided by operating activities:				
Depreciation and amortization		41,582,280		38,120,194
Operating lease right-of-use asset amortization		12,458,746		-
Amortization of deferred financing costs		228,770		212,496
Deferred compensation plan liability adjustment		789,431		(1,609,635)
Restricted contributions and grants		(4,767,614)		(1,151,766)
Earnings recognized from unconsolidated subsidiaries				
and affiliates		(2,197,709)		(1,943,590)
Amortization of physician income guarantees		98,362		26,348
Inherent contribution on business combination, net of cash received		(8,338,485)		-
Cumulative effect of change in accounting principle		1,097,627		=
Loss on disposal of property and equipment		14,670,635		-
Net realized and unrealized gains and losses on investments		(7,381,743)		3,128,140
Change in net unrealized gains and losses on investments in debt securities		(8,144,221)		3,582,832
Change in net unrealized gain on derivative financial instrument		(700,697)		(700,697)
Change in value of beneficial interest in trusts and charitable gift obligation		204,626		69,836
Change in discount on pledges receivable and provision for				
doubtful pledges		(25,622)		508,987
Changes in assets and liabilities:				
Patient accounts receivable		(20,225,577)		(1,546,625)
Other receivables		(405,066)		3,947,778
Inventories, prepaid expenses and other current assets		(1,915,020)		113,996
Accounts payable and accrued expenses		17,732,171		(186,791)
Accrued compensation and related items		7,242,684		(104,879)
Interest payable		140,565		28,371
Estimated self-insured professional liability		1,343,097		2,462,540
Due to third party payors		(971,611)		2,162,617
Operating lease obligations		(15,961,759)		=
Other noncurrent assets and liabilities		474,929		397,341
Net cash provided by operating activities		60,541,800		67,119,966
, , , , ,		- /- /		, -,

Consolidated Statements of Cash Flows Years Ended December 31, 2019 and 2018

		2019		2018
Cash Flows From Investing Activities			(4	As Adjusted)
Purchase of property and equipment Increase in investments and investments in unconsolidated subsidiaries Additions to land held for healthcare development	\$	(157,328,472) (15,129,013) (2,686,274)	\$	(159,276,923) (4,779,492) (2,309,960)
Proceeds from sale of land for healthcare development Distributions from investments in unconsolidated subsidiaries		9,608,328		4,565,265 2,524,000
Purchase of investment in unconsolidated subsidiary Cash received in the acquisition of Fort Washington Decrease in trustee held funds and restricted cash		(3,781,111) 1,292,965 57,057,942		(1,182,000) - 105,751,759
Net cash used in investing activities		(110,965,635)		(54,707,351)
Cash Flows From Financing Activities				
Payment of financing costs		(589,794)		-
Repayments on long-term obligations, net		(9,235,873)		(13,360,724)
Repayment of financing lease obligations		(1,088,539)		-
Proceeds from restricted contributions and grants		4,767,614		1,151,766
Net cash used in financing activities		(6,146,592)		(12,208,958)
Net (decrease) increase in cash, cash equivalents and restricted cash and cash equivalents		(56,570,427)		203,657
Cash, Cash Equivalents and Restricted Cash and Cash Equivalents, Beginning		100,073,953		99,870,296
Cash, Cash Equivalents and Restricted Cash and Cash Equivalents, Ending	\$	43,503,526	\$	100,073,953
Supplemental Disclosure of Cash Flow Information Interest paid	\$	18,918,874	\$	12,464,520
Supplemental Disclosure of Noncash Investing and Financing Activities Financing/capital lease obligation incurred for equipment	\$		\$	3,203,212
r mancing/capital lease obligation incurred for equipment	Ψ		Ψ	3,203,212
Land contributed to investment in unconsolidated subsidiary	\$	8,627,000	\$	1,153,672
Construction payable for property and equipment	\$	10,894,297	\$	33,038,715
Reconciliation of Cash, Cash Equivalents and Restricted Cash and Cash Equivalents				
Cash and cash equivalents  Cash and cash equivalents restricted for capital acquisitions  Cash and cash equivalents included in the current portion	\$	25,807,370 922,325	\$	41,673,365 1,512,793
of assets whose use is limited  Cash and cash equivalents included in the noncurrent portion		3,716,230		3,573,229
of assets whose use is limited		13,057,601		53,314,566
Total cash, cash equivalents and restricted cash and cash equivalents	\$	43,503,526	\$	100,073,953

Notes to Consolidated Financial Statements December 31, 2019 and 2018

#### 1. Nature of Operations and Summary of Significant Accounting Policies

### **Nature of Operations**

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

Shady Grove Medical Center (SGMC) is a 248-bed acute care hospital located in Rockville, Maryland. Effective August 1, 2018, Behavioral Health & Wellness Services (BH&WS) became a department of SGMC and as a result is reimbursed under SGMC's global budget revenue agreement. BH&WS is comprised of BH&WS - Rockville, a 117-bed psychiatric hospital.

White Oak Medical Center (WOMC) is a 191-bed acute care hospital located in Silver Spring, Maryland. On August 25, 2019, the newly constructed WOMC opened.

Rehabilitation (Rehab) operates one inpatient hospital with two sites in Maryland, as well as two outpatient locations. Rehab - Rockville is a 55-bed rehabilitation facility and Rehab - Takoma Park is a 42-bed rehabilitation facility. The Rehab – Takoma Park facility is scheduled to relocate to WOMC in late 2020.

Adventist HealthCare Imaging (Imaging) operates seven clinical sites and provides inpatient and outpatient imaging services at SGMC and WOMC.

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

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

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

Notes to Consolidated Financial Statements December 31, 2019 and 2018

In October 2019, Adventist HealthCare Fort Washington Medical Center, Inc., a subsidiary of AHC, acquired Fort Washington Medical Center (FWMC) (Note 3). FWMC is a 27-bed acute care hospital located in Fort Washington, Maryland.

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

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

Adventist HealthCare Urgent Care Center, Inc. (Urgent Care) is comprised of three urgent care centers located in Germantown, Laurel and Rockville, Maryland. These centers provide ambulatory services to patients without life threatening conditions, as well as occupational health screenings to the community.

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

The Foundations operating division is comprised of Washington Adventist Hospital Foundation, Inc., d/b/a White Oak Medical Center Foundation Inc. and Shady Grove Medical Center Foundation, Inc. (collectively, the Foundations). Each are separate nonstock corporations that operate for the furtherance of each named hospital's health care objectives primarily through the solicitation of contributions, gifts and bequests. The Foundations also exist to help fund new equipment purchases and capital improvement projects for their respective hospitals.

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

### **Principles of Consolidation**

The consolidated financial statements for 2019 and 2018 include the accounts of AHC, the controlling parent, SGMC, WOMC, Rehab, Imaging, CIS, LWS, CCPL, the Support Center, FWMC, the Lourie Center, AHCS, Urgent Care, OHQA, and the Foundations, which include their majority-owned subsidiaries and controlled affiliates (collectively, the Corporation). All significant intercompany balances and transactions have been eliminated in the consolidated financial statements of the Corporation.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

### **Subsequent Events**

The Corporation evaluated subsequent events for recognition or disclosure through April 30, 2020, the date the consolidated financial statements were issued.

During the first several months of 2020, the Coronavirus disease (COVID 19), an infectious disease caused by the SARS-CoV-2 virus, spread globally, resulting in a pandemic. The COVID-19 pandemic is having significant effects on global markets, supply chains, businesses, and communities. The Corporation's evaluation of the effects of these events is ongoing as of the date the accompanying consolidated financial statements were issued. COVID-19 may impact various parts of the Corporation's 2020 operations and financial performance including, but not limited to, additional costs for emergency preparedness, disease control and containment, potential shortages of personnel, supply chain disruption, closure of certain facilities or service lines, or declines in revenue related to decreases in volumes of certain revenue streams. The extent of the impact is unknown and will depend on future developments, including the duration and spread of the outbreak and related governmental or other regulatory actions.

Numerous government programs at the federal, state and local levels are currently being developed to provide relief funds to healthcare providers on the front lines of the COVID-19 pandemic. In April 2020, the Centers for Medicare & Medicaid Services (CMS) delivered relief funds to healthcare providers through the Accelerated and Advance Payment Program. The advance and accelerated payments range from three to six months-worth of a providers Medicare reimbursement and represent a loan that providers must pay back via offsets to future claims. The offsets begin 120 days after disbursement of the accelerated/advance payments and require full repayment within 365 days (210 days for certain providers). The payments are available to all Medicare Part A providers, including hospitals, and all Medicare Part B suppliers, including doctors, non-physician practitioners and durable medical equipment suppliers. In April 2020, the Corporation received advanced payments of approximately \$141,100,000 under the Accelerated and Advance Payment Program.

In April 2020, the United States Congress passed the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), which also provides relief funds to healthcare providers on the front lines of the COVID-19 pandemic. This funding is to be used to support healthcare-related expenses or lost revenue attributable to COVID-19 and to ensure uninsured Americans can get testing and treatment for COVID-19. In April 2020, approximately 30 percent of the relief funds were distributed based on the healthcare providers share of total Medicare FFS reimbursements in 2019. All healthcare providers that received Medicare fee-for-service (FFS) reimbursements in 2019 are eligible for the relief funds. The Corporation is required to make certain certifications and has certain reporting requirements as a condition of receiving the funds. In addition, healthcare providers must agree not to seek collection of out-of-pocket payments from a COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider. In April 2020, the Corporation received approximately \$20,191,000 of relief funds under the CARES Act.

The Corporation intends to take the necessary steps to maximize relief under all possible federal, state and local government programs.

#### **Use of Estimates**

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

#### **Maryland Health Services Cost Review Commission**

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

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

As a result of the waiver, the HSCRC introduced revenue arrangements, including the Global Budget Revenue (GBR) model. The GBR methodology encourages hospitals to focus on population health strategies by establishing a fixed annual revenue cap for each GBR hospital. The agreement establishes a fixed amount of charging authority (i.e. revenue) at the beginning of the rate year. It is evergreen in nature and covers both regulated inpatient and outpatient revenues. Annual revenue is calculated from a base year and is adjusted annually for inflation, infrastructure requirements, population changes, performance in quality-based programs and changes in levels of uncompensated care. Revenue may also be adjusted annually for market levels and shifts of services from one health system to another and from a regulated setting to an unregulated setting (or vice versa).

In 2014, AHC entered into GBR Agreements with the HSCRC for SGMC, WOMC and Shady Grove Germantown Emergency Center. FWMC entered into a GBR agreement with the HSCRC in 2014. The agreements set an initial fixed amount of revenue for each entity for the period July 1, 2013 through June 30, 2014 and is subsequently updated on an annual basis every July 1.

The HSCRC requires rate-regulated hospitals under its jurisdiction to calculate the amount of revenue lost or gained due to variances from approved rates. Revenue lost due to undercharges in rates is recouped through increases in prospective rates. Similarly, revenue gained due to overcharges in rates is paid back, wholly or in part, through reductions in prospective rates. The Corporation reported net overcharges of \$1,022,206 as of December 31, 2019 and net undercharges of \$1,289,841 as of December 31, 2018. These price variances reflect the variance between actual patient charges and the pro-rata share of approved rate orders. The net amounts are reported as a component of net patient service revenue and patient accounts receivable in the accompanying consolidated financial statements. Since the HSCRC's rate year extends from July 1 through June 30, these amounts will continue to fluctuate until the end of the rate year as actual patient charges deviate from the total approved charging authority. At the conclusion of the rate year, any over/under charges are amortized on the straight-line basis over the following rate year when the price variance adjustments are actually built into each entity's rate order.

Under Maryland law, charges of specialty hospitals such as Rehab are subject to review and approval by the HSCRC. HSCRC regulations also include a provision whereby a hospital may apply for an exemption from the requirements to charge for services in accordance with HSCRC regulations. Certain conditions regarding the percentage of revenue related to Medicare and Medicaid patients and total revenues must be met to receive the initial exemption and must be met each year thereafter. Reporting requirements as established by the HSCRC continue even if an exemption regarding charging for services is received. The Corporation's management believes Rehab met the conditions for exemption during 2019 and 2018.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

BH&WS-Rockville is subject to HSCRC rate setting. For the period January 1, 2018 through July 31, 2018, BH&WS-Rockville did not enter into a Global Budget Revenue Agreement. Instead, BH&WS-Rockville continues to generate charging authority based on the volume of services it provides to patients. Unit rates are set for all payors, however Medicare and Medicaid are not required to reimburse at HSCRC rates. Services provided to Medicare beneficiaries are reimbursed under the Inpatient Psychiatric Facility Prospective Payment System. Services provided to Medicaid patients are cost-settled for outpatient services and reimbursed for inpatient services at a rate of 94 percent of charges (as set forth in the Code of Maryland Regulations 10.09.06.09). Effective August 1, 2018, BH&WS became a department of SGMC and is reimbursed under their Global Budget Revenue Agreement.

### **Cash and Cash Equivalents**

Cash and cash equivalents include investments in money market funds and certificates of deposit purchased with original maturities of less than 90 days, excluding assets whose use is limited. For purposes of the statements of cash flows, cash, cash equivalents and restricted cash and cash equivalents include investments purchased with an initial maturity of three months or less.

#### **Patient Accounts Receivable**

The Corporation assesses collectability on patient contracts prior to the recognition of net patient service revenues. Patient accounts receivable are reported at their net realizable value. Accounts are written off through bad debt expense when the Corporation has exhausted all collection efforts and determines accounts are impaired based on changes in patient credit worthiness. Patient accounts receivable also includes management's estimate of the impact of certain undercharges to be recouped or overcharges to be paid back for inpatient and outpatient services in subsequent years rates as discussed earlier.

#### Other Receivables

Other receivables represent amounts due to the Corporation for charges other than providing health care services to patients and pledges from donors and are reported at their net realizable value. These services include, but are not limited to, fees from educational programs, rental of health care facility space, interest earned and management services provided to unconsolidated subsidiaries. Other receivables are written off when they are determined to be uncollectible based on management's assessment of individual accounts.

#### **Assets Whose Use Is Limited**

Assets whose use is limited includes assets held by bond trustees under trust indentures, assets set aside as required by the Corporation's self-funded professional liability trust, assets set aside for deferred compensation agreements and those set aside in accordance with the United States Department of Housing and Urban Development (HUD) mortgage loan payable. Amounts available to meet current liabilities of the Corporation have been reclassified as current assets in the accompanying consolidated balance sheets.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

#### **Investments and Investment Risk**

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

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

#### **Inventories**

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

#### **Property and Equipment**

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful lives of the assets using the straight-line method. Equipment under capital leases is amortized on the straight-line method over the shorter period of the lease term or estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the accompanying consolidated statements of operations. As discussed in Note 2 to the consolidated financial statements, the Corporation adopted new accounting standards guidance related to the accounting for leases in 2019.

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

Impairment losses are recognized in the consolidated statements of operations as a component of revenues in excess of expenses from continuing operations as they are determined. The Corporation reviews its long-lived assets whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. In that event, the Corporation calculates the estimated future net cash flows to be generated by the asset. If those future net cash flows are less than the carrying value of the asset, an impairment loss is recognized for the difference between the estimated fair value and the carrying value of the asset. There were no impairment losses reported in 2019 or 2018.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

#### Leases and Right-of-Use Assets

Under Topic 842, the Corporation evaluates at contract inception whether a lease exists and recognizes a lease obligation and right-of-use (ROU) asset for all leases with a term greater than 12 months. Leases are classified as either financing or operating. All lease liabilities are measured as the present value of the future lease payments using a discount rate. The future lease payments used to measure the lease liability include fixed payments, as well as the exercise price of any options to purchase the underlying asset that have been deemed reasonably certain of being exercised, if applicable. Future lease payments for optional renewal periods that are not reasonably certain of being exercised are excluded from the measurement of the lease liability. For all leases, the ROU asset is initially derived from the measurement of the lease liability and adjusted for certain items, such as initial direct costs and lease incentives received. ROU assets are subject to long-lived impairment testing.

Amortization of financing lease ROU assets, which is recognized on a straight-line basis over the lesser of the lease term and the estimated useful life of the asset, is included within depreciation and amortization expense in the consolidated statements of operations. Interest expense associated with financing lease obligations is included within interest expense in the consolidated statements of operations. Operating lease expense is recognized on a straight-line basis over the lease term and is included within building and maintenance in the consolidated statements of operations. The lease term is determined based on the date the Corporation acquires control of the leased premises through the end of the lease term. Optional renewal periods are initially not included in the lease term unless they are deemed to be reasonably certain of being exercised at lease commencement.

#### **Intangible Assets**

The Corporation's intangible assets primarily include costs in excess of net assets acquired related to certain business acquisitions. The Corporation is amortizing certain intangible assets over a period not to exceed 40 years. Amortization of these intangible assets was \$230,622 in 2019 and \$218,792 in 2018. Accumulated amortization of intangible assets was \$4,057,430 and \$3,826,808 as of December 31, 2019 and 2018, respectively.

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

#### **Deferred Financing Costs**

Costs incurred in connection with the issuance of long-term obligations have been deferred and are being amortized over the term of the related obligation using the straight-line method. Deferred financing costs remaining as of December 31, 2019 and 2018 totaled \$5,212,539 and \$4,850,301, respectively, and are included in the consolidated balance sheets as a reduction of bonds payable.

Amortization expense was \$228,770 and \$212,496 in 2019 and 2018, respectively, and is included as a component of interest expense in the consolidated statements of operations. Accumulated amortization of deferred financing costs was \$3,303,088 and \$3,074,318 at December 31, 2019 and 2018, respectively, and is included as a component of bonds payable in the consolidated balance sheets.

### **Due to Third Party Payors**

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

Notes to Consolidated Financial Statements December 31, 2019 and 2018

Settlements with third party payors for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on reimbursable costs, the terms of the payment agreement with the payor, correspondence with the payor and the Corporation's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information become available), or as years are settled or no longer subject to such audits, reviews and investigations. Adjustments arising from a change in the transaction price, were not significant in 2019 or 2018.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result, health care entities, may from time to time and in the ordinary course of business, receive requests for information and notices from government agencies regarding alleged noncompliance with those laws and regulations, some of which may result in settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties and potential exclusion from the related programs. Management is not aware of any material incidents of noncompliance; however, there can be no assurance that regulatory authorities will not challenge the Corporation's compliance in the future.

#### **Derivative Financial Instruments**

The Corporation has an interest rate swap agreement, which is considered a derivative financial instrument, to manage its interest rate exposure on certain long-term obligations (Note 13). The interest rate swap agreement is reported at fair value in the accompanying consolidated balance sheets. The interest rate swap agreement is not designated as a cash flow hedge. Changes in fair value are reported as a component of other nonoperating income (expense).

### **Estimated Self-Insured Professional Liability**

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

### **Net Assets**

Net assets, revenues, gains and losses are classified based on the existence or absence of donor imposed restrictions. Accordingly, net assets and changes therein are classified and reported as follows:

**Net Assets Without Donor Restrictions** includes amounts available for use in general operations and not subject to donor restrictions. All revenue not restricted by donors and donor restricted contributions whose restrictions are met in the same period in which they are received are accounted for in net assets without donor restrictions.

Net Assets With Donor Restrictions includes amounts subjected to donor imposed restrictions which are temporary in nature, such as those that will be met by the passage of time or other events specified by the donor. Other donor-imposed restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity. All revenues restricted by donors as to either timing or purpose of the related expenditures or required to be maintained in perpetuity as a source of investment income are accounted for in net assets with donor restrictions. When a donor restriction expires, that is when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified to net assets without donor restrictions. Net assets were released from donor restriction by satisfying their restricted purposes in the amount of \$5,293,993 in 2019 and \$6,176,180 in 2018.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

Net assets with donor restrictions includes those whose use by the Corporation has been limited by donors to specific purposes in the amount of \$5,618,042 and \$4,907,290 as of December 31, 2019 and 2018, respectively. Net assets with donor restrictions that have been restricted by donors to investments to be held in perpetuity was \$341,421 as of December 31, 2019 and 2018.

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received or when the underlying conditions have been substantially met. The gifts are reported as net assets with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. Restricted funds to be used for capital acquisitions have been reported as noncurrent assets in the accompanying consolidated balance sheets, while other restricted cash and investments are included with the cash and cash equivalents of net assets without donor restrictions.

#### **Measure of Operations**

The consolidated statements of operations reflects all changes in net assets without donor restrictions, including changes from both operating and nonoperating activities. Operating revenues and expenses consist of those items that are an integral part of the Corporation's provision of healthcare and related supporting activities. Nonoperating activities are limited to resources that generate return from investments and other activities considered to be of a more unusual or nonrecurring nature.

#### **Revenues in Excess of Expenses from Continuing Operations**

The consolidated statements of operations include the determination of revenues in excess of expenses from continuing operations. Revenues in excess of expenses from continuing operations is the Corporation's performance indicator. Changes in net assets without donor restriction which are excluded from the determination of revenues in excess of expenses from continuing operations, consistent with industry practice, include the change in net unrealized gains and losses on investments in debt securities, the effective portion of the net unrealized gain on derivative financial instruments, the deferred compensation plan liability adjustment, contributions of long-lived assets (including contributions which by donor restriction were to be used for the purpose of acquiring such long-lived assets), other net asset without donor restriction activity, and the loss from discontinued operations.

#### **Net Patient Service Revenue**

Net patient service revenues are recognized at the amount that reflects the consideration to which the Corporation expects to be entitled in exchange for providing patient care. These amounts are due from patients, third party payors (including commercial and governmental programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews and investigations. Generally, the Corporation bills the patients and third party payors after the services are performed and/or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

> Performance obligations are determined based on the nature of the services provided by the Corporation. Revenues for performance obligations satisfied over time are recognized based on actual charges incurred in relation to total expected (or actual) charges, ultimately adjusted in accordance with the charging authority awarding at the beginning of every year by the HSCRC. The Corporation believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in our hospitals receiving services over multiple days. The Corporation measures the performance obligation from admission into the hospital to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge. Revenue for performance obligations satisfied at a point in time are generally recognized when goods or services are provided and the Corporation does not believe it is required to provide additional services to the patient. Generally, performance obligations satisfied at a point in time relate to patients receiving outpatient services in a single day. The Corporation measures the performance obligation from the commencement of the outpatient service, to the point when it is no longer required to provide services to that patient, which is generally the completion of the outpatient service.

All of the Corporation's performance obligations generally relate to contracts with a duration of less than one year, therefore the Corporation has elected to apply the optional exemptions provided in FASB ASC 606-10-50-14(a) and as a result is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

The Corporation determines the transaction price based on standard charges for services provided, reduced by contractual adjustments provided to third party payors, financial assistance provided to uninsured or underinsured patients in accordance with the Corporation's policies, and/or implicit price concessions provided to uninsured or underinsured patients. The Corporation determines its estimates of contractual adjustments based on contractual agreements, its financial assistance policies and historical experience. The Corporation determines its estimates of implicit price concessions based on its historical collection experience with a respective class of patient. Certain amounts categorized as implicit price concessions under ASC 606 were previously categorized as provision for doubtful accounts. The Corporation pursues collection of amounts defined as implicit price concessions.

The Corporation has elected the practical expedient allowed under FASB ASC 606-10-32-18 and does not adjust the promised amount of consideration from patients and third party payors for the effects of a significant financing component due to the Corporation's expectation that the period between the time the service is provided to a patient and the time that the patient or a third party payor pays for that service will be one year or less.

#### **Income Taxes**

The Corporation accounts for uncertainty in income taxes using a recognition threshold of more-likely-than-not to be sustained upon examination by the appropriate taxing authority. Measurement of the tax uncertainty occurs if the recognition threshold is met. Management determined there were no tax uncertainties that met the recognition threshold in 2019 or 2018.

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

Notes to Consolidated Financial Statements December 31, 2019 and 2018

#### **Charity Care**

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

The Corporation maintains records to identify and monitor the level of charity care it provides. The costs associated with the charity care services provided are estimated by applying a cost-to-charge ratio to the amount of gross uncompensated charges for the patients receiving charity care. The level of charity care provided by the Corporation amounted to approximately \$13,819,000 in 2019 and \$8,958,000 in 2018.

#### **Advertising Costs**

The Corporation expenses advertising costs as they are incurred.

### 2. Adoption of Accounting Standards

#### **Financial Instruments**

During 2019, the Corporation prospectively adopted the Financial Accounting Standards Board's (FASB) Accounting Standards Update (ASU) No. 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities*. The provisions of ASU No. 2016-01 require marketable equity securities to be reported at fair value with changes in fair value recognized within the performance indicator, establishes a qualitative factor in evaluating impairment on equity investments without readily determinable fair values, and eliminates the requirement to disclose the fair value on financial instruments measured at amortized cost. The Corporation has adjusted the presentation of the consolidated financial statements accordingly.

### **Restricted Cash**

In 2019, the Corporation retrospectively adopted the FASB ASU No. 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash.* The amendments in this update require that a consolidated statement of cash flows explain the change during the period in total of cash, cash equivalents and amounts generally described as restricted cash or restricted cash equivalents. Amounts generally described as restricted cash and restricted cash equivalents should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts shown on the statement of cash flows. The decrease in trustee held funds and restricted cash was decreased \$754,824 and cash and cash equivalents, beginning was increased \$58,400,588 on the consolidated statements of cash flows for the year ended December 31, 2018 as a result of this change in accounting principle.

#### **Lease Accounting**

Effective January 1, 2019, the Corporation adopted the FASB's ASU No. 2016-02, *Leases (as amended) (Topic 842)*. ASC 842 was issued to increase transparency and comparability among organizations by recognizing lease assets and lease liabilities on the balance sheet and disclosing key information about leasing arrangements. Under the provisions of ASC 842, a lessee is required to recognize a right-of-use asset and lease liability, initially measured at the present value of the remaining lease payments, in the consolidated balance sheets. In addition, lessees are required to provide qualitative and quantitative disclosures that enable users to understand more about the nature of the Corporation's leasing activities.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

The Corporation elected the option to apply the transition requirements at the effective date of January 1, 2019, which allows the effects of initially applying ASU No. 2016-02 (as amended) to be recognized as a cumulative effect adjustment to net assets without donor restrictions in the period of adoption. Consequently, the consolidated financial statements and disclosures required under ASC 842 have not been updated as of and for year ending December 31, 2018. The Corporation also elected the package of practical expedients, which permits the Corporation to not reassess prior conclusions about lease identification, classification and initial direct costs. In addition, the Corporation elected the short-term lease recognition exemption for all leases that qualify under Topic 842.

The adoption of ASU No. 2016-02 (as amended) had a material effect on the Corporation's consolidated financial statements. The most significant effects relate to the recognition of new right-of-use assets and lease liabilities on its consolidated balance sheets for operating leases and providing significant new disclosures about leasing activities. Upon adoption, the Corporation recognized operating lease obligations of \$86,694,778 based on the present value of the remaining minimum rental payments as determined in accordance with Topic 842 for leases that had historically been accounted for as operating leases under Topic 840. The Corporation recognized the corresponding right-of-use assets of approximately \$85,597,151 based on the operating lease liabilities. The resulting net impact of \$1,097,627 associated with this change in accounting was recognized as a reduction to net assets without donor restrictions as of January 1, 2019.

#### Goodwill

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

### 3. Business Combination

On October 27, 2019, AHC and Adventist Healthcare Fort Washington Medical Center, Inc. entered into an asset purchase agreement (the Purchase Agreement) with Fort Washington Medical Center, Inc., Fort Washington Ambulatory Services, LLC, Nexus Health, Inc. (owner of Fort Washington Medical Center, Inc. and Fort Washington Ambulatory Services, LLC) and Carolyn Boone Lewis Health Care Center (former subsidiary of Nexus Health, Inc.) (collectively, Fort Washington). In accordance with the terms of the Purchase Agreement, substantially all assets and liabilities of Fort Washington were acquired in exchange for no consideration. The contractual amounts of accounts receivable approximate fair value due to their short-term nature.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

In accordance with the authoritative guidance, the assets and liabilities of Fort Washington were recorded at fair market value as of the date of acquisition as follows:

Assets Acquired		
Cash and cash equivalents	\$	1,292,965
Accounts receivable		2,515,900
Trustee held funds		1,659,265
Property and equipment		17,273,239
Other assets		2,201,189
Inventories		1,299,245
Total assets acquired		26,241,803
Liabilities Assumed Accounts payable and accrued expenses		7,160,047
Other liabilities		5,072,362
Long-term obligations		6,856,874
Total liabilities assumed		19,089,283
Net Assets Assumed	_\$_	7,152,520
Inherent Contribution Without Donor Restrictions	_\$_	7,045,520
Inherent Contribution With Donor Restrictions	\$	107,000

The following table summarizes the operating results of Fort Washington for the years ended December 31 (unaudited):

	 2019	 2018
Revenues Expenses	\$ 46,075,099 46,038,904	\$ 45,830,699 44,440,761
Income from operations	36,195	1,389,938
Inherent contribution on business combination	 7,045,520	 
Revenues in excess of expenses from continuing operations	\$ 7,081,715	\$ 1,389,938

The following table summarizes the operating results of Fort Washington for the period October 27, 2019 through December 31, 2019:

Revenues Expenses	\$ 8,420,176 8,124,077
Income from operations	296,099
Inherent contribution on business combination	7,045,520
Revenues in excess of expenses from continuing operations	\$ 7,341,619

Notes to Consolidated Financial Statements December 31, 2019 and 2018

#### 4. Discontinued Operations and Assets Held for Sale

In July 2019, AHC entered into an agreement to sell the Takoma Park campus to an unrelated third party for \$12,000,000. The opportunities for growth and expansion at the Takoma Park campus were limited, and the Corporation wanted to expand access to care throughout the Washington DC region, leading to the decision to sell the campus. The closing will take place on the later of July 31, 2020 or the date that the rehabilitation hospital located on the Takoma Park campus relocates to WOMC.

The current operations on the Takoma Park Campus consist of a walk -in clinic, which began in August 2019, are included in the loss from discontinued operations in the accompanying consolidated statements of operations.

As a result of entering into the sale agreement, a significant amount of property and equipment (other than real estate) was disposed of and a loss of approximately \$11,576,000 was recognized in 2019 and included in the loss from discontinued operations in the accompanying consolidated statements of operations.

Assets held for sale in the accompanying consolidated balance sheets is comprised of land and improvements of \$330,152 and building and improvements of \$15,609,672 at December 31, 2019 that will be sold as part of the agreement. No gain or loss on sale has been recognized in 2019.

The following amounts related to discontinued operations are included in the loss from discontinued operations in the accompanying consolidated statements of operations in 2019:

Total revenues	\$ 308,312
Total expenses, including loss on disposal of approximately	
\$11,576,000	 (15,149,584)
Loss on discontinued operations	\$ (14.841.272)

#### 5. Net Patient Service Revenues

The Corporation routinely obtains assignments of (or is otherwise entitled to receive) patient benefits receivable under their health insurance programs, plans or policies (i.e. third party payors). Third party payors include both government payors, which include Medicare, Medicaid and Management Care Organizations and commercial insurance carriers. Agreements with third party payors typically provide for payments at amounts less than established charges. A summary of payment arrangements with third party payors, by service type, is as follows:

- Global budget revenue SGMC, WOMC and FWMC have entered into agreements by which the
  third party payors pay a percentage of approved HSCRC charges. A reduced percentage can be
  obtained if the payor advances a certain amount of working capital.
- Rehabilitation services Rehab has entered into agreements by which the third party payors pay
  at a contract rate per day or visit.
- Physician practice services AMG has entered into agreements by which the third party payors
  pay negotiated rates per procedures as defined in the term sheet of the agreements.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

- Imaging services Imaging has entered into agreements by which the third party payors pay negotiated rates per procedures as defined in the term sheet of the agreements.
- Home health services AHCS has entered into agreements by which the third party payors pay negotiated rates on a per visit basis.

Generally, patients who are covered by third party payors are responsible for related deductibles and coinsurance, which vary in amount. The Corporation also provides services to uninsured patients, and offers those uninsured or underinsured patients financial assistance, by either policy or law, from standard charges. The Corporation estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charges by any contractual adjustment, financial assistance and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustment to net patient service revenues in the period of the change. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense.

Consistent with the Corporation's mission, care is provided to patients regardless of their ability to pay. Therefore, the Corporation has determined it has provided implicit price concessions to uninsured patients and other patient balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Corporation expects to collect based on its collection history with those patients.

The Corporation disaggregates revenue from contracts with customers by type of service and payor source as this depicts the nature, amount, timing and uncertainty of its revenue and cash flows as affected by economic factors. Tables providing details of these factors are presented below.

Net patient service revenues disaggregated by service type for the years ended December 31, 2019 and 2018 are as follows:

	2019	2018
Global budget revenue	\$ 673,535,497	\$ 636,611,309
Rehabilitation services	51,093,067	46,385,493
Physician practice services	29,281,063	30,529,693
Imaging services	29,653,620	29,948,092
Home health services	29,741,785	28,779,161
Other health services	8,270,577	7,049,672
Total	\$ 821,575,609	\$ 779,303,420

Net patient service revenues disaggregated by payor for the years ended December 31, 2019 and 2018 are as follows:

	Medicare	Medicaid	Other Third Party Payors	Self-Pay and Other	Total
December 31, 2019	\$ 312,084,164	\$ 85,808,181	\$ 391,026,645	\$ 32,656,619	\$ 821,575,609
December 31, 2018	\$ 292,876,720	\$ 85,066,955	\$ 368,341,417	\$ 33,018,328	\$ 779,303,420

Notes to Consolidated Financial Statements December 31, 2019 and 2018

### 6. Investments

#### **Short-Term Investments**

The Corporation's short-term investments at December 31, 2019 and 2018 are comprised of the following:

	 2019		2018
Cash and cash equivalents	\$ 17,760,607	\$	4,671,466
Corporate bonds	66,538,726		70,694,426
Asset backed securities	49,013,159		58,864,628
U.S. government securities,			
U.S. treasury notes	61,879,184		36,563,482
Mutual funds:			
Equity, balanced	19,696,954		16,628,693
Equity, growth	 11,811,424		8,647,093
	_		
Total	\$ 226,700,054	\$	196,069,788

### **Assets Whose Use is Limited**

The composition of assets whose use is limited at December 31, 2019 and 2018 is set forth in the following tables:

	2019		2018
Under trust indentures and capital lease purchase financing facilities, held by trustees and banks:			
Cash and cash equivalents U.S. government securities:	\$	14,586,051	\$ 55,754,102
U.S. treasury notes		26,293,806	82,672,276
U.S. government agency notes		1,197,960	2,355,520
Total		42,077,817	140,781,898
Less funds held for current liabilities		1,786,969	1,777,498
Noncurrent portion of assets held under trust indentures and capital lease purchase financing facilities	\$	40,290,848	\$ 139,004,400

Notes to Consolidated Financial Statements December 31, 2019 and 2018

		2019	2018	
Professional liability trust fund: Cash and cash equivalents	\$	2,187,780	\$	1,133,693
Mutual funds:	Ψ	2,107,700	Ψ	1,100,000
Equity, large value		4,189,348		3,618,514
Equity, growth		1,745,440		1,179,972
Fixed income, intermediate		3,820,847		3,907,005
Fixed income, multi-sector		1,957,923		921,591
Fixed income, short-term		1,976,259		2,163,217
Total		15,877,597		12,923,992
Less funds held for current liabilities		1,929,261		1,795,731
Noncurrent portion of professional liability trust				
fund	\$_	13,948,336	\$	11,128,261
Deferred compensation fund: Mutual funds:				
Equity, growth	\$	299,960	\$	203,128
Equity, large value		276,730		226,707
Equity, midcap value		111,786		111,635
Equity, other		423,336		313,022
Fixed income, intermediate		426,109		445,594
	\$	1,537,921	\$	1,300,086

The indenture requirements of certain tax-exempt financings provide for the establishment and maintenance of various accounts with a trustee (Note 12). These arrangements require the trustee to control the payment of interest and the ultimate repayment of respective debt to bondholders.

The composition of trustee held and escrow funds at December 31, 2019 and 2018 is as follows:

		2019		
Debt service reserve funds	\$	28,803,898	\$	28,401,140
Principal and interest funds		9,179,467		17,902,335
Project fund		2,435,187		94,478,423
Mortgage reserve funds		1,659,265		-
Total	_ \$	42,077,817	\$	140,781,898

Notes to Consolidated Financial Statements December 31, 2019 and 2018

Investment income and gains and losses for investments, assets whose use is limited and cash and cash equivalents without donor restrictions are comprised of the following in 2019 and 2018:

	2019	2018		
Investment income: Interest and dividends, net Interest on trustee held funds Net realized and unrealized gains and losses on	\$ 5,821,027 953,525	\$	5,292,594 120,511	
investments	7,381,743		(3,128,140)	
Total	\$ 14,156,295	\$	2,284,965	
Other changes in net assets without donor restriction, Change in net unrealized gains and losses on investments in debt securities	\$ 8,144,221	\$	(3,582,832)	

#### 7. Fair Value Measurements and Financial Instruments

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

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

The levels of the fair value hierarchy are as follows:

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

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

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

Notes to Consolidated Financial Statements December 31, 2019 and 2018

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

	2019							
						Other		
		Fair Value	Act	ted Prices in tive Markets (Level 1)		bservable Inputs (Level 2)		bservable Inputs Level 3)
Reported at Fair Value								
Assets:								
Mutual funds:								
Fixed income, intermediate	\$	4,246,956	\$	4,246,956	\$	_	\$	_
Fixed income, multi-sector	•	1,957,923	Ψ	1,957,923	Ψ.	_	Ψ	_
Fixed income, short-term		1,976,259		1,976,259		_		_
Equity, growth		13,856,824		13,856,824		_		_
Equity, large value		4,466,078		4,466,078		_		_
Equity, balanced		19,696,954		19,696,954		_		_
Equity, midcap value		111,786		111,786				
Equity, other		423,336		423,336				
U.S. government securities:		-,		-,				
U.S. treasury notes		88,172,990		_		88,172,990		_
U.S. government agency		, , , ,				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
notes		1,197,960		-		1,197,960		-
Asset backed securities		49,013,159		-		49,013,159		-
Corporate bonds		66,538,726		-		66,538,726		_
Beneficial interest in trusts		566,205		<u>-</u>				566,205
Total assets measured								
at fair value		252,225,156		46,736,116	\$ 2	204,922,835		566,205
Cash and cash equivalents		35,449,101						
Total	\$	287,674,257						
Liabilities.								
Derivative financial instrument	Ф	236,291	Ф		Ф	236,291	Ф	
Derivative financial instrument	\$_	∠30,∠91	\$_	-	\$	230,291	\$	

Notes to Consolidated Financial Statements December 31, 2019 and 2018

	2018							
		Fair Value	Act	ted Prices in tive Markets (Level 1)		Other bservable Inputs (Level 2)		bservable Inputs _evel 3)
Reported at Fair Value Assets: Mutual funds:								
Fixed income, intermediate	\$	4,352,599	\$	4,352,599	\$	_	\$	_
Fixed income, multi-sector	Ψ	921,591	Ψ	921,591	Ψ	_	Ψ	_
Fixed income, short-term		2,163,217		2,163,217		_		_
Equity, growth		10,030,193		10,030,193		_		_
Equity, large value		3,845,221		3,845,221		_		_
Equity, balanced		16,628,693		16,628,693		_		_
Equity, midcap value		111,635		111,635		_		
Equity, other		313,022		313,022		_		
U.S. government securities:		0.0,0==		0.0,0				
U.S. treasury notes		119,235,758		-		119,235,758		_
U.S. government agency								
notes		2,355,520		-		2,355,520		-
Asset backed securities		58,864,628		-		58,864,628		-
Corporate bonds		70,694,426		-		70,694,426		-
Beneficial interest in trusts		977,231						977,231
Total assets measured at fair value		290,493,734	\$	38,366,171	\$ 2	251,150,332	\$	977,231
Cash and cash equivalents		62,449,848						
Total	\$	352,943,582						
Liabilities, Derivative financial instrument	\$	503,251	\$		\$	503,251	\$	-

The following table presents the fair value measurements for beneficial interest in trusts that have unobservable inputs at December 31, 2019 and 2018:

Balance, December 31, 2017 Distributions Decrease in value, included in changes in net assets with		1,052,891 (5,824)
donor restrictions		(69,836)
Balance, December 31, 2018 Distributions Decrease in value, included in changes in net assets with		977,231 (206,400)
donor restrictions		(204,626)
Balance, December 31, 2019	\$	566,205

Notes to Consolidated Financial Statements December 31, 2019 and 2018

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

	2019	2018
Short-term investments (Note 6) Assets whose use is limited (Note 6):	\$ 226,700,054	\$ 196,069,788
Current portion	3,716,230	3,573,229
Under trust indentures and capital lease purchase financing facilities, held by trustees and banks	40,290,848	139,004,400
Professional liability trust fund Deferred compensation fund	13,948,336 1.537.921	11,128,261 1.300.086
Investments held by foundations (Note 9)	914,663	890,587
Beneficial interest in trusts, included in deposits and other noncurrent assets	566,205	977,231
	\$ 287,674,257	\$ 352,943,582

The following is a description of the valuation methodologies used for assets and liabilities measured at fair value. There have been no changes in methodologies used at December 31, 2019 and 2018.

Mutual funds: Valued based on quoted market prices.

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

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

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

Notes to Consolidated Financial Statements December 31, 2019 and 2018

#### 8. Property and Equipment, Accumulated Depreciation and Amortization

Property and equipment and accumulated depreciation and amortization at December 31, 2019 and 2018 consist of the following:

	2019	2018
Land and improvements Buildings and improvements Office furniture and equipment Computer software and hardware Equipment under capital leases	\$ 35,832,732 704,920,261 205,545,207 131,686,833	\$ 31,408,104 469,717,964 201,151,320 137,906,569 27,952,929
Total	1,077,985,033	868,136,886
Less accumulated depreciation and amortization	(367,926,785)	(512,122,004)
Total	710,058,248	356,014,882
Construction in progress	14,785,582	296,867,837
	\$ 724,843,830	\$ 652,882,719

Interest incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. During 2019 and 2018, the Corporation incurred interest expense, including amortization expense related to deferred financing costs, of approximately \$17,533,000 and \$12,679,000, respectively, of which approximately \$763,000 was capitalized in 2019 and \$727,400 was capitalized in 2018.

Depreciation expense, including amortization of equipment under capital leases, was approximately \$38,264,000 in 2018. Accumulated amortization of equipment under capital lease as of December 31, 2018 was approximately \$21,515,000. As discussed in Note 2 to the consolidated financial statements, the Corporation adopted new accounting standards guidance related to the accounting for leases in 2019. See Note 14 for further information on the Corporation's financing and operating right-of-use assets and lease obligations.

Construction in progress as of December 31, 2019 consists primarily of major renovation and expansion projects of clinical facilities. Purchase commitments related to these and other miscellaneous projects were approximately \$15,418,000 at December 31, 2019. The cost of these projects is expected to be funded through operations, as well as transfers from the Corporation's related foundations.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

#### 9. Investments and Investments in Unconsolidated Subsidiaries

The Corporation's investments and investments in unconsolidated subsidiaries include the following at December 31, 2019 and 2018:

	2019			2018
Investment in healthcare entities Investment in Premier Investments held by foundations	\$	19,673,109 2,047,709 834,382	\$	6,417,119 9,831,206 809,672
Total	\$	22,555,200	\$	17,057,997

#### Investment in Healthcare Entities

The Corporation recognized earnings of \$431,407 and \$521,675 during 2019 and 2018, respectively, related to its ownership interest in the healthcare entities accounted for under the equity method. A brief description of these investments is presented below:

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

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

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

White-Oak AHF-1 Manager, LLC (White-Oak) - White-Oak was organized for the purpose of developing and constructing a medical office building on the White Oak campus of WOMC. The Corporation has a 50 percent ownership in White-Oak.

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

The Corporation has invested \$3,884,672 in Advanced Health Collaborative II, LLC (AHC II) for a 25 percent interest. AHC II was formed to hold a 24 percent interest in Maryland Health Advantage, LLC which is a Medicare preferred provider network providing health services to its members.

The Corporation has invested \$450,000 in CoreLife Adventist, LLC (CoreLife) for a 50 percent interest. CoreLife was formed to provide weight loss services.

FWMC has invested \$475,000 in Fort Washington Urgent Care, Now, LLC. The purpose of Fort Washington Urgent Care, Now, LLC is to provide urgent and primary care and other health services to the community served by FWMC.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

Summarized financial information related to these entities is presented below:

	 2019		2018	
Net revenue	\$ 20,939,803	\$	18,786,903	
Revenues in excess of expenses	1,844,746		1,919,276	
Total assets	84,299,897		49,884,592	
Total liabilities	44,571,905		24,630,109	

#### **Investment in Premier**

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

The remaining 414,864 Class B common units held by the Corporation are exchangeable for Class A common stock over a 7-year quarterly vesting period. The Corporation recognized a gain of \$1,824,832 and \$1,421,915 during 2019 and 2018, respectively, based on the market value of the units available for exchange. In addition, the Corporation recognized earnings of \$871,757 and \$669,776 during 2019 and 2018, respectively, related to distributions. The Corporation sold 296,330 shares in 2019, resulting in a gain on sale of \$1,855,686. Both the gains and the distributions are included in other revenues in the accompanying consolidated statements of operations.

#### **Investments Held by Foundations**

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

#### 10. Land Held for Healthcare Development

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

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

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

In April 2017, the Corporation entered into a purchase and sale agreement with an unrelated third party to sell 9.95 acres of the land located in Clarksburg at a purchase price of \$7,250,792. The Corporation's share of \$4,565,265 was received in November and December of 2018.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

The total proceeds received related to the parcels of land sold by the Corporation through December 31, 2019 was \$30,997,245. No gain or loss was recognized on the sale of the parcels of land as of December 31, 2019 and 2018. Total remaining land held for healthcare development in Clarksburg as of December 31, 2019 and 2018, was \$48,091,039 and \$45,404,765, respectively.

#### 11. Short-Term Financing

The Corporation has a \$3,000,000 unsecured line of credit with a commercial bank, with interest at LIBOR plus 1.50 percent (3.2 percent at December 31, 2019). There were no borrowings outstanding under this line of credit as of December 31, 2019 or 2018. In January 2020, the line of credit was increased to \$10,000,000.

### 12. Long-Term Obligations

Long-term obligations as of December 31, 2019 and 2018 are comprised of the following:

	2019	2018
Fixed rate revenue bonds	\$ 520,240,447	\$ 523,782,204
Variable rate revenue bonds	21,165,000	21,985,000
Note payable	21,295,957	22,089,282
Mortgage loan payable	6,838,270	-
Other long-term liabilities	7,181,371	14,092,321
Total obligations	576,721,045	581,948,807
Plus bond premium Less:	9,782,453	10,144,766
Current maturities	(14,070,657)	(9,151,220)
Deferred financing costs	(5,212,539)	(4,850,301)
Noncurrent portion of long-term obligations, net	\$ 567,220,302	\$ 578,092,052

#### **Fixed Rate Revenue Bonds**

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

	P	ar Amounts	mounts Interest Rates 2019		2018		
Adventist Healthcare, Inc.:							
Series 2011A	\$	57,205,000	5-6.25%	\$	57,205,000	\$	57,205,000
Series 2013		15,623,500	3.21%		6,750,447		8,342,204
Series 2014A		24,280,000	3.56%		21,315,000		22,090,000
Series 2016A		269,750,000	5.00%		269,750,000		269,750,000
Series 2016B		126,395,000	3.72%		126,395,000		126,395,000
Series 2017		40,000,000	2.77%		38,825,000		40,000,000
Total				\$	520,240,447	\$	523,782,204

Notes to Consolidated Financial Statements December 31, 2019 and 2018

The above bond issues are subject to trust indentures which impose various covenants on SGMC, WOMC, Rehab, Imaging, CIS, Other Health Services and the Support Center (collectively, the Obligated Group) which include restrictions on the transfer or disposition of property, the incurrence of additional liabilities and the achievement of certain pre-established financial indicators. Management believes it has complied with these required financial covenants for the years ended December 31, 2019 and 2018. Debt service reserve funds are required on the Series 2011A, Series 2016A and Series 2017 bonds.

#### Variable Rate Revenue Bonds

The variable rate revenue bonds consist of the Maryland Health and Higher Educational Facilities Authority Revenue Refunding Bonds, Series 2014B, Adventist HealthCare, Inc. which had an outstanding balance of \$21,165,000 and \$21,985,000 as of December 31, 2019 and 2018, respectively. The Series 2014B Bonds bear interest at a variable rate of one month LIBOR plus 2.3 percent (4.0 percent at December 31, 2019). The Series 2014B bonds are subject to an Amended and Restated Master Trust Indenture that imposes various covenants on the Obligated Group which include restrictions on the transfer or disposition of property, the incurrence of additional liabilities, and the achievement of certain pre-established financial indicators. Management believes it has complied with these required financial covenants for the years ended December 31, 2019 and 2018.

The bonds subject to the Amended and Restated Master Trust Indenture are secured by the unrestricted revenues of the Obligated Group as well as a mortgage interest in the facilities of SGMC, WOMC, and Rehab.

#### **Note Payable**

In December 2014, the corporation entered into a taxable term note for \$25,000,000 with a commercial bank, which is secured by a Master Note issued under the Amended and Restated Master Trust Indenture dated as of February 1, 2003. The note bears interest at one month LIBOR plus 2.45 percent (4.1 percent as of December 31, 2019). The amortization on the note extends to December 18, 2034, however, the note matures on December 18, 2024. As of December 31, 2019 and 2018, the outstanding balance was \$21,295,957 and \$22,089,282, respectively.

### Mortgage Loan Payable

On December 23, 2004, FWMC entered into an \$11,055,000 taxable mortgage loan insured by HUD through its Federal Housing Administration (FHA). The loan provided for the satisfaction of FWMC's previous bond obligation and for construction, new equipment and financing costs.

During the year ended December 31, 2013, the loan was refinanced through the same lender to lower the interest from 6.125 percent to 3.95 percent per annum payable in monthly installments. The term of the loan was not changed and the last payment is due in 2030.

As of December 31, 2019, the outstanding balance on the loan was \$6,838,270 and payable in \$63,098 monthly installments including interest at 3.95 percent. The loan is subject to restrictive covenants, including restrictions on additional long-term borrowings and prepayment of the outstanding obligation. In accordance with the terms of the Regulatory Agreement with HUD, FWMC is required to meet certain financial covenants in order to distribute assets to affiliates or incur additional indebtedness. Under the terms of the HUD-insured mortgage loan, FWMC is required to maintain certain deposits with a trustee. Such deposits are included in assets whose use is limited. The loan is secured by the FWMC premises and all the assets and cash flows contained therein.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

#### Other Long-Term Liabilities

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

Scheduled principal repayments of long-term obligations, excluding financing and operating lease obligations at December 31, 2019 are as follows:

Years ending December 31:	
2020	\$ 14,070,657
2021	13,760,601
2022	14,257,932
2023	13,664,023
2024	13,476,022
Thereafter	507,491,810_
Total	\$ 576,721,045

#### 13. Derivative Financial Instrument

The Corporation has an interest rate swap agreement, which is considered a derivative financial instrument. The agreement is for a notional amount of \$18,780,000 and requires the Corporation to pay a fixed interest rate of 3.457 percent while receiving variable interest rates based upon 67 percent of LIBOR, maturing January 2021. The agreement was entered into in order to manage interest rate exposure. The principal objective of the swap agreement is to minimize the risks associated with financing activities by reducing the impact of changes in interest rates on its debt portfolio. The notional amount of the swap agreement is used to measure the interest to be paid or received and does not represent the amount of exposure to credit loss. Exposure to credit loss is limited to the receivable, if any, which may be generated as a result of the swap agreement. The interest rate swap agreement is reported at fair value in the consolidated balance sheets. At December 31, 2019 and 2018, the fair value of the Corporation's derivative financial instrument was \$236,291 and \$503,251, respectively.

During 2016, the Corporation terminated one of its interest rate swap agreements with a notional amount of \$78,000,000 that was designated as a cash flow hedge with the counterparty for \$16,875,000. The Corporation borrowed the termination fee, which was included as a component of the proceeds for the 2016B bonds. No gain or loss was recognized on the termination of the swap. As of December 31, 2019 and 2018, \$10,923,435 and \$11,606,149, respectively, remained in net assets without donor restriction and is being amortized over the remaining term of the hedge, or through January 2035.

The net cash paid or received under the swap agreement is recognized as either an adjustment to interest expense or other income. The net cash paid under the interest rate swap agreement was \$368,462 in 2019 and \$582,142 in 2018. The remaining amounts for 2019 and 2018 are reported as a component of other income (expense) in the accompanying consolidated statements of operations, which is related to the swap agreement that does not qualify for hedge accounting.

The fair value of the interest rate swap agreement is estimated to be the amount the Corporation would receive or pay to terminate the swap agreements at the reporting date and was based on information supplied by an independent third party valuation agent (Note 7). Additionally, the fair value reflects a credit risk adjustment required under accounting principles generally accepted in the United States of America. Gains or losses resulting from the interest rate swap agreement are entirely recognized as a component of revenues in excess of expenses from continuing operations. The impact on the consolidated statements of operations were gains of \$266,960 in 2019 and \$642,052 in 2018.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

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

On October 16, 2008, the Corporation terminated this agreement and concurrently entered into an agreement with a new counterparty that assumed all existing terms and conditions of the original agreement. The termination of the original swap agreement resulted in a loss of \$472,023 which is included in net assets without donor restriction in the consolidated balance sheets. This loss is being amortized over the remaining term of the designated period of the hedge, or through January 2035. As of December 31, 2019 and 2018, accumulated amortization of \$219,615 and \$201,632, respectively, is included in other changes in net assets without donor restriction and interest expense in the consolidated statements of operations and changes in net assets.

#### 14. Leases

The Corporation leases office space and equipment used in operations. For many of these leases, the Corporation is responsible for paying property taxes, insurance, as well as maintenance and repair costs. The Corporation's real estate leases generally have initial lease terms of 3 to 20 years or more and typically include one or more options to renew, with renewal terms that generally extend the lease term for an additional five to ten years or more. The Corporation assesses renewal options using a "reasonably certain" threshold, which is understood to be a high threshold, and therefore the majority of its leases' terms do not include renewal periods for accounting purposes. For leases where the Corporation is reasonably certain to exercise its renewal option, the option periods are included within the lease term and, therefore, the measurement of the right-of-use asset and lease liability. The payment structure of the Corporation's leases generally include annual escalation clauses that are either fixed or variable in nature, some of which are dependent upon published indices. Leases with an initial term of 12 months or less are not recorded on the consolidated balance sheets and expenses for these leases are recognized on a straight-line basis over the lease term as an operating expense.

Certain leases include an option to purchase the leased assets. The Corporation assesses the likelihood of exercising the purchase option using a "reasonably certain" threshold, which is understood to be a high threshold and, therefore, purchase options are generally accounted for when a compelling economic reason to exercise the option exists. Certain leases include an option to terminate the lease, the terms and condition of which vary by contract. These options allow the parties to the contract to terminate their obligations typically in return for an agreed upon financial consideration amount. The Corporation's lease agreements do not contain material residual value guarantees.

The Corporation makes certain assumption and judgements in determining the discount rate, as most leases do not provide an implicit rate. The Corporation uses a risk-free discount rate based on information available at the commencement date in determining the present value of lease payments. In order to apply discount rate, a portfolio approach was utilized to group assets based on similar lease terms in a manner whereby the Corporation reasonably expects that the application does not differ materially from application to individual leases.

Subsequent to the lease commencement date, the Corporation reassesses lease classification when there is a contract modification that is accounted for as a separate contract, a change in the lease term, or a change in the assessment of whether the lessee is reasonably certain to exercise an option to purchase the underlying asset or terminate the lease.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

Future minimum payments under operating lease obligations as of December 31, 2019 were as follows:

Years ending December 31:		
2020	\$	16,161,098
2021		15,133,534
2022		14,183,765
2023		13,091,393
2024		8,033,413
Thereafter		17,229,976
Total		83,833,179
Lease amount representing interest		9,621,728
Total operating lease obligations		74,211,451
Less current portion		13,242,576
	•	
Long-term obligation	\$	60,968,875

Future minimum payments under financing lease obligations as of December 31, 2019 were as follows:

Years ending December 31: 2020 2021 2022 2023 2024	\$	1,124,746 850,712 745,208 230,745 31,357
Total		2,982,768
Less amount representing interest		181,059
Total financing lease obligations		2,801,709
Less current portion		1,053,932
Total	\$_	1,747,777
Total lease costs are comprised of the following in 2019:		
Financing lease cost: Amortization of right-of-use asset Interest on lease obligations Operating lease cost	\$	1,126,052 103,857 17,034,804
Total lease cost	\$	18,264,713

Notes to Consolidated Financial Statements December 31, 2019 and 2018

Other supplemental information as of and for the year ended December 31, 2019 is as follows:

Weighted-average remaining lease term:

Financing lease obligations 3.03 years
Operating lease obligations 6.12 years

Weighted-average discount rate:

Financing lease obligations 3.19%
Operating lease obligations 4.44%

Certain lease agreements contain a number of restrictive covenants that, among other things, and subject to certain exemptions, impose operating and financial restrictions on the Corporation. These leases also require the Corporation to meet financial covenants, including a liquidity ratio and maximum net leverage ratio.

# 15. Retirement, Health Plan and Life Insurance

## **Defined Contribution Retirement Plan**

The Corporation sponsors a 401(a) defined contribution retirement plan, which covers substantially all full-time employees. After twelve months of full-time or regular part-time employment of at least 1,000 base hours, the Corporation will contribute a total of 2 percent of eligible employees' compensation, plus a matching employer contribution equal to 50 percent of employee contributions (to the 403(b) plan) up to 6 percent of base salary. The Corporation also has a 403(b) retirement savings plan for employees. Employee contributions are made to the 403(b) retirement savings plan. Retirement plan expense was \$11,087,036 in 2019 and \$10,101,533 in 2018.

### Supplemental Executive Retirement Plan

The Corporation also has a Supplemental Executive Retirement Plan (SERP) that became effective in 2015 and covers a group of key executives. SERP expense was \$201,322 in 2019 and \$236,635 in 2018. In addition, a SERP liability adjustment was recorded for \$789,431 in 2019 and \$(1,609,635) in 2018, which was recognized in net assets without donor restriction in the consolidated statements of changes in net assets. At December 31, 2019 and 2018, the Corporation's liability for the SERP was \$2,619,727 and \$2,418,405, respectively, which is included in other liabilities in the consolidated balance sheets.

# **Executive Retention 457(F) Plan**

Effective January 1, 2015, the Corporation established the Executive Retention 457(F) Plan (the 457(F) Plan). The 457(F) Plan is a tax-deferred plan offered to key executives, whereby annual employer contributions are made to the Plan. Plan participants become vested in the contributions and receive plan payments in the second calendar year after the contribution is made, if the participant is still employed. The final contribution will be made to the Plan for the year in which the plan participant becomes 62. The 457(F) plan expense was \$2,198,352 in 2019 and \$1,305,693 in 2018. The Corporation's liability for the 457(F) plan at December 31, 2019 and 2018 was \$2,468,554 and \$2,549,173, respectively, which is included in other liabilities in the consolidated balance sheets.

### Salary Deferral (457(b)) Plan

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

Notes to Consolidated Financial Statements December 31, 2019 and 2018

# **Health Plan**

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

### Life Insurance

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

# 16. Commitments and Contingencies

## Litigation and Claims

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

# Insurance

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

It is the Corporation's policy to accrue for the ultimate cost of uninsured asserted and unasserted malpractice claims, if any, when incidents occur. Based on a review of the Corporation's prior experience and incidents occurring through December 31, 2019, management determined that the fully-funded professional liability reserve reported at December 31, 2019 and 2018 is adequate in light of the program's excess umbrella policy currently in force and historical claims experience. The estimated professional liability for both asserted and unasserted claims was \$18,068,182 and \$16,725,085 at December 31, 2019 and 2018, respectively. The discount rate used in determining these liabilities was 2.5 percent at both December 31, 2019 and 2018.

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

Notes to Consolidated Financial Statements December 31, 2019 and 2018

### Remediation

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

# 17. Business and Credit Concentrations

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

At December 31, 2019 and 2018, concentrations of gross receivables from third party payors and others are as follows:

	2019	2018
Medicare	21 %	22 %
Medicaid	13	12
Other third party payors	46	41
Self-pay and others	20	25
	100 %	100 %

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

# 18. Liquidity and Availability

The Corporation's financial assets available for general expenditure within one year of the consolidated balance sheet date, consist of the following at December 31:

	2019	2018
Cash and cash equivalents	\$ 25,807,370	\$ 41,673,365
Short-term investments	226,700,054	196,069,788
Patient accounts receivable, net	117,498,048	94,756,571
Other receivables, net Assets whose use is limited,	13,764,346	12,096,855
Professional liability trust fund	13,948,336_	11,128,261
Total	\$ 397,718,154	\$ 355,724,840

The Corporation has designated certain assets as available for settling professional liability claims however these assets could be used for general expenditure if necessary and therefore have been included in the information above.

As part of the Corporation's liquidity management plan, it has a policy to structure its financial assets to be available as its general expenditures, liabilities and other obligations come due. In addition, the Corporation invests excess cash in short-term investments.

Notes to Consolidated Financial Statements December 31, 2019 and 2018

# 19. Functional Expenses

A summary of the Corporation's operating expenses by function for the year ended December 31, 2019 is as follows:

	Hospital Acute and Ambulatory Services	Home Care Services		Other Health Care Services	Other, Including General and Administrative	_F	undraising	Total
Salaries and wages Employee benefits and payroll taxes	\$ 237,701,341 46,478,154	\$ 19,811,6		\$ 88,846,505 15,608,146	\$ 38,079,526	\$	-	\$ 384,439,065
Contract labor	35,780,089	3,414,4 479,3		2,167,499	8,175,118 272,084		-	73,675,888 38,699,033
		•			*		-	, ,
Medical supplies	101,992,687	406,6	56	5,369,499	(31,596)		-	107,737,246
General and administrative	56,215,257	1,136,9	04	21,347,473	46,741,649		1,982,059	127,423,342
Building and maintenance	29,982,952	688,0	95	11,153,982	2,175,935		-	44,000,964
Insurance	4,777,573	117,6	80	2,007,774	48,017		-	6,950,972
Interest	13,355,155		-	535,784	2,695,241		-	16,586,180
Depreciation and amortization Loss on disposal of	26,247,404	321,9	48	4,108,322	10,904,606		-	41,582,280
property and equipment					3,265,295			3,265,295
Total	\$ 552,530,612	\$ 26,376,7	35	\$ 151,144,984	\$ 112,325,875	\$	1,982,059	\$ 844,360,265

In 2019, the Corporation also incurred other health care services expenses of \$15,149,584 related to the Takoma Park campus that were included in the loss from discontinued operations in the consolidated statements of operations. These expenses were comprised of the loss on disposal of \$11,575,977, building and maintenance of \$1,173,959, interest of \$1,860,402 and miscellaneous other operating expenses related to the operations of the walk-in clinic.

A summary of the Corporation's operating expenses by function for the year ended December 31, 2018 is as follows:

	Hospital Acute and Ambulatory Services	Home Care Services		Other Health Care Services		Other, Including General and Administrative		Fundraising		Total	
Salaries and wages Employee benefits and	\$ 220,718,693	\$ 1	18,731,190	\$	88,625,657	\$	38,100,836	\$	-	\$ 366,176,37	'6
payroll taxes	47,966,466		3,553,383		13,110,485		7,591,278		-	72,221,61	2
Contract labor	32,343,445		245,199		2,963,787		202,224		-	35,754,65	55
Medical supplies	98,202,724		458,492		5,875,860		43,582		-	104,580,65	8
General and administrative	55,707,950		1,215,423		17,182,465		48,146,794		110,280	122,362,91	2
Building and maintenance	30,686,995		704,542		7,821,497		2,131,732		-	41,344,76	6
Insurance	4,741,326		105,956		1,861,698		2,404,029		-	9,113,00	)9
Interest Depreciation and	8,724,197		-		530,114		2,696,971		-	11,951,28	12
amortization	22,503,068		314,415	_	4,087,192	_	11,215,519		-	38,120,19	14
Total	\$ 521,594,864	\$ 2	25,328,600	\$	142,058,755	\$	112,532,965	\$	110,280	\$ 801,625,46	<u>34</u>

# Adventist HealthCare, Inc. and Controlled Entities Consolidating Schedule, Balance Sheet December 31, 2019

	Shady Grove Medical Center	White Oak Medical Center	Rehabilitation	Imaging Services	Clinical Integration Services	Other Health Services	Support Center	Eliminating Entries	Total Combined Obligated Group	Fort Washington Medical Center	Lourie Center	Adventist Home Care Services	Urgent Care Centers	One Health Quality Alliance	Adventist HealthCare, Inc. Foundations	Eliminating Entries	Consolidated Adventist HealthCare, Inc.
Assets																	
Current Assets Cash and cash equivalents Short-term investments Assets whose use is limited Patient accounts receivable Other receivables Inventories	\$ 213,113,631 - 56,963,630 2,887,460 5,024,652	\$ (113,924,577) - 40,524,481 3,382,019 5,708,507	\$ 23,994,274 - - 5,839,124 68,345 95,929	\$ (23,719,381) - 2,554,761 1,071,529	\$ (36,213,052) - - 838,474 173,389	\$ (1,023,315) - (15,305) 546,234 138,909	\$ (33,841,725) 226,700,054 3,716,230 150 4,335,747	\$ - - - (782,297)	\$ 28,385,855 226,700,054 3,716,230 106,705,315 11,682,426 10,967,997	\$ 1,478,359 - - 5,246,936 (959,034) 1,450,231	\$ 373,750 - - 2,329,485	\$ 9,311,478 - - 4,965,569 19,406 152	\$ (14,085,019) - - 580,228	\$ (3,278,261) - - - -	\$ 3,621,208 - - - - 692,063	\$ - - - -	\$ 25,807,370 226,700,054 3,716,230 117,48,048 13,764,346 12,418,380
Prepaid expenses and other current assets	867,991	569,290	111,820	122,538	137,032	61,056	5,287,534		7,157,261	774,424	42,915	49,710	49,890				8,074,200
Total current assets	278,857,364	(63,740,280)	30,109,492	(19,970,553)	(35,064,157)	(292,421)	206,197,990	(782,297)	395,315,138	7,990,916	2,746,150	14,346,315	(13,454,901)	(3,278,261)	4,313,271	-	407,978,628
Property and Equipment, Net	180,743,158	426,431,717	9,290,726	6,722,931	2,011,625	153,335	74,058,769	-	699,412,261	16,942,558	1,324,794	1,064,185	6,100,032	-	-	-	724,843,830
Financing Lease Right-of-Use Asset	-	-	-	2,711,291	-	-	-	-	2,711,291	254,535	-	-	-	-	-	-	2,965,826
Operating Lease Right-of-Use Asset	38,502,293	3,962,433	785,412	5,081,361	2,563,571	705,809	9,029,531	-	60,630,410	198,798	2,268,005	2,199,183	7,842,011	-	-	-	73,138,407
Assets Whose Use is Limited Under trust indentures and capital lease purchase financing facilities, held by trustees and banks Professional liability trust fund Deferred compensation fund	1,362,948 - -	33,432,715 - -	456,266 - -	- - -	- - -	- - -	3,379,654 13,948,336 1,537,921	- - -	38,631,583 13,948,336 1,537,921	1,659,265 - -	- - -	- - -	- - -	- - -	:	- - -	40,290,848 13,948,336 1,537,921
Cash and Cash Equivalents Restricted for Capital Acquisitions	333,897	-	112,854	-	-	-	-	-	446,751	598	365,923	-	-	-	109,053	-	922,325
Investments and Investments in Unconsolidated Subsidiaries	(1,942,436)	12,769,669	-	-	-	-	17,867,204	-	28,694,437	475,000	-	-	-	-	834,382	(7,448,619)	22,555,200
Land Held for Healthcare Development	-	-	-	-	-	-	48,091,039	-	48,091,039	-	-	-	-	-	-	-	48,091,039
Intangible Assets, Net	1,547,663	-	781,077	5,435,091	-	11,204	-	-	7,775,035	-	-	143,676	-	-	-	-	7,918,711
Deposits and Other Noncurrent Assets	1,291,161	31,351	43,000	51,351	21,371	32,754	416,891	-	1,887,879	44,097	5,054	30,828	200,582	-	1,509,233	-	3,677,673
Assets Held for Sale						15,939,824			15,939,824								15,939,824
Total assets	\$ 500,696,048	\$ 412,887,605	\$ 41,578,827	\$ 31,472	\$ (30,467,590)	\$ 16,550,505	\$ 374,527,335	\$ (782,297)	\$ 1,315,021,905	\$ 27,565,767	\$ 6,709,926	\$ 17,784,187	\$ 687,724	\$ (3,278,261)	\$ 6,765,939	\$ (7,448,619)	\$ 1,363,808,568

# Adventist HealthCare, Inc. and Controlled Entities Consolidating Schedule, Balance Sheet December 31, 2019

	Shady Grove Medical Center	White Oak Medical Center	Rehabilitation	Imaging Services	Clinical Integration Services	Other Health Services	Support Center	Eliminating Entries	Total Combined Obligated Group	Fort Washington Medical Center	Lourie Center	Adventist Home Care Services	Urgent Care Centers	One Health Quality Alliance	Adventist HealthCare, Inc. Foundations	Eliminating Entries	Consolidated Adventist HealthCare, Inc.
Liabilities and Net Assets																	
Current Liabilities																	
Accounts payable and accrued expenses	\$ 37,047,302	\$ 27,374,311	\$ 2,202,028	\$ 1,353,322	\$ 1,463,814	\$ 1,105,357	\$ 30,029,204	\$ -	\$ 100,575,338	\$ 7,093,724	\$ 572,604	\$ 1,377,738	\$ 470,821	\$ 212,713	\$ 34,708	\$ -	110,337,646
Accrued compensation and related items	16,032,365	9,618,707	3,089,449	226,519	723,109	257,413	11,254,762	(782,297)	40,420,027	2,100,781	767,217	2,003,217	383,367	-	-	-	45,674,609
Interest payable	-	-	-	-	-	-	9,648,902	-	9,648,902	267,328	-	-	-	-	-	-	9,916,230
Due to third party payors	11,383,135	8,024,033	(465,307)	-	-	-	67,547	-	19,009,408	579,746	-	-	-	-	-	-	19,589,154
Estimated self-insured professional liability	-	-	-	-	-	-	1,929,261	-	1,929,261	-	-	-	-	-	-	-	1,929,261
Current maturities of:																	
Long-term obligations	4,835,201	6,299,663	_	-	-	-	2,252,990	-	13,387,854	499,670	_	-	183,133	-	-	-	14,070,657
Financing lease obligations	· · · · -	-	_	996,874	-	_		-	996,874	57,058	_	_	_	-	-	-	1,053,932
Operating lease obligations	6,899,728	799,049	298,105	1,475,879	486,033	200,009	1,386,194	-	11,544,997	105,478	620,101	417,594	554,406	-	-	-	13,242,576
Total current liabilities	76,197,731	52,115,763	5,124,275	4,052,594	2,672,956	1,562,779	56,568,860	(782,297)	197,512,661	10,703,785	1,959,922	3,798,549	1,591,727	212,713	34,708	-	215,814,065
Construction Payable	2,421,408	8,104,689	3,620	13,750	-	-	350,830	-	10,894,297	-	-	-	-	-	-	-	10,894,297
Long-Term Obligations, Net																	
Bonds payable	125,177,952	369,180,227	4,299,099	-	-	-	37,687,813	-	536,345,091	-	-	-	(13,446)	-	-	-	536,331,645
Notes payable	1,497,700	703,997	-	-	-	-	18,651,916	-	20,853,613	5,883,532	-	-	4,151,512	-	-	-	30,888,657
Financing lease obligations	-	-	-	1,537,415	-	-	-	-	1,537,415	210,362	-	-	-	-	-	-	1,747,777
Operating lease obligations	32,192,898	3,216,970	491,983	3,676,838	2,116,351	516,461	7,808,544	-	50,020,045	93,320	1,670,477	1,817,611	7,367,422	-	-	-	60,968,875
Derivative Financial Instrument	-	-	-	-	-	-	236,291	-	236,291	-	-	-	-	-	-	-	236,291
Other Liabilities	1,605,154	-	-	-	464,689	-	8,218,894	-	10,288,737	3,216,258	-	-	-	-	47,598	-	13,552,593
Estimated Self-Insured Professional Liability							16,138,921		16,138,921								16,138,921
Total liabilities	239,092,843	433,321,646	9,918,977	9,280,597	5,253,996	2,079,240	145,662,069	(782,297)	843,827,071	20,107,257	3,630,399	5,616,160	13,097,215	212,713	82,306	-	886,573,121
Net Assets (Deficit)  Net assets (deficit) without donor restrictions  Net assets (deficit) with donor restrictions	261,786,691 (183,486)	(21,243,431)	31,386,196 273,654	(9,274,125) 25,000	(35,721,586)	14,471,265	228,222,993 642,273		469,628,003 1,566,831	7,351,510 107,000	2,666,176 413,351	12,168,027	(12,409,491)	(3,490,974)	2,704,352 3,979,281	(7,341,619) (107,000)	471,275,984 5,959,463
Total net assets (deficit)	261,603,205	(20,434,041)	31,659,850	(9,249,125)	(35,721,586)	14,471,265	228,865,266		471,194,834	7,458,510	3,079,527	12,168,027	(12,409,491)	(3,490,974)	6,683,633	(7,448,619)	477,235,447
Total liabilities and net assets (deficit)	\$ 500,696,048	\$ 412,887,605	\$ 41,578,827	\$ 31,472	\$ (30,467,590)	\$ 16,550,505	\$ 374,527,335	\$ (782,297)	\$ 1,315,021,905	\$ 27,565,767	\$ 6,709,926	\$ 17,784,187	\$ 687,724	\$ (3,278,261)	\$ 6,765,939	\$ (7,448,619)	\$ 1,363,808,568

# Adventist Healthcare, Inc. and Controlled Entities Consolidating Schedule, Statement of Operations Year Ended December 31, 2019

	Shady Grove Medical Center	White Oak Medical Center	Rehabilitation	Imaging Services	Clinical Integration Services	Other Health Services	Support Center	Eliminating Entries	Total Combined Obligated Group	Fort Washington Medical Center	Lourie Center	Adventist Home Care Services	Urgent Care Centers	One Health Quality Alliance	Adventist HealthCare, Inc. Foundations	Eliminating Entries	Consolidated Adventist HealthCare, Inc.
Revenues																	
Net patient service revenue	\$ 418,126,760	\$ 266,594,362	\$ 53,718,379	\$ 29,653,620	\$ 8,645,083	\$ -	\$ -	\$ (62,038)	\$ 776,676,166	\$ 8,514,690	\$ 801,425	\$ 29,741,785	\$ 6,535,352	\$ -	\$ -	\$ (693,809)	\$ 821,575,609
Other revenues	11,740,940	4,670,930	610,188	1,811,592	867,448	6,773,596	7,736,877	(9,439,612)	24,771,959	87,846	16,216,023	258,521	80	157,548	2,055,876	(2,619,640)	40,928,213
Total revenues	429,867,700	271,265,292	54,328,567	31,465,212	9,512,531	6,773,596	7,736,877	(9,501,650)	801,448,125	8,602,536	17,017,448	30,000,306	6,535,432	157,548	2,055,876	(3,313,449)	862,503,822
Expenses																	
Salaries and wages	152,430,057	100,783,017	29,956,596	16,172,790	8,011,835	2,829,676	38,079,526	(310,681)	347,952,816	4,070,934	8,726,097	19,811,693	3,871,526	5,999	-	-	384,439,065
Employee benefits	30,113,310	18,601,084	5,564,034	2,921,792	1,209,595	515,328	8,175,118	(48,025)	67,052,236	831,168	1,740,098	3,414,470	634,614	3,302	-	-	73,675,888
Contract labor	22,859,819	14,425,581	903,894	(1,712,712)	100,000	626,834	272,084	(71,100)	37,404,400	635,598	249,333	479,361	135,433	100,307	-	(305,399)	38,699,033
Medical supplies	55,997,110	45,770,940	1,846,157	1,495,224	426,710	743,573	(31,596)	(42,796)	106,205,322	697,972	117,289	406,656	310,007	-	-	-	107,737,246
General and administrative	37,326,733	27,910,464	3,503,927	4,255,890	1,914,893	1,374,937	49,494,413	(6,164,536)	119,616,721	1,356,322	4,145,495	1,136,904	1,218,247	656,518	1,982,059	(2,688,924)	127,423,342
Building and maintenance	25,407,813	7,955,502	1,873,442	4,027,383	1,955,535	1,701,847	2,175,935	(4,269,405)	40,828,052	315,099	999,554	688,095	1,192,891	300	-	(23,027)	44,000,964
Insurance	3,251,156	2,171,984	311,358	428,688	398,762	5,366	48,017	-	6,615,331	133,133	10,633	117,608	74,267	-	-		6,950,972
Interest	6,241,238	7,056,513	189,569	125,479	-	1,860,402	2,695,241	(1,860,402)	16,308,040	57,404	-	-	220,736	-	-	-	16,586,180
Depreciation and amortization	16,411,917	9,749,295	1,047,674	2,280,351	64,532	59,624	10,904,606	-	40,517,999	208,807	171,341	321,948	362,185	-	-	-	41,582,280
Loss (gain) on disposal of property and equipment	· · ·	-	· · ·	· · · · -		11,575,977	3,265,295	(11,575,977)	3,265,295	· -				-	-	-	3,265,295
IT depreciation	6,346,694	2,985,655	464,189	85,777	-	27,534	(9,985,325)	-	(75,476)	-	-	75,476	-	-	-	-	-
IT services	21,497,051	11,673,974	2,111,537	1,179,465	119,613	135,074	(37,412,027)	_	(695,313)	-	_	695,313	-	-	-	-	_
Shared services	19,213,206	10,681,284	1,634,724	492,538	756,952	73,496	(33,626,500)	_	(774,300)	_	310,355	410,472	53,473	-	-	-	_
Management fees	9,940,544	5,716,347	1,417,193	494,121	492,538	145,592	(19,571,019)		(1,364,684)		338,708	875,479	150,497	-			
Total expenses	407,036,648	265,481,640	50,824,294	32,246,786	15,450,965	21,675,260	14,483,768	(24,342,922)	782,856,439	8,306,437	16,808,903	28,433,475	8,223,876	766,426	1,982,059	(3,017,350)	844,360,265
Income (loss) from operations	22,831,052	5,783,652	3,504,273	(781,574)	(5,938,434)	(14,901,664)	(6,746,891)	14,841,272	18,591,686	296,099	208,545	1,566,831	(1,688,444)	(608,878)	73,817	(296,099)	18,143,557
Other Income (Expense)																	
Investment income	6,527,427	844,601	615,581	_	_	44,644	5,889,110	_	13,921,363	_	11,847	223,085	_	_	_	_	14,156,295
Other income (expense)	(237,480)	(180,058)	(8,665)	19,615	560	-	(1,102,030)	_	(1,508,058)	_	(272)	(2,384)	_	_	_	_	(1,510,714)
Inherent contribution on business combination				-		<u>-</u>	7,045,520		7,045,520	7,045,520	-					(7,045,520)	7,045,520
Total other income (expense)	6,289,947	664,543	606,916	19,615	560	44,644	11,832,600		19,458,825	7,045,520	11,575	220,701				(7,045,520)	19,691,101
Revenues in excess of (less than)																	
expenses from continuing operations	29,120,999	6,448,195	4,111,189	(761,959)	(5,937,874)	(14,857,020)	5,085,709	14,841,272	38,050,511	7,341,619	220,120	1,787,532	(1,688,444)	(608,878)	73,817	(7,341,619)	37,834,658
Change in net unrealized gains and losses on investments in debt securities Change in net unrealized gain on derivative financial instrument	3,375,542	621,438	314,694	-	-	21,361	3,689,557 700,697	-	8,022,592 700,697	-	1,485	109,906	-	-	10,238	-	8,144,221 700,697
Transfers from (to) subsidiaries	(40,578)	(16,396,175)	-	(1,041,352)	2	29,541,589	(12,063,487)	-	(1)	-	2	(1)	-	-	-	-	700,697
Net assets released from restriction for purchase of property and equipment	106,859	1,670,807	_	_	_	_	(42)	_	1,777,624	_	_	_	_	_	_	_	1,777,624
Deferred compensation plan liability adjustment	,	.,0.0,00.	_	_	_	_	(789,431)	_	(789,431)	_	_	_	_	_	_	_	(789,431)
Other net asset activity						(2,174,643)	2,150,395		(24,248)		-						(24,248)
Increase (decrease) in net assets (deficit) without donor restrictions from continuing operations	32,562,822	(7,655,735)	4,425,883	(1,803,311)	(5,937,872)	12,531,287	(1,226,602)	14,841,272	47,737,744	7,341,619	221,607	1,897,437	(1,688,444)	(608,878)	84,055	(7,341,619)	47,643,521
Loss from discontinued operations								(14,841,272)	(14,841,272)								(14,841,272)
Increase (decrease) in net assets (deficit) without donor restrictions	\$ 32,562,822	\$ (7,655,735)	\$ 4,425,883	\$ (1,803,311)	\$ (5,937,872)	\$ 12,531,287	\$ (1,226,602)	\$ -	\$ 32,896,472	\$ 7,341,619	\$ 221,607	\$ 1,897,437	\$ (1,688,444)	\$ (608,878)	\$ 84,055	\$ (7,341,619)	\$ 32,802,249

Adventist HealthCare, Inc. - Foundations
Combining Schedule, Balance Sheet
December 31, 2019

	Shady Grove Medical Center Foundation, Inc.	White Oak Medical Center Foundation, Inc.	Eliminating Entries	Combined Adventist HealthCare, Inc. Foundations
Assets				
Current Assets Cash and cash equivalents Current portion of pledges receivable, less allowance for doubtful pledges	\$ 3,093,500 241,315	\$ 527,708 450,748	\$ -	\$ 3,621,208 692,063
Total current assets	3,334,815	978,456	-	4,313,271
Cash and Cash Equivalents Restricted for Capital Acquisitions	-	109,053	-	109,053
Investments	834,382	-	-	834,382
Beneficial Interest in Trusts	180,282	428,036	-	608,318
Noncurrent Portion of Pledges Receivable	147,054	753,861		900,915
Total assets	\$ 4,496,533	\$ 2,269,406	\$ -	\$ 6,765,939
Liabilities and Net Assets				
Current Liabilities Accounts payable and accrued expenses	\$ 34,708	\$ -	\$ -	\$ 34,708
Liability to Charitable Gift Annuitants	47,598	<u> </u>		47,598
Total liabilities	82,306	<u> </u>		82,306
Net Assets Net assets without donor restrictions Net assets with donor restrictions	2,555,227 1,859,000	149,125 2,120,281	<u> </u>	2,704,352 3,979,281
Total net assets	4,414,227	2,269,406		6,683,633
Total liabilities and net assets	\$ 4,496,533	\$ 2,269,406	\$ -	\$ 6,765,939

# Adventist HealthCare, Inc. - Foundations

Combining Schedule, Statement of Operations and Changes in Net Assets Year Ended December 31, 2019

	ady Grove Medical Center Idation, Inc.	Vhite Oak Medical Center ndation, Inc.	Eliminating Entries	Hea	Combined Adventist IlthCare, Inc. oundations
Changes in Net Assets Without Donor Restrictions Revenues, Gains, and Other Support Contributions, net Net assets released from restrictions	\$ 326,611 63,861	\$ 177,708 1,487,696	\$ -	\$	504,319 1,551,557
Total revenues, gains, and other support	 390,472	 1,665,404			2,055,876
Expenses General and administrative expenses In-kind gifts expended	 42,955 17,678	45,013 6,625			87,968 24,303
Total expenses before transfers to the hospitals	60,633	51,638	-		112,271
Transfers to the hospitals	188,189	 1,681,599			1,869,788
Total expenses	 248,822	 1,733,237			1,982,059
Revenues in excess of (less than) expenses	141,650	(67,833)	-		73,817
Change in net unrealized gains and losses on investments in debt securities	 10,238	 			10,238
Increase (decrease) in net assets without donor restrictions	151,888	(67,833)	-		84,055
Net assets without donor restrictions, beginning	 2,403,339	216,958			2,620,297
Net assets without donor restrictions, ending	\$ 2,555,227	\$ 149,125	\$ -	\$	2,704,352
Changes in Net Assets With Donor Restrictions Contributions, net Net assets released from restrictions Change in value of beneficial interest in trusts Change in discount of pledges receivable and provision for doubtful pledges Investment income (loss) and change in unrealized gains and losses on investments	\$ 962,695 (63,861) - 3,698 14,572	\$ 847,849 (1,487,696) 11,949 21,924 (5,672)	\$ - - - -		1,810,544 (1,551,557) 11,949 25,622 8,900
Increase (decrease) in net assets with donor restrictions	917,104	(611,646)	-		305,458
Net assets with donor restrictions, beginning	 941,896	2,731,927			3,673,823
Net assets with donor restrictions, ending	\$ 1,859,000	\$ 2,120,281	\$ -	\$	3,979,281

# EXHIBIT 6: Support from Medical Community



Quality Health Care From the Heart for Those in Need

7 Metropolitan Court, Suite 1 Gaithersburg, MD 20878 mercyhealthclinic.org

June 25, 2020

Daniel Cochran President, Shady Grove Medical Center 9901 Medical Center Dr. Rockville, MD 20850

Dear Dan,

I am writing in support of the Certificate of Need application for Adventist HealthCare Shady Grove Medical Center (SGMC) to build a new tower for patient rooms.

SGMC is an integral part of the health care system in Montgomery County, serving a large and diverse community with quality, compassionate care. A new patient tower will enable SGMC to provide state-of-the-art, world-class care while improving quality, safety and operations. A new tower will facilitate the use of the latest technology to care for patients and provide a layout that maximizes clinical efficiency.

The COVID-19 pandemic reinforced the importance of containing the spread of an infectious disease within a hospital. With a new patient tower, SGMC will have single patient rooms throughout the hospital and an improved air-flow design that will reduce the risk of hospital acquired infections. Single patient rooms also promote patient privacy and improve the overall care experience for patients and family members.

Adventist HealthCare has been a valued part of Montgomery County since 1907 and has provided tremendous support and resources to the medical safety net in our county for several decades. As our healthcare delivery system evolves, our hospitals need to be able to adapt to modern standards of care as well as medical and technological innovations. SGMC must have the physical infrastructure necessary to deliver the level of care our residents need and deserve.

I applaud your commitment to the patients you serve and fully support your efforts to build a new patient tower for the benefit of our community.

Sincerely.

Mark Foraker Executive Director















July 1, 2020

Daniel Cochran President, Shady Grove Medical Center 9901 Medical Center Dr. Rockville, MD 20850

Dear Dan,

On behalf of Mobile Medical Care, Inc. (MobileMed), I am writing in support of the Certificate of Need application for Adventist HealthCare Shady Grove Medical Center (SGMC) to build a new tower for patient rooms.

SGMC is an integral part of the health care system in Montgomery County, serving a large and diverse community with quality, compassionate care. A new patient tower will enable SGMC to provide state-of-the-art, world-class care while improving quality, safety and operations. A new tower will facilitate the use of the latest technology to care for patients and provide a layout that maximizes clinical efficiency.

The COVID-19 pandemic has reinforced the importance of containing the spread of an infectious disease within a hospital. With a new patient tower, SGMC will have single patient rooms throughout the hospital and an improved air-flow design that will reduce the risk of hospital-acquired infections. Single patient rooms also promote patient privacy and improve the overall care experience for patients and family members.

MobileMed is a Federally Qualified Health Center that has been providing care to the underserved in Montgomery County for over fifty years. We are fortunate to be a long-time community partner to Adventist HealthCare which has been a leader in population health. As our healthcare delivery system evolves, our hospitals need to be able to adapt to modern standards of care as well as medical and technological innovations. SGMC must have the physical infrastructure necessary to deliver the level of care our residents need and deserve.

I applaud SGMC's commitment to the patients you serve and fully support your efforts to build a new patient tower for the benefit of our community.

Sincerely,

Peter Lowet

Executive Director

de Louis



# primary care coalition

making Daniel Cochran

July 2, 2020

health care President, Shady Grove Medical Center happen 9901 Medical Center Dr. Rockville, MD 20850

8757 Georgia Ave. 10th Floor Silver Spring, MD

Dear Dan,

On behalf of the Primary Care Coalition of Montgomery County (PCC), I am pleased to offer this letter of support to the Certificate of Need application for Adventist HealthCare Shady Grove Medical Center (SGMC) to build a new tower for patient rooms.

T: 301.628.3405 F: 301 608.2384

Adventist HealthCare has been a valued part of Montgomery County since 1907. Since 1993 the Primary Care Coalition (PCC) has also worked in Montgomery County to improve access to high-quality health care for individuals experiencing vulnerability, particularly those who are low income or uninsured. Adventist Healthcare and SGMC are an integral partner in this mission, serving a large and diverse community with quality, compassionate care.

A new patient tower will enable SGMC to provide state-of-the-art care while improving quality, safety and operations. A new tower will facilitate the use of the latest technology to care for patients and provide a layout that maximizes clinical efficiency. With a new patient tower, SGMC will have single patient rooms throughout the hospital and an improved air-flow design that will reduce the risk of hospital acquired infections. Single patient rooms also promote patient privacy and improve the overall care experience for patients and family members.

As our healthcare delivery system evolves, our hospitals need to be able to adapt to modern standards of care as well as medical and technological innovations. SGMC must have the physical infrastructure necessary to deliver the level of care our County residents need and deserve.

I applaud your commitment to the patients you serve and fully support your efforts to build a new patient tower for the benefit of our community.

Sincerely,

Leslie Graham

President & CEO

www.primarycarecoalition.org



A SUBSIDIARY OF COMMUNITY REACH OF MONTGOMERY COUNTY

8 West Middle Lane

Rockville, MD 20850

Phone: 301-917-6800

Fax: 301-917-6810

CMRocks.org

August 5, 2020

Daniel Cochran President, Shady Grove Medical Center 9901 Medical Center Dr. Rockville, MD 20850

Dear Dan,

I am writing in support of the Certificate of Need application for Adventist HealthCare Shady Grove Medical Center (SGMC) to build a new tower for patient rooms. We believe your proposal will be a significant benefit to the communities that both of our organizations serve.

The Mansfield Kaseman Health Clinic's mission is to provide quality, culturally appropriate, primary medical care, preventive services, patient navigation, and referrals to specialty care to Montgomery County adult residents who are medically underserved.

We work collaboratively with SGMC referring patients back and forth, hospital discharges to us, as well as patients from us who needs to go the hospital. Building a new tower for patient rooms will help our community significantly and it is also great planning in expanding hospital capacity as we face this global pandemic.

SGMC is an integral part of the health care system in Montgomery County. A new patient tower will enable SGMC to provide state-of-the-art care while improving quality and safety. A new tower will facilitate the use of the latest technology in patient care and promote patient privacy with single patient rooms. Private rooms are especially important in preventing the spread of infectious diseases like COVID-19.

Adventist HealthCare has been a valued partner to our organization and we support their need to adapt to modern standards of care as well as medical and technological innovations. SGMC must be permitted to deliver the level of care our residents need and deserve.

Thank you for your commitment to serve our community. We fully support your proposal to build a new patient

tower.

Sincerely,

Agnes Saenz, Executive Director

19

COMMUNITY REACH OF MONTGOMERY COUNTY



# EXHIBIT 7: Support from Elected Officials

# GG Gaithersburg-Germantown CC Chamber of Commerce, Inc.

910 Clopper Road, Suite 205N, Gaithersburg, Maryland 20878 (301) 840-1400, Fax (240) 261-6395





JOHNS HOPKINS













RODGERS Knowledge Creativity Enduring Value







July 8, 2020

Daniel Cochran President, Shady Grove Medical Center 9901 Medical Center Dr. Rockville, MD 20850

Dear Dan,

I am writing in support of the Certificate of Need application for Adventist HealthCarc Shady Grove Medical Center (SGMC) to build a new tower for patient rooms.

SGMC is an integral part of the health care system in Montgomery County, serving a large and diverse community with quality, compassionate care. A new patient tower will enable SGMC to provide state-of-the-art, world-class care while improving quality, safety and operations. A new tower will facilitate the use of the latest technology to care for patients and provide a layout that maximizes clinical efficiency.

The COVID-19 pandemic reinforced the importance of containing the spread of an infectious disease within a hospital. With a new patient tower, SGMC will have single patient rooms throughout the hospital and an improved air-flow design that will reduce the risk of hospital acquired infections. Single patient rooms also promote patient privacy and improve the overall care experience for patients and family members.

Adventist HealthCare has been a valued part of Montgomery County since 1907. As our healthcare delivery system evolves, our hospitals need to be able to adapt to modern standards of care as well as medical and technological innovations. SGMC must have the physical infrastructure necessary to deliver the level of care our residents need and deserve.

I applaud your commitment to the patients you serve and fully support your efforts to build a new patient tower for the benefit of our community.

Sincerely,

Marilyn Balcombe President & CEO

mbalcombe@ggchamber.org

www.ggchamber.org



August 3, 2020

Daniel Cochran President, Shady Grove Medical Center 9901 Medical Center Dr. Rockville, MD 20850

Dear Dan,

I am writing in support of the Certificate of Need application for Adventist HealthCare Shady Grove Medical Center (SGMC) to build a new tower for patient rooms.

SGMC is an integral part of the health care system in Montgomery County, serving a large and diverse community with quality, compassionate care. A new patient tower will enable SGMC to provide state-of-the-art, world-class care while improving quality, safety and operations. A new tower will facilitate the use of the latest technology to care for patients and provide a layout that maximizes clinical efficiency.

The COVID-19 pandemic reinforced the importance of containing the spread of an infectious disease within a hospital. With a new patient tower, SGMC will have single patient rooms throughout the hospital and an improved air-flow design that will reduce the risk of hospital acquired infections. Single patient rooms also promote patient privacy and improve the overall care experience for patients and family members.

Adventist HealthCare has been a valued part of Montgomery County since 1907. As our healthcare delivery system evolves, our hospitals need to be able to adapt to modern standards of care as well as medical and technological innovations. SGMC must have the physical infrastructure necessary to deliver the level of care our residents need and deserve.

I applaud your commitment to the patients you serve and fully support your efforts to build a new patient tower for the benefit of our community.

Sincerely,

Marji Graf, President & CEO Rockville Chamber of Commerce 1 Research Court, Suite 450 Rockville, MD. 20850



August 6, 2020

Daniel Cochran President, Shady Grove Medical Center 9901 Medical Center Drive Rockville, Maryland 20850

Dear Dan,

I am writing in support of the Certificate of Need application for Adventist HealthCare Shady Grove Medical Center (SGMC) to build a new tower for patient rooms. SGMC is an integral part of the health care system in Montgomery County that serves a large and diverse community, which includes the more than 70,000 residents in the City of Gaithersburg, with quality and compassionate care.

As the Mayor of one of the largest cities in Maryland, I know firsthand the significance of being able to provide and improve services, safety and operations. A new patient tower will enable SGMC to provide state-of-the-art, world-class care using the latest technology to care for patients, in an environment designed to maximize clinical efficiency.

The unprecedented COVID-19 pandemic has reinforced the importance of containing the spread of an infectious disease within a hospital. With a new patient tower, SGMC will have single patient rooms throughout the hospital and an improved air-flow design that will reduce the risk of hospital acquired infections. Single patient rooms also promote patient privacy and improve the overall care experience for patients and family members.

Adventist HealthCare has been a valued part of Montgomery County since 1907. As the healthcare delivery system rapidly evolves, our hospitals need to be able to adapt to modern standards of care as well as medical and technological innovations. SGMC must have the physical infrastructure necessary to deliver the level of care our residents need and deserve.

I applaud your commitment to the patients you serve and fully support your efforts to build a new patient tower. The future of our communities depends on it.

Sincerely,

Jud Ashman

Mayor

City of Gaithersburg • 31 South Summit Avenue, Gaithersburg, Maryland 20877-2038 301-258-6300 • FAX 301 948-6149 • cityhal@gaithersburgmd gov • gaithersburgmd gov



August 10, 2020

Daniel Cochran President, Shady Grove Medical Center 9901 Medical Center Dr. Rockville, MD 20850

Dear Dan,

As an organization that supports and is a resource to those your hospital serves, I am writing to express CASA's full support for Adventist HealthCare Shady Grove Medical Center's Certificate of Need application to build a new tower for patient rooms.

Your proposal will be a great benefit to the communities we both serve. A new patient tower will enable Shady Grove to provide excellent care in a modern setting with private rooms. Private rooms not only enhance patient privacy but are important in the fight against the spread of infectious diseases like COVID-19. This is especially important to CASA as we serve many communities that have been significantly impacted by this deadly disease.

Shady Grove Medical Center is an integral part of the health care system in Montgomery County and Adventist HealthCare has been a valued partner to CASA for many years. To continue to provide the level of care our residents deserve, they must be permitted to adapt to modern standards of care as well as medical and technological innovations.

CASA is in full support for your proposal to build a new patient tower for the benefit of our community. Thank you for the services you provide Montgomery County.

CASA is a powerful institution of passionate, community-conscious people working to organize, advocate for, and expand opportunities for Latino and immigrant people in the Mid-Atlantic. We do this by providing employment placement; workforce development and training; health education; citizenship and legal services; and financial, language, and literacy training to Latino and immigrant communities throughout the state.

Since our humble beginnings in 1985 at the baseman of a Church in Takoma Park assisting Central American refugees fleeing wars and civil strife at home, we have worked tirelessly to bring immigrant communities in Maryland, Virginia, and Pennsylvania out of the shadows and into greater power, dignity, and legitimacy.

Sincerely,

Gustavo Torres

Gustavo Torres Executive Director

# EXHIBIT 8: Support from Community



# MONTGOMERY COUNTY FIRE AND RESCUE SERVICE

Marc Elrich
County Executive

Scott E. Goldstein Fire Chief

July 14, 2020

Daniel Cochran President, Shady Grove Medical Center 9901 Medical Center Dr. Rockville, MD 20850

Dear Dan,

I am writing in support of the Certificate of Need application for the Adventist HealthCare Shady Grove Medical Center (SGMC) to build a new tower for patient rooms. I applaud your efforts to build a new patient tower for the benefit of our community.

Adventist HealthCare has been a valued part of Montgomery County since 1907. Today, SGMC is an integral part of the health care system in Montgomery County, serving a large and diverse community with quality, compassionate care. SGMC is a valued partner to the Montgomery County Fire & Rescue Service (MCFRS), both by receiving emergency patients from the MCFRS, and by providing educational and research resources to MCFRS clinicians.

A new patient tower will enable SGMC to provide state-of-the-art, world-class care while improving quality, safety and operations. With a new patient tower, SGMC will have single patient rooms throughout the hospital and an improved air-flow design that will reduce the risk of hospital acquired infections. Single patient rooms also promote patient privacy and improve the overall care experience for patients and family members.

As our healthcare delivery system evolves, our hospitals need to be able to adapt to modern standards of care as well as medical and technological innovations. Thank you for pursuing this project on behalf of the residents and patients that we jointly serve.

Sincerely,

Scott E. Goldstein

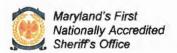
Scott Galled

Fire Chief, Montgomery County Fire & Rescue Service

Office of the Fire Chief

100 Edison Park Drive, 2nd Floor, Gaithersburg. Maryland, 20878-3204 • 240/777-2486, FAX 240/777-2443

Serving with dedication, courage and compassion





50 Maryland Avenue Rockville, Md. 20850 240-777-7000 240-777-7148 Fax

# SHERIFF DARREN M. POPKIN

July 30, 2020

Daniel Cochran President, Shady Grove Medical Center 9901 Medical Center Dr. Rockville, MD 20850

Dear Mr. Cochran,

I am writing in support of the Certificate of Need application for Adventist HealthCare Shady Grove Medical Center (SGMC) to build a new tower for patient rooms. As Director of the Montgomery County Family Justice Center, a co-location of government and non-profit entities that serves as a walk-in facility for victims of domestic violence, my team and I work with SGMC on a near daily basis. We appreciate and value the strong collaboration we share with your hospital, and the Forensic Medical Unit in particular.

SGMC is an integral part of the health care system in Montgomery County, serving a large and diverse community with quality, compassionate care. A new patient tower will enable SGMC to provide state-of-the-art, world-class care while improving quality, safety and operations. A new tower will facilitate the use of the latest technology to care for patients and provide a layout that maximizes clinical efficiency.

The COVID-19 pandemic reinforced the importance of containing the spread of an infectious disease within a hospital. With a new patient tower, SGMC will have single patient rooms throughout the hospital and an improved air-flow design that will reduce the risk of hospital acquired infections. Single patient rooms also promote patient privacy and improve the overall care experience for patients and family members.

Adventist HealthCare has been a valued part of Montgomery County since 1907. As our healthcare delivery system evolves, our hospitals need to be able to adapt to modern standards of care as well as medical and technological innovations. SGMC must have the physical infrastructure necessary to deliver the level of care our residents need and deserve.

I applaud your commitment to the patients you serve and fully support your efforts to build a new patient tower for the benefit of our community.

Sincerely,

Thomas Manion, Director

Montgomery County Family Justice Center



7300 Calhoun Place, Suite 700, Rockville, MD 20855 Phone: 240-777-4699 FAX: 240-777-4470 www.treehousemd.org

Where hope and healing take root

July 31, 2020

Daniel Cochran President, Shady Grove Medical Center 9901 Medical Center Dr. Rockville, MD 20850

Dear Dan,

I am writing in support of the Certificate of Need application for Adventist HealthCare Shady Grove Medical Center (SGMC) to build a new tower for patient rooms.

SGMC is an integral part of the health care system in Montgomery County, serving a large and diverse community with quality, compassionate care. A new patient tower will enable SGMC to provide state-of-the-art, world-class care while improving quality, safety and operations. A new tower will facilitate the use of the latest technology to care for patients and provide a layout that maximizes clinical efficiency.

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l applaud your commitment to the patients you serve and fully support your efforts to build a new patient tower for the benefit of our community.

Sincerely,

A Thomas Grazio - Director



# MONTGOMERY COUNTY COUNCIL

ROCKVILLE, MARYLAND

### OFFICE OF THE COUNCIL PRESIDENT

August 4, 2020

Daniel Cochran President, Shady Grove Medical Center 9901 Medical Center Dr. Rockville, MD 20850

Dear Dan,

I am writing in support of the Certificate of Need application for Adventist HealthCare Shady Grove Medical Center (SGMC) to build a new tower for patient rooms.

SGMC is an integral part of the health care system in Montgomery County, serving a large and diverse community with quality, compassionate care. A new patient tower will enable SGMC to provide state-of-the-art, world-class care while improving quality, safety and operations. A new tower will facilitate the use of the latest technology to care for patients and provide a layout that maximizes clinical efficiency.

The COVID-19 pandemic reinforced the importance of containing the spread of an infectious disease within a hospital. With a new patient tower, SGMC will have single patient rooms throughout the hospital and an improved air-flow design that will reduce the risk of hospital acquired infections. Single patient rooms also promote patient privacy and improve the overall care experience for patients and family members.

In addition, the new patient tower will provide dedicated space in the emergency room to offer appropriate therapeutic responses to patients experiencing mental health crises. This is critically important as Montgomery County works with community partners to develop a strategic, holistic crisis response system and strengthen its existing behavioral health services.

Adventist HealthCare has been a valued part of Montgomery County since 1907. As our healthcare delivery system evolves, our hospitals need to be able to adapt to modern standards of care as well as medical and technological innovations. SGMC must have the physical infrastructure necessary to deliver the level of care our residents need and deserve.

I applaud your commitment to the patients you serve and fully support your efforts to build a new patient tower for the benefit of our community.

Sidney A. Katz

NANCY J. KING Legislative District 39 Montgomery County

MAJORITY LEADER



James Senate Office Building 11 Bladen Street, Room 121 Annapolis, Maryland 21401 301-858-3686 · 410-841-3686 800-492-7122 Ext. 3686 Fax 301-858-3670 · 410-841-3670 Nancy.King@senate.state.md.us

# THE SENATE OF MARYLAND Annapolis, Maryland 21401

July 28, 2020

Mr. Daniel Cochran President, Shady Grove Medical Center 9901 Medical Center Dr. Rockville, MD 20850

Dear Dan,

I am writing in support of the Certificate of Need application for Adventist HealthCare Shady Grove Medical Center (SGMC) to build a new tower for patient rooms.

SGMC is an integral part of the health care system in Montgomery County, serving a large and diverse community with quality, compassionate care. A new patient tower will enable SGMC to provide state-of-the-art, world-class care while improving quality, safety and operations. A new tower will facilitate the use of the latest technology to care for patients and provide a layout that maximizes clinical efficiency.

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I applaud your commitment to the patients you serve and fully support your efforts to build a new patient tower for the benefit of our community.

Sincerely,

Senator Nandy & Ring

Bonnie Cullison Legislative District 19 Montgomery County

Health and Government Operations Committee



The Maryland House of Delegates 6 Bladen Street, Room 350 Annapolis, Maryland 21401 410-841-3883 · 301-858-3883 800-492-7122 Ext. 3883 Fax 410-841-3882 · 301-858-3882 Bonnie. Cullison@house.state.md.us

# THE MARYLAND HOUSE OF DELEGATES

Annapolis, Maryland 21401 July 30, 2020

Daniel Cochran President, Shady Grove Medical Center 9901 Medical Center Dr. Rockville, MD 20850

Dear Dan,

I am writing in support of the Certificate of Need application for Adventist HealthCare Shady Grove Medical Center (SGMC) to build a new tower for patient rooms.

SGMC is an integral part of the health care system in Montgomery County, serving a large and diverse community with quality, compassionate care. A new patient tower will enable SGMC to provide state-of-the-art, world-class care while improving quality, safety and operations. A new tower will facilitate the use of the latest technology to care for patients and provide a layout that maximizes clinical efficiency.

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I applaud your commitment to the patients you serve and fully support your efforts to build a new patient tower for the benefit of our community. Thank you for your commitment to care.

Sincerely,

Bonnie Cullison

KIRILL REZNIK Legislative District 39 Montgomery County

Appropriations Committee Chair Health and Social Services Subcommittee

House Chair

and Opioid Use Disorders

Annapolis Office The Maryland House of Delegates 6 Bladen Street, Room 427 Annapolis, Maryland 21401 301-858-3039 · 410-841-3039 800-492-7122 Ext. 3039 Fax 301-858-3126 · 410-841-3126 Kirill.Reznik@house.state.md.us

> District Office 301-284-0492

Joint Committee on Behavioral Health

THE MARYLAND HOUSE OF DELEGATES Annapolis, Maryland 21401

July 31, 2020

Daniel Cochran President, Shady Grove Medical Center 9901 Medical Center Dr. Rockville, MD 20850

Dear Dan,

I am writing in support of the Certificate of Need application for Adventist HealthCare Shady Grove Medical Center (SGMC) to build a new tower for patient rooms.

SGMC is an integral part of the health care system in Montgomery County, serving a large and diverse community with quality, compassionate care. A new patient tower will enable SGMC to provide state-of-the-art, world-class care while improving quality, safety and operations. A new tower will facilitate the use of the latest technology to care for patients and provide a layout that maximizes clinical efficiency.

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Adventist HealthCare has been a valued part of Montgomery County since 1907. As our healthcare delivery system evolves, our hospitals need to be able to adapt to modern standards of care as well as medical and technological innovations. SGMC must have the physical infrastructure necessary to deliver the level of care our residents need and deserve.

I applaud your commitment to the patients you serve, and fully support your efforts to build a new patient tower for the benefit of our community.

Sincerely,

Delegate Kirill Reznik

SENATOR BRIAN J. FELDMAN 410-841-3169 · 301-858-3169 800-492-7122 Ext. 3169



# THE MARYLAND GENERAL ASSEMBLY LEGISLATIVE DISTRICT 15 MONTGOMERY COUNTY

DELEGATE KATHLEEN M. DUMAIS 410-841-3052 · 301-858-3052 800-492-7122 Ext. 3052

DELEGATE DAVID FRASER-HIDALGO 410-841-3186 · 301-858-3186 800-492-7122 Ext. 3186

> DELEGATE LILY QI 410-841-3090 · 301-858-3090 80-492-7122 Ext. 3090

August 10, 2020

Daniel Cochran President, Shady Grove Medical Center 9901 Medical Center Dr. Rockville, MD 20850

Dear Mr. Cochran,

As the delegation from Maryland's 15<sup>th</sup> legislative district, we are writing in support of the Certificate of Need application for Adventist HealthCare Shady Grove Medical Center (SGMC) to build a new tower for patient rooms.

SGMC is an integral part of the health care system in Montgomery County, serving a large and diverse community with quality, compassionate care. A new patient tower will enable SGMC to provide state-of-the-art, world-class care while improving quality, safety and operations. A new tower will facilitate the use of the latest technology to care for patients and provide a layout that maximizes clinical efficiency.

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We applaud your commitment to the patients you serve and fully support your efforts to build a new patient tower for the benefit of our community.

Sincerely,

Senator Brian J. Feldman

Det Mugar - To

Delegate David Fraser-Hidalgo

Delegate Kathleen M. Dumais

Sackley De Dunais

Delegate Lily Qi

SENATOR CRAIG J. ZUCKER SENATE DELEGATION CHAIR

SENATOR SUSAN C. LEE BENATE DELEGATION VICE CHAIR

301-858-3625 · 410-841-3625 800-492-7122 Ext. 3625



DELEGATE MARC KORMAN HOUSE DELEGATION CHAIR

DELEGATE ALFRED C. CARR, JR. HOUSE DELEGATION VICE CHAIR

301-858-3010 · 410-841-3010 800-492-7122 Ext. 3010

# THE MARYLAND GENERAL ASSEMBLY Annapolis, Maryland 21401 MONTGOMERY COUNTY DELEGATION

August 13, 2020

Mr. Daniel Cochran President, Shady Grove Medical Center 9901 Medical Center Dr. Rockville, Maryland 20850

Dear President Cochran:

We write on behalf of the full Montgomery County Senate and House Delegations in support of the Certificate of Need application for Adventist HealthCare Shady Grove Medical Center (SGMC) to build a new tower for patient rooms.

SGMC is an integral part of the health care system in Montgomery County, serving a large and diverse community with quality, compassionate care. A new patient tower will enable SGMC to provide state-of-the-art, world-class care while improving quality, safety and operations. A new tower will facilitate the use of the latest technology to care for patients and provide a layout that maximizes clinical efficiency.

The COVID-19 pandemic reinforced the importance of containing the spread of an infectious disease within a hospital. With a new patient tower, SGMC will have single patient rooms throughout the hospital and an improved air-flow design that will reduce the risk of hospital acquired infections. Single patient rooms also promote patient privacy and improve the overall care experience for patients and family members.

Adventist HealthCare has been a valued part of Montgomery County since 1907. As our healthcare delivery system evolves, our hospitals need to be able to adapt to modern standards of care as well as medical and technological innovations. SGMC must have the physical infrastructure necessary to deliver the level of care our residents need and deserve.

Daniel Cochran August 13, 2020 Page 2

We applaud your commitment to the patients you serve and fully support your efforts to build a new patient tower for the benefit of our community.

Sincerely,

Senator Craig Zucker Chair, Montgomery County

Senate Delegation

Delegate Marc Korman Chair, Montgomery County

House Delegation



# THE MARYLAND GENERAL ASSEMBLY Annapolis, Maryland 21401

August 31, 2020

Mr. Ben Steffen Maryland Health Care Commission 4160 Patterson Avenue Baltimore, MD 21215

Dear Mr. Steffen:

We are writing in support of the Certificate of Need application for Adventist HealthCare Shady Grove Medical Center (SGMC) to build a new tower for patient rooms.

The COVID-19 pandemic has reinforced the importance of containing the spread of infectious diseases within a hospital. With a new patient tower, SGMC will have single patient rooms throughout the hospital and an improved air-flow design that will reduce the risk of hospital-acquired infections. Single patient rooms also promote patient privacy and improve the overall care experience for patients and family members.

SGMC is an integral part of the health care system in Montgomery County, serving a large and diverse community with quality, compassionate care. A new patient tower will enable SGMC to provide state-of-the-art, world-class care while improving quality, safety, and operations. A new tower will facilitate the use of the latest technology to care for patients and provide a layout that maximizes clinical efficiency.

Adventist HealthCare has been a valued part of Montgomery County since 1907. As our health care delivery system evolves, our hospitals need to adapt to modern standards of care as well as medical and technological innovations. SGMC must have the physical infrastructure necessary to deliver the level of care our residents need and deserve.

We believe that a new patient tower will help provide first-rate care to northern Montgomery County. Thank you for your consideration.

Sincerely,

Cheryl C. Kagan

Kumar Barve

Senator Cheryl C. Kagan

Delegate Kumar Barve

Jim Gilchrist

Julie Palakovich Carr

Delegate Jim Gilchrist

Delegate Julie Palakovich Carr

cc: Daniel Cochran, President, Shady Grove Medical Center

# Congress of the United States Washington, DC 20515

August 14, 2020

Dr. Andrew N. Pollack, M.D. Chairman Maryland Health Care Commission 4160 Patterson Avenue Baltimore, MD 21215

Dear Dr. Pollack,

I write to you to offer my support for the application submitted by Adventist HealthCare Shady Grove Medical Center (SGMC) to the Maryland Health Care Commission for a Certificate of Need to build a new tower for patient rooms.

SGMC is an integral part of the health care system in my district, serving the large and diverse community of Montgomery County with quality, compassionate care. Construction of the proposed tower will enable SGMC to provide first rate care while improving upon the hospital's already high-quality care, safety and operations. Additionally, the new tower will facilitate the use of the latest technology to care for patients and provide a layout that maximizes clinical efficiency.

The COVID-19 pandemic reinforced the importance of containing the spread of infectious disease within the hospital setting. With the proposed facility, SGMC will have single patient rooms throughout the hospital and an improved air-flow design that will reduce the risk of hospital acquired infections. Single patient rooms also promote patient privacy and improve the overall care experience for patients and family members.

Adventist HealthCare has been a valued part of Montgomery County since 1907. As our healthcare delivery system evolves, our hospitals need to be able to adapt to modern standards of care as well as medical and technological innovations. SGMC must have the physical infrastructure necessary to deliver the level of care that our residents need and deserve.

I respectfully request that you give the application submitted by SGMC all due consideration, and look forward to seeing their efforts to build a new patient tower come to fruition. If you have any questions or concerns, please feel free to reach out to Andrew Donlon of my staff at <a href="mailto:Andrew.Donlon@mail.house.gov">Andrew.Donlon@mail.house.gov</a> or 301-926-0300.

Sincerely,

David Trone

Member of Congress

## EXHIBIT 9:

Summary of Revenue & Volumes

### **Shady Grove Medical Center**

### Summary of Revenue and Volume Assumptions FY 2021-2026

### Rates:

Global Budget Revenue Update Assumptions: (1)	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026
Update Factor	2.36%	2.36%	2.36%	2.36%	2.36%	2.36%
Age Adjusted Population Growth	-0.01%	-0.01%	-0.01%	-0.01%	-0.01%	-0.01%
Population Infrastructure	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Market Share	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Deferred Revenue	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Capital in Rates	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other Reversals/One-time Adjustments/Change in MU	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	2.35%	2.35%	2.35%	2.35%	2.35%	2.35%
Volumes:						
Total Inpatient Discharges (2)	3.84% <sup>(3)</sup>	0.92%	0.87%	0.85%	0.81%	0.78%
Outpatient and Emergency Visits (4)	45.07% <sup>(5)</sup>	0.80%	0.80%	0.80%	0.80%	0.80%

### **Footnotes:**

- (1) Global Budget Revenue assumptions are based on estimates of changes for FY 2021. The Update Factor was estimated at 2.64% less 0.28% for Shared Savings = 2.36%. Likewise, the Age Adjusted Population Growth adjustment was based on the FY 2021 estimate. These estimate were carried forward into future years.
- (2) Changes in total inpatient discharges are estimated based on projected changes in the population and use rates for the total service area.
- (3) Changes in total inpatient discharges for FY 2021 from FY 2020 is a combination of the projected changes in the population and use rates for the total service area as well as the normalization of volumes impacted by COVID-19 during FY 2020 as elective medical procedures were temporarily suspended on March 13, 2020 by order of the State of Maryland.
- (4) Changes in outpatient and emergency visits are estimated based on projected changes in the population for the primary service area.
- (5) Changes in outpatient and emergency visits for FY 2021 from FY 2020 is a combination of the projected changes in the population for the primary service area and the normalization of volumes impacted by COVID-19 during FY 2020 as elective medical procedures were temporarily suspended on March 13, 2020 by order of the State of Maryland. Outpatient volumes were significantly impacted by this order.

### EXHIBIT 10:

Adventist Health Care Shady Grove Medical Center List of Representative Hospital Charges September 10, 2020 Hospital charges are made available to the public in order to provide useful information to our patients and community regarding the cost of care for the most common inpatient and outpatient procedures performed at Shady Grove Medical Center. Please note that these are estimates and are subject to change. The actual cost of your procedure may be higher or lower based on your specific clinical needs. Hospital rates are set in compliance with the Maryland Health Services Cost Review Commission (HSCRC). This information will be updated on a quarterly basis and reflects actual charges for the 12 months ending June 30, 2020. Patients may request an estimate of charges for a specific procedure by calling the *Patient Access Department at (240) 826-5427*.

	Average
Common Inpatient Procedures	Charges
Septicemia & disseminated infections	\$ 16,498
Other pneumonia	\$ 12,365
Kidney & Urinary tract infection	\$ 10,288
Acute myocardial infarction	\$ 10,777
Heart failure	\$ 11,993
Hip joint replacement	\$ 22,632
CVA & precerebral occlusion w infarct	\$ 13,132
Knee joint replacement	\$ 22,120
Cardiac Arrhythmia & Conduction Diseases	\$ 7,178
Percutaneous cardiovascular procedures w AMI	\$ 25,358
Chronic obstructive pulmonary disease	\$ 12,939
Diabetes	\$ 9,493
Infectious & parasitic diseases including HIV w O.R. procedure	\$ 32,737
Major respiratory infections & inflammations	\$ 15,840
Peptic ulcer & gastritis	\$ 11,991
Vaginal delivery	\$ 7,113
Cesarean delivery	\$ 6,801
Neonate birthwt >2499g, normal newborn or neonate w other problem	\$ 8,938
Other pneumonia (Pediatric)	\$ 7,309
Bronchiolitis & RSV pneumonia	\$ 7,700
Neonate birthwt>2499g w respiratory distress syndrome/other major respiratory condition	\$ 24,069
Neonate bwt 2000-2499g, normal newborn or neonate w other problem	\$ 3,209
Neonate birthwt >2499g w other significant condition	\$ 24,069
Major depressive disorders & other/unspecified psychoses	\$ 13,085
Bipolar disorders	\$ 10,734
Schizophrenia	\$ 14,652
Depression except major depressive disorder	\$ 9,046

	Α	verage
Common Outpatient Procedures	C	Charges
Dental procedures	\$	5,161
Upper gastrointestinal endoscopy w/biopsy, single or multiple	\$	2,919
Extracapsular cataract removal w/insertion of intraocular lens prosthesis	\$	4,157
Debridement, subcutaneous tissue	\$	3,940
Application of multi-layer compression system	\$	3,176
Colonoscopy, with or without biopsy	\$	2,745
Laparoscopy, cholecystectomy	\$	6,644
Treatment missed abortion, First Trimester Surgical	\$	3,167
Insertion of tunneled centrally inserted central venous access device, with subcutaneous port, 5 years or older	\$	4,023
Abdominal paracentesis with imaging guidance	\$	4,827
Mastectomy, partial	\$	8,114
Chemical cauterizatin of granualtion tissue	\$	2,762
Catheter placement in coronary artery(s) for foronary angiography, with left heart catheterization	\$	7,510

Laparoscopy, appendectomy	\$ 7,385
Hysteroscopy	\$ 5,726

### **Ancillary Services at Shady Grove Adventist Hopital**

Laboratory		Avg Charge	
Blood Count Complete	\$	17.34	
Comprehensive metabolic panel ( w CO2, AST)	\$	28.86	
Infection Agent Antigen Detection by ImmunoAssay Direct Optical Observation	\$	25.23	
Urinalysis, auto, w/o scope	\$	7.28	
Assay of Troponin, quantitative	\$	33.20	
Glucose blood test, monitoring device	\$	6.47	
Creatine kinase (CK), (CPK), total Basic Metabolic panel (w Calcium)	\$	9.47 18.85	
Assay of Magnesium	\$	9.97	
Level IV Surg Pathaology Gross & Microscopic Exam	\$	65.11	
Assay of Lipase	\$	15.70	
Drug tests	\$	13.21	
Blood Typing Serologic	\$	5.13	
Creatine kinase (CK), (CPK) MB fraction only	\$	23.65	
Urinalysis, auto, w/scope	\$	9.99	

Radiology	Avg Charge
Duplex scan of arterial inflow and venous outflow of	\$1,230.90
MRI Brain w/o contrast	\$287.75
X-Ray Knee, complete	\$142.20
Ultrasound, pelvic, nonobstetrical, complete	\$407.72
Ultrasound, abdominal, limited	\$344.68
Doppler scan, veins, unilateral, limited	\$536.42
CT Angiography, chest (non coronary) w & w/o contrast	\$260.53
CT Head/Brain w/o contrast	\$91.25
X-Ray Chest, 2 views	\$96.01
X-Ray Chest, 1 view	\$59.52
X-Ray Abdomen, 1 view	\$75.29
X-Ray Shoulder, minimum 2 views	\$92.95
Ultrasound, transvaginal	\$483.24
CT Abdomen & Pelvis w/contrast	\$272.40
CT Abdomen & Pelvis w/o contrast	\$140.60

### Physician Groups at Shady Grove Adventist Hospital

Hospital charges do not include physician and other provider services that are billed separately. Other providers may include

	Billing		Billing
Group	Questions	Group	Questions
FCAA (First Colonies Anesthesia)	240-364-2500	Shady Grove Orthopedic Associates	301-251-4143
Inpatient Surgical Consultants	301-650-6753	Cardiac Associates	301-924-5590
GW Medical Faculty Associates	301-212-4260	Jatinder Sekhon, MD (GI)	301-982-2441
Sound Physicians of Maryland	301-652-5771	Urological Consultants, PA	301-670-4250
Simmonds & Simmonds, (OB)	301-414-2305	Horizon Health Group	301-330-1170
US Acute Care Solutions - Mid Atlantic ER	877-763-1373	Community Hematology-Oncology Pract.	301-774-6460
Adventist Medical Group	410-872-9188	Steve Behram, MD & Associates	301-340-1230
Intensivists-Gaithersburg Critical Care	240-489-6269	Capital Women's Care	800-529-3489
Cardiac Associates	301-924-5590	Montgomery Medical Associates	301-279-2779
Pediatrix of Maryland, P.A.	240-826-6480	Birns, Gloger, & Witten, MD., P.C.	240-485-5200
Neonatology Associated Pediatrix of Maryland	301-355-5688		
Montogomery Cardiology, L.L.C.	301-780-5627		

# EXHIBIT 11: Policy AHC 3.19.2 Public Disclosure of Charges

## 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
Reviewed: 10.15.13 Authority: EC
Revised: 11.01.13, 08.26.19 Page: 1 of 2

### **SCOPE:**

This policy applies to Adventist HealthCare acute care hospitals located in the State of Maryland; Shady Grove Medical Center, White Oak Medical Center, and Fort Washington Medical Center.

### **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.

Page: 1/3
Revision: 8.0
Printed On: 06/10/2020

This copy will expire in 24 hours

### 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
Reviewed: 10.15.13 Authority: EC
Revised: 11.01.13, 08.26.19 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 alphabrowse/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.

Page: 2/3 Revision: 8.0

### **Document Information**

### **Document Title**

AHC 3.19.2 Public disclosure of charges policy

### **Document Description**

N/A

### **Approval Information**

**Approved On:** 08/26/2019

Approved By: LaTicia Graves, Paralegal III

Approval Expires: 08/26/2024

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 12: Policy AHC 3.19 Financial Assistance Policy

**Corporate Policy Manual** Financial Assistance (Formerly "Charity Care")

Effective Date

01/08

Cross Referenced: Previously: Financial Assistance Policy

Policy No:

AHC 3.19

(see AHC 3.19.1 for Decision Rules / Application)

Origin:

PFS/FC

Reviewed:

02/09, 9/19/13, 10/10/17

Authority:

05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13,

Page: 1 of 13

EC

Revised:

2/01/16, 11/09/17, 08/26/19

### FINANCIAL ASSISTANCE POLICY SUMMARY

### SCOPE:

This policy applies to the following Adventist HealthCare facilities: Shady Grove Medical Center, Germantown Emergency Center, White Oak Medical Center, Adventist Rehabilitation Hospital of Maryland, and Fort Washington Medical Center 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:

Page: 1/14 Revision: 9.0

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### **Corporate Policy Manual** Financial Assistance (Formerly "Charity Care")

Policy No: AHC 3.19 Effective Date 01/08

Cross Referenced: Previously: Financial Assistance Policy Origin: PFS

(see AHC 3.19.1 for Decision Rules / Application)

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,

2/1/16, 11/09/17, 08/26/19 Page: 2 of 13

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

Page: 2/14 Revision: 9.0 Printed On: 06/09/2020

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## Corporate Policy Manual Financial Assistance (Formerly "Charity Care")

Effective Date 01/08 Policy No: AHC 3.19

Cross Referenced: Previously: Financial Assistance Policy Origin: PFS

(see AHC 3.19.1 for Decision Rules / Application)

Reviewed: 02/09, 9/19/13, 10/10/17

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2/1/16, 11/09/17, 08/26/19 Page: 3 of 13

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

Authority: EC

- <u>Uninsured Patient</u>: Person not enrolled in a healthcare service coverage insurance plan. May or may not be eligible for charitable care.
- <u>Self-pay Patient</u>: 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.

Page: 3/14 Revision: 9.0

**Corporate Policy Manual** Financial Assistance (Formerly "Charity Care")

Effective Date 01/08 Policy No: AHC 3.19

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Origin: PFS (see AHC 3.19.1 for Decision Rules / Application)

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Authority: EC Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13,

2/1/16, 11/09/17, 08/26/19 Page: 4 of 13

- 1.4. Eligibility for Emergency Medical Care: Patients may be eligible for financial assistance for Emergency Medical Care under this Policy if:
  - 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
  - They apply for financial assistance within the Financial Assistance 1.4.3. Application Period (i.e. within the period ending on the 240th day after the first post-discharge billing statement is provided to a patient).
- Eligibility for non-emergency Medically Necessary Care: Patients may be 1.5. eligible for financial assistance for non-emergency Medically Necessary Care under this Policy if:
  - 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
  - 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

#### **Considerations:** 1.6.

- 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

Page: 4/14 Revision: 9.0 Printed On: 06/09/2020

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### **Corporate Policy Manual** Financial Assistance (Formerly "Charity Care")

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Cross Referenced: Previously: Financial Assistance Policy (see AHC 3.19.1 for Decision Rules / Application)

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Policy No: AHC 3.19

Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13,

2/1/16, 11/09/17, 08/26/19 Page: 5 of 13

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

- **Exclusions:** Patients are INELIGIBLE for financial assistance for Emergency Medical Care or other non-emergency Medically Necessary Care under this policy if:
  - Purposely providing false or misleading information by the patient or responsible party; or
  - Providing information gained through fraudulent methods in order to 1.7.2. 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
  - The patient or responsible party refuses to apply for government 1.7.4. 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:
  - Patients, unless otherwise eligible for Medicaid or CHIP, 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;

Page: 5/14 Revision: 9.0 Printed On: 06/09/2020

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01/08

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(see AHC 3.19.1 for Decision Rules / Application)

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2/1/16, 11/09/17, 08/26/19

Policy No: AHC 3.19

Origin: PFS

Authority: EC

Page: 6 of 13

### 1.8.1.4. Women, Infants and Children (WIC)

- 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
- Additionally, patients who fit one or more of the following criteria may be eligible for financial assistance for emergency or nonemergency 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

Page: 6/14 Revision: 9.0

### **Corporate Policy Manual** Financial Assistance (Formerly "Charity Care")

Effective Date 01/08 Policy No: AHC 3.19

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Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13,

2/1/16, 11/09/17, 08/26/19 Page: 7 of 13

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

Authority: EC

- 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.
  - As a standard process, Adventist HealthCare will provide Plain Language 2.1. 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
  - Adventist HealthCare facilities will prominently and conspicuously post 2.3. 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:

Page: 7/14 Revision: 9.0

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Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13,

2/1/16, 11/09/17, 08/26/19 Page: 8 of 13

2.3.1. Financial Assistance Policy (FAP)

- Financial Assistance Application Form (FAA Form) 2.3.2.
- 2.3.3. Plain Language Summary of the Financial Assistance Policy (PLS)

Authority: EC

### 3. Policy Application and Determination Period

- The Financial Assistance Policy applies to charges for medically necessary 3.1. 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.
- Each application for Financial Assistance will be reviewed, and a 3.3. 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
- **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

Page: 8/14 Revision: 9.0 Printed On: 06/09/2020

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Authority: EC Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13,

2/1/16, 11/09/17, 08/26/19 Page: 9 of 13

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

- 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

#### Adventist HealthCare responsibilities 4.6.

- AHC has a financial assistance policy to evaluate and determine an individual's eligibility for financial assistance.
- AHC has a means of communicating the availability of financial assistance to all individuals in a manner that promotes full participation by the individual.
- 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.
- 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.

Page: 9/14 Revision: 9.0

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Authority: EC Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13,

2/1/16, 11/09/17, 08/26/19 Page: 10 of 13

> 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.

- AHC provides options for payment arrangements. 4.6.7.
- 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.

#### **Individual Patient's Responsibilities** 4.7.

- 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.
- 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.
- 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.

Page: 10/14 Revision: 9.0

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2/1/16, 11/09/17, 08/26/19 Page: 11 of 13

### 5. Identification Of Potentially Eligible Individuals

5.1. Identification through socialization and outreach

- 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.
- 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.).
  - 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.

Page: 11/14 Revision: 9.0

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Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13,

2/1/16, 11/09/17, 08/26/19 Page: 12 of 13

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

Authority: EC

- 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

Page: 12/14 Revision: 9.0

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Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13,

2/1/16, 11/09/17, 08/26/19 Page: 13 of 13

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 <u>Adventist HealthCare's Public Notice of Financial Assistance & Charity Care</u>:

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

Page: 13/14 Revision: 9.0

### **Document Information**

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# EXHIBIT 13: Policy 3.19A Financial Assistance - Spanish

### Manual de Política Corporativa

### Asistencia financiera

(Anteriormente "Atención de beneficencia")

Fecha de entrada en vigor:	08/Ene	Política No:	AHC 3.19
Referencia cruzada:	Anteriormente: Política de Asistencia Financiera	Origen:	PFS / FC
	(Consulte el documento AHC 3.19.1 para más		
	información sobre Reglas de decisión / Solicitud)		
Evaluado:	02/09, 19/9/13, 10/10/17	Autoridad:	EC
Revisado:	09/05, 09/06, 09/10, 15/06/10, 02/03/11,	Página:	1 de 13
	02/10/13, 01/02/16, 09/11/17, 26/08/19		

### RESUMEN DE LA POLÍTICA DE ASISTENCIA FINANCIERA

### **ALCANCE:**

Esta política se aplica a los siguientes centros de Adventist HealthCare: Shady Grove Medical Center, Germantown Emergency Center, White Oak Medical Center, Adventist Rehabilitation Hospital of Maryland y Fort Washington Medical Center, denominados conjuntamente como AHC.

### **PROPÓSITO**

En concordancia con la misión de AHC de demostrar que el cuidado que Dios tiene de nosotros al mejorar 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 brinda una forma sistemática y equitativa de garantizar que los pacientes que carecen de seguro, tienen un seguro insuficiente, han experimentado un evento catastrófico y/o no cuentan con los recursos adecuados para pagar sus servicios, puedan acceder a la atención médica que necesitan.

Adventist HealthCare brinda atención de emergencia y otra atención médicamente necesaria no electiva a pacientes individuales sin discriminación e independientemente de su capacidad de pago, capacidad para calificar para asistencia financiera o la disponibilidad de cobertura por un tercero. En el caso de que no se disponga de cobertura de un tercero, se iniciará una determinación de posible elegibilidad para recibir Asistencia financiera antes o en el momento de la admisión. Esta política identifica aquellas circunstancias en las que AHC podría brindar atención sin cargo o con descuento en función de la necesidad financiera de la persona.

La comunicación pública impresa sobre el programa se hará anualmente en los periódicos de los condados de Montgomery y Prince George, del estado de Maryland y se publicará en los departamentos de emergencia, las oficinas comerciales y las áreas de registro de los centros mencionados anteriormente.

Esta política ha sido adoptada por el consejo directivo de AHC de acuerdo 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 lineamientos para:

 Asistencia financiera para el pago de gastos a cargo de pacientes individuales que reciben servicios de emergencia y otros servicios médicamente necesarios no electivos en función de la necesidad médica y financiera.

Página: 1/14 Revisión: 9.0

### Manual de Política Corporativa

### Asistencia financiera

(Anteriormente "Atención de beneficencia")

Fecha de entrada en vigor:	08/Ene	Política No:	AHC 3.19
Referencia cruzada:	Anteriormente: Política de Asistencia Financiera	Origen:	PFS / FC
	(Consulte el documento AHC 3.19.1 para más		
	información sobre Reglas de decisión / Solicitud)		
Evaluado:	02/09, 19/9/13, 10/10/17	Autoridad:	EC
Revisado:	09/05, 09/06, 09/10, 15/06/10, 02/03/11,	Página:	2 de 13
	02/10/13, 01/02/16, 09/11/17, 26/08/19	-	

- Descuentos por pronto pago (%) que pueden cobrarse a los pacientes que cubren sus gastos y reciben servicios médicamente necesarios que no se consideran emergentes o no son electivos.
- Atención especial, cuando corresponda, para aquellas personas que podrían obtener una atención especial debido a una asistencia de catástrofes.

### **BENEFICIOS:**

Mejorar el servicio comunitario por medio de servicios médicos de calidad independientemente de la capacidad de pago del paciente (o de sus garantes). Disminuir la colocación innecesaria o inapropiada de cuentas con agencias de cobro cuando una designación de atención caritativa es más apropiada.

### **DEFINICIONES:**

- Médicamente necesario: servicios o suministros de atención médica necesarios para prevenir, diagnosticar o tratar una enfermedad, lesión, afección, dolencia o sus síntomas y que cumplan con los estándares aceptados de la medicina
- <u>Servicios médicos de emergencia</u>: tratamiento de personas en situaciones de crisis de salud que podrían poner en riesgo la vida con o sin tratamiento
- Servicios no electivos: una enfermedad que, sin atención inmediata:
  - o Pone la vida de la persona en grave peligro
  - O Provoca un deterioro grave de las funciones corporales o una disfunción grave de un órgano del cuerpo.
  - O Pueden incluir, pero no se limitan a:
    - Pacientes ambulatorios en el Departamento de emergencias
    - Admisiones al Departamento de emergencias
    - Seguimiento de pacientes ambulatorios/hospitalizados relacionado con una visita previa a Emergencias
- Asistencia en caso de catástrofes: una enfermedad grave que requiere hospitalización o recuperación prolongada. Los ejemplos incluirían coma, cáncer, leucemia, ataque cardíaco o accidente cerebrovascular. Estas enfermedades suelen implicar altos costos para los hospitales, los médicos, así como de medicamentos y pueden incapacitar a la persona para trabajar, lo que crea una dificultad financiera.
- **Descuento por pronto pago:** el estado de Maryland permite un descuento del 1% por pronto pago a aquellos pacientes que pagan por los servicios médicos en el momento en que se prestan los servicios.
- <u>NFP (Nivel federal de pobreza)</u>: es el monto mínimo establecido de ingresos brutos que una familia necesita para alimentos, ropa, transporte, vivienda y otras necesidades. En los Estados Unidos, el Departamento de Salud y Servicios Humanos determina este nivel.

Página: 2/14 Revisión: 9.0

### Manual de Política Corporativa

### Asistencia financiera

(Anteriormente "Atención de beneficencia")

Fecha de entrada en vigor:	08/Ene	Política No:	AHC 3.19
Referencia cruzada:	Anteriormente: Política de Asistencia Financiera	Origen:	PFS / FC
	(Consulte el documento AHC 3.19.1 para más	-	
	información sobre Reglas de decisión / Solicitud)		
Evaluado:	02/09, 19/9/13, 10/10/17	Autoridad:	EC
Revisado:	09/05, 09/06, 09/10, 15/06/10, 02/03/11,	Página:	3 de 13
	02/10/13, 01/02/16, 09/11/17, 26/08/19	-	

- <u>Paciente no asegurado</u>: persona no inscrita en un plan de seguro de cobertura de servicios de atención médica. Podría o no ser elegible para recibir atención caritativa.
- <u>Pacientes que cubren sus gastos</u>: un Paciente sin seguro que no califica para recibir asistencia financiera de AHC debido a que sus ingresos superan los lineamientos de ingresos cubiertos del NFP

### POLÍTICA

### 1. Elegibilidad general

- 1.1. Todos los pacientes, independientemente de su raza, credo, género, edad, orientación sexual, nacionalidad de origen o situación económica, pueden solicitar Asistencia financiera.
- 1.2. Es parte de la misión de Adventist HealthCare brindar la atención médica necesaria a quienes no pueden pagarla. El programa de Asistencia financiera contempla que la atención sea gratuita o con un costo reducido para:
  - 1.2.1. los más necesitados según la evaluación actual del Nivel de pobreza federal (NPF), (por ejemplo, personas que tienen ingresos menores o iguales al 200% del nivel de pobreza federal (consulte el Anexo A para conocer el NPF actual).
  - 1.2.2. aquellos con alguna necesidad según el NPF actual, (por ejemplo, personas que tienen ingresos que se encuentran entre el 201% y el 600% de los lineamientos actuales del NPF
  - 1.2.3. pacientes que atraviesan dificultades económicas (deuda médica contraída en el transcurso de los 12 meses anteriores, la cual representa más del 25% de los ingresos familiares) y/o
  - 1.2.4. falta de otros recursos financieros para pagar la atención médica urgente o de emergencia
- 1.3. Esta política requiere que un paciente o su garante cooperen y hagan uso de todos los programas disponibles (incluyendo los ofrecidos por AHC, Medicaid, compensación para trabajadores y otros programas estatales y locales), los cuales podrían proporcionar cobertura para los servicios, antes de la aprobación final de la Asistencia Financiera de Adventist HealthCare

Página: 3/14 Revisión: 9.0

### Manual de Política Corporativa

### Asistencia financiera

(Anteriormente "Atención de beneficencia")

Fecha de entrada en vigor:	08/Ene	Política No:	AHC 3.19
Referencia cruzada:	Anteriormente: Política de Asistencia Financiera	Origen:	PFS / FC
	(Consulte el documento AHC 3.19.1 para más		
	información sobre Reglas de decisión / Solicitud)		
Evaluado:	02/09, 19/9/13, 10/10/17	Autoridad:	EC
Revisado:	09/05, 09/06, 09/10, 15/06/10, 02/03/11,	Página:	4 de 13
	02/10/13, 01/02/16, 09/11/17, 26/08/19		

- 1.4. **Elegibilidad para Atención médica de emergencia:** los pacientes podrían ser elegibles para recibir asistencia financiera para atención médica de emergencia según esta Política si:
  - 1.4.1 No tienen seguro, han agotado o agotarán todos los beneficios disponibles de su seguro; y
  - 1.4.2 Su ingreso familiar anual no excede el 200% de los Lineamientos federales de pobreza actuales para calificar para recibir asistencia financiera completa o el 600% de los Lineamientos federales de pobreza actuales para recibir asistencia financiera parcial; y
  - 1.4.3 Solicitan asistencia financiera dentro del Período de Solicitud de asistencia financiera (es decir, dentro del período de 240 días posteriores a que se proporcione al paciente el primer estado de cuenta después de haber sido dado de alta).
- 1.5. Elegibilidad para Atención médicamente necesaria que no es de emergencia: los pacientes podrían ser elegibles para recibir asistencia financiera para Atención médicamente necesaria que no es de emergencia según esta Política si:
  - 1.5.1 No tienen seguro, han agotado o agotarán todos los beneficios disponibles de su seguro; y
  - 1.5.2 Su ingreso familiar anual no excede el 200% de los Lineamientos federales de pobreza actuales para calificar para recibir asistencia financiera completa o el 600% de los Lineamientos federales de pobreza actuales para recibir asistencia financiera parcial; y
  - 1.5.3 Solicitan asistencia financiera dentro del Período de Solicitud de asistencia financiera (es decir, dentro del período que finaliza el día 240 después de que se proporciona al paciente el primer estado de cuenta después de haber sido dado de alta) y
  - 1.5.4 Un equipo de atención de AHC desarrolló y proporcionó el plan de tratamiento.

### 1.6. Consideraciones:

1.6.1 Los pacientes asegurados que incurren en gastos de desembolso directo elevados (deducibles, coseguro, etc.) podrían ser elegibles para recibir Asistencia financiera

Página: 4/14 Revisión: 9.0

### Manual de Política Corporativa

### Asistencia financiera

(Anteriormente "Atención de beneficencia")

Fecha de entrada en vigor:	08/Ene	Política No:	AHC 3.19
Referencia cruzada:	Anteriormente: Política de Asistencia Financiera	Origen:	PFS / FC
	(Consulte el documento AHC 3.19.1 para más		
	información sobre Reglas de decisión / Solicitud)		
Evaluado:	02/09, 19/9/13, 10/10/17	Autoridad:	EC
Revisado:	09/05, 09/06, 09/10, 15/06/10, 02/03/11,	Página:	5 de 13
	02/10/13, 01/02/16, 09/11/17, 26/08/19	-	

aplicada a la parte de responsabilidad de pago del paciente de sus servicios médicamente necesarios.

- 1.6.2 Asistencia financiera aprobada previamente para servicios médicos programados la segunda medianoche después de una admisión a la sala de emergencias son revisadas por el personal apropiado con base en los criterios de necesidad médica establecidos en esta política, y podría o no ser aprobado para asistencia financiera.
- 1.7. **Exclusiones:** los pacientes NO SON ELEGIBLES para recibir asistencia financiera para Atención médica de emergencia ni otra Atención médicamente necesaria que no sea de emergencia según esta política si:
  - 1.7.1 El paciente o responsable intencionalmente proporciona información falsa o engañosa; o
  - 1.7.2 Proporciona información obtenida través de métodos fraudulentos con el fin de 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 solicitar 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 principal cuando corresponda.
- 1.8. **Consideraciones especiales (Presunta elegibilidad):** Adventist HealthCare pone a disposición de los pacientes asistencia financiera en función de su "supuesta elegibilidad", si cumplen con los siguientes criterios:
  - 1.8.1 Los pacientes, salvo 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 en el transcurso de 30 días, a menos que se solicite una prórroga de 30 días. La Asistencia continuará en vigencia siempre y cuando el paciente siga siendo un beneficiario activo de uno de los siguientes programas:

Página: 5/14 Revisión: 9.0

### Manual de Política Corporativa

### Asistencia financiera

(Anteriormente "Atención de beneficencia")

Fecha de entrada en vigor:	08/Ene	Política No:	AHC 3.19
Referencia cruzada:	Anteriormente: Política de Asistencia Financiera	Origen:	PFS / FC
	(Consulte el documento AHC 3.19.1 para más		
	información sobre Reglas de decisión / Solicitud)		
Evaluado:	02/09, 19/9/13, 10/10/17	Autoridad:	EC
Revisado:	09/05, 09/06, 09/10, 15/06/10, 02/03/11,	Página:	6 de 13
	02/10/13, 01/02/16, 09/11/17, 26/08/19		

- 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 programas del condado de Montgomery que se enumeran más adelante son elegibles para recibir asistencia financiera luego de cumplir con los requisitos de copago que el programa exige, siempre y cuando el paciente presente un comprobante de inscripción en el transcurso de 30 días, a menos que se solicite una prórroga de 30 días. La Asistencia continuará en vigencia siempre y cuando 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 clasificado 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 (aplicarán otros requisitos)

Página: 6/14 Revisión: 9.0

### Manual de Política Corporativa

### Asistencia financiera

(Anteriormente "Atención de beneficencia")

Fecha de entrada en vigor:	08/Ene	Política No:	AHC 3.19
Referencia cruzada:	Anteriormente: Política de Asistencia Financiera	Origen:	PFS / FC
	(Consulte el documento AHC 3.19.1 para más		
	información sobre Reglas de decisión / Solicitud)		
Evaluado:	02/09, 19/9/13, 10/10/17	Autoridad:	EC
Revisado:	09/05, 09/06, 09/10, 15/06/10, 02/03/11,	Página:	7 de 13
	02/10/13, 01/02/16, 09/11/17, 26/08/19		

1.8.3.6 es anciano y víctima de abuso

1.8.3.7 es un menor no acompañado

1.8.3.8 es actualmente elegible para Medicaid, pero no lo era cuando se prestó el 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: bajo esta política para atención de emergencia u otro tipo de atención médicamente necesaria, no se le cobrará a una persona que sea elegible para recibir asistencia, salvo los montos que se cobran generalmente (AGB) a una persona que no sea elegible para recibir dicha 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 aseguradoras comerciales, Medicare, Medicaid o pacientes que cubren sus gastos) 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 establecido 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 que se atienden en cualquier momento durante el proceso en los idiomas principales adecuados para el área de servicio de Adventist HealthCare.
  - 2.1. Como parte de un proceso estándar, Adventist HealthCare proporcionará Resúmenes de la Política de Asistencia financiera en lenguaje sencillo.
    - 2.1.1. Durante el registro en el Departamento de Emergencias
    - 2.1.2. Durante las sesiones de asesoramiento financiero
    - 2.1.3. Si lo solicita
  - 2.2. Los centros de Adventist HealthCare publicarán de manera visible y manifiesta versiones completas y actuales del Resumen de la política de Asistencia financiera en lenguaje sencillo.

Página: 7/14 Revisión: 9.0

### Manual de Política Corporativa

### Asistencia financiera

(Anteriormente "Atención de beneficencia")

Fecha de entrada en vigor:	08/Ene	Política No:	AHC 3.19
Referencia cruzada:	Anteriormente: Política de Asistencia Financiera	Origen:	PFS / FC
	(Consulte el documento AHC 3.19.1 para más		
	información sobre Reglas de decisión / Solicitud)		
Evaluado:	02/09, 19/9/13, 10/10/17	Autoridad:	EC
Revisado:	09/05, 09/06, 09/10, 15/06/10, 02/03/11,	Página:	8 de 13
	02/10/13, 01/02/16, 09/11/17, 26/08/19	-	

- 2.2.1. En todas las áreas 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 y manifiesta versiones completas y actuales de lo siguiente en sus respectivos sitios web en inglés y en los idiomas principales adecuados para el área de servicio de Adventist HealthCare:
  - 2.3.1 Política de Asistencia Financiera (FAP)
  - 2.3.2 Formulario de solicitud de Asistencia financiera (Formulario FAA)
  - 2.3.3 Resumen de la Política de asistencia financiera (PLS) en lenguaje sencillo:

### 3. Periodo de solicitud y determinación de la Política

- 3.1 La Política de Asistencia financiera rige los cargos por servicios médicamente necesarios proporcionados a los pacientes por uno de los centros de Adventist HealthCare mencionados. Un paciente (o garante) puede solicitar Asistencia financiera en cualquier momento dentro de 240 días desde que se determine que el paciente tiene un saldo deudor.
- 3.2 Se comunicará la posible elegibilidad al paciente dentro de 2 días laborales después de la presentación de la solicitud.
- 3.3 Se analizará cada una de las solicitudes de Asistencia financiera y se llegará a una determinación en función de la evaluación de la capacidad de pago 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 los 10 días laborales siguientes a la presentación de una solicitud completa para Asistencia financiera.
- 3.4 La asistencia financiera preaprobada para servicios médicos programados es autorizada 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.** Pasado este

Página: 8/14 Revisión: 9.0

### Manual de Política Corporativa

### Asistencia financiera

(Anteriormente "Atención de beneficencia")

Fecha de entrada en vigor:	08/Ene	Política No:	AHC 3.19
Referencia cruzada:	Anteriormente: Política de Asistencia Financiera	Origen:	PFS / FC
	(Consulte el documento AHC 3.19.1 para más		
	información sobre Reglas de decisión / Solicitud)		
Evaluado:	02/09, 19/9/13, 10/10/17	Autoridad:	EC
Revisado:	09/05, 09/06, 09/10, 15/06/10, 02/03/11,	Página:	9 de 13
	02/10/13, 01/02/16, 09/11/17, 26/08/19		

tiempo, los pacientes que requieran asistencia financiera deberán volver a enviar la solicitud y completar el proceso de solicitud nuevamente

- 4. **EXCLUSIONES DE LA POLÍTICA:** Los servicios no cubiertos por la Política de asistencia financiera de AHC incluyen, pero no se limitan a:
  - 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 indicado 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 los médicos tratantes.
  - 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 un servicio gratuito o con descuento.
  - 4.4 Los pacientes, o sus garantes, 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 un medio para comunicar la disponibilidad de asistencia financiera a todas las personas para fomentar una participación absoluta de la persona.

Página: 9/14 Revisión: 9.0

### Manual de Política Corporativa

### Asistencia financiera

(Anteriormente "Atención de beneficencia")

Fecha de entrada en vigor:	08/Ene	Política No:	AHC 3.19
Referencia cruzada:	Anteriormente: Política de Asistencia Financiera	Origen:	PFS / FC
	(Consulte el documento AHC 3.19.1 para más		
	información sobre Reglas de decisión / Solicitud)		
Evaluado:	02/09, 19/9/13, 10/10/17	Autoridad:	EC
Revisado:	09/05, 09/06, 09/10, 15/06/10, 02/03/11,	Página:	10 de 13
	02/10/13, 01/02/16, 09/11/17, 26/08/19		

- 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 trasladar las 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 de la organización para la prestación de asistencia financiera y las políticas/procesos que rigen el proceso de asistencia financiera.
- 4.6.6. Después 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 respalde la oferta, la solicitud y la provisión de asistencia financiera por un periodo mínimo de siete años.
- 4.6.10. AHC analizará e incorporará periódicamente actualizaciones de los lineamientos federales de pobreza publicados por el Departamento de Salud y Servicios Humanos de los Estados Unidos

### 47. 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 proporcionando a AHC 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

Página: 10/14 Revisión: 9.0

### Manual de Política Corporativa

### Asistencia financiera

(Anteriormente "Atención de beneficencia")

Fecha de entrada en vigor:	08/Ene	Política No:	AHC 3.19
Referencia cruzada:	Anteriormente: Política de Asistencia Financiera	Origen:	PFS / FC
	(Consulte el documento AHC 3.19.1 para más		
	información sobre Reglas de decisión / Solicitud)		
Evaluado:	02/09, 19/9/13, 10/10/17	Autoridad:	EC
Revisado:	09/05, 09/06, 09/10, 15/06/10, 02/03/11,	Página:	11 de 13
	02/10/13, 01/02/16, 09/11/17, 26/08/19		

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 hospitalizados que cubren sus gastos durante el curso de su estadía 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 verbales respecto al 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 dar 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 ni paga el monto adeudado antes de una fecha

Página: 11/14 Revisión: 9.0

#### Manual de Política Corporativa

#### Asistencia financiera

(Anteriormente "Atención de beneficencia")

Fecha de entrada en vigor:	08/Ene	Política No:	AHC 3.19
Referencia cruzada:	Anteriormente: Política de Asistencia Financiera	Origen:	PFS / FC
	(Consulte el documento AHC 3.19.1 para más		
	información sobre Reglas de decisión / Solicitud)		
Evaluado:	02/09, 19/9/13, 10/10/17	Autoridad:	EC
Revisado:	09/05, 09/06, 09/10, 15/06/10, 02/03/11,	Página:	12 de 13
	02/10/13, 01/02/16, 09/11/17, 26/08/19	-	

límite especificada. La fecha límite no puede ser anterior a 120 días después 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. Solicitudes de Asistencia financiera: Se pueden recibir solicitudes de asistencia financiera de varias fuentes (incluyendo el paciente, un familiar, una organización comunitaria, una iglesia, una agencia de cobros, un cuidador, la Administración, etc.).
  - 5.2.1. Las solicitudes recibidas 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 con un seguro insuficiente podría no involucrarse en el proceso tradicional de solicitud de asistencia financiera. Si el paciente no proporciona la información requerida, 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, en inglés) prevé la probabilidad de que un paciente califique para recibir Asistencia financiera en las fuentes de datos disponibles para el público. 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 aplica 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 recaen fuera del ámbito de 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.

Página: 12/14 Revisión: 9.0

Impreso el: 9 de junio de 2020 Esta copia caducará en 24 horas.

#### Manual de Política Corporativa

#### Asistencia financiera

(Anteriormente "Atención de beneficencia")

Fecha de entrada en vigor:	08/Ene	Política No:	AHC 3.19
Referencia cruzada:	Anteriormente: Política de Asistencia Financiera	Origen:	PFS / FC
	(Consulte el documento AHC 3.19.1 para más		
	información sobre Reglas de decisión / Solicitud)		
Evaluado:	02/09, 19/9/13, 10/10/17	Autoridad:	EC
Revisado:	09/05, 09/06, 09/10, 15/06/10, 02/03/11,	Página:	13 de 13
	02/10/13, 01/02/16, 09/11/17, 26/08/19	_	

- 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 consensuadas 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 <u>Aviso público de Adventist HealthCare sobre</u> <u>Asistencia financiera y Atención de beneficencia:</u>

Títulos de los documentos
AHC Financial Assistance Plain Language Summary - English
Resumen de la Asistencia financiera de AHC en lenguaje sencillo – español
Lineamientos federales de pobreza de AHC
AHC Financial Assistant Application - English
Solicitud de Asistencia financiera de AHC - español
Lista de proveedores que no están cubiertos bajo la Política de Asistencia financiera de AHC

Página: 13/14 Revisión: 9.0

Impreso el: 9 de junio de 2020 Esta copia caducará en 24 horas.

#### Información de documentos

<u>Títulos de los documentos</u>	
Asistencia Financiera AHC 3.19	9
Descripción de documentos	
N/A	
Información de aprobación	
Aprobado el:	26/8/2019
Aprobado por:	LaTicia Graves, Paralegal III
La aprobación vence el:	26/8/2019
Tipo de aprobación:	Entrada manual
Ubicación de documentos:	/ Adventist HealthCare / AHC Corporate Policies / Finance N/A
Palabras claves:	N/A
Impreso por:	Usuario invitado
Referencias estándar:	N/A

Esta copia caducará en 24 horas.

Aviso:

# EXHIBIT 14: Policy AHC 3.19.0 Financial Assistance - Decision Rules/Application

#### **Corporate Policy Manual**

#### Financial Assistance – Decision Rules/Application (Formerly known as Charity Care Policy)

Effective Date 01/08 Policy No: AHC 3.19.0 Origin: PFS

Cross Referenced: Financial Assistance - Decision Rules/Application

(see Master Policy 3.19 Financial Assistance)

Authority: EC Reviewed: 02/09, 06/15/10, 9/19/13 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13, 08/26/19 Revised: Page: 1 of 12

#### **DECISION RULES:**

- Α. The patient would be required to fully complete an application for Charity Care and/or completion of the "Income" and "Family Size" portions of the State Medicaid Application could be considered as "an application for Charity Care." A final decision will be determined by using; an electronic income estimator, the state of Maryland poverty guidelines and the review of requested documents. An approved application for assistance will be valid for twelve (12) months from the date of service and may be applied to any qualified services (see "A" above), rendered within the twelve (12) month period. The patient or Family Representative may reapply for Charity Care if their situation continues to merit assistance.
  - 1. Once a patient qualifies for Charity Care under this policy the patient or any immediate family member of the patient living in the same household shall be eligible for Charity Care at the same level for medically necessary care when seeking subsequent care at the same hospital during the 12 month period from the initial date of service.
  - 2. When the patient is a minor, an immediate family member is defined as; mother, father, unmarried minor natural or adopted siblings, natural or adopted children residing in the same household.
  - 3. When the patient is not a minor, an immediate family member is defined as: spouse, minor natural or adopted siblings, natural or adopted children residing in the same household.
- B. Where a patient is deceased with no designated Executor, or no estate on file within the appropriate jurisdiction(s), the cost of any services rendered can be charged to Charity Care without having completed a formal application. This would occur after a determination that other family members have no legal obligation to provide Charity Care. After receiving a death certificate and appropriate authorization, the account balance will be adjusted via the appropriate adjustment codes 23001 – Account in active AR, 33001 – Account in Bad Debt.
- C. Where a patient is from out of State with no means to pay, follow instructions for "A" above.
- D. A Maryland Resident who has no assets or means to pay, follow instructions for "a" above.

Page: 1/13 Revision: 8.0

#### **Corporate Policy Manual**

# Financial Assistance – Decision Rules/Application (Formerly known as Charity Care Policy)

Effective Date 01/08 Policy No: AHC 3.19.0

Cross Referenced: Financial Assistance - Decision Rules/Application Origin: PFS

(see Master Policy 3.19 Financial Assistance)

Reviewed: 02/09, 06/15/10, 9/19/13 Authority: EC Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13, 08/26/19 Page: 2 of 12

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- **E.** A Patient who files for bankruptcy, and has no identifiable means to pay the claim, upon receipt of the discharge summary to include debt owed to AHC, charity will be processed without a completed application and current balances adjusted as instructed in "b" above.
- **F.** Where a patient has no address or social security number on file and we have no means of verifying assets or, patient is deemed homeless, charity will be processed without a completed application and current balances adjusted as instructed in "b" above.
- **G.** A Patient is denied Medicaid but is not determined to be "over resource" follow instructions for "a" above.
- **H.** A Patient who qualifies for federal, state or local governmental programs whose income qualifications fall within AHC Charity Care Guidelines, automatically qualifies for AHC Charity Care without the requirement to complete a charity application.
- I. Patients with a Payment Predictability Score (PPS) of 500 or less, and more than 2 prior obligations in a Collection Status on their Credit Report and Income and Family Size are within the Policy Guidelines, charity will be processed without a completed application and current balances adjusted as instructed in "C" above.
- **J.** If a patient experiences a material change in financial status, it is the responsibility of the patient to notify the hospital within ten days of the financial change.

Page: 2/13
Revision: 8.0

#### **Corporate Policy Manual**

#### Financial Assistance – Decision Rules/Application (Formerly known as Charity Care Policy)

01/08 Effective Date Policy No: AHC 3.19.0 Origin: PFS

Cross Referenced: Financial Assistance - Decision Rules/Application

(see Master Policy 3.19 Financial Assistance)

02/09, 06/15/10, 9/19/13 Reviewed: Authority: EC Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13, 08/26/19 Page: 3 of 12

#### NOTICE TO BE POSTED IN THE ADMISSIONS OFFICE, BUSINESS OFFICE AND THE **EMERGENCY DEPARTMENT**

#### ADVENTIST HEALTHCARE NOTICE OF AVAILIBILITY OF CHARITY CARE

Shady Grove Medical Center, White Oak Medical Center, Fort Washington Medical Center, and Adventist Rehab Hospital of Maryland will make available a reasonable amount of health care without charge to persons eligible under Community Services Administration guidelines. Charity Care is available to patients whose family income does not exceed the limits designated by the Income Poverty Guidelines established by the Community Services Administration. The current income requirements are the following. If your income is not more than six times these amounts, you may qualify for Charity Care.

Size of Family Unit	<b>Guideline</b>
1	\$11,490
2	\$15,510
3	\$19,530
4	\$23,550
5	\$27,570
6	\$31,590
7	\$35,610
8	\$39,630

**Note:** The guidelines increase \$4,020 for each additional family member.

If you feel you may be eligible for Charity Care and wish to apply, please obtain an application for Community Charity Care from the Admissions Office or by calling (301) 315-3660.

Revised July 2013

Page: 3/13 Revision: 8.0

**Corporate Policy Manual** 

# Financial Assistance – Decision Rules/Application (Formerly known as Charity Care Policy)

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Effective Date 01/08 Policy No: AHC 3.19.0

Cross Referenced: Financial Assistance - Decision Rules/Application Origin: PFS

(see Master Policy 3.19 Financial Assistance)

Reviewed: 02/09, 06/15/10, 9/19/13 Authority: EC Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13, 08/26/19 Page: 4 of

Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13, 08/26/19 Page: 4 of 12



#### Adventist HealthCare

Patient Financial Services, 820 West Diamond Ave, Suite 500, Gaithersburg, MD 20878

☐ White Oak Medical Center☐ Shady Grove Medical Center☐	☐ Fort Washington Medical Center ☐ Adventist Rehabilitation Hospital of Maryland
	APPLICATION- DEMOGRAPHICS
Date:Account Number(s)	
Patient Name:	Birth Date:
Address:	Sex:
Home Telephone: Work Te	elephone: Cell Phone:
Social Security #:	US Citizen: No Residence:
Marital Status: Married S	Single Divorced
Name of Person Completing Application	
Dependents Listed on Tax Form:	
Name:	Age:Relationship:
Employment: Patient employer	Spouse employer
Name:	Name:
Address:	Address:
Telephone #:	Telephone #:
Social Security #:	Social Security #:
How long employed:	How long employed:
TOTAL F	AMILVINCOME \$

**Note:** All Financial applications must be accompanied by income verification for each working family member. Be sure you have attached income verification for all amounts listed above. This verification may be in the following forms: minimum of 3 months' worth of pay-stubs, an official income verification letter from your employer and/or your current taxes or W-2s. If you are not working and are not receiving state or county assistance, please include a "Letter of Support" from the individual or organization that is covering your living expenses. Any missing documents will result in a delay in processing your application or could cause your application to be denied. Thank you for your cooperation.

Page: 4/13 Revision: 8.0

#### **Corporate Policy Manual**

#### Financial Assistance – Decision Rules/Application (Formerly known as Charity Care Policy)

01/08 Policy No: Effective Date AHC 3.19 Cross Referenced: Financial Assistance - Decision Rules/Application Origin: **PFS** (see Master Policy 3.19 Financial Assistance) Reviewed: 02/09, 06/15/10, 9/19/13 Authority: EC Revised: 05/09, 06/09, 10/09, 06/15/10, 03/11, 10/02/13, 08/26/19 5 of 12 Page: CHARITY CARE APPLICATION- LIVING EXPENSES **EXPENSES:** Rent / Mortgage Food Transportation Utilities Health Insurance premiums Medical expenses not covered by insurance Doctor: Hospital: TOTAL: \_\_\_\_\_ Has the applicant ever applied or is currently applying for Medical Assistance? Please Circle the appropriate answer: YES or NO If yes, please provide the status of your application below (caseworker name, DSS office location, etc.) I hereby certify that to the best of my knowledge and belief, the information listed on this statement is true and represents a complete statement of my family size and income for the time period indicated. **Date:** \_\_\_\_\_ Applicant Signature:

Return Application To: Adventist HealthCare

Page: 5/13 Revision: 8.0

**Corporate Policy Manual** 

#### Financial Assistance – Decision Rules/Application (Formerly known as Charity Care Policy)

Effective Date 01/08 Policy No: AHC 3.19 **PFS** 

Cross Referenced: Financial Assistance - Decision Rules/Application (see Master Policy 3.19 Financial Assistance)

Origin:

Authority:

EC

02/09, 06/15/10, 9/19/13 Reviewed: Revised:

05/09, 06/09, 10/09, 06/15/10, 03/11, 10/02/13, 08/26/19

Page: 6 of 12

**Patient Financial Services Attn: Customer Service Manager** 820 West Diamond Avenue. Suite 500

Gaithersburg, MD 20878

#### COMMUNITY CHARITY CARE APPLICATION- OFFICIAL DETERMINATION ONLY

This application was: <b>Den</b>	ed /Approved /Need more information
The reason for Denial:	
What additional information is	needed?:
Approval Details:	
Patient approved for will be a Charity ( \$ will be the patient	2% L'are Adjustment s responsibility
Approval Letter was sent on	
AUTHORIZED SIGNATUR	ES:
CS/COLLECTION MANAG UP TO \$1500.00	ER
Sr. ASSISTANT DIRECTOR UP TO \$2500.00	
REGIONAL DIRECTOR UP TO \$25,000.00	
VP of Revenue Cycle or HOS	PITAL CFO

Page: 6/13 Revision: 8.0

#### **Corporate Policy Manual**

#### Financial Assistance – Decision Rules/Application (Formerly known as Charity Care Policy)

Effective Date 01/08 Policy No: AHC 3.19 **PFS** 

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(see Master Policy 3.19 Financial Assistance)

02/09, 06/15/10, 9/19/13 Reviewed: Authority: EC

05/09, 06/09, 10/09, 06/15/10, 03/11, 10/02/13, 08/26/19 Revised:

Page: 7 of 12

Revised July 2013

#### **2013 POVERTY GUIDELINES**

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	100%	\$11,490	100%	0%
2	100%	\$15,510	100%	0%
3	100%	\$19,530	100%	0%
4	100%	\$23,550	100%	0%
5	100%	\$27,570	100%	0%
6	100%	\$31,590	100%	0%
7	100%	\$35,610	100%	0%
8	100%	\$39,630	100%	0%
FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	125%	\$14,363	100%	0%
2	125%	\$19,388	100%	0%
3	125%	\$24,413	100%	0%
4	125%	\$29,438	100%	0%
5	125%	\$34,463	100%	0%
6	125%	\$39,488	100%	0%
7	125%	\$44,513	100%	0%
8	125%	\$49,538	100%	0%
FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	150%	\$17,235	100%	0%
2	150%	\$23,265	100%	0%
3	150%	\$29,295	100%	0%

Page: 7/13 Revision: 8.0

#### **Corporate Policy Manual**

#### Financial Assistance – Decision Rules/Application (Formerly known as Charity Care Policy)

Effective Date Policy No: 01/08 AHC 3.19 Origin: **PFS** 

Cross Referenced: Financial Assistance - Decision Rules/Application

(see Master Policy 3.19 Financial Assistance) 02/09, 06/15/10, 9/19/13

05/09, 06/09, 10/09, 06/15/10, 03/11, 10/02/13, 08/26/19 Revised:

Reviewed:

Page: 8 of 12

Authority:

EC

4	150%	\$35,325	100%	0%
5	150%	\$41,355	100%	0%
6	150%	\$47,385	100%	0%
7	150%	\$53,415	100%	0%
8	150%	\$59,445	100%	0%
FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	175%	\$20,108	100%	0%
2	175%	\$27,143	100%	0%
3	175%	\$34,178	100%	0%
4	175%	\$41,213	100%	0%
5	175%	\$48,248	100%	0%
6	175%	\$55,283	100%	0%
7	175%	\$62,318	100%	0%
8	175%	\$69,353	100%	0%
FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	200%	\$22,980	100%	0%
2	200%	\$31,020	100%	0%
3	200%	\$39,060	100%	0%
4	200%			
_	20070	\$47,100	100%	0%
5	200%	\$47,100 \$55,140	100% 100%	0% 0%
6		` '		
	200%	\$55,140	100%	0%
6	200%	\$55,140 \$63,180	100% 100%	0% 0%
6 7	200% 200% 200%	\$55,140 \$63,180 \$71,220	100% 100% 100%	0% 0% 0%
6 7 8 FAMILY UNIT	200% 200% 200% 200% INCOME	\$55,140 \$63,180 \$71,220 \$79,260	100% 100% 100% 100% UNCOMPENSATED	0% 0% 0% 0% PATIENT RESPONSIBILITY
6 7 8 FAMILY UNIT SIZE	200% 200% 200% 200% INCOME GUIDELINE	\$55,140 \$63,180 \$71,220 \$79,260 ANNUAL INCOME	100% 100% 100% 100% UNCOMPENSATED CARE AMOUNT	0% 0% 0% 0% PATIENT RESPONSIBILITY AMOUNT
6 7 8 FAMILY UNIT SIZE 1	200% 200% 200% 200% INCOME GUIDELINE 225%	\$55,140 \$63,180 \$71,220 \$79,260 ANNUAL INCOME \$25,853	100% 100% 100% 100% UNCOMPENSATED CARE AMOUNT 90%	0% 0% 0% 0% PATIENT RESPONSIBILITY AMOUNT 10%
6 7 8 FAMILY UNIT SIZE 1 2	200% 200% 200% 200% INCOME GUIDELINE 225% 225%	\$55,140 \$63,180 \$71,220 \$79,260 ANNUAL INCOME \$25,853 \$34,898	100% 100% 100% 100% UNCOMPENSATED CARE AMOUNT 90% 90%	0% 0% 0% 0% PATIENT RESPONSIBILITY AMOUNT 10%

Page: 8/13 Revision: 8.0

#### **Corporate Policy Manual**

# Financial Assistance – Decision Rules/Application (Formerly known as Charity Care Policy)

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Effective Date 01/08 Policy No: AHC 3.19

Cross Referenced: Financial Assistance - Decision Rules/Application Origin: PFS

(see Master Policy 3.19 Financial Assistance)

Reviewed: 02/09, 06/15/10, 9/19/13 Authority: EC

Revised: 05/09, 06/09, 10/09, 06/15/10, 03/11, 10/02/13, 08/26/19 Page:

6	225%	\$71,078	90%	10%
7	225%	\$80,123	90%	10%
8	225%	\$89,168	90%	10%
FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	250%	\$28,725	80%	20%
2	250%	\$38,775	80%	20%
3	250%	\$48,825	80%	20%
4	250%	\$58,875	80%	20%
5	250%	\$68,925	80%	20%
6	250%	\$78,975	80%	20%
7	250%	\$89,025	80%	20%
8	250%	\$99,075	80%	20%
FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	275%	\$31,598	70%	30%
2	275%	\$42,653	70%	30%
3	275%	\$53,708	70%	30%
4	275%	\$64,763	70%	30%
5	275%	\$75,818	70%	30%
6	275%	\$86,873	70%	30%
7	275%	\$97,928	70%	30%
8	275%	\$108,983	70%	30%
FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	300%	\$34,470	60%	40%
2	300%	\$46,530	60%	40%
3	300%	\$58,590	60%	40%
4	300%	\$70,650	60%	40%
5	300%	\$82,710	60%	40%
6	300%	\$94,770	60%	40%
7	300%	\$106,830	60%	40%

Page: 9/13 Revision: 8.0

Printed On: 09/23/2020

9 of 12

#### **Corporate Policy Manual**

#### Financial Assistance – Decision Rules/Application (Formerly known as Charity Care Policy)

Effective Date 01/08 Policy No: AHC 3.19 **PFS** 

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02/09, 06/15/10, 9/19/13 Reviewed: Authority: EC

05/09, 06/09, 10/09, 06/15/10, 03/11, 10/02/13, 08/26/19 Revised: Page: 10 of 12

8	300%	\$118,890	60%	40%
FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	350%	\$40,215	50%	50%
2	350%	\$54,285	50%	50%
3	350%	\$68,355	50%	50%
4	350%	\$82,425	50%	50%
5	350%	\$96,495	50%	50%
6	350%	\$110,565	50%	50%
7	350%	\$124,635	50%	50%
8	350%	\$138,705	50%	50%
FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	400%	\$45,960	40%	60%
2	400%	\$62,040	40%	60%
3	400%	\$78,120	40%	60%
4	400%	\$94,200	40%	60%
5	400%	\$110,280	40%	60%
6	400%	\$126,360	40%	60%
7	400%	\$142,440	40%	60%
8	400%	\$158,520	40%	60%
FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	450%	\$51,705	30%	70%
2	450%	\$69,795	30%	70%
3	450%	\$87,885	30%	70%
4	450%	\$105,975	30%	70%
5	450%	\$124,065	30%	70%
6	450%	\$142,155	30%	70%
7	450%	\$160,245	30%	70%
8	450%	\$178,335	30%	70%

Page: 10/13 Revision: 8.0

#### **Corporate Policy Manual**

#### Financial Assistance – Decision Rules/Application (Formerly known as Charity Care Policy)

Effective Date 01/08 Policy No: AHC 3.19 **PFS** 

Origin: Cross Referenced: Financial Assistance - Decision Rules/Application

(see Master Policy 3.19 Financial Assistance)

02/09, 06/15/10, 9/19/13 Reviewed:

05/09, 06/09, 10/09, 06/15/10, 03/11, 10/02/13, 08/26/19 Revised:

Page: 11 of 12

EC

Authority:

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	500%	\$57,450	20%	80%
2	500%	\$77,550	20%	80%
3	500%	\$97,650	20%	80%
4	500%	\$117,750	20%	80%
5	500%	\$137,850	20%	80%
6	500%	\$157,950	20%	80%
7	500%	\$178,050	20%	80%
8	500%	\$198,150	20%	80%
FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	550%	\$78,994	10%	90%
2	550%	\$106,631	10%	90%
3	550%	\$134,269	10%	90%
4	550%	\$161,906	10%	90%
5	550%	\$189,544	10%	90%
6	550%	\$217,181	10%	90%
7	550%	\$244,819	10%	90%
8	550%	\$272,456	10%	90%
FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	600%	\$103,410	5%	95%
2	600%	\$139,590	5%	95%
3	600%	\$175,770	5%	95%
4	600%	\$211,950	5%	95%
5	600%	\$248,130	5%	95%
6	600%	\$284,310	5%	95%
7	600%	\$320,490	5%	95%
8	600%	\$356,670	5%	95%

Page: 11/13 Revision: 8.0

**Corporate Policy Manual** 

#### Financial Assistance – Decision Rules/Application

Policy No:

Origin:

AHC 3.19

**PFS** 

(Formerly known as Charity Care Policy)

Effective Date Cross Referenced: Financial Assistance - Decision Rules/Application

(see Master Policy 3.19 Financial Assistance)

02/09, 06/15/10, 9/19/13

EC Reviewed: Authority: 05/09, 06/09, 10/09, 06/15/10, 03/11, 10/02/13, 08/26/19 Revised: Page: 12 of 12 EMDEON- Search PFS Current Manual Writeoff and Adjustment > \$100 Process America- will develop Tuesday, November 25, 2008 automated write-off for charity approved accounts PFS Collectors request adjustment amount less than / equal \$150 Tier 1.2- Third party Collections Tier 1.1 - Selfpay collections Manager review and approve all Manager reviews and approves requests greater than \$150 and charity WOFF adjustment greater under / equal \$1,500 from team ( than 150 and under / equal GOV and Non-Gov team) \$1,500 Tier 2- Asst. Director review and approve all requests greater than \$1,500 and under/equal \$2,500 from team ( GOV and Non-Gov team) Data Control to post approved charity writoff/ adjustment Tier 3- Requests greater \$2,500 and less than \$25,000 will be approved by PFS Regional Director Tier 4- Requests greater than \$25,000 will be approved by Facility CFO, CFOs send approval back to PFS This copy will expire in 24 hours Reginal Director

Page: 12/13 Revision: 8.0

#### **Document Information**

#### **Document Title**

AHC 3.19.0 Financial Assistance-Decision Rules & Application

#### **Document Description**

N/A

#### **Approval Information**

**Approved On:** 08/26/2019

Approved By: LaTicia Graves, Paralegal III

Approval Expires: 08/26/2024

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

Page: 13/13 Revision: 8.0

# EXHIBIT 15:

Financial Assistance Application Form



#### **Adventist Healthcare Financial Assistance Application**

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

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

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

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

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

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

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

Deliver your application in person:

**Shady Grove Medical Center** 

White Oak Medical Center

9901 Medical Center Drive Rockville, MD 20850 11890 Healing Way Silver Spring, MD 20904

#### OR

Mail your application to:

Adventist HealthCare
Patient Financial Services
820 West Diamond Avenue Suite 500
Gaithersburg, MD 20878

☐ White Oak Medical Center	☐ Shady Grove Medical Center
☐ Germantown Emergency Center	☐ Adventist Rehabilitation

#### **Maryland State Uniform Financial Assistance Application**

#### Information About You Name: First Middle Initial Last Social Security Number Marital Status: Single Married Separated US Citizen: Yes □Nο Permanent Resident: Yes Home Phone: Home Street Address Address: (Area Code) ### - #### City State Zip code Country **Employer** Work Phone: Name & Employer Name Address: Street Address (Area Code) ### - #### City State Zip code Household Members: Name Relationship AgeName Relationship AgeName Age Relationship Name Relationship AgeName Relationship AgeName Relationship AgeName Age Relationship Name Age Relationship Have you applied for Medical Assistance If yes, what was the date you applied? (MM/DD/YYYY) If yes, what was the determination? Do you receive any type of state or county assistance? Yes

#### I. Family Income

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

1	, ,	**	Monthly Amount	C
Employment				
Retirement/pension b	enefits			
Social security benefit	its			
Public assistance bene	efits			
Disability benefits				
Unemployment benef	fits			
Veterans benefits				
Alimony				
Rental property incor	ne			
Strike benefits				
Military allotment				
Farm or self employn				
Other income source:				
		Total		_
II. Liquid Asse	ets		<b>Current Balance</b>	
Checking account				<u></u>
Savings account				
Stocks, bonds, CD, or	r money market			
Other accounts				
		Total		
III. Other Asso	ets			
	following items, please list the	ne type and approxim	ate value.	
Home:	Loan Balance:	31	Approximate value:	
Automobile:	Make:	Year:	Approximate value:	
Additional vehicle:	Make:	Year:	Approximate value:	-
Additional vehicle:	Make:	Year:	Approximate value:	
Other property:			Approximate value:	
			Tota	1
IV. Monthly E	Expenses		Amount	
Rent or Mortgage	T			
Utilities				<u> </u>
Car payment(s)				<u> </u>
Credit card(s)				<u> </u>
Car insurance				<u> </u>
Health insurance				<u> </u>
Other medical expens	ses			<u> </u>
Other expenses				_
•		Total		_
Do you have any othe	on unnaid madical hills?	J Vac □ No		<del>_</del>
For what service?	er unpaid medical bills?	」Yes □ No		
_	a payment plan, what is the m	onthly payment?		
ii you have allaliged	a payment pian, what is the in			
make a supplemental	e hospital extend additional fit determination. By signing th anges to the information prov	is form, you certify t	nat the information provided	
	Applicant signature		Date K	Pelationship to Patient
			•••	r

# EXHIBIT 16:

Financial Assistance Application Form - Spanish



#### Solicitud Para Asistencia financiera de Adventist Healthcare

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

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

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

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

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

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

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

Para llevar su solicitud en persona:

**Shady Grove Medical Center** 9901 Medical Center Drive Rockville, MD 20850 White Oak Medical Center 11890 Healing Way Silver Spring, MD 20904

0

Envíe su solicitud por correo a:

Adventist HealthCare
Patient Financial Services
820 West Diamond Avenue Suite 500
Gaithersburg, MD 20878

☐ White Oak Medical Center	☐ Shady Grove Medical Center
☐ Germantown Emergency Center	Adventist Rehabilitation

### Solicitud de Asistencia financiera uniforme del estado de Maryland

#### Información acerca de usted

Nombre:						
Primer nombre		Inicial 2 <sup>do</sup> no	Inicial 2 <sup>do</sup> nombre		Apellido	
Nro. de segui	ridad social:			Estado c	ivil: □ Solte	ro □ Casado □ Separado
Ciudadano de	e los EE. UU.: 🗆 S	Sí □ No		Resident	e permanente:	□ Sí □ No
Dirección: _						Tel. casa:
		Ca	ılle			(Cód. de área) ### - ####
-	Ciudad	Estado	Cód.	postal	País	(2021-20-21-04)
Nombre y dia	rección					Tel. trabajo:
del empleado	del empleador: Nombre del empleador		(Cód. de área) ### - ####			
Di			ección			(
Ciudad Estado		Estado	Cód. postal Pa		País	
Miembros de	l hogar:					
Nombre			Edad	-		Relación
Nombre			Edad	-		Relación
Nombre			Edad	-		Relación
Nombre			Edad	-		Relación
Nombre			Edad	-		Relación
Nombre			Edad	-		Relación
Nombre			Edad	-		Relación
Nombre			Edad	-		Relación
¿Ha solicitad	o Asistencia médic	ca?	Sí □ No			
Si la respuest	a es sí, ¿en qué fec	cha la solicitó?	/	/	(MM/DD	/YYYY)
Si la respuest	a es sí, ¿cuál fue la	a determinación?				
¿Recibe algú	n tipo de asistencia	a del estado o el condad	o? □Sí □No	)		

#### I. Ingresos familiares

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

		Mo	<u>Monto mensual</u>			
Empleo						
Beneficios de jubilación/pens	sión					
Beneficios de seguridad socia	al					
Beneficios de asistencia públ	ica					
Beneficios de discapacidad						
Beneficios de desempleo						
Beneficios de veteranos						
Manutención						
Ingresos por alquiler de prop	iedades					
Beneficios de huelgas						
Asignación militar						
Agricultura o empleo indepen	ndiente					
Otra fuente de ingresos:						
		Total				
II. Activos líquidos		<u>S</u>	Saldo actual			
Cuenta corriente				_		
Caja de ahorro				_		
	s de depósito, o mercado monetario			_		
Otras cuentas				_		
		Total		_		
III. Otros activos						
	ntes bienes, enumere el tipo y valor	r aproximado.				
Vivienda:	Saldo del préstamo:		Valor aproximado:	_		
Automóvil:	Marca:	 Año:	_			
Vehículo adicional:	Marca:					
Vehículo adicional:	<u></u>	Año:				
Otra propiedad:			Valor aproximado:			
			Total	_		
IV. Gastos mensual	los.		Monto			
Renta o hipoteca			11201110			
Servicios públicos				_		
Pagos de automóvile(s)		-				
				_		
Tarjeta(s) de crédito				_		
Seguro del automóvil		-		_		
Seguro médico		-				
Otros gastos médicos				_		
Otros gastos						
		Total		_		
¿Tiene alguna otra factura mo ¿Por qué servicio?	édica impaga?	No				
Si ha acordado un plan de pa	gos, ¿cuál es el monto mensual?					

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

Firma del solicitante Fecha Relación

# EXHIBIT 17:

Public Notice of Charity Care Policy-Washington Post

T0003 Account 2010239567

W. DISTRIC

Ad # 12312718 Class 820 PO#

#### PROOF OF PUBLICATION

District of Columbia, ss., Personally appeared before me, a Notary Public in and for the said District, Chatisha Cadlett well known to me to be ACCOUNTING SPECIALIST 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 \$481.44 and was circulated in the Washington metropolitan area.

Published I time(s). Date(s):08 of July 2020

Account 2010239567

Chattolia Cadlett

Witness my hand and official seal this 13th day of July 20 20

Chattolia Cadlett

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.



# EXHIBIT 18:

Public Notice of Charity Care Policy- El Tiempo Latino

# **ElTiempo Latino**

WASHINGTON D.C. METRO AREA NEWSPAPER IN SPANISH 1440 G STREET NW, 9TH FLOOR, WASHINGTON DC 20005

#### WWW.ELTIEMPOLATINO.COM

NAME: Adventist HealthCare, Inc.

AD# 18694

Class El Tiempo Latino

Size 2 CO x 5 IN

Account 12732

**Authorized by Cheryl** 

#### NOTIFICACIÓN PÚBLICA

Annealth, healthyteen, into y aus esticaces oppositioning accesses a today that personned by the transfer of the service of th

Accidentamente, rengues personal executado de personal en existido de personales, y de obra representa se rel especia y de obra representa se rel especia y de obra representa se rel especial de personales y describados adendades, servicia la paracella de sur obra especial de personales de la paracella de sur obra especial de personales de la pe

#### CERTIFICATE OF PUBLICATION

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, is the duly authorized agent of EL TIEMPO LATINO NEWSPAPER to execute this certificate on its behalf; and that a notice of which the annexed a tear sheet is a true copy was printed and published in said newspaper on the following date(s) 07-10-2020 at a total cost of \$250.00

9/2/2020

Zujema Tijero

VP of Advertising

Arika Chelsea Seymour Notary Public - Maryland Montgomery County My Commission Expires Feb. 20, 202

9/2/2020

# EXHIBIT 19:

Photographs of Hospital Postings of Charity Care Policy



Patient Financial Advisor

Triage



Main Registration

Tirark You -



Reception



ED

# EXHIBIT 20: Maryland Hospital License and OHCQ Letters



# MARYLAND DEPARTMENT OF HEALTH OFFICE OF HEALTH CARE QUALITY

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

License No. 15023

Issued to:

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

Type of Facility: Acute General Hospital

Date Issued: August 1, 2018

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.

Patricia Tomoko May Mist

Director

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



#### HEALTH AND HUMAN SERVICES LICENSURE AND REGULATORY SERVICES

255 Rockville Pike, 1st Floor, Suite 100 Rockville, Maryland 20850 240-777-3986 • FAX 240-777-3088

# HOSPITAL LICENSE

This Certifies That

ADVENTIST HEALTHCARE, INC 820 W DIAMOND AVE GAITHERSBURG, MD 20878

is licensed to operate an Acute General Hospital Facility at:

SHADY GROVE MEDICAL CENTER & Adventist Behavior Health 9901 MEDICAL CENTER DR ROCKVILLE, MD 20850

This license is issued under the authority of Chapter 25, of the Montgomery County Code, 2004, as amended.

Raymond L. Crowel, Director

Effective Date: 12/1/2019 Expiration Date: 12/1/2020 License No: 15315

THIS LICENSE BECOMES VOID IF THE STATE LICENSE/CERTIFICATE IS DENIED OR REVOKED.

This license is not transferable, must be conspicuously posted on the premises, and renewed prior to the expiration date.



Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Office of Health Care Quality
Spring Grove Center
Bland Bryant Building, 55 Wade Ave.
Catonsville MD 21228

July 25, 2018

John Sackett, President and CEO Adventist Healthcare Shady Grove Medical Center 9901 Medical Center Drive Rockville, MD 20850

Dear Mr. Sackett,

This letter is to acknowledge the merger of Adventist Healthcare Shady Grove Medical Center and Adventist Healthcare Behavioral Health and Wellness Services effective August 1, 2018. This letter recognizes the health care services provided by Adventist Healthcare Behavioral Health and Wellness Services will now be operated under the license for Adventist Healthcare Shady Grove Medical Center. These services include the inpatient behavioral units and outpatient behavioral health programs operated at 14901 Broschart Road Rockville MD 20851.

It is the hospital's responsibility to insure that the behavioral health services and its sites must be reviewed and accredited under the accreditation issued by The Joint Commission to Adventist Healthcare Shady Grove Medical Center.

The Department of Health retains the authorities as specified in Health-General Article, Title 19 of the Annotated Code of Maryland and may revoke this license for failure to comply with its provisions. This license is the hospital's authority to operate an Acute General Hospital.

This license should be displayed in a conspicuous place, at or near the entrance to the hospital, plainly visible and easily read by the public.

Sincerely, Patricia Tomsko-Nay, MD

Patricia Nay, MD

**Executive Director** 

cc: Maryland Health Care Commission

Maryland Health Services Cost Review Commission

Office of Operations & Eligibility Services Montgomery County Health Department

Montgoomery County Fire Department



Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Office of Health Care Quality Spring Grove Center Bland Bryant Building, 55 Wade Ave Catonsville MD 21228

August 1, 2018

John Sackett, President and CEO Adventist Healthcare Shady Grove Medical Center 9901 Medical Center Drive Rockville, MD 20850

Dear Mr. Sackett,

This letter is to acknowledge the consolidation of Adventist Healthcare Behavioral Health and Wellness Services with Adventist Healthcare Shady Grove Adventist Hospital effective on August 1, 2018. As of that date, the license for Adventist Healthcare Behavioral Health and Wellness Services to operate as a Special Hospital Psychiatric issued on July 1, 2018 is no longer valid. Please return that license for Adventist Healthcare Behavioral Health and Wellness Services to this office but retain a copy for your records.

A new license and letter reflecting the changes has been issued to Adventist Healthcare Shady Grove Adventist Hospital. Services previously provided by Adventist Healthcare Behavioral Health and Wellness Services will now be provided under Maryland license number 15-023. That license should be displayed in a conspicuous place, at or near the entrance to the hospital, plainly visible and easily read by the public.

Sincerely,

Renee B. Webster

Assistant Deputy Director

Non-LongTerm Care Federal Programs

cc: Maryland Health Care Commission

Maryland Health Services Cost Review Commission

License File



Larry Hogan, Governor . Boyd K. Rutherford, Lt. Governor . Robert R. Neall, Secretary

Office of Health Care Quality 7120 Samuel Morse Drive, Second Floor Columbia, MD 21046-3422

September 10, 2020

Mr. Dan Cochran, President Adventist HealthCare Shady Grove Medical Center 9901 Medical Center Drive Rockville, MD 20850

Dear Mr. Cochran,

Based on the recent communications with your team and review of the internal documents, the Office of Health Care Quality (OHCQ) would like to acknowledge that on August 25, 2019, sixteen (16) acute psychiatric beds previously licensed under Adventist Healthcare Washington Adventist Hospital (WAH) were consolidated with the acute psychiatric beds at Adventist HealthCare Shady Grove Medical Center (SGMC). This transfer was authorized by the Maryland Health Care Commission in a memorandum dated October 16, 2018. Our records indicate that the FY 2020 Acute General Hospital Licensed Bed Designation was not revised on after August 25, 2019.

Due to an order issued by Secretary Robert Neall, the FY2021 Acute General Hospital Licensed Bed Designation was not issued on July 1, 2020 due to the pandemic. MHCC indicated that , had the recalculation of July 1, 2020 for FY 2021 been issued, it would have reflected an increase in acute licensed beds for Adventist Health Care Shady Grove Medical Center in excess of the 16 beds.

OHCQ has updated its records to reflect the current acute psychiatric bed count as 133 and total licensed acute bed count of 345 for the hospital effective 8/25/2019.

Respectfully,

B. Webster, Deputy Director Federal Programs

201 W. Preston Street · Baltimore, M.D 21201 · health maryland.gov · Toll Free: 1-877-463-3461 · Deaf and Hard of Hearing Use Relay

## EXHIBIT 21: TJC Accreditations



December 17, 2019

Terry Forde CEO Adventist HealthCare Shady Grove Medical Center 9901 Medical Center Drive Rockville , MD 20850

Joint Commission ID #: 6297
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards

Compliance

Accreditation Activity Completed: 12/12/2019

Dear Mr. Forde:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

#### Comprehensive Accreditation Manual for Hospital

This accreditation cycle is effective beginning September 28, 2019 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark G.Pelletier, RN, MS

Chief Operating Officer and Chief Nurse Executive Division of Accreditation and Certification Operations



December 17, 2019

Terry Forde CEO Adventist HealthCare Shady Grove Medical Center 9901 Medical Center Drive Rockville , MD 20850 Joint Commission ID #: 6297 Program: Behavioral Health Care Accreditation Accreditation Activity: 60-day Evidence of Standards Compliance

onnomitation Satisfas Completed at 1

Accreditation Activity Completed: 12/12/2019

Dear Mr. Forde:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

#### Comprehensive Accreditation Manual for Behavioral Health Care

This accreditation cycle is effective beginning September 26, 2019 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark G.Pelletier, RN, MS

Chief Operating Officer and Chief Nurse Executive
Division of Accreditation and Certification Operations



December 12, 2019

Re: 6297 CCN: 210057

Program: Hospital

Accreditation Expiration Date: September 28, 2022

Terry Forde CEO Adventist HealthCare Shady Grove Medical Center 9901 Medical Center Drive Rockville, Maryland 20850

Dear Mr. Forde:

This letter confirms that your September 24, 2019 - September 27, 2019 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on December 06, 2019 and the successful on-site unannounced Medicare Deficiency Follow-up event conducted on November 04, 2019, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of September 28, 2019. We congratulate you on your effective resolution of these deficiencies.

§482.41 Physical Environment §482.42 Infection Control

The Joint Commission is also recommending your organization for continued Medicare certification effective September 28, 2019. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged te share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following locations:

Adventist HealthCare Germantown Emergency Center 19731 Germantown Road, Rockville, MD, 20850

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

Aquilino Cancer Center 9905 Medical Center Drive,, Rockville, MD, 20850

Shady Grove Adventist Hospital Maternity Center

www.jointcommission.org

Headquisters
One Renaistance Boulevard
Oakbrook Terrace, II. 60181
630 792 5000 Voice



19735 Germantown Rd. # 270, Germantown, MD, 20874

Shady Grove Medical Center (Behavioral Health) d/b/a Shady Grove Medical Center (Behavioral Health) 14901 Brochart Rd, Rockville, MD, 20850

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark G. Pelletier, RN, MS

Mark Pelletie

Chief Operating Officer and Chief Nurse Executive Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services CMS/Regional Office 3 /Survey and Certification Staff

### EXHIBIT 22: CMS Compliance Letter

#### DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services 801 Market Street, Suite 9400

Philadelphia, PA 19107-3134



#### Northeast Consortium/ Division of Survey & Certification

September 9, 2019

Mr. John Sackett, Administrator Adventist Healthcare Shady Grove Medical Center 9901 Medical Center Drive Rockville, MD 20850

Re: Merger of Adventist Healthcare Behavioral Health & Wellness Services, CMS Certification Number 214013 into Adventist HealthCare Shady Grove Hospital, CMS Certification Number 210057

Dear Mr. Sackett:

This is to acknowledge the merger that was effective August 1, 2018 for Adventist HealthCare Shady Grove Hospital. Adventist HealthCare, Inc. merged its psychiatric hospital, Adventist Healthcare Behavioral Health & Wellness Services, located at 14901 Broschart Road, Rockville, MD, CMS Certification Number (CCN) 214013 into its acute care hospital, Adventist HealthCare Shady Grove Hospital, CCN 210057. As both hospitals were owned and operated by Adventist HealthCare, Inc., this action does not constitute a change of ownership.

Therefore, effective August 1, 2018, the Medicare provider agreement for Adventist Healthcare Behavioral Health & Wellness Services is subsumed into the provider agreement of Adventist HealthCare Shady Grove Hospital and CCN 214013 is retired. The location of 14901 Broschart Road, Rockville, MD became a remote location of Adventist HealthCare Shady Grove Hospital on August 1, 2018.

You should use the CMS Certification Number (CCN) shown above on all Medicare claims and correspondence. The Medicare Administrative Contractor (MAC) remains Novitas.

Should there be any questions, please contact me at (215) 861-4223.

Sincerely,

Monica Goodwin

1.0

Principal State Representative

Certification and Enforcement Branch

# EXHIBIT 23: Assessment and Rating of Options for SGMC

#### ASSESSMENT AND RATING OF OPTIONS FOR SGMC

				Option 1	Option 2	Option 3
		Rating System: 1-5		Maintain facilities as currently	Build up vertically from the	Build a new patient tower with
		Decision Criteria is		exist. No	hospital's	modern ICU
		1 = Not Met 2 = Minimally Met		renovation	original	and ED
		3 = Moderately Met		or facility	patient	space, all
		4 = Significantly Met		enhancem	tower.	private
		5 = Fully Met		ents.		acute care
						rooms.
De	ecis	ion Criteria Categories				
1.	Cli	nical Patient Experience	ı		T	1
	a.	Improves Patient Safety		1	2	5
	b.	Private Bed Capability		1	4	5
	C.	Modernizes Aging Patient Care Areas		1	3	4
	d.	Efficient Clinical Workflow		1	2	5
	e.	Observation Capability		1	1	5
		Subtotal		5	12	24
_	<b>F</b> :	and Cardon there				
2.		nancial Considerations	T		4	1
	a.	Feasibility		5	4	4
	b.	Viability		4	4	4
		Subtotal		9	8	8
3.	Но	spital Impact				
-	a.	Minimizes Impact on Current Operations		5	1	3
	b.	Ability to Achieve Project Completion		5	3	5
	~·	Subtotal		10	4	8
		Justotai		10	,	
4.	Со	mmunity Impact	<u> </u>	<u> </u>		1
	a.	Future Surge Capability		1	2	4
	b.	Impact to Existing Providers		5	5	5
	C.	Impact on Access to Care		3	3	5
		Subtotal		9	10	14
		Grand Totals		33	34	54

# EXHIBIT 24: Shady Grove Medical Center Board Resolution

### RESOLUTION OF THE GOVERNING BOARD OF ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER APPROVING APPLICATION FOR CERTIFICATE OF NEED TO DEVELOP A NEW PATIENT TOWER AT ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER

WHEREAS, Adventist HealthCare, Inc., a Maryland nonstock, non-profit corporation (the "Corporation"), owns and operates Adventist HealthCare Shady Grove Medical Center, a 443-bed acute care hospital located in Rockville, Maryland and serving patients in most of Montgomery County and parts of Frederick County, Maryland (the "Hospital");

WHEREAS, the Hospital offers a full array of community-based and regional clinical services, including without limitation, behavioral health inpatient and outpatient care, adult and pediatric emergency departments, maternity and neonatal intensive care services, heart and vascular services, neurosciences services, pediatrics, forensic medicine, and adult intensive care services;

WHEREAS, the Hospital's emergency departments are comprised primarily of emergency room bays separated by curtains and have not been significantly renovated in nearly thirty years;

WHEREAS, the Governing Board of Adventist HealthCare Shady Grove Medical Center (the "Board") has determined that the current Hospital facility has a need to modernize patient care areas in the emergency departments as well as too few private inpatient rooms, an aging and undersized intensive care unit ("ICU"), and an overall need for other space that enhances clinical workflow and operational efficiency;

WHEREAS, the Board has reviewed and evaluated the resulting clinical patient experience, Hospital impact, community impact and the financial viability and feasibility of the following alternative actions that could be taken to address the challenges of the current Hospital facility:

- a. The Hospital maintains its facility as such facility currently exists, with no renovations or facility enhancements;
- The Hospital renovates certain existing facility space and constructs additional facility space through a vertical build-up from the Hospital's original patient tower;
- The Hospital renovates certain existing facility space and constructs additional facility space by building a new patient tower; and

WHEREAS, after a thorough review, comparison and discussion of these alternatives, the Board has determined that that for the continuous, dependable and efficient provision of comprehensive medical services, as well as in order to ensure the proper and efficient operation thereof, it is in the best interests of the Hospital, its patients and the community to develop and construct an additional 171,838 square foot, 7-floor patient care tower and to renovate 25,696 square feet of existing space for a projected cost of \$165 million (collectively, the "Tower Project"). Specifically, the Board finds that, as a result of the Tower Project, patient safety, patient experience and clinical efficiency will be enhanced and the following benefits will be gained:

- All medical surgical inpatient rooms will be private rooms, which will reduce noise levels for patients, create an improved level of privacy for patients and family members, and improve infection control measures;
- A modern ICU with appropriately-sized rooms, with the new construction specifically designed to provide efficient transport to and from the surgery suite and emergency department;
- c. A modern emergency department treatment space, including private emergency department treatment spaces to ensure patient privacy, which space will also be designed to create direct and safe access to emergency department entrances by patients;
- d. A clinical decision unit for safe, efficient care for patients in transition from the emergency department to inpatient care, observation or discharge and located in closer proximity to the main emergency department to minimize travel distance and contact with other patient treatment spaces; and
- Location of additional departments, such as cardiovascular and interventional radiology departments, to allow shared support functions with the surgery suite for improved operational efficiencies; and
- f. A nursing line providing decentralized nursing and clear lines of sight into patient rooms to enhance visibility and monitoring capabilities for each patient, along with optimally located supply and medication rooms.

NOW, THEREFORE, BE IT RESOLVED by the Governing Board of Adventist HealthCare Shady Grove Medical Center, that the Board hereby consents to, authorizes and approves the Tower Project and the filing of a Certificate of Need Application with the Maryland Health Care Commission (the "MHCC") for the development and construction required to implement the Tower Project (the "CON").

**RESOLVED FURTHER**, the Board hereby authorizes, directs and empowers any one or more officers of the Hospital (each an "Authorized Representative") to take such actions as such Authorized Representative deems necessary or appropriate to carry out these resolutions and to consummate the filing of the CON.

[Remainder of page intentionally left blank.]

UNANIMOUSLY ADOPTED by the Governing Board of Adventist HealthCare Shady Grove Medical Center on this the 22nd day of June 2020, in an official meeting duly assembled.

> GOVERNING BOARD OF ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER

By:

Terry Forde Chair

### EXHIBIT 25:

Marshall Valuation Service Tables

### Shady Grove Medical Center - Bed Tower Addition MVS COST CALCULATION

Construction Class/Quality

Class A / Good

	Total
Number of Stories	6
Square Feet	150,352
Perimeter	4,356
Averge Floor to Floor Height	16.0
Base Costs per SF (11/19)	\$398.00
Sprinklers	\$2.97
Adjusted Base Cost per SF	\$400.97
Adjustment Factor For Department Cost Differences	1.00455
Gross Base Cost	\$402.79
Perimeter Multiplier	0.92123
	 \$371.06
Height per Story Multiplier	1.08871
	\$403.98
Multi-Story Multiplier	1.00214
Refined Square Foot Cost	\$404.85
Update Multiplier (7/20)	1.02
	\$412.94
Location Multiplier (Bethesda)	1.09
	 \$450.11
Total Cost Based on MVS	\$67,674,935
Benchmark MVS Cost per SF	\$450.11
Adjustments to MVS Benchmark	
Site Demolition	\$ 101,514
Storm Drains	\$ 319,990
Rough Grading	\$ 88 <b>6</b> ,247
Pilings & Hillside Foundations	\$ 3,962,135
Paving	\$ 1,401,878
Exterior Signs	\$ 82,814
Landscaping	\$ 399,995
Site Walls, Stairs & Structures	\$ 337,766
Yard Lighting	\$ 369,143
Other	
Sheeting & Shoring for Excavation Adjacent to Existing Building	\$ 1,306,643
Relocate Existing Utilities to New Tunnel	\$ 1,472,782
Sediment and Erosion Control	\$ 73,829
Montgomery County Land Use Costs	\$ 1,500,000
New Helipad	\$ 799,810
Pneumatic Tube System	\$ 461,429

Page 1 of 2

REV. 4 - FINAL DRAFT 9/15/20

### Shady Grove Medical Center - Bed Tower Addition MVS COST CALCULATION

Exterior Canopies	\$ 952,512	
Vegetated Roofs	\$ 771,657	
Additional Service Elevator	\$ 602,934	
Enhanced Commissioning	\$ 139,040	
Underground Oxygen Piping	\$ 470,657	
Temporary Construction for Access	\$ 246,095	
Extended General Conditions for Phased Construction	\$ 2,890,451	
A/E Fees Associated with Extraordinary Costs	\$ 1,452,052	
On-Site Exclusions	\$ 21,001,373	
Jurisdictional Hook-up Fees	\$ 970,846	
Adjustments, Subtotal	\$ 21,972,219	
	\$ 146.14	
CURRENT CONSTRUCTION COST	\$ 95,149,202	
CURRENT CONSTRUCTION COST PER SF	\$ 632.84	/SF
ADJUSTED CURRENT CONSTRUCTION COST	\$ 73,176,983	
ADJUSTED CURRENT CONSTRUCTION COST PER SF	\$ 486.70	/SF
ABOVE/BELOW MVS BENCHMARK COST	\$ 5,502,048	
ABOVE/BELOW MVS BENCHMARK PER SF	\$ 36.59	/SF

MVS
Shady Grove Medical Center New Construction Costs

New Co	nstruction	-	200
Type	Hospital	Computation	18
Construction Quality/Class	Good/A	Computation	10
Stories	6		
Perimeter	4,356		
Average Floor to Floor Height	16.0		
Square Feet	150,352		
Base Costs (11/19)		\$398.00	
Sprinkler Amount	2.97	\$400.97	
Adjustment for Diff Cost Factors	1.00455	\$402.79	
Additions			
Elevator	0		
Other	0		
Perimeter Multiplier	0.92123	\$371.06	
Height per Story Multiplier	1.08871	\$403.98	
Multi-Story Multiplier	1.00214	\$404.85	
Update & Location Multipliers			
Update Multiplier (7/20)	1.02	\$412.94	
Location Multiplier (Bethesda)	1.09	\$450.11	
MVS Cost Standard		\$ 67,674,935	\$ 450.11
Current Construction Costs (TABLE E.)		\$ 95,129,014	\$ 632.71
Extraordinary Costs (TABLE D.)		\$ 21,968,561	\$ 146.11
Adjusted Current Construction Costs		\$ 73,160,453	\$ 486.59
Above/(Below) MVS Standard		\$ 5,485,517	\$ 36.48

MVS
Shady Grove Medical Center Cost of Renovations

Ren	ovation		
Туре	Hospital	 Computa	ations
Construction Quality/Class	Good/A		
Stories	4		
Perimeter	1,205		
Average Floor to Floor Height	16.0		
Square Feet	25,696		
Base Costs (11/19)		\$398.00	
Sprinkler Amount	2.97	\$400.97	
Adjustment for Diff Cost Factors	1.09006	\$437.08	
Additions			
Elevator	0		
Other	0		
Perimeter Multiplier	0.96852	\$423.32	
Height per Story Multiplier	1.09200	\$462.26	
Multi-Story Multiplier	1.00000	\$462.26	
Update & Location Multipliers			
Update Multiplier (7/20)	1.02	\$471.51	
Location Multiplier (Bethesda)	1.09	\$513.95	
MVS Cost Standard		\$ 13,206,338	\$ 513.95
Current Construction Costs (TABLE E.	)	\$ 9,783,923	\$ 379.01
Extraordinary Costs (TABLE D.)		\$ 0	\$ 0.00
Adjusted Current Construction Costs		\$ 9,783,923	\$ 379.01
Above/(Below) MVS Standard		\$ (3,467,415)	\$(134.94)

#### Shady Grove Medical Center Bed Tower Project - Explanation of Extraordinary Costs

Project Budget Item		Cost	<b>Explanation of Requirement</b>	Scope of Work	Basis of Estimate
(1) Costs of buying land such	as a	escrow fees	, legal fees, property taxes, right of wo	y costs, demolition, storm drains, rou	gh grading.
Demolition	\$	101,514	MVS excludes site demolition.	Remove existing paving, curbs,	Quantity take-off from
Demontion	7		iviva excludes site demonition.	sidewalks & paths.	conceptual plans.
Storm Drains	\$	310 000	MVS excludes storm drains.	New system incl. pipe, excavation,	Quantity take-off from
Storm Brains	<u> </u>	315,550	Wivs excludes storm drams.	culverts & manholes.	conceptual plans.
Rough Grading	\$	886,247	MVS excludes rough grading in	Sloping site requires cut and fill to	Quantity take-off from
Hough Grading	ľ	000,247	excess of building pads.	create building pads.	conceptual plans.
Site Utility Relocation	١	1 //72 782	MVS excludes utility relocation.	Relocate exist. elec. & domestic	Quantity take-off from
Site office Nelocation	, ,	1,472,702	Wive excludes attility relocation.	water to new tunnel.	conceptual plans.
Sediment and Erosion	s	73,829	Montgomery County requirement to	Super silt fence, dikes, rip-rap, gravel	Quantity take-off from
Control	Ľ		meet NPDES standards.	and baffelboard.	conceptual plans.
(2) Pilings or hillside founda	tion	s, soil comp	action and vibration, terracing.		
Pilings & Hillside	\$	3,962,135	MVS excludes pilings. Pilings are	104 auger cast piles @ 30' deep and	Quantity take-off from
Foundations	۶	5,902,155	required due to existing soils.	84 piles @ 46' deep.	conceptual plans.
		1,306,643	1	Sheeting and shoring as required for	Overality talls off form
Sheeting and Shoring	\$			excavation adjacent to existing	Quantity take-off from
				building.	conceptual plans.
(3) Cost of land planning, int	tere:	st/taxes on i	and, feasibility studies, CON, EIS repo	rts, haz mat testing, appraisal, & const	ulting fees.
Montgomery County		- 1 500 000 1	MVS excludes cost of land planning. Additional site plan approvals req'd.	County application fees, design &	****
Land Use Costs	\$			legal consultants, community	Allowance.
Land Ose Costs				outreach, recordation costs.	
(5) Yard improvements inclu	ding	septic syste	ems, signs, landscaping, paving, walls,	yard lighting, pools or other recreation	onal facilities.
Paving	c	1 401 070	MVS excludes site paving.	Site roadways, parking and	Quantity take-off from
raving	٦	1,401,070	10103 excludes site paving.	sidewalks.	conceptual plans.
Exterior Signs	\$	02 01/	MAVE evaludes site signame	Code manufact site signs	Allowance per conceptual
Exterior signs	٦	02,014	MVS excludes site signage.	Code-required site signage.	plans.
Landscaping	\$	200 005	MVS excludes landscaping.	Cround source plants trans	Allowance per conceptual
Landscaping	٦	333,333	lwws excludes landscaping.	Ground cover, plants, trees.	plans.
Walls, Stairs, Structures	Ś	337 766	MVS excludes site walls.	Site retaining walls, stairs,	Quantity take-off from
wans, stairs, structures	۶	33/,/66	TIVIVS excludes site walls.	structures.	conceptual plans.
Yard Lighting	\$	360 142	MVS excludes yard lighting.	Site lighting allowers	Allowance per conceptual
Tara cignting	۲	303,143	TWIVE EXCITUTES YELL TIGHTHING.	Site lighting allowance.	plans.

REV 4 - FINAL DRAFT 09/15/20

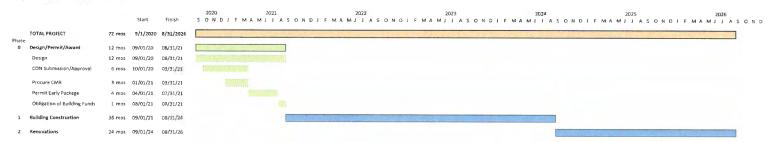
#### Shady Grove Medical Center Bed Tower Project - Explanation of Extraordinary Costs

(6) Off-site costs including ro	ads,	utilities, po	ark fees, jurisdictional hookup, tap-in,	impact or entitlement fees and assess	ments.
Jurisdictional Hook-up	\$	970,846	MVS excludes jurisdictional hook-up	Connection fees for electrical,	Allowance per conceptual
Fees	٦	370,640	fees.	telecom, water, gas, & cable.	plans.
(7) Furnishings and fixtures,	usua	lly not four	nd in the general contract, that are pa	rticular to a definite tenant.	
Helipad	\$	700 910	MVS excludes helipads.	Helipad, lighting, windsock,	Quantity take-off from
Tielipau	٦	733,610	iwws excludes helipads.	barricades, striping.	conceptual plans.
Pneumatic Tube System	\$	461,429	MVS excludes pneumatic tube	12 stations, blower, tubing, connect	Quantity take-off from
Friediliatic Tube System	٦	401,429	systems.	to existing system.	conceptual plans.
Additional required adjustm	ents.				
Canopies	\$	052 512	MVS excludes exterior canopies.	Canopies at main entrance, ER drop-	Quantity take-off from
Carlopies	٦	932,312	invo excludes exterior canopies.	off & ambulance bays.	conceptual plans.
Vegetated Roofs	\$	771 657	MVS evaludes vegetated reads	Extensive vegetated roof system at	Quantity take-off from
vegetated Roots	٦	//1,03/	MVS excludes vegetated roofs.	low roofs.	conceptual plans.
Additional Service	\$	602,934	MVS includes code-required vertical	Additional elevator required for	Quantity take-off from
Elevator	٦	002,934	transportation.	public/private separation.	conceptual plans.
Enhanced	\$	120.040	MAVE includes basis commissioning	Cost for enhanced commissioning	Allowance per conceptual
Commissioning	٦	139,040	MVS includes basic commissioning.	req'd for LEED.	plans.
Underground Oxygen	\$	470,657	MVS includes on-site utilities.	Oxygen piping required from remote	Quantity take-off from
Piping	٦	470,037	iwvs includes on-site utilities.	farm.	conceptual plans.
Temporary Construction			MVS excludes temporary	Tenporary construction as required	Allowance per conceptual
for Access	\$	246,095	construction costs.	to maintain access to existing	
Tot Access			Construction costs.	hospital.	plans.
Extended General				Extended general conditions due to	Proportional allocation of
Conditions	\$ 2	2,890,451	MVS excludes phasing costs.	required phased construction, 24	· ·
Conditions				months of 60 month schedule .	estimated general conditions.
A/E Fees Associated w/		_	MVS excludes all aspects of	A/E and consultant fees associated	Proportional allocation of
Extraordinary Costs	\$ 2	1,452,052			Proportional allocation of
Extraordinary Costs			extraordinary costs.	with extraordinary costs at 7.4%.	estimated A/E costs.
<b>Total Adjustments to Cost</b>	\$ 21	1,972,219			

	NEW CONSTRUCTION	TABLE E	INCLUDED IN
	COSTS	CATEGORY	TABLE E SITE PREP
SITE PREPARATION COSTS			
Normal Site Preparation	\$1,696,406	\$0	\$0
Utilities from Structure to Lot Line	\$1,230,477	\$0	\$0
Subtotal included in Marshall Valuation Costs	\$2,926,883	\$0	\$0
Site Demolition Costs	\$101,514	Site/Infrastructure	\$101,514
Storm Drains	\$319,990	Site/Infrastructure	\$319,990
Rough Grading	\$886,247	Site/Infrastructure	\$886,247
Pilings & Hillside Foundation	\$3,962,135	Building	\$0
Paving	\$1,401,878	Site/Infrastructure	\$1,401,878
Exterior Signs	\$82,814	Site/Infrastructure	\$82,814
Landscaping	\$399,995	Site/Infrastructure	\$399,995
Walls, Stairs, Structures	\$337,766	Site/Infrastructure	\$337,766
Yard Lighting	\$369,143	Site/Infrastructure	\$369,143
Other (Specify/add rows if needed)			
Sheeting & Shoring for Excavation Adjacent to Exist. Bldg.	\$1,306,643	Site/Infrastructure	\$1,306,643
Relocate Existing Utilities to New Tunnel	\$1,472,782	Site/Infrastructure	\$1,472,782
Sediment and Erosion Control	\$73,829	Site/Infrastructure	\$73,829
Montgomery County Land Use Costs	\$1,500,000	Permits + A/E Fees	\$0
New Helipad	\$799,810	Building	\$0
Pneumatic Tube System	\$461,429	Fixed Equipment	\$0
Exterior Canopies	\$952,512	Building	\$0
Vegetated Roofs	\$771,657	Building	\$0
Additional Service Elevator	\$602,934	Building	\$0
Enhanced Commissioning	\$139,040	Building	\$0
Underground Oxygen Piping	\$470,657	Site/Infrastructure	\$470,657
Temporary Construction for Access	\$246,095	Building	\$0
Extended General Conditions for Phased Construction	\$2,890,451	Building	\$0
A/E Fees Associated wih Extraordinary Costs	\$1,452,052	Architect/Engineering Fees	\$0
Subtotal On-Site excluded from Marshall Valuation Costs	\$21,001,373	PROPERTY OF BUILDING	\$7,223,258

OFFSITE COSTS			
Jurisdictional Hook-up Fees	\$970,846	Permits	\$0
Other (Specify/add rows if needed)	\$0	\$0	\$0
Subtotal Off-Site excluded from Marshall Valuation Costs	\$970,846	\$0	\$0
TOTAL Estimated On-Site and Off-Site Costs <u>not</u> included in Marshall Valuation Costs	\$21,972,219	\$0	\$7,223,258
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	\$24,899,102	\$0	\$10,150,141

#### Shady Grove Medical Center - Bed Tower Addition PROJECT SCHEDULE AND PHASING



## EXHIBIT 26: Utilization Trends

## Utilization Trends Summary of Outpatient Emergency Trends All Maryland Hospitals and Freestanding Emergency Rooms FY 2017-2019

		2017	2018	2019	CAGR (1)
		Statewide			
EMG	RVUs	19,503,275	19,292,979	18,978,009	
			-1.08%	-1.63%	-1.36%
EMG	Visits	2,155,221	2,087,070	2,056,078	
			-3.16%	-1.48%	-2.33%
		Montgomery Cou	inty		
EMG	RVUs	2,451,727	2,444,578	2,429,215	
			-0.29%	-0.63%	-0.46%
EMG	Visits	281,465	275,450	276,807	
			-2.14%	0.49%	-0.83%
		Shady Grove Medica	Center		
EMG	RVUs	666,176	672,341	631,007	
			0.93%	-6. <b>1</b> 5%	-2.68%
EMG	Visits	81,483	79,798	78,296	
			-2.07%	-1.88%	-1.98%

<sup>(1)</sup> Compound Annual Growth Rate

Saurce: HSCRC Maryland Hospital Experience Reports (https://hscrc.maryland.gov/Pages/hsp\_Data2.aspx)

## Utilization Trends Summary of Outpatient Obersvation Trends All Maryland Hospitals FY 2017-2019

		<u>2017</u>	2018	2019	CAGR (1)
		Statewide			
OBV	Hours	4,380,227	4,401,986	4,625,663	
			0.50%	5.08%	2.76%
OBV	Visits	229,746	241,540	265,122	
			5.13%	9.76%	7.42%
		Montgomery Cou	inty		
OBV	Hours	636,198	657,060	721,745	
			3.28%	9.84%	6.51%
OBV	Visits	24,578	25,930	26,291	
			5.50%	1.39%	3.43%
		Shady Grove Medical	Center		
OBV	Hours	127,544	175,292	206,059	
			37.44%	17.55%	27.11%
OBV	Visits	5,388	7,131	7,562	
			32.35%	6.04%	18.47%

<sup>(1)</sup> Compound Annual Growth Rate

Source: HSCRC Maryland Hospital Experience Reports (https://hscrc.maryland.gov/Pages/hsp\_Data2.aspx)

## Utilization Trends Summary of Admission Trends (excluding Births) All Maryland Hospitals FY 2017-2019

		2017	2018	2019	CAGR (1)
		Statewide			
ADM	Admissions	564,644	551,398	532,389	
			-2.35%	-3.45%	-2.90%
		Montgomery Cou	inty		
ADM	Admissions	82,828	81,617	78,755	
			-1.46%	-3.51%	-2.49%
		Shady Grove Medical	Center		
ADM	Admissions	20,359	20,024	18,871	
			-1.65%	-5. <b>76</b> %	-3.72%

<sup>(1)</sup> Compound Annual Growth Rate

Source: HSCRC Maryland Hospital Experience Reports (https://hscrc.maryland.gov/Pages/hsp\_Data2.aspx)

### Utilization Trends Summary of Admission Trends (excluding Births) + Observation Visits All Maryland Hospitals

FY 2017-2019

		2017	2018	2019	CAGR (1)
		Statewide			
ADM + OBV	Admissions + OBV Visits	794,390	792,938	797,511	
			-0.18%	0.58%	0.20%
		Montgomery Cou	inty		
ADM + OBV	Admissions + OBV Visits	107,406	107,547	105,046	
			0.13%	-2.33%	-1.10%
	S	hady Grove Medical	Center		
ADM + OBV	Admissions + OBV Visits	25,747	27,155	26,433	
	-		5.47%	-2.66%	1.32%

<sup>(1)</sup> Compound Annual Growth Rate

Source: HSCRC Maryland Haspital Experience Reports (https://hscrc.maryland.gov/Pages/hsp\_Data2.aspx)

EXHIBIT 27:

Ziegler Letter



One North Wacker Suite 2000 Chicago, IL 60606

Phone: 312.596.1596

www.Ziegler.com

September 28, 2020

Maureen L. Dymond Vice President, Financial Operations 820 W. Diamond Avenue, Suite #600 Gaithersburg, MD 20878

Dear Ms. Dymond,

B.C. Ziegler and Company ("Ziegler") understands that Shady Grove Medical Center ("SGMC") located in Rockville, MD, seeks to build a new medical tower, undertake other renovations and improve its emergency department (collectively the "Project"). Adventist HealthCare ("AHC"), the entity under which SGMC operates, is applying for a Certificate of Need ("CON") for the construction of the Projects.

You have stated that AHC will likely finance the Project through the issuance of up to \$155,000,000 of the estimated Project cost through tax-exempt revenue bonds (the "Proposed Bonds") on a parity basis with the senior indebtedness of the AHC's Obligated Group. Based on your estimated costs associated with the Project, Ziegler has prepared a preliminary sources and uses of funds and bond debt service schedule, related to the Proposed Bonds, based on a cost of capital of 4.50%.

Having served as AHC's investment banker since 2001, Ziegler has a strong understanding of AHC's financial profile and has worked with AHC in its interface with rating agencies and investors. We have reviewed with AHC management, its historical and long-term financial projections and the financing assumptions for the Project. Based on the discussions and the projections prepared and provided by AHC, we believe this Project is financially feasible in the current bond market environment.

Ziegler looks forward to continuing work with AHC on this Project.

John P. Hanley

Senior Managing Director

Head of Healthcare Investment Banking

EXHIBIT 28:

Affirmations

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

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

Date 5 2020

Signature of Owner or Board-designated Official

President and Chief Executive Officer Adventist HealthCare, Inc.

Position/Title

Terry Forde

Printed Name

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

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

10/5/2020 Date

Signature of Owner or Board-designated Official

President, Adventist HealthCare Shady Grove Medical Center

Position/Title

Daniel L. Cochran

Printed Name

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

Robert Jepson

Chief Operating Officer

Adventist HealthCare White Oak Medical Center

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

Geoffery Morgan
VP, Chief Facilities and Property Management Officer

Adventist HealthCare

09/30/20

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

Mike Lukens

Vice President and Chief Financial Officer

Adventist HealthCare Shady Grove Medical Center

September 29, 2020

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

Andrew Nicklas

Deputy General Counsel &

Director of Government Relations

Adventist HealthCare

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

Maureen L. Dymond

Vice President, Financial Operations

Adventist HealthCare

9-29-21

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

Kuster Pulio	
	Levenue Officer & CFO Non-Hospital Services
9/29/2020	

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

Linda Beth Berman

Manager, Grants Management Department

September 30, 2020

Adventist HealthCare

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

Daniel Sull van

President

Sullivan Consulting Group

October 1, 2020