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December 11, 2020

VIA FEDERAL EXPRESS AND E-MAIL

Kevin McDonald, Chief - Certificate of Need Division
William D. Chan, Program Manager
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Re: Shady Grove Medical Center Proposed Construction and Renovation
Docket No. 20-15-2443
Responses to Completeness Questions Received on November 4, 2020

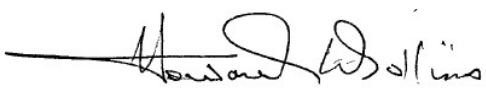
Dear Mr. McDonald and Mr. Chan:

On behalf of Adventist HealthCare, Inc. d/b/a Adventist HealthCare Shady Grove Medical Center ("Shady Grove"), we are hereby submitting the required four (4) copies of our responses to the November 4, 2020 completeness questions regarding the above-referenced project. We will also provide Word, Excel and PDF copies of our responses and exhibits as appropriate.

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

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

Sincerely,



Howard L. Sollins

HLS/tjr
Enclosures

cc (*via First Class Mail and Email)*:

Travis A. Gayles, M.D., Ph.D., Health Officer
Montgomery County Department of Health and Human Services
Daniel L. Cochran, President, AHC Shady Grove Medical Center
Robert Jepson, AHC
Mike Lukens, VP and CFO, AHC Shady Grove Medical Center
Andrew Nicklas, Deputy General Counsel, AHC
Linda Beth Berman, CON Consultant
Ms. Ruby Potter
Ms. Laura Hare

Shady Grove Medical Center Proposed Construction and Renovation
Matter No. 20-15-2443
Answers to November 4, 2020 Completeness Questions

PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. You responded to question 5 by identifying the organization as a "Non-profit." In order to complete this answer, provide the state and date of incorporation.

Applicant Response:

Adventist HealthCare was incorporated in the state of Maryland on May 31, 1983.

2. Please provide a description of the emergency department's (ED) current physical layout, the changes/improvements planned for the new ED, and what will happen to spaces that are vacated as a result of this portion of the project. Your response should include a "before" and "after" description of all spaces.

Applicant Response:

The Main ED will be relocated from the existing building into the new construction. The current treatment bays are organized into pods, which creates challenges in terms of privacy and safety, increased noise and distractions, as well as infection control issues due to the use of curtains for bay separation. The relocated ED will feature all private treatment rooms, separated by walls, which will address these issues.

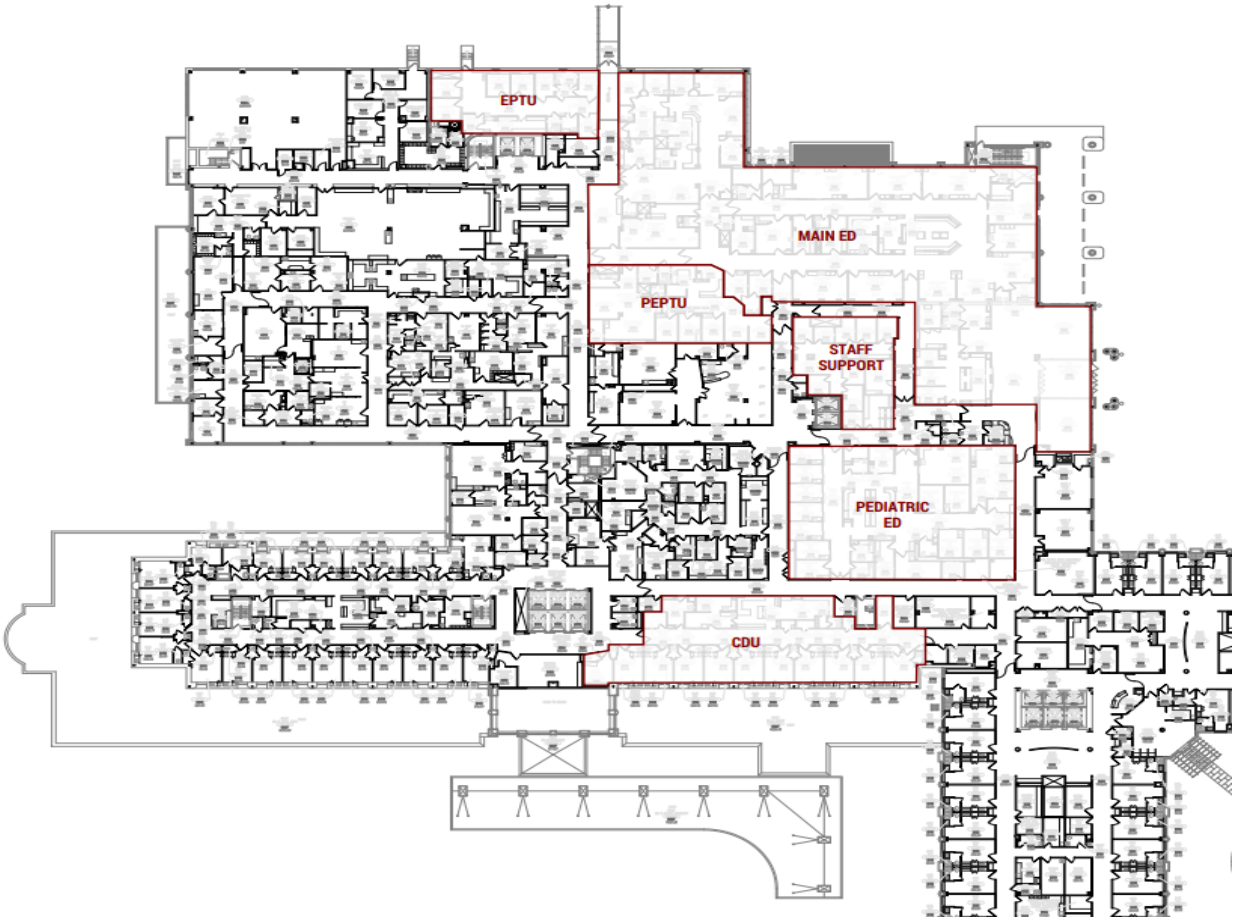


Figure 1 Current ED and Second Floor

The clinical decision unit (CDU) will relocate from unit 2C to the vacated existing Main ED and is part of the renovations project after the tower addition is complete. The new CDU will include private rooms with adjacent toilets for each patient to improve safety and reduce the risk of infection for patients. The current rooms on 2C will be vacated and its future use will be determined through a masterplan effort which is currently ongoing. This unit is in an undesirable patient location and has defaulted to a pedestrian right of way. Our study currently calls Unit 2C to be re-programmed for non-clinical space.

The adult Emergency Psychiatric Treatment Unit (EPTU) will relocate to be closer to the Main ED. Relocating this function reduces patient travel from the ambulance/police arrival process and avoids the EPTU patient from travelling through the Main ED which can compromise the patient's privacy and create disruptions. The existing EPTU space will be vacated and used for storage.

Staff support offices will relocate to the back of the current department in the existing building. This allows patient treatment and clinical spaces to be centralized in the ED. The Pediatric ED and Pediatric EPTU (PEPTU) will remain in place and are not in scope for the addition or renovation phases of the project.

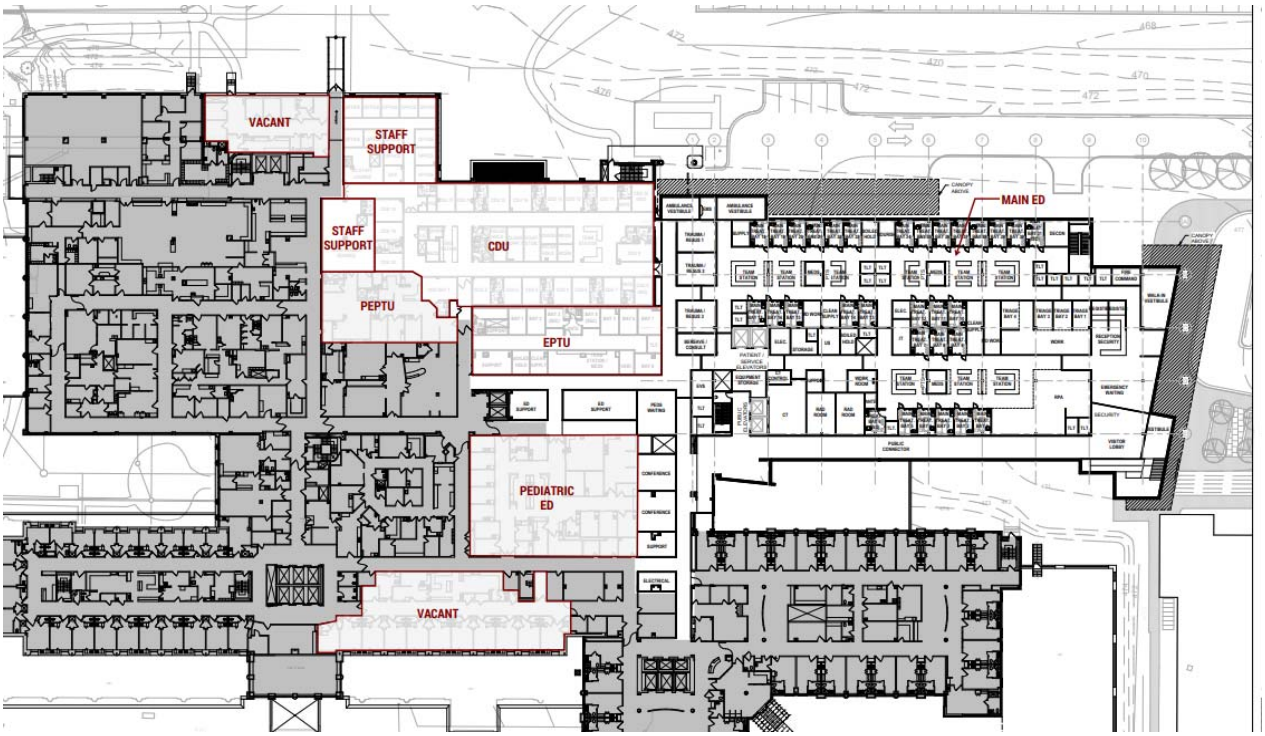


Figure 2 Proposed ED and Second Floor

3. Please provide a chronological description of each phase of this Patient Tower project, including your plans to renovate/construct the new patient tower "in-place."

Applicant Response:

See answer to #4, below.

4. The project schedule (question 11) shows a total project timeline of 72 months. However, the sum of the projected timeline for the various checkpoints is only 66 months. Please explain, or provide a corrected version of this timeline. A Gantt chart or timeline may be useful.

Applicant Response:

The project is scheduled to be 66 months with a 6-month period for CON review and approval, thus the timeline shows 72 months. A Gantt chart has been included as part of Exhibit 25, Page 9 of 9 (Marshall Valuation Service Tables), and is attached here as Exhibit 29.

PROJECT BUDGET

5. Please provide a description of the improvements included with the Central Utility Plant (CUP) upgrade, which has a project budget of $11.9M. How will this portion of the project improve either the efficiency or operation at Shady Grove?

Applicant Response:

The Central Utility Plant (CUP) upgrade includes the central heating and cooling equipment (boilers, chillers, cooling towers, pumps, piping, insulation, controls) and the associated electrical connections (transformers, switches, panels, breakers, conduits, feeders, disconnects) to support the new bed tower. The CUP upgrade also includes the distribution piping to connect this remote equipment to the Air Handling Units (AHUs) in the new bed tower. This upgrade is required to provide heated and chilled water to the bed tower. Of note, the CUP is off campus and requires a long distance for services to route via conduit back to the main building – new and existing.

6. Provide the basis or assumptions used to calculate the following:
   a) $12,847,170 in Contingency Allowance;
   b) $14,611,596 in Gross Interest during Construction period;
   c) $14,682,334 in Inflation Allowance;
   d) $1,925,187 in loan placement fees;
   e) $560,000 in Interest Income from bond proceeds; and
   f) $7,473,375 in Debt Service Reserve Fund.

Applicant Response:

a) The contingency allowance is calculated at 10% of New Construction Cost plus 10% of Renovation Cost plus 10% of Other Capital Costs (exclusive of Contingencies).

b) $14,611,596 in Gross Interest during Construction period; the attached file (Exhibit 30, Replacement for Exhibit 1 Table E) includes references to support this amount.

c) The inflation allowance is calculated at 3.5% per year, compounded monthly, to the midpoint of each construction phase, including a proportional allocation of Other Capital Costs. So, the New Construction costs, (including a proportional allocation of Other Capital Costs) are escalated by 0.2917% per month for 31 months, and the Renovation costs (including a proportional allocation of Other Capital Costs) are escalated for 0.2917% per month for 61 months.

d) $1,925,187 in loan placement fees; the attached file includes references to support this amount

e) $560,000 in Interest Income from bond proceeds; and See explanation for #8 below

f) $7,473,375 in Debt Service Reserve Fund. The attached file includes references to support this amount.

7. Please respond to the following:
   a) How much of the $16M projected philanthropic funds are:
      (i) in-hand and
      (ii) already pledged?
   b) On what basis is the remaining amount projected?

c) If there are remaining philanthropic funds that need to be collected, what is the applicant's solicitation plan?

d) How will the applicant cover any shortfalls in that projection?

Applicant Response:

a) Fundraising efforts are just beginning so no pledges have been received, however there is $1M on hand that the Foundation has earmarked for the project.

b) The $16 million is based on past campaigns. We are currently working with a consultant to prepare for the campaign, planning to launch in 2021 with the goal to raise $16 million over 3-4 years.

c) AHC is prepared to extend the campaign another year for a 5-year campaign.

d) AHC will cover any shortfalls in fundraising from operating funds.

8. The Project Budget (Table B) shows a Total Sources of Funds in each of the columns for the *Hospital Building*, *CUP Upgrade*, and *Total* that does not match the sum of the sources within that section. The difference is in the projected interest income from the bond proceeds. Please submit a mathematically corrected table where Use and Source of Funds are equal.

Applicant Response:

An updated Table is included in Exhibit 30. Note that $560,831 of interest income was removed from the table. While there will be interest earnings on the project funds, these earnings were not contemplated by AHC's investment bankers when sizing the bond issue. As a result, this amount was removed from the table.

9. Cite the line item from your audited financial statements that shows the source for the $10 million in cash.

Applicant Response:

Please refer to the balance sheet in the 2019 audited financials (Exhibit 5, page 49 of 92). Cash and cash equivalents of $25,807,370 and Short-term investments of $226,700,054 total $252,507,424. This amount is sufficient to cover the $10 million in cash.

10. Provide information on the $154 million in authorized bonds, such as who will underwrite the bonds, the rating for the bond issue, interest rate, term length, and any other details.

Applicant Response:

AHC has a long history of working with Ziegler Healthcare Investment Banking and continues to work with them in planning for this debt issue. At this stage of the transaction, we

don't have specifics, but anticipate a traditional tax-exempt municipal financing with a term of 30 years. The interest rate used to project the sources of funds is 4.5%, which is a conservative estimate, higher than current market rates, which will provide a cushion if rates should move higher. AHC will review the transaction with the rating agencies at the appropriate time.

11. The Project Budget does not show any legal or other costs for either CON Application Assistance or Non-CON Consulting Fees. Please confirm that this is accurate, or submit a corrected project budget.

Applicant Response:

Legal and other costs associated with issuing the bonds are included on the line A.2.a. titled Loan Placement Fees. Legal and other costs directly related to the project are included in the budget, on line A.1.a.(4) titled Architect/Engineering Fees.

CONSISTENCY WITH GENERAL REVIEW CRITERIA (COMAR 10.24.01.08G(3))

(A) THE STATE HEALTH PLAN

COMAR 10.24.10 - ACUTE HOSPITAL SERVICES standards

Charity Care Policy

12. For each of the following subparts of this standard, please provide the quote from the policy that meets each provision, and in what section of the policy it can be found.

Standard	Quote from the policy	Section citation
10.24.01.04A(2) (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:		See Revised Policy in EXHIBIT 31
(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.	1.8.3. 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

Standard	Quote from the policy	Section citation
	1.8.3.4. individual is eligible by the State to receive assistance under the Violent Crimes Victims Compensation Act or the Sexual Assault Victims Compensation Act; 1.8.3.5. a victim of a crime or abuse (other requirements will apply) 1.8.3.6. Elderly and a victim of abuse 1.8.3.7. an unaccompanied minor 1.8.3.8. is currently eligible for Medicaid, but was not at the date of service For any individual presumed to be eligible for financial assistance in accordance with this policy, all actions described in the "Eligibility" Section and throughout this policy would apply as if the individual had submitted a completed Financial Assistance Application form and will be communicated to them within two business days of the request for assistance. 3.2. Probable eligibility will be communicated to the patient within 2 business days of the request for assistance 4.6.6. After receiving the individual's request for financial assistance, AHC notifies the individual of the eligibility determination within two business days	3.2 4.6.6
(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;	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. 2. Policy Transparency: Financial Assistance Policies are transparent and available to the individuals served at any point in the care continuum in the primary languages that are appropriate for the Adventist HealthCare service area. 2.1. As a standard process, Adventist HealthCare will provide Plain Language Summaries of the Financial Assistance Policy 2.1.1. During ED registration 2.1.2. During financial counseling sessions 2.1.3. Upon request	Purpose Paragraph 3

Standard	Quote from the policy	Section citation
	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 registration's 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)	
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.	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. 2. Policy Transparency: Financial Assistance Policies are transparent and available to the individuals served at any point in the care continuum in the primary languages that are appropriate for the Adventist HealthCare service area. 2.1. As a standard process, Adventist HealthCare will provide Plain Language Summaries of the Financial Assistance Policy 2.1.1. During ED registration 2.1.2. During financial counseling sessions 2.1.3. Upon request 2.2. Adventist HealthCare facilities will prominently and conspicuously post complete and current versions of the Plain Language Summary of the Financial Assistance policy 2.2.1. At all registration 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	Purpose Paragraph 3 and Section 2

Standard	Quote from the policy	Section citation
	primary languages that are appropriate for the Adventist HealthCare service area: 2.3.1. Financial Assistance Policy (FAP) 2.3.2. Financial Assistance Application Form (FAA Form) 2.3.3. Plain Language Summary of the Financial Assistance Policy (PLS)	
3. 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.	2. Policy Transparency: Financial Assistance Policies are transparent and available to the individuals served at any point in the care continuum in the primary languages that are appropriate for the Adventist HealthCare service area. 2.1. As a standard process, Adventist HealthCare will provide Plain Language Summaries of the Financial Assistance Policy 2.1.1. During ED registration 2.1.2. During financial counseling sessions 2.1.3. Upon request 2.2. Adventist HealthCare facilities will prominently and conspicuously post complete and current versions of the Plain Language Summary of the Financial Assistance policy 2.2.1. At all registration 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)	Section 2

13. The applicant's policy states that the determination of probable eligibility will be made within two days of a completed application. It is required that the determination of probable eligibility occur within 2 days of a request. Change your charity care policy accordingly.

Applicant Response:

The revised Adventist HealthCare Financial Assistance Policy 3.19 is included in Exhibits 31 and 32, annotations are included in the table above.

14. In Exhibit 12 or Exhibit 14, provide a citation and excerpt the language that discusses the type of information a patient must provide for a "determination of probable eligibility" to be in compliance with Paragraph .04A(2)(i).

Applicant Response:

The Determination of Probable Financial Assistance Eligibility Workflow, Exhibit 34 (Replacement for Exhibit 14), states that the Patient Access team requests family size and family income and Medicaid linkage.

15. Provide a copy of your procedures, if any, and other documents that detail your process for making a determination of probable eligibility and your procedures, if any, for making a final determination.

Note that requiring the completion of an application and requiring documentation does not comply with this standard, which is intended to ensure that a procedure is in place to inform a potential charity/reduced fee care recipient of his/her probable eligibility within two business days of initial inquiry or application.

A two-step process that allows for a probable determination to be communicated within two days based on an abridged set of information, followed by a final determination based on a completed application with the required documentation is permissible, but the policy must include the more easily navigated determination of probable eligibility.

Applicant Response:

The Plain Language Summary of the Financial Assistance Policy and the Determination of Probable Financial Assistance Eligibility Workflow are provided in Exhibits 33 and 34.

16. The application document provided by Shady Grove that is required for the determination of probable eligibility presents several issues which need correction:
    a. This application should not request information regarding citizenship or immigration status.
    b. The application should not require significant documentation in order to provide a determination for presumptive eligibility (as noted above in question 15).

    Amend the document to address these issues.

Applicant Response:

Adventist HealthCare is using the Maryland State Uniform Financial Assistance Application as required by COMAR, with the only difference that hospital names have been inserted across the top of page 1. While AHC does not request or use citizenship or immigration status as part of our determination for eligibility or coverage, those questions are part of the application as provided by the state.

Adverse Impact

17. Under what circumstances or conditions will Shady Grove discuss with HSCRC the potential of renegotiating an increase in reimbursement rates to fund the incremental depreciation and interest costs of the project?

Applicant Response:

Shady Grove will evaluate its eligibility for a potential rate adjustment for capital under the HSCRC's capital policy. If a determination is made that Shady Grove is eligible to receive a capital adjustment, the hospital will file for a partial rate application for capital.

Construction Cost of Hospital Space

18. Each of the five floors shows differing square footage (ranging from 21,486 to 38,560 SF), perimeters (ranging from 375 to 821 feet) and wall height (ranging from 15 to 16 feet). Please confirm and explain why.

Applicant Response:

The area, perimeter and floor to floor height varies per floor on this project. This is due to a combination of required areas for programmatic functions, constraints of existing conditions, and cost saving measures.

Area and Perimeter

Level 1 – As shown in the plans, Level 1 is below grade. Due to utilities running through the site this level cannot fill out the entire footprint of Level 2 above. The area contained on this floor is appropriate for the relocated CVIR and required mechanical, electrical and plumbing areas.

Level 2 – Due to the contours of the site, Level 2 is actually at grade. This floor, which primarily contains the expanded ED, is the largest floor of the expansion due to programmatic requirements.

Levels 3, 4, 5 – The upper, occupiable, 3 levels of the building contain bed units (ICU, PCU, and Medical-Surgical units respectively). These floors are all relatively similar in area. There are slight differences due to some programmatic differences. The ICU floor (level 3) contains 2 additional beds (26 beds, versus 24 on the levels above). The ICU also has additional storage requirements and a family waiting area.

Minor differences in area and perimeter between the upper floors are also due to slight differences in the new corridors which connect back to the existing hospital. These differences are simply due to variations in the existing conditions on each floor.

Floor to Floor Height

Levels 1 through 4 of the new addition connect directly to the existing hospital. It was therefore necessary to match the existing (16 foot) floor to floor height. Level 5 of the new addition is higher than the existing hospital's occupiable floors and therefore no connections are required. In an effort to reduce cost, the floor to floor height between levels 4 and 5 was reduced to 15 feet. The floor to floor height for the Mechanical Penthouse on level 6 was set to be adequate for required equipment.

19. How will the existing CVIR space on the third floor be repurposed after project completion?

Applicant Response:

As part of this project, the CVIR will be relocated from the west side of level 3 to the east side of level 1 within the new expansion. In the new location, it will be immediately adjacent to the existing Surgery Department and Peri-Operative services. It will also be one level below the new ED, directly connected by a one-stop elevator ride.

The intention is to eventually locate a NICU in the space to the west of the current CVIR (space that will be left vacant due to the relocation of the ICU). The space vacated by the CVIR will be back-filled with support space and other staff or administrative functions related to peri-natal services (NICU and all obstetrical services are on this floor). The space is not intended to be used for clinical functions and because it is interior to the building (without access to natural light) it would not be used for future beds. All interventional laboratory clinical equipment will be moved to the new location making the current labs unusable space for patient care.

Inpatient Nursing Unit Space

20. The size of the nursing unit spaces on floors three, four, and five shown in the table on page 73 of the application occupy approximately half of the square footage shown for these floors in Table C of Exhibit 1. Yet the drawings of these floors contained in Exhibit 3 appear to show the nursing units comprising the entirety of these floors. Explain the major discrepancy in square footage between the two.

Applicant Response:

The size of the nursing unit spaces shown in the table on page 73 were measured per the definition of 'Inpatient Nursing Unit Space per bed'. The areas include patient rooms, family space and support space within the given unit. The inpatient unit program space does not include circulation (building and intradepartmental, horizontal and vertical), interior walls, structural columns, exterior envelope, mechanical and electrical support (shafts, closets, chases).

Efficiency

21. Your response to this standard is inadequate. Guidance offered by staff in the *Acute Care Hospital Review Standards* document shared with you states that: "Ideally an applicant would compare productivity and staffing metrics to illustrate improvements resulting from the proposed project." According to Table L, this project adds a significant number of FTEs in a project that does not add new services or capacity, on the face of it perhaps making the facility less efficient in terms of output per FTE (e.g., visits, patient days, or other volume measures per FTE).

    Your response describes a variety of features/improvements that will inevitably have an effect on efficiency. Your task in responding to this standard is to quantify the impact of these improvements on operational efficiency in the ED, CDU, CVIR and perioperative services, patient care (MSGA), and critical care (ICU) units. In short, we are looking for you to provide estimated metrics related to productivity and efficiency.

Applicant Response:

The new departmental adjacencies promote efficiency as departments with interrelated services are located adjacent to one another. For example, CVIR is relocated adjacent to surgery which allows for efficient space use. Various support functions as well as family waiting can be shared between departments and reduce travel distances. The existing travel between CVIR and PACU is roughly 600 feet. With the new adjacencies, the travel distance between CVIR and PACU is 125 feet. Similar reduced travel distances can be seen by collocating the ED, CVIR and CDU.

The critical relationship between ICU and Surgery is improved. In existing conditions, the travel between ICU and OR is roughly 800 feet, and the distance with the relocated ICU is 420 feet.

The helipad is relocated from an on-grade, exterior location to the roof. The new indoor travel path will now be a direct elevator ride to the roof. This will be a major improvement over the current travel path which requires the patient to be transported through the front door of the ED and outside through weather conditions.

In the nursing units, the support spaces are decentralized. This promotes efficiency by reducing waiting and staff queuing in supply rooms. Staff can spend more time providing patient care and less time waiting for supplies and medications. Bedside documentation in patient rooms, as opposed to moving workstations on wheels, allows for reduced motion for staff, as well. With less time spent transporting and travelling, more time can be spent providing care to the patient.

Efficiency gains as noted above will invariably have a positive impact on the throughput, flow, and work environment for patients and staff. Many of these efficiencies, however, are not intended to materially reduce the number of staff members needed to care for patients or the physical plant.

Inclusive of all changes in FTEs from 2020 to 2026, including the addition of staff to support the added scope and square footage of a new patient tower, total FTEs per Adjusted Occupied Bed decreases slightly, as shown in the table below. What this shows is despite the need to staff and manage additional square footage, the various efficiencies gained throughout the hospital will offset the added staffing needs.

	CY 2020	CY 2026
Adjusted Occupied Bed	517.4	530.3
Employed Staff	2,149.9	2,149.9
Contract Labor	114.0	53.7
Other Expected Changes through Last Year of Operation		59.5
New Tower FTEs		48.8
Total FTEs	2,263.9	2,311.9
Total FTEs per Adjusted Occupied Bed	**4.38**	**4.36**

22. Please illustrate how the addition of 48.8 FTEs will improve the efficiency or operations of Shady Grove upon project completion. A metric such as the number of FTEs per Equivalent Inpatient Admission (EIPA) before and after the project will be illustrative.

Applicant Response:

In addition to the Total FTEs per Adjusted Occupied Bed productivity metric in question 21, a Total FTEs per Equivalent Inpatient Admission productivity metric can be found in the table below. From 2020 to 2026, Total FTEs/EIPA decreases approximately 6%. The addition of staff to support the added scope and square footage of a new patient tower will be offset through the various efficiencies gained throughout the hospital as a result of the project.

	CY 2020	CY 2026
Equivalent Inpatient Admissions	38,425	41,615
Employed Staff	2,149.9	2,149.9
Contract Labor	114.0	53.7
Other Expected Changes through Last Year of Operation		59.5
New Tower FTEs		48.8
Total FTEs	2,263.9	2,311.9
Total FTEs per EIPA	**0.0589**	**0.0556**

Patient Safety

23. Provide additional information that addresses how the project addresses patient safety and organize it in terms of how it will impact the patients, the workplace, and/or the design of the unit.

Applicant Response:

The project addresses patient safety through the design of each department. Design features can improve patient safety as well as promote a safer work environment for staff. These design features are listed with patient or workplace impacts described below:

1. All private MSGA, ICU and ED rooms in the hospital addition and renovation will have handwashing sinks located directly inside of the entry door to each patient room and in the corridor.
   a. Eliminates infection risks inherent in semi-private rooms occupied by two patients.
   b. Private rooms improve patient privacy.
   c. Handwashing sinks for staff and visitors further reduce the risk of infection to patients.
   d. All private rooms will impact the footprint of the departments, and space per patient will increase, but this is mitigated by including decentralized workstations outside of the patient room and wall mounted bedside documentation stations.
   e. Multiple units from the existing, aged hospital building will close, vacating undersized patient rooms, shared toilets, and shared patient showers.

2. Private patient toilets adjacent to the private patient rooms.
   a. Proximity of the washroom to the patient's bed and appropriate lighting levels reduces fall risks for the patient.
   b. Shady Grove has established a standard for inpatient rooms under construction which includes, when possible, outboard (window wall) toilet/shower rooms to improve the staff's line of sight from the corridor (fall risk reduction).

3. Wall mounted equipment (e.g. documentation stations) in the patient room.
   a. Reduces patient fall risk. Minimal equipment around the bed promotes fewer obstacles for patients to navigate in the room.
   b. Access to medical records and medication bar coding at the patients' bedside can reduce errors.

4. The nursing unit design decentralizes caregivers and supplies.
   a. Corridor and bedside documentation improve line of sight to patients
   b. Decentralized supply and medication rooms reduce travel paths for staff, reducing fatigue and increasing staff efficiency.

5. Decontamination, ambulance and walk-in entrances are separated at the ED.
   a. A designated decontamination entry isolates and extracts potential contaminants before they can enter the ED.
   b. Separate ambulance and walk-in entrances reduce congestion in the ED and provides more efficient patient travel in emergent situations.

6. EPTU is secure and separate from the Main ED treatment rooms. It is located in close proximity to the ambulance entrance.

a. Travel distance and contact with other patient treatment spaces is minimized.

b. The direct route, bypassing the Main ED, allows for more secure and safe patient transport from police or EMS units.

7. CVIR is relocated to new constructed space, adjacent to perioperative areas in the surgery department.

a. The existing aging, inefficient, and undersized interventional space will be vacated.

b. Patient registration and prep/recovery will now be co-located on the first floor with surgery, creating efficiencies in staffing and travel for staff and patients.

c. Patient privacy is improved by reduced travel, that is within a department, as opposed to public corridors. In existing conditions, the patient can be transported through major corridors and across multiple levels.

8. Updated and improved interior finishes will be specified for the new addition and renovations.

a. Thresholds at doors and between different flooring types will be seamless and finishes that are easily cleaned and maintained will be included to support reduced risk of hospital-acquired infections.

Emergency Department Treatment Capacity and Space

24. The applicant is requesting an expansion of emergency room capacity from 69 to 71 treatment spaces. As instructed in subparagraph B(14) (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.*

Provide a classification of the proposed emergency room as either low range or high range based on the most recent edition of Emergency Department Design: A Practical Guide to Planning for the Future from the American College of Emergency Physicians. Provide the rationale used for the classification.

Applicant Response:

Shady Grove is not planning to expand the ED space. The current complement of 69 beds will be retained. There was an error noted in the original application where 71 treatment bays were incorrectly stated – the correct answer is 69 rooms. Thus, the above provision referring to a new or expanded ED does not apply.

According to the most recent edition of Emergency Department Design: A Practical Guide to Planning for the Future from the American College of Emergency Physicians and the criteria for classifying an ED as a high or low range department, we have determined the Shady Grove ED skews towards the high range category. The determination is influenced by significant and unique clinical services offerings as described below:

1. Adult Emergency Psychiatric Treatment Unit (EPTU): Shady Grove has a large inpatient bed complement for the behavioral health patient population; we are well known regionally for this service. Having a large adult psychiatric stabilization area within the ED is a differentiator and carries a higher level of care.

2. Pediatric Emergency Psychiatric Treatment Unit (PEPTU): Shady Grove recently invested in a 5-bed pediatric psychiatric treatment and stabilization unit. Realizing the complexities of inpatient placement for various diagnoses in the pediatric behavioral health population, Shady Grove has again demonstrated its mission towards serving this population within the ED. This patient population regularly has protracted lengths of stay due to limited options for disposition. This further supports the need for isolated and specialized care. Acute behavioral changes carry high demands on staff and requires separation from the main pediatric ED population for safety reasons.

3. Dedicated Pediatric Emergency Room within the broader ED.

4. Emergency Department features a Forensic Medical Unit for acutely injured victims of sexual and other assaults. This important service is unique in Montgomery County as Shady Grove is the only hospital offering this service.

5. Shady Grove is located near the Montgomery County Detention Center. Inmates are routinely brought to the Shady Grove ED. We are the closest hospital to the detention center.

6. Adjacent CDU placement (20 private rooms) will be renovated out of the old ED.

7. Medical Imaging Facilities within the ED: 1 CT room, 2 Diagnostic Radiology rooms, and 1 Ultrasound suite will be located within the Emergency Unit.

8. Patient volume data (69,052 visits per annum).

25. The applicant is proposing 71 total ED treatment rooms (including behavioral health rooms). That is very high in comparison to the ACEP standard, which offers a range of 35 to 47 total ED treatment spaces for an applicant with the Shady Grove ED volume (around

60,000 visits/year). Provide an explanation of why Shady Grove is requesting such a large number of ED treatment rooms.

Applicant Response:

Consistent with the response to question 24, the Shady Grove ED skews to the high range and operates capacity to care for the unique populations requiring comprehensive behavioral health (for both pediatric and adult populations), and the general pediatric population. This results in ED treatment capacity for this project that is consistent with current capacity (69 rooms) and with ACEP capacity for a high range ED experiencing approximately 60,000 visits/year. There was an error noted in the original application where 71 treatment bays were incorrectly stated – the correct answer is 69 rooms (56 treatment rooms and 13 behavioral health adult and pediatric stabilization comprising 8 adult and 5 pediatric rooms).

26. Please respond to the following:
    a) Identify the zip codes in Shady Grove's primary service area for the ED.
    b) As indicated on p. 85 of the CON, why are EDs located at such hospitals such as either Holy Cross Germantown or MedStar Montgomery not included in your primary service area?

Applicant Response:

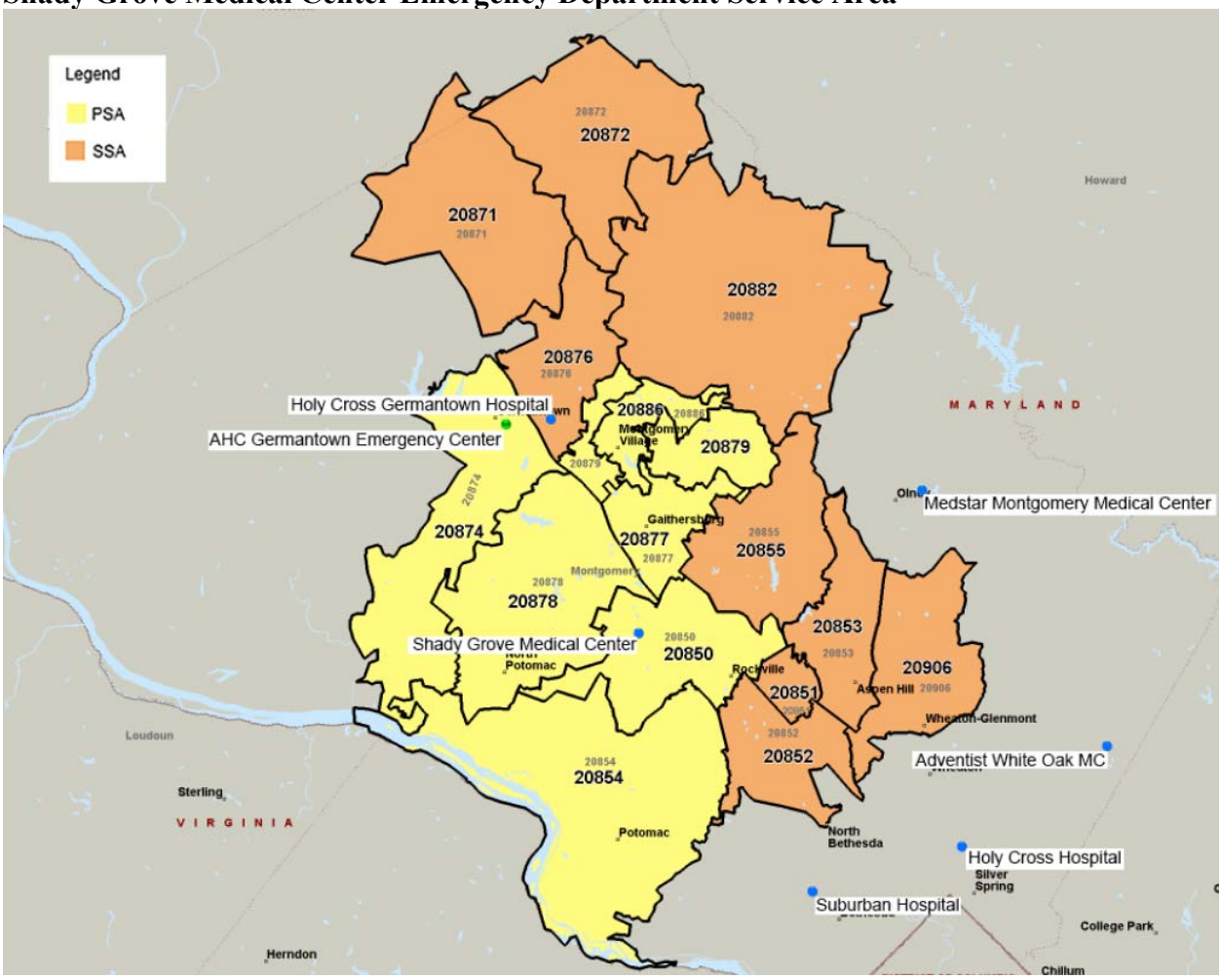
a) The Primary Service Area of Shady Grove's ED is made up of seven ZIP Codes that surround Shady Grove's location. There is no specific definition of a 'Primary Service Area' for Emergency Services in the Maryland State Health Plan, so Shady Grove has elected to follow the formula provided in COMAR 10.24.10 for acute care hospital services and include the ZIP Codes that provide 60 percent of visits to the ED as a definition of a Primary Service Area. The secondary service area representing an additional 20 percent of Shady Grove's total ED visits includes nine ZIP Codes.

The following table provides patient origin data for the ED for the past three full calendar years, 2017 through 2019. In each of those years the seven ZIP Codes that comprise the Primary Service Area have accounted for at least 60 percent of visits to the Shady Grove ED. The seven ZIP Codes of the ED Primary Service Area are contained within the nine ZIP Codes that make up the Primary Service Area of the MSGA services of Shady Grove, as displayed in the table provided on page 24 of the original application.

Shady Grove Medical Center Emergency Department Patient Origin Based on Visits 2017 through 2019									
	Year ended								
	December 31, 2017			December 31, 2018			December 31, 2019		
		Percent			Percent			Percent	
ZIP Code	Visits	Total	Cum %	Visits	Total	Cum %	Visits	Total	Cum %
Primary Service Area									
20878	6,961	12.6%	12.6%	7,141	12.9%	12.9%	7,334	13.1%	13.1%
20877	6,187	11.2%	23.7%	6,364	11.5%	24.4%	6,849	12.2%	25.3%
20850	6,654	12.0%	35.8%	6,558	11.9%	36.3%	6,826	12.2%	37.5%
20874	4,161	7.5%	43.3%	4,017	7.3%	43.6%	3,923	7.0%	44.5%
20886	3,987	7.2%	50.5%	3,823	6.9%	50.5%	3,726	6.7%	51.2%
20879	3,118	5.6%	56.1%	3,170	5.7%	56.2%	3,153	5.6%	56.8%
20854	2,231	4.0%	60.1%	2,214	4.0%	60.2%	2,045	3.7%	60.4%
Subtotal	33,299	60.1%		33,287	60.2%		33,856	60.4%	
Secondary Service Area									
20855	1,635	3.0%	63.1%	1,724	3.1%	63.3%	1,716	3.1%	63.5%
20852	1,597	2.9%	66.0%	1,532	2.8%	66.1%	1,608	2.9%	66.4%
20853	1,303	2.4%	68.3%	1,422	2.6%	68.7%	1,517	2.7%	69.1%
20906	1,455	2.6%	70.9%	1,467	2.7%	71.3%	1,475	2.6%	71.7%
20851	1,361	2.5%	73.4%	1,406	2.5%	73.9%	1,455	2.6%	74.3%
20876	1,459	2.6%	76.0%	1,475	2.7%	76.5%	1,378	2.5%	76.8%
20871	1,124	2.0%	78.1%	1,189	2.2%	78.7%	1,122	2.0%	78.8%
20882	669	1.2%	79.3%	684	1.2%	79.9%	726	1.3%	80.1%
20872	705	1.3%	80.6%	693	1.3%	81.2%	704	1.3%	81.3%
Subtotal	11,308	20.4%		11,592	21.0%		11,701	20.9%	
Total Service Area	44,607	80.6%		44,879	81.2%		45,557	81.3%	
Other	10,769	19.4%	100.0%	10,411	18.8%	100.0%	10,456	18.7%	100.0%
Grand Total	55,376	100.0%		55,290	100.0%		56,013	100.0%	
Source: Health Services Cost Review Commission Discharge Abstract Data.									

The Primary Service Area of the Shady Grove ED is shown on the map of the Service Area that is provided in the figure below.

Shady Grove Medical Center Emergency Department Service Area



b) The map provided in the previous section shows the location of EDs at hospitals that are reasonably proximate to the defined Primary Service Area of the Shady Grove ED. As the map indicates, only Shady Grove and the AHC Germantown Emergency Center are located physically within the Primary Service Area.

The discussion in the application on page 85 of other ED providers in the area surrounding Shady Grove excluded providers other than Shady Grove and the AHC Germantown EC because the definition was geographic and was based on the patient origin of ED visits to Shady Grove. Both Shady Grove and the AHC Germantown EC are located within the Primary Service Area. Holy Cross Germantown Hospital is the only provider located in the Secondary Service Area.

In addition to geographic considerations, the discussion of area EDs excluded other hospital based EDs on the basis of historical patterns of utilization. The following tables show market share data of the area EDs for the past three years. Data for 2019 were available only for the six-months ended June 30, 2019.

As the data presented in the first of the following tables show, Shady Grove and the AHC Germantown EC taken together have accounted for more than 65 percent of ED visits in the

Primary Service Area during the time period shown in the table. Holy Cross Germantown Hospital has nearly the same market share as the AHC Germantown ED, but no other provider has even one-half the share of ED visits of either of these facilities.

The data presented in the second table shows that as the other hospital based EDs are located more proximately to the Secondary Service Area of the Shady Grove ED, their market shares of ED visits increase in direct correspondence. While Shady Grove and the AHC Germantown EC combined have the greatest share of the ED market, there is a substantial dispersion among the other hospital EDs.

The EDs listed in the tables below account for an extremely high percentage of total visits in the respective Service Areas – 97 percent in the case of the Primary Service Area and 96 percent for the Secondary Service Area. Residents of the Service Area have a high reliance on the hospitals listed in the tables. The patient origin data and the market share data for the Primary Service Area of the Shady Grove ED indicate that the Shady Grove ED is an extremely important component to that particular patient base.

Shady Grove Medical Center
Emergency Department
Primary Service Area
Market Share of Area Providers

	Twelve Months ended December 31,					
	2017		2018		2019 (a)	
	Visits	Mkt Shr	Visits	Mkt Shr	Visits	Mkt Shr
Shady Grove Medical Center	33,471	44.3%	32,902	44.4%	16,527	44.8%
AHC Germantown Emergency Center	15,954	21.1%	14,634	19.7%	7,324	19.8%
Holy Cross Germantown Hospital	13,412	17.8%	14,238	19.2%	7,253	19.6%
Suburban Hospital	6,460	8.6%	6,462	8.7%	3,142	8.5%
MedStar Montgomery Medical Center	1,880	2.5%	1,807	2.4%	782	2.1%
Holy Cross Hospital	1,597	2.1%	1,512	2.0%	698	1.9%
White Oak Medical Center	440	0.6%	384	0.5%	179	0.5%
Subtotal	73,214	97.0%	71,939	97.0%	35,905	97.2%
Other Providers	2,293	3.0%	2,188	3.0%	1,021	2.8%
Total	75,507	100.0%	74,127	100.0%	36,926	100.0%

(a) Partial Year ended June 30, 2019

Source: Health Services Cost Review Commission Discharge Abstract Data.

27. What is the source for the "Statewide Data" cited in the tables located on pages 86 and 87 of the application?

Applicant Response:

A complete citation for the source of the data in the tables located on pages 86 and 87 of the application is the 'Health Services Cost Review Commission Discharge Abstract Data.'

28. Provide and cite the source of the ED use rate and population growth data discussed on page 87 of the application.

Applicant Response:

The comment on page 87 was intended to point out generally that projected utilization of emergency services in a service area is derived from the use rate (visits per 1,000 population) for emergency services applied to the projected population of the service area. In the application the utilization projections were assumed to follow the changes in population. This is reasonable as the use rates and market shares were assumed to remain unchanged.

In the response to Question 26 above, Shady Grove has presented a definition of the Service Area for its ED based on patient origin and defined by ZIP Codes. The following table shows how projected utilization of the Shady Grove ED would be derived from the use rates, market share, and population projections within the Service Area. Population data are taken from Claritas and historical utilization from the Statewide HSCRC Discharge Abstract Data.

Shady Grove Medical Center Historical and Projected Emergency Department Utilization Based on Service Area Use Rates and Shady Grove Market Share								
	Years ending December 31,							
	Historical		Projected					
	2017	2018	2021	2022	2023	2024	2025	2026
Primary Service Area								
ED Visits, PSA	75,507	74,127	76,474	77,108	77,742	78,377	79,011	79,645
Population, PSA	308,143	310,466	320,295	322,952	325,608	328,265	330,922	333,579
ED Visits per 1,000 Population	245.0	238.8	238.8	238.8	238.8	238.8	238.8	238.8
Shady Grove PSA Market Share	44.3%	44.4%	44.4%	44.4%	44.4%	44.4%	44.4%	44.4%
Shady Grove PSA Visits	33,471	32,902	33,944	34,225	34,507	34,788	35,070	35,351
Secondary Service Area								
ED Visits, SSA	56,925	57,110	59,134	59,633	60,133	60,633	61,133	61,632
Population, SSA	232,491	234,532	242,842	244,895	246,947	249,000	251,052	253,104
ED Visits per 1,000 Population	244.8	243.5	243.5	243.5	243.5	243.5	243.5	243.5
Shady Grove SSA Market Share	19.5%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%
Shady Grove SSA Visits	11,096	11,401	11,805	11,905	12,005	12,104	12,204	12,304
Total Service Area								
ED Visits, TSA	132,432	131,237	135,607	136,741	137,876	139,010	140,144	141,278
Population, TSA	540,633	544,998	563,137	567,846	572,556	577,265	581,974	586,683
ED Visits per 1,000 Population	245.0	240.8	240.8	240.8	240.8	240.8	240.8	240.8
Shady Grove TSA Market Share	33.7%	33.8%	33.7%	33.7%	33.7%	33.7%	33.7%	33.7%
Shady Grove TSA Visits	44,567	44,303	45,749	46,130	46,511	46,893	47,274	47,655
Out of Area Visits	10,809	10,987	11,158	11,232	11,310	11,391	11,476	11,565
Out of Area (%)	19.5%	19.87%	19.6%	19.6%	19.6%	19.5%	19.5%	19.5%
Total ED Visits	55,376	55,290	56,907	57,362	57,821	58,284	58,750	59,220

As the table shows, the projections are based on the assumptions that the use rates and market shares remain constant from their levels in 2018. As expected, the increases in projected utilization follow the increases in population. It should be noted, further, that the Service Area for the ED defined in #26 above contains fewer ZIP Codes than the Service Areas presented for inpatient services in the application. As a result, it would be expected that a greater percentage of patients to the ED would reside outside of its Service Area than was the case for inpatient services. The Out of Area Percent has been adjusted upward accordingly in the preceding table.

29. Identify the name and location for the two urgent care centers cited on page 87 of the application. Please provide copies of the educational material provided to the local community "to increase awareness of the availability of urgent care centers for non-emergent services."

Applicant Response:

The two urgent care centers cited on page 87 are:

Adventist HealthCare Urgent Care, 19825 Frederick Road, Germantown, MD 20876
Adventist HealthCare Urgent Care, 750 Rockville Pike, Rockville, MD 20852

Educational materials about the Urgent Care Centers are included in Exhibit 35, and are distributed at community events, as hand outs in the urgent care centers and are distributed to

Adventist HealthCare's employer health clients. Additionally, information about the difference between Emergency Care and Urgent Care is posted on the Adventist HealthCare website at: https://www.adventisthealthcare.com/services/urgent-care/emergency-room/

30. Provide the historical volume of behavioral health patients to Shady Grove's ED for the last five years. Provide some background information on the top ten diagnoses or types of behavioral health patients that appear at Shady Grove's ED.

Applicant Response:

The following table displays the historical volume of behavioral health patients for Shady Grove's ED for the last five years. The data for 2020 have been annualized, based on the actual results for the first nine months, January through September of 2020. The data have been obtained from the internal records of Shady Grove.

The behavioral health patients have been classified according to the Mental, Behavioral, and Neurological development disorders (F01-F99) diagnoses in the ICD-10-CM Codes. The table presents patients classified by primary psychiatric diagnosis.

Shady Grove Medical Center

Summary of ED Visits (IP & OP) with Primary Psych diagnosis (F01-F99)

CY 2016 thru CY 2020 YTD September Annualized

	2016	2017	2018	2019	2020 YTD Sept Annualized
Mood [affective] disorders	1,522	1,475	1,846	2,119	1,721
Mental and behavioral disorders due to psychoactive substance use	1,087	1,199	1,156	1,276	943
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	655	627	685	748	777
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	600	680	678	603	497
Mental disorder, not otherwise specified	114	240	242	66	67
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	108	118	185	188	135
Other mental disorders due to known physiological condition	61	54	49	53	31
Disorders of adult personality and behavior	53	33	30	24	17
Personality and behavioral disorders due to known physiological condition	44	35	24	23	21
Pervasive and specific developmental disorders	20	22	28	35	12
Behavioral syndromes associated with physiological disturbances and physical factors	21	7	14	12	11
Intellectual disabilities	-	3	-	2	-
Grand Total	**4,285**	**4,493**	**4,937**	**5,149**	**4,232**

Source: Shady Grove Medical Center internal data

From 2016 to 2019, the number of Shady Grove's ED visits with a primary behavioral health diagnosis was increasing steadily. The annualized volume of such patients in 2020 is somewhat lower due to the impact of COVID-19. Once the pandemic is contained, it is expected that behavioral health ED visits will return to historical levels.

(B) NEED

31. The application shows that Shady Grove's patient days have been steadily decreasing since 2016. The applicant also states that the occupancy rate in 2020 is projected to be 88.5%

despite the impact of COVID-19. How much of that 88.5% projection is due to COVID? Has there been a further decrease in non-COVID related hospital stays?

Applicant Response:

The reduction in patient days from 2016 through 2019 was a direct result of the conversion of patients from inpatient to observation status during that time. The average length of stay for an observation patient is considerably shorter than the average length of stay of an inpatient. Even taking that into account, the growth in observation days from 2015 to 2019 made up for the decline in inpatient patient days for the same period. The table below illustrates the change over time in both inpatient patient days and observation days. The patient day information presented comes from the table "Historical Utilization, Adult MSGA Beds" in the CON application (page 22). The observation day information comes from the table "Observation Patients" in the CON application (page 36).

	2015	2016	2017	2018	2019
Inpatient Patient Days	55,237	56,113	53,062	51,917	51,160
Observation Days	5,153	5,151	5,959	8,261	8,760
Total Inpatient & Observation Days	60,390	61,264	59,021	60,178	59,920
Change from Previous Period		1.4%	-3.7%	2.0%	-0.4%

As the table illustrates, the total number of inpatient patient days and observation days remains virtually flat from 2015 through 2019 with slight variation year-to-year.

The projected occupancy rate for MSGA beds in 2020 increased significantly from 2019 (as indicated in Table F) due to a reduction in the number of licensed MSGA beds from 190 to 156 as a result of the annual adjustment. The true impact of COVID-19 on occupancy is difficult to calculate as the number of patients lost from the suspension of elective medical procedures and patients delaying medical treatment are unknown. Because of these reasons, it was assumed that the hospital would see fewer patients in MSGA beds due to the COVID-19 pandemic than it would have if COVID-19 had not occurred. Thus, the comment of "despite the impact of COVID-19" was merely to illustrate that had 2020's volumes been similar to 2019's volumes, and with the reduction in the number of licensed MSGA beds from 190 to 156 as a result of the annual adjustment, it is believed that the occupancy rate in 2020 would have been higher than the 88.5% that is shown.

32. Shady Grove's market share for both primary and secondary service areas has steadily decreased by 10% from 2016-2018 (Page 30). How does the applicant account for this decrease? It is projected that market share will stabilize through 2026. How does the applicant predict the project will result in a stable market share?

Applicant Response:

Shady Grove's total service area market share decreased by only 1.2% between 2015 and 2018, with a small decline in the Primary Service Area market share and a small increase in the Secondary Service Area market share. As discussed in the application, Shady Grove has

experienced significant growth in observation patients that have resulted from its population health initiatives, which may explain in part why its share of inpatient discharges saw a small reduction. With an expanded and renovated facility, particularly with the conversion to all private MSGA beds, Shady Grove expects that it will see stabilization in its MSGA inpatient market shares in future years.

33. Cite the source labelled as "Statewide Data" for all of the tables in the Need section.

Applicant Response:

A complete citation for the source of the data in the tables in the Need section is the (statewide) 'Health Services Cost Review Commission Discharge Abstract Data.'

(C) AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

34. Consider and discuss the alternative of other hospitals in the service area meeting the same needs of the community that you propose to address with the project.

Applicant Response:

Shady Grove wishes to emphasize that the proposed project is not intended to increase the hospital's bed capacity or to offer new services. Rather, it is intended to modernize the facility in a fashion that is consistent with current industry-wide operational standards.

Other facilities in Maryland have set forth similar projects – notably, Greater Baltimore Medical Center – and have received approval by MHCC. Over the course of time, patient care has evolved, and facilities constructed several decades ago cannot accommodate the additional medical equipment now employed in hospitals without renovation. It also has been well-established that the patient experience and treatment outcomes are enhanced when patients are placed in private rooms. The current proposal will convert semi-private rooms to private rooms, consistent with this view.

Throughout the application, it has been stated that the goals for the project are focused on improving the operational efficiency and patient care provided by Shady Grove. It will also create space to accommodate the specific needs of types of patients already served in the hospital.

The utilization projections are based on assumptions that are clear in their intent not to increase the market share of Shady Grove for any of its current services and not to alter the current patient referral patterns in the Service Area.

It may well be the case that other hospitals in Montgomery County, most of which are located outside of the Service Area of Shady Grove, offer acute care services. Such a consideration does not detract from the need of Shady Grove to perform important upgrades to its existing facility.

TABLES

Table A

35. Within "After Project Completion," under Psychiatric Beds, 6 private beds and 64 semi-private beds are listed; the total is listed as 133 beds. This is inconsistent with the total that MHCC staff calculated, which was 134 beds. Please resolve this discrepancy as to whether Shady Grove will have 403 or 404 physical beds after project completion.

Applicant Response:

One of the semi-private rooms is actually private. The answer should be updated on the table to 7 private rooms and 63 semi-private rooms. This yields 7 and 126 beds or 133 total behavioral health beds.

36. Please provide an explanation as to what will happen to the following patient rooms removed from service after project completion:
    a. The 11 Private and 13 semi-private rooms on Unit 2D;
    b. The 2 private and 10 semi-private rooms on Unit 4C;
    c. The 2 private and 10 semi-private rooms on Unit 4D;
    d. The 8 semi-private rooms on Unit 3D; and
    e. The 9 semi-private rooms on Unit 2C

Applicant Response:

a. This unit will be closed and staged as a swing unit for future renovations to other clinical inpatient units. The beds to the north are insufficient in terms of square footage. See also answer to question #2.

b. These two rooms have insufficient square footage. They are located in the elevator lobby and are separate from the nursing unit. While the rooms line up contiguous to one another, they sit physically outside of the unit's cross corridor doors which is isolating and creates longer distances for staff to travel.

c. These two rooms have insufficient square footage. They are located in the elevator lobby and are separate from the nursing unit. While the rooms line up contiguous to one another, they sit physically outside of the unit's cross corridor doors which feels isolating and creates longer distances for staff to travel.

d. These rooms have insufficient square footage, lack modern safety-influenced accommodations for patient care and each shares a common shower with the neighboring patient room. The rooms will be closed and will be purposed as call rooms for house staff.

e. These rooms are currently the observation beds which will re-locate to the CDU after the renovation phase. The 2C unit sits in the middle of what has become a thoroughfare for pedestrian traffic wayfinding back to the central elevators of the original building, which includes

access to the café. It will close to patient care after the relocation to the newly renovated CDU. See also the response to question #2.

37. Why does floor "2C" become "2nd" after project completion?

Applicant Response:

The observation beds occupying Unit 2C will be relocated to the CDU, which will be in the current ED space on the Second Floor. It is internal to the unit and does not have a letter assigned to it. "2nd" should say "2nd floor Existing ED, Transition to Occur after ED is Renovated to CDU". See also answer to question #2.

Table F

38. Did COVID-19 have a disproportionate impact on pediatric inpatient stays and ALOS in CY2020? If not, what accounts for the substantial decrease of pediatric inpatient stays compared to other categories?

Applicant Response:

Pediatric Emergency Room visits, which are a main driver for inpatient and observation Pediatric admissions, have declined due to COVID-19. Likewise, the pediatric inpatient decrease is directly attributable to Shady Grove's response to COVID-19. During the height of the COVID-19 surge from April through June 2020, Shady Grove transferred many of its pediatric admissions to Children's Medical Center in Washington D.C., allowing the hospital to use the pediatric inpatient space as a COVID-19 ICU overflow unit. Immediately following the first surge, the pediatric unit was closed for a period of time to allow for minor renovation and repairs in preparation for any future COVID-19 surges. During and immediately after the first COVID-19 surge, pediatric patients who were admitted to Shady Grove were cared for on the Mother/Baby unit.

39. Discuss the current impact of COVID-19 on the inpatient utilization and revenue/expenses at Shady Grove. Does the applicant anticipate any long-term impact due to the pandemic on either your future revenue/expense projections or utilization projections?

Applicant Response:

Due to the COVID-19 pandemic, Shady Grove has seen a number of changes to its historical volume trends. Inpatient admissions have decreased from historical levels due to the suspension of elective surgical procedures, a reduction in the number of pediatric inpatients, and a reluctance by some to seek care in the ways they were previously accustomed to prior to the pandemic. Revenue has also experienced a decrease due to the reduction in volumes since the start of the pandemic, but less severe than the volume changes. Temporary expansion of the rate corridors by the HSCRC allowed Shady Grove to remain closer to its Global Budget Revenue (GBR) target than if the normal rate corridors were in effect. In addition, funds available to Shady Grove through local, state, and federal sources to help combat COVID-19, such as the federal

CARES Act, have allowed Shady Grove to recognize revenue to help offset some of the reduction in charges due to volume decreases and mitigate a portion of the COVID-19 specific costs associated with preparing for and responding to the pandemic. Expenses overall have been lower than normal due to the reduction in volume. However, there are several areas where the COVID-19 pandemic has increased the cost of care. The need and cost of contract labor to care for COVID-19 patients and the high cost of personal protective equipment (PPE) to safely protect patients and staff are two examples of increases in the cost of providing care because of the COVID-19 pandemic.

With the eventual remission of COVID-19, it is expected that Shady Grove will return to historical volume, revenue, and expense trends. The volume and financial projections in years 2021 through 2026 do not include specific impacts from the COVID-19 pandemic.

Table L

40. Explain how and why you are reducing contractual labor from 114 FTE to 53.7 FTE.

Applicant Response:

The 114 FTEs of contract labor staff shown in 2020 are due in large part to Shady Grove's response to COVID-19 by ensuring an adequate workforce to provide safe and effective care to patients. This is approximately twice the number of contract labor staff that Shady Grove has historically utilized as part of routine patient care. As the effects of the COVID-19 pandemic subside, it is anticipated that Shady Grove will be able to reduce the usage of contract labor back to historical levels. Much of the reduction in the number of contract labor FTEs will be converted back to employed staff as current vacancies are filled.

The use of contract labor increases operating costs because of the high premium that must be paid to utilize those staff members. Reducing contract labor usage to historical levels reduces operating expense that can be reinvested in employed staff development through annual education opportunities and ensuring compensation remains competitive with the market. Additionally, replacing contract labor staff with employed staff allows for a more engaged workforce related to Shady Grove's culture, mission, and values. Shady Grove has several programs geared toward recruiting, training, and retaining its nursing staff. One program is a robust Nurse Residency program for recent graduates that provides training, mentorship, and support in order to prepare new nurses for the rigors of daily patient care. Another program is the Professional Career Advancement Program which seeks to develop and improve skillsets critical for nurses to be successful.

41. Do you expect any difficulty in recruiting 48.8 additional FTEs for the new project? How will the applicant recruit these personnel? In addition, what are the reasons for the additional 59.5 FTEs stated as "other expected changes in operations through the last year of projection?" Explain why the number of FTEs is shifting considerably.

Applicant Response:

The additional personnel for the new tower project will be recruited using the same processes that are currently employed by Shady Grove, and it is not anticipated that there will be any difficulties with hiring the additional positions. The 59.5 FTEs expected to be added over the next six years are related to the following: 1) the conversion of contract labor staff that were higher than normal because of the COVID-19 response to employed staff; 2) efficiencies gained over time related to process improvement and optimizing patient flow and care, and 3) the projected increases in volumes over that time. Inclusive of the additional FTEs related to the new tower project, Shady Grove will achieve an FTEs per Adjusted Occupied Bed metric that declines slightly by 2026, as shown in the table below.

	CY 2020	CY 2026
Adjusted Occupied Bed	517.4	530.3
Employed Staff	2,149.9	2,149.9
Contract Labor	114.0	53.7
Other Expected Changes through Last Year of Operation		59.5
New Tower FTEs		48.8
Total FTEs	2,263.9	2,311.9
Total FTEs per Adjusted Occupied Bed	**4.38**	**4.36**

42. Why does the "revenue cycle" category drop from 74 FTEs to zero FTEs?

Applicant Response:

This was an error on the Workforce table (Table L) submitted as part of the CON application due to missing a formula in the specified cell. The total number of FTEs as presented on the total line was correct since the table foots across the total line. This has been corrected and an updated Table L is provided as part of this response (Exhibit 36).

List of Exhibits

29. Gantt Chart

30. Replacement for Exhibit 1 Table E

31. Replacement for Exhibit 12: AHC Policy 3.19 Financial Assistance

32. Replacement for Exhibit 13: AHC Policy 3.19A Financial Assistance – Spanish

33. Plain Language Summary of Financial Assistance Policy

34. Replacement Exhibit 14: Determination of Probable Financial Assistance Eligibility Workflows

35. AHC Urgent Care Materials

36. Replacement for Exhibit 1 Table L

37. Affirmations

Exhibit 29:
Gantt Chart

Adventist HealthCare

Shady Grove Medical Center - Bed Tower Addition

Project Schedule and Phasing

ID	Task Name	Duration	Start	Finish
1	**Total Project**	72 mons	Tue 9/1/20	Mon 8/31/26
2	**Design / Permitting**	**12 mons**	**Tue 9/1/20**	**Tue 8/31/21**
3	Design Phases	12 mons	Tue 9/1/20	Tue 8/31/21
4	CON Submission / Approval	6 mons	Thu 10/1/20	Wed 3/31/21
5	CMR Procurement	3 mons	Fri 1/1/21	Wed 3/31/21
6	Permit Package	4 mons	Thu 4/1/21	Sat 7/31/21
7	Obligation of Building Funds	1 mon	Sun 8/1/21	Tue 8/31/21
8	**Building Construction**	**36 mons**	**Wed 9/1/21**	**Sat 8/31/24**
9	Construction	36 mons	Wed 9/1/21	Sat 8/31/24
10	**Renovation**	**24 mons**	**Sun 9/1/24**	**Mon 8/31/26**
11	Renovation	24 mons	Sun 9/1/24	Mon 8/31/26

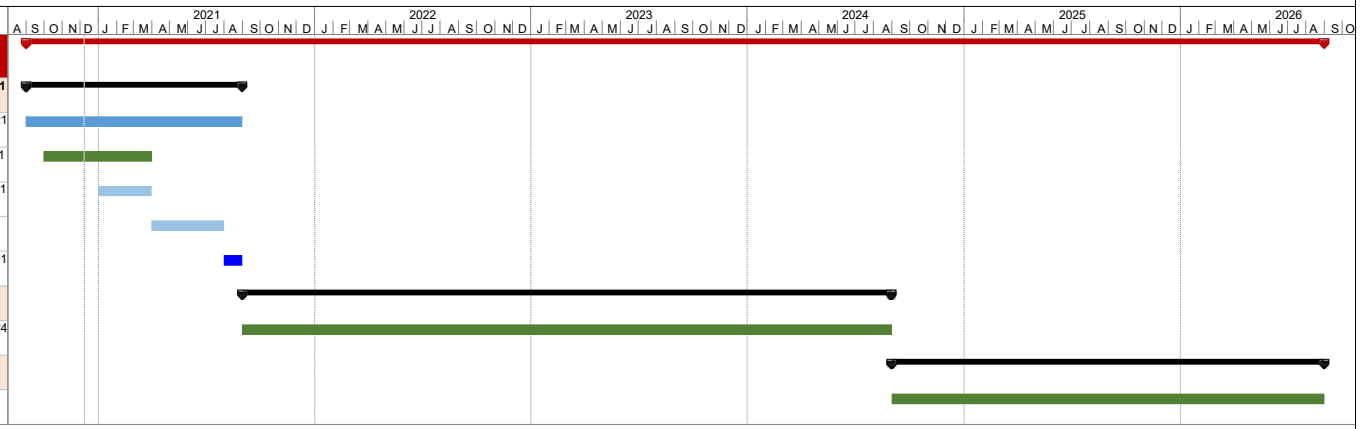


Exhibit 30:
Replacement for Exhibit 1 Table E

TABLE E. PROJECT BUDGET

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

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

	Hospital Building	CUP Upgrade	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building	$73,458,451	$6,752,441	$80,210,892
(2) Fixed Equipment	$3,525,375	$301,922	$3,827,297
(3) Site and Infrastructure	$10,150,141	$408,005	$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	$8,840,236	$0	$8,840,236
(2) Fixed Equipment (not included in construction)	$0	$0	$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			
(1) Movable Equipment	$3,629,400	$200,000	$3,829,400
(2) Contingency Allowance	$11,997,789	$849,381	$12,847,170
(3) Gross interest during construction period	$13,653,795	$957,801	$14,611,596
(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	$6,615,000	$50,000	$6,665,000
d. Security system	$1,250,000	$15,000	$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			
a. Loan Placement Fees	**$1,798,990**	**$126,197**	$1,925,187
b. Bond Discount			$0
c CON Application Assistance			
c1. Legal Fees			$0
c2. Other (Specify/add rows if needed)			
d. Non-CON Consulting Fees			
d1. Legal Fees			$0
d2. Other (Specify/add rows if needed)			$0
e. Debt Service Reserve Fund	**$6,986,996**	**$486,379**	$7,473,375
f Other *(Specify/add rows if needed)*			$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***
B. Sources of Funds			
1. Cash	$9,337,090	$659,269	$9,996,359
2. Philanthropy (to date and expected)	$14,958,694	$1,041,306	$16,000,000
3. Authorized Bonds	$143,919,200	$10,095,800	$154,015,000
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$168,214,984***	***$11,796,375***	***$180,011,359***
	Hospital Building	***CUP Upgrade***	***Total***
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

Exhibit 31:
Replacement for Exhibit 12:
AHC Policy 3.19 Financial Assistance

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance

(Formerly "Charity Care")

Effective Date: 01/08	Policy No:	AHC 3.19
Cross Referenced: Previously: Financial Assistance Policy (see AHC 3.19.1 for Decision Rules / Application)	Origin:	PFS / FC
Reviewed: 02/09, 9/19/13, 10/10/17	Authority:	EC
Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13, 2/01/16, 11/09/17, 08/26/19, 12/20	Page:	1 of 14

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:

- prompt-pay discounts (%) that may be charged to self-pay patients who receive medically necessary services that are not considered emergent or non-elective.
- special consideration, where appropriate, for those individuals who might gain special consideration due to catastrophic care.

BENEFITS:

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

DEFINITIONS:

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

- **FPL** (Federal Poverty Level): is the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services.
- **Uninsured Patient**: Person not enrolled in a healthcare service coverage insurance plan. May or may not be eligible for charitable care.
- **Self-pay Patient**: an Uninsured Patient who does not qualify for AHC Financial Assistance due to income falling above the covered FPL income guidelines

POLICY

1. General Eligibility

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

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

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

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

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

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

1.3. This policy requires that a patient or their guarantor to cooperate with, and avail themselves of all available programs (including those offered by AHC, Medicaid, workers compensation, and other state and local programs) which

might provide coverage for services, prior to final approval of Adventist HealthCare Financial Assistance.

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

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

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

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

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

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

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

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

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

1.6. **Considerations:**

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

1.6.2. Pre-approved financial assistance for medical services scheduled past the 2nd midnight post an ER admission are reviewed by the appropriate staff based on medical necessity criteria established in this policy and may or may not be approved for financial assistance.

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

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

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

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

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

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

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

1.8.1. Patients, unless otherwise eligible for Medicaid or CHIP, who receive benefits from a social security program as determined by the Department and the Commission, including but not limited to those listed below are eligible for

free care, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below

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

1.8.1.2. Supplemental Nutritional Assistance Program (SNAP);

1.8.1.3. Low-income-household energy assistance program;

1.8.1.4. Women, Infants and Children (WIC)

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

1.8.2.1. Montgomery Cares;

1.8.2.2. Project Access;

1.8.2.3. Care for Kids

1.8.3. Additionally, patients who fit one or more of the following criteria may be eligible for financial assistance for emergency or 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 and throughout this policy would apply as if the individual had submitted a completed Financial Assistance Application form and will be communicated to them within two business days of the request for assistance.

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

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

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

2.1.1. During ED registration

2.1.2. During financial counseling sessions

2.1.3. Upon request

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

2.2.1. At all registrations sites

2.2.2. In specialty area waiting rooms

2.2.3. In specialty area patient rooms

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

2.3.1. Financial Assistance Policy (FAP)

2.3.2. Financial Assistance Application Form (FAA Form)

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

3. Policy Application and Determination Period

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

3.2. Probable eligibility will be communicated to the patient within 2 business days of the request for assistance

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

within 10 business days of the submission of a completed application for Financial Assistance.

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

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

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

4.1. Services deemed not medically necessary by AHC clinical team

4.2. Services not charged and billed by an Adventist HealthCare facility listed within this policy are not covered by this policy. Examples include, but at are not limited to; charges from physicians, anesthesiologists, emergency department physicians, radiologists, cardiologists, pathologists, and consulting physicians requested by the admitting and attending physicians.

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

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

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

4.5.1. Physician charges are billed **separately** from hospital charges. **Roles and Responsibilities**

4.6. **Adventist HealthCare responsibilities**

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

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

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

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

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

4.6.6. After receiving the individual's request for financial assistance, AHC notifies the individual of the eligibility determination within two business days

4.6.7. AHC provides options for payment arrangements.

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

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

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

4.7. **Individual Patient's Responsibilities**

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

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

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

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

5. Identification Of Potentially Eligible Individuals

5.1. Identification through socialization and outreach

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

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

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

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

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

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

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

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

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

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

5.2.4. **AUTOMATED CHARITY PROCESS** for Accounts sent to outsourced agencies: Adventist HealthCare recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional financial assistance application process. If the required information is not provided by the patient, Adventist HealthCare may employ an automated, predictive scoring tool to qualify patients for financial assistance. The Payment Predictability Score (PPS) predicts the likelihood of a patient to qualify for Financial Assistance based on publicly available data sources. PPS provides an estimate of the patient's likely socio-economic standing, as well as, the patient's

household income size. Approval used with PPS applies only to accounts being reviewed by Patient Financial Services. All other dates of services for the same patient or guarantor will follow the standard Adventist HealthCare collection process.

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

7. **POLICY REVIEW AND MAINTAINENCE:**

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

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

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

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

CONTACT INFORMATION AND ADDITIONAL RESOURCES

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

Effective Date: 01/08	Policy No:	AHC 3.19
Cross Referenced: Previously: Financial Assistance Policy (see AHC 3.19.1 for Decision Rules / Application)	Origin:	PFS / FC
Reviewed: 02/09, 9/19/13, 10/10/17	Authority:	EC
Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13, 2/01/16, 11/09/17, 08/26/19, 12/20	Page:	14 of 14

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

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

Exhibit 32:
Replacement for Exhibit 13:
AHC Policy 3.19A Financial Assistance – Spanish

ADVENTIST HEALTH CARE, INC.

Manual de Política Corporativa

Asistencia financiera

(Anteriormente "Atención de beneficencia")

Fecha de entrada en vigor: 8/1	Política No.	AHC 3.19
Referencia cruzada: Anteriormente: Política de Asistencia Financiera (Consulte el documento AHC 3.19.1 para más información sobre Reglas de decisión / Solicitud)	Origen:	PFS/ FC
Evaluado: 02/09, 19/9/13, 10/10/17	Autoridad:	EC
Revisado: 05/09, 06/09, 10/09, 15/06/10, 2/3/11, 2/10/13, 1/2/16, 9/11/17, 26/8/19, 12/20	Página:	1 de 15

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 AHC.

PROPÓSITO:

Fiel a 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 ingresos bajos a medios que necesitan nuestros servicios. El Plan de asistencia financiera de AHC brinda una forma sistemática y equitativa de garantizar que los pacientes no asegurados, con 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 cargos 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 antes mencionados.

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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:

- descuentos por pronto pago (%) que pueden cobrarse a los pacientes que cubren sus gastos que reciben servicios médicamente necesarios que no se consideran de emergencia o no electivos.
- atención especial, cuando corresponda, para aquellas personas que podrían obtener una atención especial debido a atención 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
- **Servicios médicos de emergencia:** tratamiento de personas en situaciones de crisis de salud que podrían poner en riesgo la vida con o sin tratamiento
- **Servicios no electivos:** una afección médica que, sin atención inmediata:
  - Pone la vida de la persona en grave peligro
  - Provoca un deterioro grave de las funciones corporales o una disfunción grave de un órgano del cuerpo.
  - 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

- **Atención 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 en hospitales, médicos y 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.
- **NFP** (Nivel federal de pobreza): 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.
- **Paciente no asegurado:** Persona no inscrita en un plan de seguro de cobertura de servicios de atención médica. Podría o no ser elegible para recibir atención caritativa.
- **Pacientes que cubren sus gastos:** un Paciente no asegurado que no califica para recibir Asistencia financiera de AHC debido a ingresos que 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 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, previo a la aprobación final de la Asistencia Financiera de Adventist HealthCare.

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

1.4.1. No están asegurados, 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 están asegurados, 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 que se aplicará 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 en virtud de 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 y/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 es elegible para dichos programas; o

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

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 reciben beneficios de un programa de seguridad social según lo determinado por el Departamento y la Comisión, incluyendo, pero sin limitarse 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 vigor siempre y cuando el paciente sea un beneficiario activo de uno de los siguientes programas

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

1.8.1.2. Programa de Asistencia Nutricional Suplementaria (SNAP);

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

1.8.1.4. Mujeres, infantes y niños (WIC)

1.8.2. Los pacientes que son beneficiarios de los 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 vigor siempre y cuando el paciente sea 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 en virtud de esta política con o sin una solicitud completada, 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. es incapaz de proporcionar la información de elegibilidad necesaria para la asistencia financiera debido a su estado o capacidades mentales

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

1.8.3.4. según el Estado, la persona 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)

1.8.3.6. es anciano y víctima de abuso

1.8.3.7. es un menor no acompañado

1.8.3.8. actualmente es elegible para Medicaid, pero no lo era cuando se prestó del servicio

Para cualquier persona que se considere elegible para recibir asistencia financiera en virtud de esta póliza, todas las acciones descritas en la sección "Elegibilidad" y en otras partes de esta política aplicarán de la misma manera que si hubiese presentado un formulario de solicitud de Asistencia financiera completado y se les comunicará dentro de los dos días hábiles siguientes a la solicitud de asistencia.

1.9. **Monto generalmente facturado:** En el marco de 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, en inglés) 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 en virtud de 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 atendemos 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.

2.2.1. En todas las áreas de registro

2.2.2. En las salas de espera de áreas de especialidad

2.3.3. 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. Período de solicitud y determinación de la Política

3.1. La Política de Asistencia financiera se aplica a los cargos por servicios médicamente necesarios proporcionados a los pacientes por uno de los centros de Adventist HealthCare. Un paciente (o garante) puede solicitar Asistencia financiera en cualquier momento dentro de un plazo de **240 días después de 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 en un plazo de 10 días laborales después de haber presentado una solicitud completa para Asistencia financiera.

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

3.5. Periodo de elegibilidad de la política: Si se aprueba la asistencia financiera de un paciente en virtud de 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 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:** Servicios no cubiertos por la Asistencia financiera de AHC La política incluye, pero no se limita 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 incluidos 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.

4.6.3. Los miembros de las áreas de personal de Servicios Financieros para Pacientes y de Registro comprenden la política de asistencia financiera de AHC y pueden trasladar las preguntas sobre la política a los representantes correspondientes 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 en el plazo de dos días laborales.

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 exige 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

4.7. Responsabilidades individuales de los pacientes

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

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

4.7.4. La persona que califique para recibir descuentos parciales debe esforzarse de buena fe para honrar el plan de pago de sus facturas de hospital con descuento. La persona es responsable de notificar oportunamente a AHC de cualquier cambio en su situación financiera para que el impacto de este cambio pueda ser evaluado en función de las políticas de asistencia financiera que rigen para la prestación de asistencia financiera.

5. Identificación de personas potencialmente elegibles

5.1. Identificación a través de socialización y divulgación

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

5.1.2. Los asesores financieros se esforzarán por contactar a todos los pacientes 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 acerca 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 límite especificada. La fecha límite no puede ser antes de haber transcurrido 120 días del envío del 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 de la familia y los ingresos del hogar. La aprobación mediante PPS aplica solo para cuentas que estén bajo

análisis por parte de 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.

   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 HealthCare.

   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

ADVENTIST HEALTH CARE, INC.

Manual de Política Corporativa

Asistencia financiera

(Anteriormente "Atención de beneficencia")

Fecha de entrada en vigor: 8/1	Política No.	AHC 3.19
Referencia cruzada: Anteriormente: Política de Asistencia Financiera (Consulte el documento AHC 3.19.1 para más información sobre Reglas de decisión / Solicitud)	Origen:	PFS/ FC
Evaluado: 02/09, 19/9/13, 10/10/17	Autoridad:	EC
Revisado: 05/09, 06/09, 10/09, 15/06/10, 2/3/11, 2/10/13, 1/2/16, 9/11/17, 26/8/19, 12/20	Página:	15 de 15

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

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

Exhibit 33:
Plain Language Summary of Financial Assistance Policy

PLAIN LANGUAGE SUMMARY
Financial Assistance Policy

Adventist HealthCare is committed to meeting the health care needs of our community through the ministry of physical, mental and spiritual healing. All patients, regardless of race, creed, sex, age, national origin or financial status, may apply for financial assistance.

Availability of Financial Assistance: You may be able to get financial assistance if you do not have insurance, are underinsured, or if it would be a financial hardship to pay in full your expected out-of-pocket expenses for emergency and other medically necessary care that Adventist HealthCare provides.

Eligibility: Adventist HealthCare provides financial assistance based upon need. To determine need, we review your household income and compare it to the Federal Poverty Level guidelines set by the U.S. Department of Health and Human Services. We also review the amount of charges for which you are responsible.

If you and/or the party responsible for payment has combined income equal to or below 200 percent of the federal poverty guidelines, you will have no financial responsibility for the care that Adventist HealthCare provides. If you fall between 200 percent and 600 percent of the guidelines, you may qualify for discounted rates for our care.

If you are eligible for financial assistance under this policy, Adventist HealthCare will inform you within two business days of your request. Adventist HealthCare will not charge more for your emergency or other medically necessary care than the amounts we generally bill to individuals who have insurance for such care. In certain cases, we may presume you are eligible for financial assistance if you already qualify for certain types of governmental aid.

You may be ineligible for financial assistance if you have sufficient insurance coverage or we determine your income is enough to pay for care. Please see the links below for our full policy, which provides more explanation and details.

How to Apply for Aid

Obtain a free copy of our application:

- Call our Patient Financial Services Department (PFS) at **301-315-3660**
- Visit PFS at: **Adventist HealthCare**
  PFS Department, 5th Floor
  810 W. Diamond Avenue Gaithersburg,
  MD 20878
- Download at AdventistHealthcare.com/FinancialAssistance

PLAIN LANGUAGE SUMMARY
Financial Assistance Policy

☎ **If you need help with the application or have questions:**

- Call PFS at **301-315-3660**
- Visit us at: **Adventist HealthCare**
  PFS Department, 5th Floor
  810 W. Diamond Avenue
  Gaithersburg, MD 20878

Mail or drop off your application with the required documentation to**: Adventist HealthCare**
PFS Department, 5th Floor
810 W. Diamond Avenue Gaithersburg,
MD 20878

Translation Services: The Financial Assistance Policy, application form and this plain language summary is available in English or Spanish. Adventist HealthCare can provide assistance through a qualified bilingual interpreter upon request.

Additional Resources

HHS FPL Guidelines

RESUMEN EN LENGUAJE SENCILLO
Política de Asistencia Financiera

Adventist HealthCare se compromete a satisfacer las necesidades de atención médica de nuestra comunidad a través del ministerio de sanación física, mental y espiritual. Todos los pacientes, independientemente de su raza, credo, género, edad, nacionalidad de origen o situación económica pueden solicitar asistencia financiera.

Disponibilidad de Asistencia Financiera: Es posible que pueda obtener asistencia financiera si no tiene seguro, su seguro es insuficiente o si, pagar la totalidad de sus gastos de desembolso directo previstos para la atención de emergencia y otra atención médicamente necesaria que brinda Adventist HealthCare podría causar una dificultad financiera.

Elegibilidad: Adventist HealthCare brinda asistencia financiera basado en la necesidad. Para determinar la necesidad, revisamos los ingresos de su hogar y los comparamos con los Lineamientos federales de nivel de pobreza establecidas por el Departamento de Salud y Servicios Humanos de los Estados Unidos. También revisamos la cantidad de cargos por los que usted es responsable.

Si usted y/o la parte responsable del pago tienen ingresos combinados iguales o inferiores al 200 por ciento de los lineamientos federales de pobreza, no tendrá responsabilidad financiera alguna por la atención que brinda Adventist HealthCare. Si usted se encuentra entre el 200 y el 600 por ciento de los lineamientos, puede calificar para tarifas con descuento para nuestra atención.

Si usted es elegible para recibir asistencia financiera bajo esta política, Adventist HealthCare le informará en un plazo de dos días hábiles posteriores a la presentación de su solicitud. Adventist HealthCare no cobrará un monto mayor por su atención de emergencia u otra atención médicamente necesaria a las cantidades que generalmente facturamos a las personas que tienen seguro para dicha atención. En ciertos casos, podemos suponer que es usted elegible para recibir asistencia financiera si ya califica para ciertos tipos de ayuda gubernamental.

Es posible que no sea elegible para recibir asistencia financiera si la cobertura de seguro es suficiente o si determinamos que sus ingresos son suficientes para pagar la atención. Consulte los siguientes enlaces para conocer nuestra política completa, que proporciona más explicaciones y detalles.

Cómo solicitar Ayuda

Obtenga una copia gratuita de nuestra solicitud:

- Llame a nuestro Departamento de Servicios Financieros para Pacientes (PFS) al **301-315-3660**
- Visite el PFS en: **Adventist HealthCare**
  Departamento de PFS, 5to piso
  810 W. Diamond Avenue Gaithersburg,
  MD 20878
- Puede descargarla en AdventistHealthcare.com/FinancialAssistance

RESUMEN EN LENGUAJE SENCILLO
Política de Asistencia Financiera

☎ **Si necesita ayuda con la solicitud o tiene preguntas:**

- Llame al PFS al **301-315-3660**
- Visítenos en: **Adventist HealthCare**
  Departamento de PFS, 5to piso
  810 W. Diamond Avenue
  Gaithersburg, MD 20878

Envíe por correo postal o entregue en persona su solicitud con la documentación requerida en**: Adventist HealthCare**
Departamento de PFS, 5to piso
810 W. Diamond Avenue Gaithersburg,
MD 20878

Servicios de traducción: La Política de Asistencia Financiera, el formulario de solicitud y este resumen en lenguaje sencillo están disponibles en inglés o español. Adventist HealthCare puede brindar asistencia a través de un intérprete bilingüe calificado, si lo solicita.

Recursos adicionales

HHS Lineamientos de FPL

Exhibit 34:
Replacement Exhibit 14: Determination of Probable Financial Assistance Eligibility Workflows

Determination of Probable Financial Assistance Eligibility Workflow

Adventist HealthCare, Inc.

(Shady Grove Medical Center, White Oak Medical Center, Fort Washington Medical Center, Adventist HealthCare Rehabilitation, Germantown Emergency Center)

When pre-determining probable Financial Assistance (FAP) Eligibility, our Patient Access team does the following request for assistance:

- For Self-proclaimed financial need:
    - Request family size and family income from the patient or patient family member
        - If there is no income, determine how patient pays living expenses
        - If homeless, utilize appropriate program
        - Medicaid linkage
            - If Medicaid approved, assume Medicaid coverage
            - If Medicaid denied, check for FAP linkage
    - Compare family size and income to FAP financial eligibility criteria
    - Inform patient of probable financial assistance coverage within two business days, based on financial assistance sliding scale (please used updated sliding scale).
- For Patients demonstrating financial need (inability to pay patient liability):
    - Inform of AHC FAP process
    - If patient shows interest or consents, begin probable FAP eligibility process and provides patient with a determination within two business days
    - If patient declines, begin financial counseling process to determine payment plan options.

Determinación del flujo de trabajo de probable elegibilidad de asistencia financiera

Adventist HealthCare, Inc.

(Shady Grove Medical Center, White Oak Medical Center, Fort Washington Medical Center, Adventist HealthCare Rehabilitation, Germantown Emergency Center)

Cuando se predeterminan la probable elegibilidad para asistencia financiera (FAP), nuestro equipo de acceso al paciente realiza la siguiente solicitud de asistencia:

- Para necesidad financiera autoproclamada:
    - Solicitar el tamaño de la familia y los ingresos del hogar del paciente o miembro de la familia del paciente.
        - Si no cuentan con ingresos, determine cómo paga el paciente los gastos de subsistencia.
        - Si es una persona sin hogar, utilice el programa apropiado
        - Vinculación con Medicaid
            - Si se aprueba para Medicaid, asuma la cobertura de Medicaid
            - Si se deniega Medicaid, verifique la vinculación con la FAP
    - Compare el tamaño y los ingresos de la familia con los criterios de elegibilidad financiera de la FAP
    - Informe al paciente de la probable cobertura de asistencia financiera en un plazo de dos días hábiles, con base en la escala variable de asistencia financiera (utilice la escala móvil actualizada).
- Para pacientes que demuestren necesidad financiera (incapacidad de pagar la responsabilidad del paciente):
    - Informar del proceso FAP de
    - Si el paciente muestra interés o está de acuerdo, comience el proceso de probable elegibilidad de FAP y proporcione al paciente una determinación dentro de dos días hábiles
    - Si el paciente no lo acepta, comience el proceso de asesoramiento financiero para determinar las opciones del plan de pago.

Exhibit 35:
AHC Urgent Care Materials

Convenient
Urgent Care

**Open daily from 8 a.m. – 8 p.m.
and 24/7 in Takoma Park**

**Walk in or make an
online reservation**

On-site x-rays & labs

**Self-pay & most
insurance plans accepted**

750 Rockville Pike • Rockville
301-424-0658

19825 Frederick Road • Germantown
240-801-9944

14421 Baltimore Avenue • Laurel
240-786-6684

7600 Carroll Avenue • Takoma Park
301-891-5079

AdventistUrgentCare.com

Adventist
HealthCare
Urgent Care

Cold & Flu

Sore Throats

Ear Aches

Stomach Aches

Breaks & Sprains

Cuts

Allergies

Back Aches

Rashes & Skin Conditions

750 Rockville Pike • Rockville
301-424-0658

19825 Frederick Road • Germantown
240-801-9944

14421 Baltimore Avenue • Laurel
240-786-6684

7600 Carroll Avenue • Takoma Park
301-891-5079

AdventistUrgentCare.com

Urgent Care vs. Emergency Care

For minor illnesses and injuries, Adventist HealthCare Urgent Care offers:

- Open daily from 8 a.m. - 8 p.m., Takoma Park location open 24/7
- Walk in or make an online reservation
- On-site x-rays
- Treatment for adults and children ages 6 months and up
- Occupational health services available in Germantown, Rockville and Laurel

Common conditions treated at Urgent Care and the Emergency Department

Urgent Care

Allergies
Asthma
Back pain
Bronchitis
Cold, Flu, Fever
Cough
Fractures
Headaches
Infections
Lacerations (stitches)
Minor burns
Nausea
Rash
Sore throat
Sprains
Vomiting
Diarrhea
Pink eye
Ear Aches

Emergency Care

Chest pain
Compound fractures (bones visible)
Ingestion of poisons
Major head injury
Major trauma
Seizures
Severe burns
Shock
Snake bites
Uncontrollable bleeding
Difficulty breathing
Stroke

Walk in or make an online reservation at **AdventistUrgentCare.com**.

Adventist HealthCare
Urgent Care

Rockville
301-424-0658

Germantown
240-801-9944

Laurel
240-786-6684

Takoma Park
301-891-5079

Adventist HealthCare Urgent Care Locations

Laurel
14421 Baltimore Ave.
Laurel, MD 20707
240-786-6684

Germantown
19825 Frederick Rd.
Germantown, MD 20876
240-801-9944

Rockville
750 Rockville Pike
Rockville, MD 20852
301-424-0658

Takoma Park
7600 Carroll Ave.
Takoma Park, MD, 20912
301-891-5079

Walk in or make an online reservation at **AdventistUrgentCare.com**.

Adventist HealthCare
Urgent Care

Exhibit 36:
Replacement for Exhibit 1 Table L

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	*CURRENT ENTIRE FACILITY*			*PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)*			*OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)*			*PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT*	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Hospital Leadership	38.6	$ 127,798	$ 4,937,277			$0			$0	38.6	$4,937,277
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
						$0			$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

Support Staff *(List general categories, add rows if needed)*											
Administrative Support	18.8	$ 62,818	$ 1,181,096				3.0	$ 62,818	$ 188,453	21.8	$1,369,549
Care Navigation	74.5	71,998	5,366,792				2.6	71,998	187,196	77.1	5,553,987
Clinical Support	182.8	70,243	12,839,157	12.4	45,324	562,016				195.2	13,401,173
Environmental Services	93.5	45,929	4,293,785	11.0	40,276	443,040	2.1	45,929	94,615	106.5	4,831,439
Facility Support	114.9	49,945	5,738,976	9.0	63,093	567,840	2.3	49,945	116,871	126.2	6,423,687
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
Other	42.9	56,985	2,444,016							42.9	2,444,016
Revenue Cycle	74.0	54,186	4,010,380				2.7	54,186	143,592	76.7	4,153,972
Support Staff	45.6	54,543	2,485,495							45.6	2,485,495
										0.0	-
Rate Change for FTEs due to 1/2 year of inflation in FY2021									$2,214,868		2,214,868
Total Support	722.2	$ 57,854	$ 41,784,716	37.4	$ 47,618	$ 1,780,896	14.7	$ 206,728	$ 3,038,894	774.3	$46,604,506
REGULAR EMPLOYEES TOTAL	***2,149.9***	***$ 76,522***	***$ 164,513,011***	***48.8***	***$ 63,184***	***$ 3,083,392***	***59.47***	***$ 114,185***	***$ 6,790,591***	***2,258.1***	***$174,386,994***
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
Clinical Staff	114.0	$153,582	$17,508,312			$0	-60.3	157,478	(9,491,182)	53.7	$8,017,130
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
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			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES T	***114.0***	***$ 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								$36,103,576
% of Total Salaries											

TABLE L. WORKFORCE INFORMATION

TOTAL COST	***2,263.9***	***$216,080,675***	***48.8***	***$3,083,392***	***-0.8***	***$ (2,700,591)***	***$218,507,700***

Exhibit 37:
Affirmations

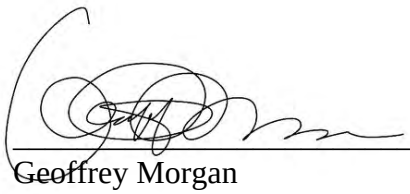
Adventist HealthCare Shady Grove Medical Center CON

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 L. Cochran
President
Adventist HealthCare Shady Grove Medical Center

12/9/2020
Date

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.



Geoffrey Morgan
VP, Chief Facilities and Property Management Officer
Adventist HealthCare

12/08/20
Date

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

12/7/2020
Date

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 R Nicklas

Andrew Nicklas
Deputy General Counsel
Adventist HealthCare

12/4/2020

Date

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

12-7-20
Date

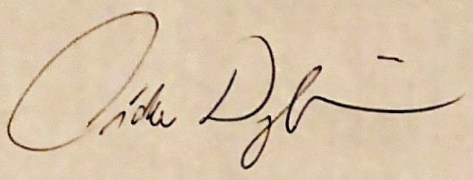
I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Kristen Pulio
SVP, Chief Revenue Officer & CFO Non-Hospital Services
Adventist HealthCare

12/7/2020
Date

AFFIRMATION

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 Dziuban
Associate Vice President of Foundation
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.

Martha Velez
Director of Finance
Adventist HealthCare Shady Grove Medical Center

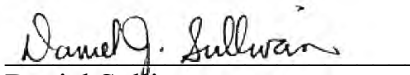
12/07/2020
Date

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 12/8/2020

Linda Beth Berman
Certificate of Need Consultant
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 Sullivan
President
Sullivan Consulting Group

12/4/20

Date