BOARD OF APPEALS
for
MONTGOMERY COUNTY

Stella B. Werner Council Office Building
100 Maryland Avenue, Room 217
Rockville, Maryland 20850
(240) 777-6600
http://www.montgomerycountymd.gov/boa/

CASE NO. A-6938

APPEAL OF WASHINGTON ADVENTIST ACC, BOARD OF COUNCIL OF UNIT OWNERS by LAVANYA SITHANANDAM, MD, PRESIDENT

NOTICE OF HEARING

Please take notice that the Board of Appeals for Montgomery County, Maryland, will hold a public hearing in the Stella B. Werner Council Office Building Second Floor Davidson Memorial Hearing Room, at 100 Maryland Avenue, Rockville, Maryland, **on Wednesday, the 17th day of December, 2025, at 9:30 a.m.**, or as soon thereafter as this matter can be heard, on the above-captioned application pursuant to Section 2-112 of the Montgomery County Code

The Appellant charges administrative error on the part of the Department of Permitting Services in its August 11, 2025, issuance of Building Permit No. 1116230. In accordance with Chapter 2A, Administrative Procedures Act, copies of the "Charging Documents" are attached to this Notice.

T**he Board will hold a pre-hearing conference on the appeal** on **Wednesday, the 22nd day of October, 2025, at 9:30 a.m.** The subject of the conference will be pre-hearing submissions by the parties, pursuant to Section 2A-7(a) of the Montgomery County Code. Failure to appear at the pre-hearing conference may result in the dismissal of the appeal.

The subject property is Block P51, Parcel N360, B F G Subdivision, located at 7600 Carroll Avenue, Takoma Park, Maryland, 20912, in the CR-1.25 C-1.25 R-1.25 H-120 Zone.

Notice forwarded this 22nd day of September, 2025, to:

Exhibit 5(b)

Soo Lee-Cho, Esquire
Lavantha Sithanandam, MD, President,
Washington Adventist ACC, Board of Council of Unit Owners
Patrick O'Neil, Esquire
Adventist Healthcare, Inc.
Elana Robison, Associate County Attorney
Washington Suburban Sanitary Commission
State Highway Administration
County Board of Education
Contiguous and confronting property owners
Local Citizens Associations

County Board of Appeals

Barbara Jay
Executive Director

Note: **All parties who make submissions, after an initial filing, in Special Exception, Variance and Administrative Appeals cases, must furnish copies of the submission to all other parties in the case. For the purpose of this requirement, a party includes: (1) Counsel of record who have formally entered their appearance; (2) Any person to whom the Board of Appeals has granted Intervener status; and (3) The Applicant, Petitioner or Appellant in the case.**

Submissions must be accompanied by a written statement certifying that copies have been sent to all parties. Effective September 6, 2002, failure to supply such written certification will result in refusal of the submission.

Case files are available for public review at the office of the Board of Appeals, Monday through Friday, 8:30 a.m. – 4:00 p.m.

BOA Form 3 (Revised 4/23/25)

BOARD OF APPEALS
FOR
MONTGOMERY COUNTY, MARYLAND
(240) 777-6600

Docket No. A- 6938
Date Filed 8-29-25
Hearing Date 12-17-25
Time 9:30 a.m.

Pre-hearing: 10-22-25 @ 9:30 a.m.

APPEAL CHARGING ERROR IN ADMINISTRATIVE ACTION OR DETERMINATION

Please note instructions on reverse side.
Attach additional sheets if required for answers.

Appeal is hereby made pursuant to Section 2-112 of the Montgomery County Code 2024, as amended, from the decision or other action of an official or agency of Montgomery County specified below which Appellant contends was erroneous.

Official or agency from whose action or determination this appeal is made: Department of Permitting Services

Brief description of action or determination from which this appeal is made (attach document indicating such action or determination) Issuance of Building Permit No. 1116230 for construction of a commercial miscellaneous structure

Date of that action or determination: 08/11/2025
Brief description of what, in appellant's view, the ruling or action should have been: Denial of Permit

Number of Section, and Subsection, if any, of the Montgomery County Code 2024, as amended, or citation or other statutory provision, which appellant contends was misinterpreted: N/A
Reason for appeal: Unlawful obstruction of legal right of access and use of property

Description of real property, if any, involved in this appeal: Lot N/A Block P51 Parcel N360
Subdivision Takoma Park Street and Number 7600 Carroll Avenue
City Takoma Park Zip 20912 Zone Classification R-60

Name of Property owner: Adventist Healthcare, Inc.
Mailing address of property owner if different from above address: C/O Washington Adv Hosp, 820 W Diamond Ave Suite 600, Gaithersburg, MD 20878
Appellant's present legal interest in above property, if any: X Owner (including joint ownership) ____ Lessee ____ Contract to lease or rent ____ Contract to purchase ____ Neighbor ____ Civic Association ____ Other

Explain Appellants are owners of Condo building located on the subject property who have legal rights to access and use existing surface parking areas to meet its off street parking requirements and who will be irreparably harmed by proposed fence obstruction.

I hereby affirm that all of the statements and information contained in or filed with this appeal are true and correct.

Soo Lee-Cho, Esq.
Signature of Attorney ***(Please print next to signature)***
Bregman, Berbert, Schwartz & Gilday, LLC
7315 Wisconsin Avenue, Suite 800, Bethesda, MD 20814
Address of Attorney

301-656-2707
Telephone Number

sleecho@bregmanlaw.com
Email Address

Lavanya Sithanandam, MD, President
Signature of Appellant(s) ***(Please print next to signature)***
Washington Adventist ACC, Board of Council of Unit Owners
7610 Carroll Avenue, Takoma Park, MD 20912
Address of Appellant(s)

301-891-6141
Home and Work Telephone Numbers

lavanyasith@gmail.com
Email Address

(OVER)

Exhibit 1

DEPARTMENT OF PERMITTING SERVICES

Marc Elrich
County Executive

Rabbiah Sabbakhan
Director

BUILDING PERMIT

Issue Date: 08/11/2025

Permit No: 1116230
AP Type: COMBUILD
Expires: 08/12/2026
X Ref.:
Rev. No:
ID: 1524617

THIS IS TO CERTIFY THAT: Terry Edmondson
145 West Ostend Street
Suite 110
BALTIMORE, MD 21230

HAS PERMISSION TO: CONSTRUCT COMMERCIAL MISCELLANEOUS STRUC

PERMIT CONDITIONS: **An approx. 3400 feet long site security fence is proposed around construction,Special Exception**

MODEL NAME:

PREMISE ADDRESS: 7600 CARROLL AVE, TAKOMA PARK, MD 20912

LOT - BLOCK: N/A - P51 ZONE: R-60 ELECTION DISTRICT: 13

BOND NO.: BOND TYPE: PS NUMBER:

PERMIT FEE: $ 1,532.63 SUBDIVISION: TAKOMA PARK

The permit fee is calculated based on the approved Executive Regulations multiplied by the Enterprise Fund Stabilization Factor for the current fiscal year.

TRANSPORTATION IMPACT TAX DUE: $0.00
SCHOOLS IMPACT TAX DUE: $0.00
UTILIZATION PREMIUM PAYMENT DUE: $0.00

Impact taxes must be paid before a final inspection of your project can be performed. Impact tax rates are subject to change. The rate of the tax or Payment due is the rate in effect when the tax or Payment is paid.

MUST BE KEPT AT JOB SITE
AN APPROVED FINAL INSPECTION IS REQUIRED PRIOR TO USE OR OCCUPANCY

Every new one- or two-family dwelling, ***every townhouse*** and any ***attached accessory structure*** must be equipped with a ***fire sprinkler system.*** A separate sprinkler permit is required for the installation of the fire sprinkler system.

Many subdivisions and neighborhoods within Montgomery County have private deed restrictions and covenants regulating building construction. Obtaining a building permit does not relieve the property owner of responsibility for complying with applicable covenants.

NOTICE
THIS APPROVAL DOES NOT INCLUDE PLUMBING, GAS PIPING OR ELECTRICAL OR CONSTRUCTION IN ANY DEDICATED RIGHT-OF-WAY.

NOTE
THIS PERMIT DOES NOT INCLUDE APPROVAL FOR ANY ELECTRICAL WORK. YOU MUST HAVE A SEPARATE ELECTRICAL PERMIT TO DO ANY ELECTRICAL WORK.

Rabbiah Sabbakhan
Director, Department of Permitting Services

Exhibit 3

BEFORE THE BOARD OF APPEALS
FOR MONTGOMERY COUNTY, MARYLAND

APPEAL OF WASHINGTON ADVENTIST ACC, BOARD OF COUNCIL OF UNIT OWNERS OF BUILDING PERMIT NO. 1116230	:	Case No.: A-6938

MOTION TO INTERVENE

Pursuant to Section 2A-7(c) and 2A-8(h)(16) of the Montgomery County Code, Adventist HealthCare Mid-Atlantic Corporation ("AHC"), through undersigned counsel, hereby files this Motion to Intervene in the above-captioned proceeding and requests party status to participate in this administrative appeal.

AHC is the owner of the property located at 7600 Carroll Avenue, Takoma Park, Maryland 20912 (the "Property"). Washington Adventist ACC filed this administrative appeal to challenge Building Permit No. 1116230, which the Montgomery County Department of Permitting Services issued to ACC to construct approximately 3,400 feet of security fencing in preparation for the demolition of structures on the Property. Thus, ACC has a direct interest in the outcome of the appeal.

ACC, therefore, requests an opportunity to participate as a party of record in the proceedings before the Board of Appeals. Please enter our appearance in the above-captioned appeal on ACC's behalf.

Exhibit 4

Respectfully submitted,

LERCH, EARLY & BREWER, CHARTERED

Patrick L. O'Neil
7600 Wisconsin Avenue, Suite 700
Bethesda, MD 20814
Phone: 301-657-0738
ploneil@lerchearly.com

CERTIFICATE OF SERVICE

I HEREBY CERTIFY THAT, on this 19th day of September 2025, I caused copies of the foregoing Motion to Intervene to be mailed first-class, postage prepaid, and by electronic mail to:

Elana M. Robison, Esq.
Assistant County Attorney
101 Monroe Street, Third Floor
Rockville, Maryland 20850
elana.robison@montgomerycountymd.gov

and

Soo Lee-Cho, Esq.
7315 Wisconsin Avenue, Suite 800
Bethesda, Maryland 20814
sleecho@bregmanlaw.com

Patrick L. O'Neil

BEFORE THE BOARD OF APPEALS
FOR MONTGOMERY COUNTY, MARYLAND

IN RE:	*	
	*	Docket No.: A-6938
Appeal of Washington Adventist ACC, Board of Council of Unit Owners	*	
	*	

MOTION TO DISMISS OR FOR SUMMARY DISPOSITION

Montgomery County, Maryland ("County"), by and through its undersigned attorneys, pursuant to §§ 2A-7 and 2-112 of the Montgomery County Code (County Code), and §§ 3.2.1 and 3.2.2 of Appendix J, Board of Appeals Rules of Procedure, moves to dismiss, or for summary disposition, of the Appeal filed by Washington Adventist ACC, Board of Council of Unit Owners ("Appellant"), and, in support thereof, states:

1. On August 29, 2025, the Appellant filed an Appeal Charging Error ("Appeal") before this Board. The Appeal challenges the issuance of Building Permit No. 1116230, issued by the Department of Permitting Services ("DPS"), for the construction of a commercial miscellaneous structure on the property located at 7600 Carroll Avenue, Takoma Park, Maryland 20912 ("Subject Property").

2. Although, the Appeal is not related to the construction of the commercial miscellaneous structure, but rather is tailored towards the permit condition which allows the construction of a temporary construction fence proposed to be approximately 3400 feet long and serve as a site security fence around the construction area.

3. Appellant claims that the proposed temporary construction fence obstructs Appellant's "legal rights of access and use [of] existing surface parking areas . . ."

4. Section 59-6.4.3.C.2.c of the Montgomery County Zoning Ordinance states, "A wall or fence must not be located within any required drainage, utility or similar easement, unless

Exhibit 6

approved by the agency with jurisdiction over the easement."

5. As indicated on the approved Site Plan, which is attached and incorporated hereto as *Exhibit A*, no easement or "legal rights to access" is noted.

6. Any private agreement, if even in existence, between the Appellant and the owner of the Subject Property would not be a part of the permit review unless it is recorded and shown on the record plat.

7. As shown on the record plat, which is attached and incorporated hereto as *Exhibit B*, no easement or "legal rights to access" is noted.

8. Thus, the Permit, including the condition for the construction of the proposed fence, was issued properly by DPS.

9. Under mere speculation, if the alleged "legal rights to access and use" is based on an adverse possession and/or prescriptive easement claim, then this Board does not have jurisdiction to decide that claim.[1]

10. Accordingly, there are no genuine issues of material fact or law to be resolved and dismissal of this Appeal should be rendered as a matter of law.

Wherefore, the County respectfully requests that the Board dismiss the Appeal without oral argument and with prejudice.

JOHN P. MARKOVS
COUNTY ATTORNEY
/s/ *Elana M. Robison*

Elana M. Robison
Assistant County Attorney
Elana.Robison@montgomerycountymd.gov

[1] See Sec. 2-112 of the Montgomery County Code which does not grant the Board jurisdiction over adverse possession or easement cases. Jurisdiction would lie with a court of general jurisdiction for those types of cases.

Attorneys for Appellee,
Montgomery County, Maryland
101 Monroe Street, Third Floor
Rockville, Maryland 20850
(240) 777-6700

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 3rd day of October, 2025, a copy of the foregoing Motion to Dismiss or for Summary Disposition was sent by electronic mail and regular mail, first-class, postage prepaid, to:

Soo Lee-Cho, Esq.
Bregman, Berbert, Schwartz & Gilday, LLC
7315 Wisconsin Avenue, Suite 800
Bethesda, MD 20814
sleecho@bregmanlaw.com
Counsel for Appellant

Patrick L. O'Neil, Esq.
Lerch, Early & Brewer, Chartered
7600 Wisconsin Avenue, Suite 700
Bethesda, MD 20814
ploneil@lerchearly.com
Counsel for Intervenor

/s/ *Elana M. Robison*
Elana M. Robison

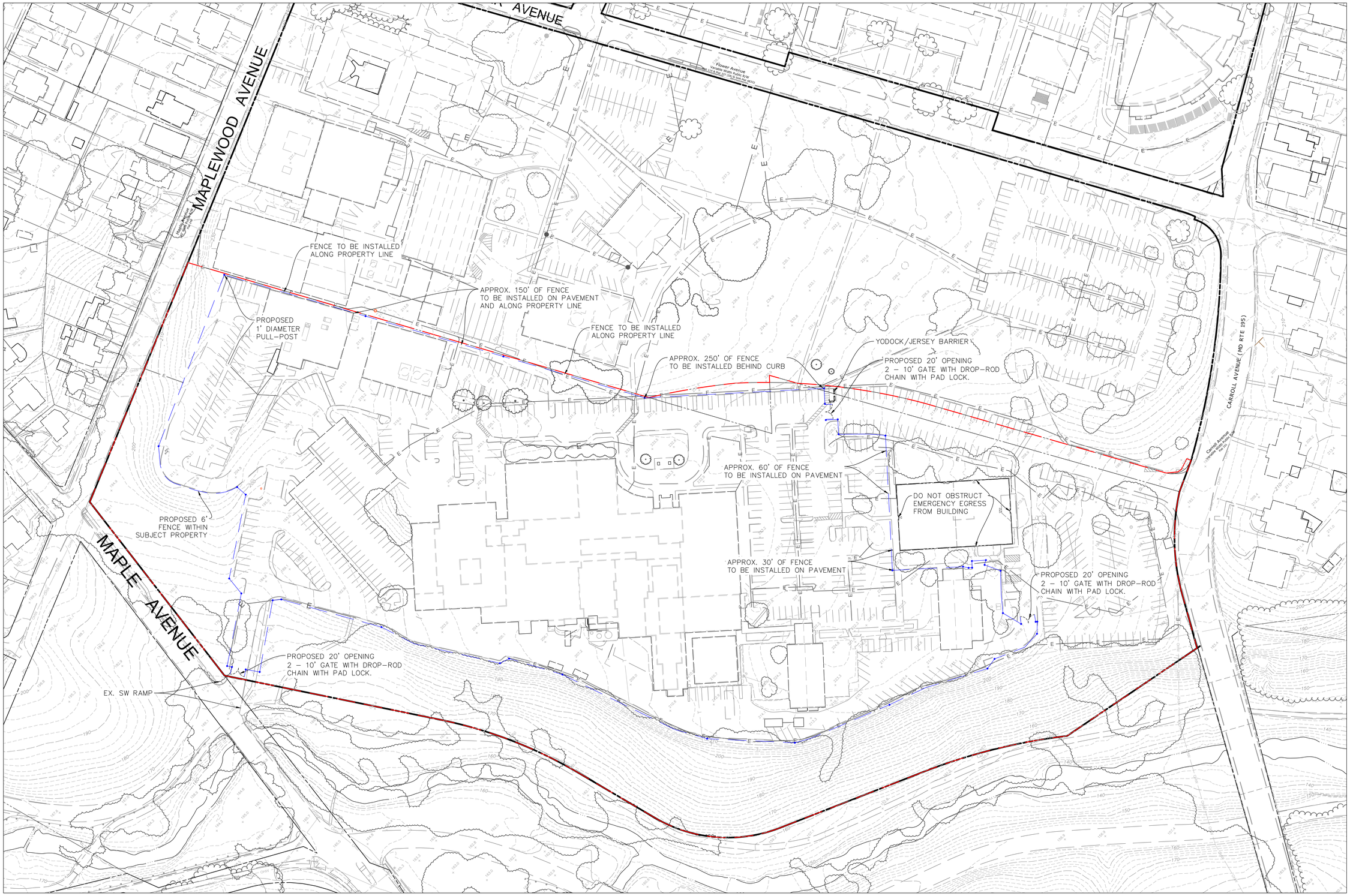
APPROVED
Department of Permitting Services
Permit # COMBUILD-1116230
Date 8/11/2025
Stamped By: Rebecca Jones

CONSTRUCTION TAKE-OFFS

- APPROX. 3409 FEET OF FENCING
- APPROX. 42 PULL POSTS
- (6) - 10 FT GATES WITH DROP-ROD CHAIN AND PAD LOCK

SHEET NOTES

1. REFER TO MSHA STANDARD NO. MD-690.02 AND MD-690.01 FOR FENCE DETAILS.
2. FENCE SHALL BE 6' NOMINAL HEIGHT.
3. ALL FENCES ARE TO HAVE TOP AND BOTTOM TENSION WIRES.
4. UNLESS OTHERWISE NOTED ALL GATES ARE TO HAVE 20' OPENINGS WITH 2 - 10' GATE PANELS WITH DROP-ROD & CHAIN WITH PAD LOCK.
5. UNLESS OTHERWISE NOTED A PULL POST SHALL BE ADDED AT ALL HORIZONTAL BENDS GREATER THAN 15-DEGREES, ABRUPT GRADE CHANGES AND / OR SPACED A MAXIMUM OF 250'.
6. ALL PAD LOCKS ARE TO BE KEYED THE SAME.
7. THE CONTRACTOR MAY MAKE MINOR ADJUSTMENT TO THE FENCE ALIGNMENT IN ORDER TO AVOID UTILITY LINES AND / OR EXISTING TREES.
8. FENCE IS TO BE INSTALLED BEHIND THE CURB AND/OR SIDEWALK UNLESS OTHERWISE NOTED.



GRAPHIC SCALE
50' 0 25' 50' 100' 200'
1 INCH = 50 FT

Exhibit A

RODGERS CONSULTING
19847 Century Boulevard, Suite 200, Germantown, Maryland 20874
Ph: 301.948.4700 (Main), Fx: 301.948.6256, www.rodgers.com

DESIGN TEAM
Owner / Developer
Adventist HealthCare
820 West Diamond Avenue
Gaithersburg, Maryland 20878
301.315.3374
Attn: Geoff Morgan

Civil Engineering / Planning
Rodgers Consulting, Inc.
19847 Century Boulevard, Suite 200
Germantown, Maryland 20874
301.948.4700
Attn: Robert Graham and Victoria Holtzman

SEAL & SIGNATURE

STATE OF MARYLAND — JEFFREY LYNCH — 56854 — PROFESSIONAL ENGINEER

Jeffrey Lynch
PROFESSIONAL CERTIFICATION

"I hereby certify that these documents were prepared or approved by me, and that I am a duly licensed professional engineer under the laws of the State of Maryland, License No. 56854, Expiration Date: 12/16/26."

Adventist HealthCare
SITE SECURITY FENCING

Takoma, Montgomery County, Maryland - 4th Election District

KEY PLAN

ISSUANCE:
DATE DESCRIPTION

REVISIONS:
NO DATE DESCRIPTION

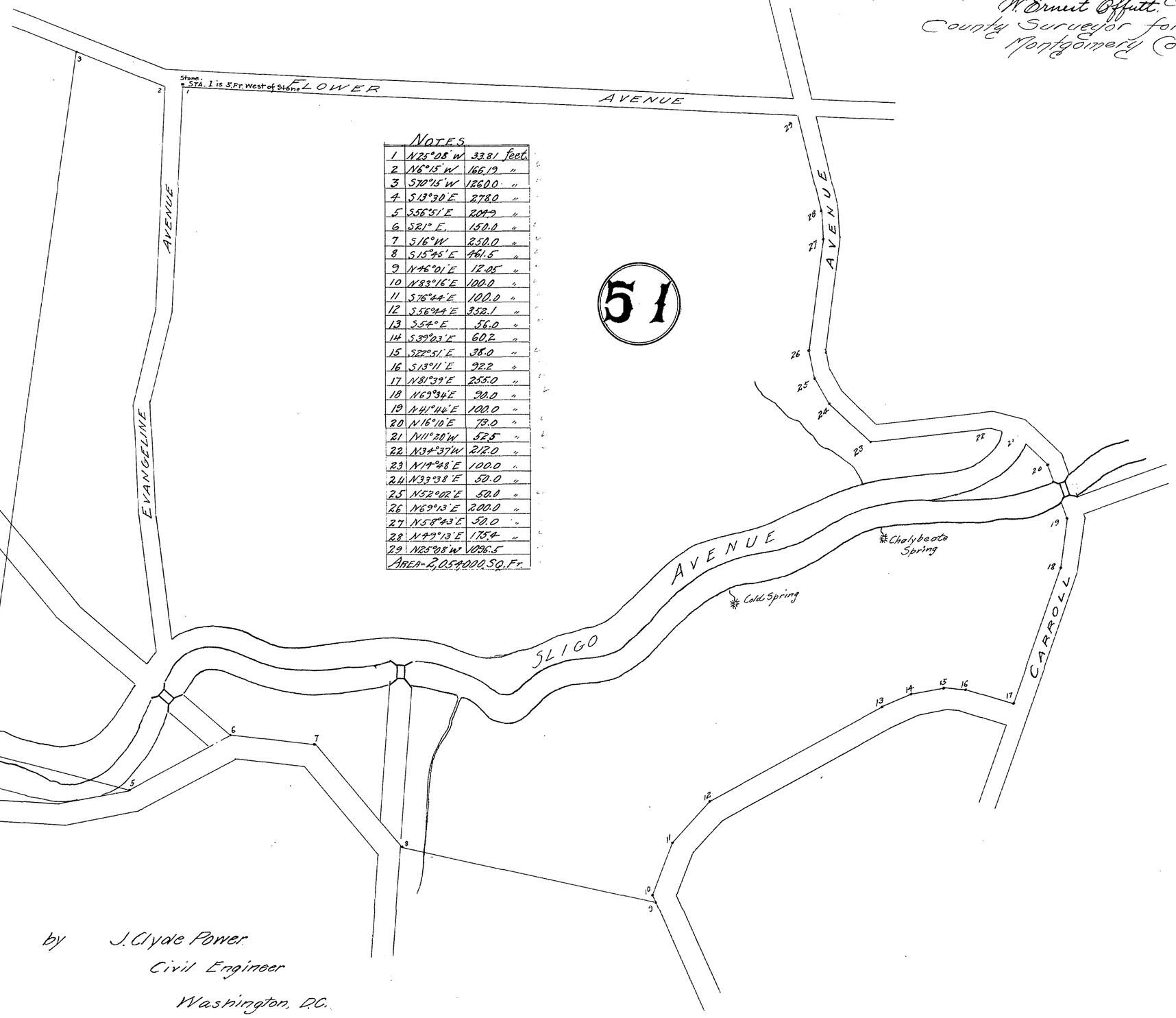
PROJECT NUMBER 785-B3
DATE JUNE 2025
SCALE 1" = 50'
DRAWING TITLE
SITE PLAN-OVERALL
PACKAGE DRAWING NUMBER **CS-103**
PLOT_STAMP

C:\ACDC\ACDDocs\Rodgers Consulting\MC-Adventist Healthcare\Project Files\autocad\Plot Plans\Site Security Fencing\Overall Plan.dwg

Copied from liber J.A. No. 13. folio 87.

Pursuant to Sec. 406-D, Chapter 92, Acts of the General Assembly of Maryland, Session of 1914, I hereby certify that this plat is a true and accurate copy of the original recorded in Liber J.A. No 13 folio 87, one of the Land Records of Montg. Co, Md., of which it purports to be a copy.

W. Ernest Offutt.
County Surveyor for
Montgomery County.



NOTES		
1	N25°08'W	33.81 feet.
2	N6°15'W	166.19 "
3	S70°15'W	1260.0 "
4	S13°30'E	278.0 "
5	S56°51'E	209 "
6	S21° E.	150.0 "
7	S16°W	250.0 "
8	S15°45'E	461.5 "
9	N46°01'E	12.05 "
10	N83°16'E	100.0 "
11	S76°44'E	100.0 "
12	S56°44'E	358.1 "
13	S54° E	56.0 "
14	S39°03'E	60.2 "
15	S27°51'E	38.0 "
16	S13°11'E	92.2 "
17	N81°39'E	255.0 "
18	N69°34'E	90.0 "
19	N41°44'E	100.0 "
20	N16°10'E	73.0 "
21	N11°20'W	52.5 "
22	N34°37'W	212.0 "
23	N14°48'E	100.0 "
24	N33°38'E	50.0 "
25	N52°02'E	50.0 "
26	N69°13'E	200.0 "
27	N58°43'E	50.0 "
28	N49°13'E	1754 "
29	N25°08'W	1096.5
AREA = 2,054,000 SQ. FT.		

Surveyed by J. Clyde Power
January 30th Civil Engineer
1889. Washington, D.C.

Scale: 150' = 1"

TAKOMA PARK.

BEFORE THE
BOARD OF APPEALS FOR MONTGOMERY COUNTY, MARYLAND

IN RE: APPEAL OF WASHINGTON ADVENTIST ACC, BOARD OF COUNCIL UNIT OWNERS	Docket No.: A-6938

OPPOSITION TO MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY DISPOSITION

Pursuant to Board of Appeals Rule of Procedure 3.2.3, Appellant Washington Adventist ACC Board of Council of Unit Owners ("Adventist ACC") responds to Montgomery County's (the "County") Motion to Dismiss or, in the alternative, for Summary Disposition of this matter. Adventist ACC filed this appeal after Adventist Healthcare, Inc. (the "Hospital") received a permit from the Montgomery County Department of Permitting Services ("DPS") allowing it to erect a fence as part of its demolition of a hospital facility it has vacated. Once installed, the fence would reduce the number of available, code-compliant parking spaces on the site below what the Zoning Ordinance likely requires, and block Adventist ACC's access to parking spaces that it has needed, and used to serve its patients, for more than 40 years. By failing to evaluate Adventist ACC's parking needs and issuing a fence permit incompatible with the County Code, DPS acted arbitrarily and capriciously and exceeded its authority.

The existing site was originally approved by the Board of Appeals as part of a shared parking scheme in 1982. *Pet'n of Wash. Adventist Hosp., Inc.* ("*Special Exception Decision*"), No. S-807 at 2 (Cnty. Bd. of Appeals for Montgomery Cnty. 1982) (attached as Exhibit A.) The Hospital believes that parking for Adventist ACC should be limited to the area covered by a 1984 lease between the Hospital and Adventist ACC, which nominally contains a little over 112 parking spaces, but, as shown below, contains far fewer code-compliant parking spaces in practical terms.

Exhibit 7

(*See* Plat No. 3600 (attached as Exhibit B); Lease (attached as Exhibit C).) Clearly, a lease cannot override parking requirements established by the Zoning Ordinance, but even setting aside that fact, the lease was never enforced, as the Hospital admits. No rent was ever paid or demanded,[1] and Adventist ACC was never restricted to the lease area for its parking needs. Instead, for decades, Adventist ACC doctors and staff routinely parked outside the lease area whenever the spaces within it were insufficient, which the Hospital knew and allowed.

This shared parking regime was consistent with this Board's original vision of campus operations, which calculated the parking requirement for the entire campus under the then-applicable hospital rate.[2] *Special Exception Decision* at 2. Under that rate, Adventist ACC would require at least 115 spaces for its doctors and staff,[3] which does not even take into account the short-term parking needs of the more than 450 patients from the community who Adventist ACC serves every day. Had Adventist ACC been approved as a standalone medical clinic, which it has now become due to the Hospital's departure from the site, it would have required far more parking spaces than the leased area contains: When the Board granted the Hospital's special exception, the 1977 Zoning Ordinance required 5 spaces per 1,000 square feet of building floor area for medical clinics, meaning Adventist ACC, with 48,000 square feet of building floor area, would need 240

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1 This may have extinguished the Hospital's rights in the leased area. "If there is no demand or payment for more than 20 consecutive years of any specific rent," "the rent conclusively is presumed to be extinguished and the landlord may not set up any claim for the rent or to the reversion in the property out of which it issued." Md. Code Ann., Real Prop. § 8-107.

2 Under the 1977 Zoning Ordinance in effect when the special exception was granted, hospitals were parked at a rate of 1 space per 1,000 square feet of building floor area, plus 1 space for each resident doctor, plus adequate reserve space for visiting staff doctors, plus 1 space per 3 employees on the major shift.

3 Adventist ACC contains approximately 48,000 square feet of total floor area, has approximately 100 doctors and staff, and often sees in excess of 450 patients per day.

parking spaces. There is no indication DPS took any of this into account before issuing the fence permit. Just as DPS requires an evaluation of parking adequacy before it will issue approval of a new use/occupancy of a site, DPS should have followed the same practice before issuing a fence permit, when that fence will detrimentally affect the existing use/occupancy of Adventist ACC by blocking access to areas of the site needed to provide adequate parking.

Moreover, the County's motion—informed, as the County admits, by the County's own "mere speculation"—fails to identify any material facts, much less establish that the material facts are undisputed. To the contrary, this case raises a number of factual issues that are either disputed or unsettled, including the basic question of how many parking spaces would remain for Adventist ACC to use if the Hospital were allowed to install the fence as authorized by DPS. Adventist ACC has commissioned a parking study to determine how many parking spaces it needs, and the site can accommodate. While the preliminary findings of that study suggest that there are only 52 code-compliant spaces on the site,[4] the study is not concluded, and it would be premature to dismiss this appeal at this stage. (Gorove Slade Memorandum (attached as Exhibit D).)

After Adventist ACC filed its appeal, and in response to a request from the City of Takoma Park, the Hospital agreed to briefly modify the fence placement, to preserve Adventist ACC's access to some of the other parking spaces. But it only agreed to do so until October 31, and it "reserve[d] the right to fence off the entirety of the former Washington Adventist Hospital physician's parking lot" if the parties do not agree to a new lease. (Email from Geoffrey A. Morgan, Vice President and Chief Facilities & Real Estate Officer, to Dr. Lavanya Sithanandam

[4] Of the 52 code-compliant spaces, 11 spaces are in fact obstructed by overgrowth that the Hospital has failed to maintain. (Gorove Slade Memorandum (attached as Exhibit D).)

(Oct. 10, 2025) (attached as Exhibit E).) Adventist ACC will thus be injured as long as the Hospital holds a permit authorizing it to cut off Adventist ACC's access to parking spaces it needs.

FACTUAL BACKGROUND

Washington Adventist Hospital and the Ambulatory Care Center

For more than 100 years, the Hospital served the community in Takoma Park. *See generally*, Rebecca Tan, *After 112 Years, Takoma Park's Washington Adventist Hospital Departs for White Oak*, Wash. Post (Aug. 22, 2019) (attached as Exhibit F).) It sat on a 16-acre site in a predominately residential neighborhood bounded by Carroll Avenue, Sligo Creek Parkway, and Maple Avenue. *Special Exception Decision*, at 2.

The Hospital Site

In the early 1980s, the Hospital was a "320 bed acute care facility" providing "a full range of clinical services, including out-patient care as needed by the community." *Id.* at 2–3. For several years, "members of the medical staff" had complained of "their inability to examine patients at facilities near the hospital," which they needed to be able to do because "outpatient services offered by the hospital, including radiology, cardiology and laboratory services, are essential to the needs of diagnosis and patient care." *Id.* at 3. To address this problem and to better serve the community,

the Hospital decided to build an ambulatory care center—a facility that would "offer greater patient services than traditional medical office buildings and integrate [its] services with the existing hospital facilities," *id.* at 4—which would ultimately become Adventist ACC.

The ambulatory care center was planned for the same site as the Hospital. Since that site was zoned for residential use, the Hospital needed a special exception. It applied for one in 1981, and the Board approved it in 1982. *See generally Special Exception Decision*. In doing so, the Board noted that Adventist ACC would have "a dependent relationship with the hospital." *Id.* at 5. The new facility would "augment diagnostic service, [and] serve to strengthen medical staff," and "would be operated largely by surgeons and specialists who spend much of their time at the hospital." *Id.*

After the Board approved the Hospital's special exception, the Hospital conveyed the land where Adventist ACC would be built, in fee simple, to a development company called NuDevCon, Inc. ("NuDevCon"). (*See* Deed, attached as Exhibit G.) NuDevCon created a condominium regime for the property when it established Adventist ACC by Declaration dated June 21, 1984. (*See* Declaration, attached as Exhibit H.) NuDevCon then sold the condominium units to interested doctors, many of whom had a work relationship with the Hospital. The Hospital also leased 69,618 square feet of land for parking to NuDevCon for 40 years. (*See* Exhibit C.) In 1984, NuDevCon assigned the lease to Adventist ACC. Thus, while Adventist ACC owned the land it was built on, the Hospital attempted to subject the ACC to a parking lease that included a defined lease area that was inconsistent with the shared parking scheme represented to the Board to obtain the approval to construct the ACC in Case No. S-807. The Hospital acknowledges that there is "[n]o record of rent paid" under the lease, (*see* Washington Adventist Hospital Demolition Update at 9 (Apr. 28,

2025) (attached as Exhibit I)), and Adventist ACC's doctors and staff always had free use of parking outside the leased area because the leased area was always insufficient.

The Site's Parking Requirements

Parking at the Hospital–Adventist ACC site has always been an important issue. As the Hospital explained in 2013, "[p]ublic transportation options are limited," there (Application for Certificate of Necessity ("CON Application") at 27 (Oct. 4, 2013) (attached as Exhibit J).) "MetroBus . . . does not travel to the hospital campus," and "[t]he only bus access is from the local Montgomery County RideOn system[.]" (*Id.*) And according to a 2013 traffic study the Hospital commissioned, "98% of people arrive [at] the current Takoma Park campus by private automobile or taxi." (*Id.* at 28.)

In 1982, when the Board granted the Hospital's special exception modification, the Zoning Ordinance required a minimum of 780 spaces at the site. *Special Exception Decision* at 6 n.*. The Hospital "apparently" had "sufficient parking to satisfy" that requirement. *Id.* at 6. To meet the additional parking needs of the new ambulatory care center, the Hospital proposed—and the Board approved—"a modest increase" to 839 spaces, or 59 more than the legal minimum. *Id.* In authorizing this increase, the Board did not differentiate between parking for the Hospital and parking for Adventist ACC. On the contrary, the Board noted that "[u]pon completion of the proposed plan a total of 839 parking spaces will be provided, exceeding the requirement by 59 spaces," *id.*, clearly indicating that the Board considered the entire site to be subject to one requirement. Indeed, if the ambulatory care center had been proposed as a standalone development that did not share land or staff with the hospital, the existing Zoning Ordinance would have required around *240 spaces* based on the building's proposed 48,000 square feet of floor area. *See*

Montgomery County Code § 59-E-7.6 (1977) (attached as Exhibit K) (requiring one parking space per 200 square feet for medical clinics).

Today, the parking spaces in the leased area are not all striped and are generally in poor condition, so it is an open question as to how many usable spaces are available. The Hospital has claimed that there are 112 spots in the leased area. (*See* Adventist HealthCare Parking Exhibit (attached as Exhibit L)); Letter from Geoff Morgan, Vice President and Chief Facilities & Real Estate Officer, Adventist HealthCare, to Dr. Lavanya Sithanandam (Oct. 7, 2025) at 1 (Attached as Exhibit M).)[5] But Adventist ACC has engaged a traffic engineer, who has initially determined that *only 52* code compliant spaces can be currently identified within the leased area. (Exhibit D.) However many spaces are in the leased area, it is clearly not enough. Adventist ACC has more than 100 doctors and staff and serves over 450 patients a day. For 40 years, those doctors and staff have parked in areas of the campus outside the leased area, allowing the vast majority of the leased area to serve as much-needed short-term patient parking.

The Hospital Moves

In 2013, the Hospital sought approval from the Maryland Health Care Commission to leave its Takoma Park location and move to a new facility about six miles away. (*See generally* CON Application). The Hospital promised that even after its move, "robust clinic based-services" would "remain in Takoma Park," which would "ensur[e] that populations in the adjusted service area have access to the appropriate level of service when it is needed." (CON Application at 60.) And in response to specific questions from the Health Care Commission, the Hospital reiterated that it

[5] In a different presentation, the Hospital counted 115 spaces, (*see* Exhibit I at 8), and it has argued that an additional 45 spaces are available along the street next to Adventist ACC. (Exhibit M at 1.) In addition to being outside the leased area, it appears that many of those 45 extra spaces are not even located on the Hospital's side of the property line.

would continue to run "[a] Women's Center, behavioral health services and [a] Federally Qualified Health Center" at the Takoma Park site, and that it might consider "[o]ther outpatient services or clinics . . . ." (Resp. to Additional Completeness Questions (Feb. 14, 2014) at 1 (attached as Exhibit N).) In 2014, the Hospital submitted a modified application for a certificate of necessity to the Health Care Commission. As part of that filing, the Hospital told the Health Care Commission that "[a]fter the completion of the White Oak hospital, the Takoma Park campus will be re-developed, changing its focus to lower-intensive services more suited to campus conditions." (Takoma Park Campus Overview at 1 (Attached as Exhibit O).) In particular, the Hospital promised that:

- "Behavioral health services will remain in place in Takoma Park[.]"
- "The existing Emergency Department will be converted into space for a walk-in clinic, providing a community service and most logical re-use of the existing space."
- "The balance of the Takoma Park campus will be re-purposed for occupancies and services that make the most sense given the building condition and constraints."
- And "[t]he services in Takoma Park will meet the needs of the community while at the same time making the best use of the existing buildings."

(Exhibit O at 1–2.) In none of its statements to the Health Care Commission did the Hospital suggest that any of its plans would involve eliminating most of the parking spaces on the site.

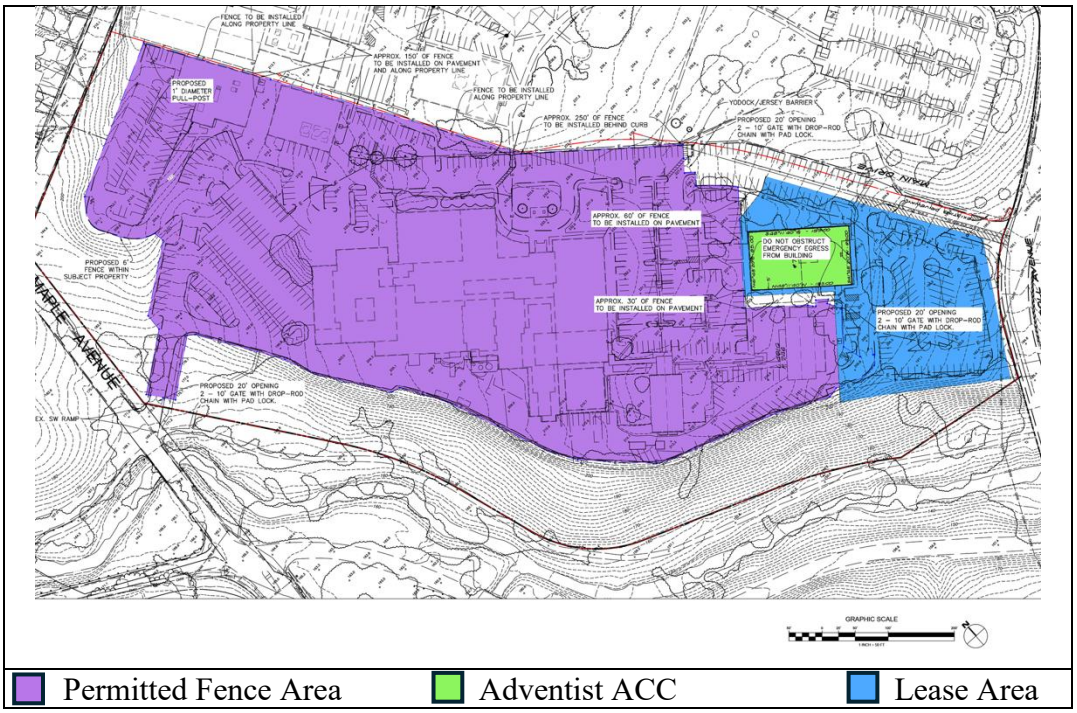
At some point around 2018, the Hospital changed its plan, and sought permission to "eliminate a 24 bed rehabilitation hospital and a 40 bed inpatient psychiatric hospital that it [had] represented to the Commission would remain on the Takoma Park . . . campus . . . ." (Letter from Suzanne R. Ludlow, Takoma Park City Manager to Ben Steffen, Executive Director, Maryland Health Care Commission at 1 (Apr. 10, 2018) (Attached as Exhibit P).) The City of Takoma Park objected that this change would "completely undermine the commitments" the Hospital had made in the approval process. (*Id.*) Ultimately, the Hospital committed to establishing "a primary care office with embedded behavioral health counseling" on the site. (Proposed Letter from Takoma

Park City Council to Paul E. Parker, Maryland Healthcare Commission at 1 (May 25, 2022) (attached as Exhibit Q).)

The Hospital's Fence Application

In August 2019, the Hospital relocated to its new campus and eventually vacated the old Takoma Park location. Adventist ACC, having no desire to relocate, continued to serve its patients in the Takoma Park community. In May 2019, after it became clear that the Hospital would relocate, Adventist ACC approached the Hospital to negotiate terms for an extension of the parking lease, as it was set to expire in 2023. The Hospital did not respond with terms, and the matter was not addressed again until May 2025, when Hospital representatives approached Adventist ACC with demolition plans that included construction of a fence that would block access to parking spaces Adventist ACC had used for over 40 years.

On May 15, 2025, the Hospital applied for a fence permit, which DPS granted on August 11, 2025. As highlighted in this composite of the Hospital's fence application and the plat for Adventist ACC, the fence DPS authorized would cut Adventist ACC off from almost all available parking spaces other than those within the limited leased area.



(*See* Exhibit A to County Mot. for Summ. Disp. (fence permit application); Exhibit B (map of leased area).)

Adventist ACC appealed DPS's decision, noting that the Hospital's fence would "obstruct[]" its "legal right of access and use of [the] property[.]" (Appeal Charging Error in Administrative Action or Determination (the "Notice of Appeal") at 1.) As Adventist ACC explained, it had "legal rights to access and use [the] existing surface parking areas to meet its off street parking requirements[.]" (*Id.*) After Adventist ACC filed its appeal, and in response to a request from the City of Takoma Park, the Hospital agreed to temporarily modify the fence placement, to preserve Adventist ACC's access to some of the other parking spaces, but it only agreed to do so until October 31, and it "reserve[d] the right to fence off the entirety of the former Washington Adventist Hospital physician's parking lot" if the parties could not agree to a new lease. (Exhibit E).)

STANDARD

The Board's rules allow a party to "move to dismiss any issue . . . on the grounds that the Board lacks jurisdiction[.]" Bd. of App. Rule 3.2.1. Similarly, summary disposition is appropriate when there is no genuine issue of material fact to be resolved, and dismissal or other appropriate relief should be rendered as a matter of law. Bd. of App. Rule 3.2.2. The decisions of an administrative agency must be supported by substantial evidence in the record, and an agency may not act arbitrarily or capriciously in its application of the law to the facts. *Para v. 1691 Ltd. P'ship*, 211 Md. App. 335, 354 (2013).

ARGUMENT

As an initial matter, the County's motion is deficient because it does not contain any documents to back up the naked assertion that there is no dispute of material fact. A motion for summary disposition "should be supported by documents, affidavits, applicable precedent, or other materials." Bd. of App. Rule 3.2.2. The County lists a few rote facts about the history of this case, which it supplements with its "mere speculation" about what Adventist ACC might argue gives it the right to access the parking spaces behind the fence. (Mot. ¶ 9.) That is not enough to demonstrate that the County is entitled to disposition in its favor. Outside of summary disposition, the Board's rules only contemplate dismissal for lack of jurisdiction. Bd. of App. Rule 3.2.1. But the County does not identify any jurisdictional defect.[6] Even setting aside the County's conclusory

[6] It is true, as the County points out (*see* Mot. at 2 n.1), that the Board lacks jurisdiction over claims involving adverse possession or prescriptive easements. *See Appeal of Brian Mattis*, Case No. A-6423, ¶ 7 (Montgomery Cnty. Bd. Of Appeals Feb. 10, 2014). But Adventist ACC has not asserted an adverse-possession or prescriptive-easement claim (although it reserves the right to do so in the appropriate forum if sufficient facts emerge).

arguments, however, this case presents a number of unresolved factual and legal questions, and is not suitable for summary disposition.

I. MATERIAL FACTS ARE IN DISPUTE.

Contrary to the County's position, fundamental facts in this case are in dispute, including the question of how many parking spaces would remain if the Hospital built its fence as authorized, which is centrally important to Adventist ACC's claim that the fence will deny it its right to "use [the] existing parking areas to meet its off street parking requirements[.]" (Notice of Appeal at 1.) Regardless of what was agreed to in the parking lease or recorded on a plat,[7] Adventist ACC has the right to operate on a site that complies with County zoning laws. And while the Hospital believes there are over 100 spaces in the lease area, Adventist ACC's most recent study found only 52 code-compliant spaces of which 11 are in fact obstructed by vegetative overgrowth left unmaintained by the Hospital. (Gorove Slade Memorandum (attached as Exhibit D).).

Similarly, there is a question whether building a fence is consistent with the Hospital's representations about how the site would be used after its move. As the City of Takoma Park's 2018 letter reflects, the Hospital made a number of assurances that the campus would continue to serve the community after the Hospital relocated. Implicit in those promises is the notion that there would remain enough parking to allow patients to use the site. But, although the Hospital's evolving position on what would become of the site after it left is a matter of public record, that

[7] The County appears to argue that short of adverse possession or a prescriptive easement, only a recorded easement would give Adventist ACC a right to use the fenced-off area. It notes that "'[a] wall or fence must not be located within any required drainage, utility or similar easement,'" and contends that "no easement or 'legal rights to access' is noted" on the approved site plan or record plat. (Mot. ¶¶ 4, 5, 7.) This misses the mark: The fact that the Zoning Ordinance specifically prohibits a fence permit from interfering with an easement does not imply that all other permits are lawful.

record is incomplete. Adventist ACC recently served Maryland Public Information Act requests to the County and several State regulators to learn more about the Hospital's commitments during the approval process, but it is too soon to receive responses. The Board should allow Adventist ACC to pursue those records, which may directly bear on the merits of this appeal.

Finally, there are questions of fact about the Hospital's knowledge that Adventist ACC used parking outside the leased area, and the Hospital's failure to collect rent under the parking lease. By treating the entire campus as one unified site for decades, and not observing any of the parking lease's formalities, the Hospital may have given Adventist ACC a right (even outside the context of adverse possession or a prescriptive easement) to use more parking spaces than the Hospital attempted to restrict through the lease. It would be premature to rule in the County's favor when the factual record of Adventist ACC's 40-year history with the Hospital is still being developed.

II. IF THE HOSPITAL BUILDS ITS FENCE, THERE WILL BE LESS PARKING FOR ADVENTIST ACC THAN NEEDED AND THAT THE ZONING ORDINANCE WOULD ALLOW.

In addition to the unresolved facts in this case, DPS acted arbitrarily and capriciously, and exceeded its authority: Not only did it authorize a fence that will reduce the number of available spaces below what is in fact justified by the use and what the Zoning Ordinance would allow, it appears not to have even considered the effect its permit would have on the available parking on site. An agency acts arbitrarily and capriciously when it "entirely fail[s] to consider an important aspect of the problem[.]" *Montgomery Park, LLC v. Md. Dep't of Gen. Servs.*, 482 Md. 706, 728 n.9 (2023). Likewise, an agency "cannot do indirectly what it is prohibited from doing directly[.]" *Hanna v. Bd. Of Ed. Of Wicomico Cnty.*, 200 Md. 49, 55 (1952).

DPS plainly could not directly authorize a violation of County zoning laws, but the Hospital's fence permit is likely to have that same effect. For medical clinics in the CR zone, like

Adventist ACC,[8] the Zoning Ordinance sets a Baseline Minimum of 1 space per 1,000 square feet of office space, and a Baseline Maximum of 4 spaces per 1,000 square feet. Montgomery County Code § 59-6.2.4(b) (2014). So if Adventist ACC were being built today, the code would require between 48 and 192 spaces for Adventist ACC's 48,000 square feet of floor space.[9] And it is likely that parking at the higher end of that range would be required,[10] because the Baseline Minimum/Maximum approach to the parking rate is a holistic method for determining the appropriate number of spaces necessary to support a given project. It looks at the proposed use and site-specific context such as accessibility for pedestrian, bike, and transit travelers to land on the right number. As the Hospital has acknowledged, the Adventist ACC site is heavily auto dependent, as there is no walkable metro station, and limited bus routes that service the immediate area, so the vast majority of doctors, staff, and patients would be expected to access the site by car. (*See* CON Application at 28.) This means that while 48 parking spaces may be suitable in some contexts, it clearly is insufficient in this case given the site-specific transit factors and number of employees and patients visiting the site on a daily basis. The required parking should likely be closer to 192 spaces than 48, and DPS erred by failing to consider what that number might be and ensure adequate parking to comply with the Zoning Ordinance was provided.

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[8] The property was rezoned CR as part of the 2024 Takoma Park Minor Master Plan Amendment.

[9] Thus, by overlooking the ordinance's Baseline *Maximum*, the Hospital misreads the Zoning Ordinance to "only require[] approximately 48 parking spaces." (Exhibit M at 1 n.1.)

[10] Given the fact-specific question of how many spaces Adventist ACC would require if it were being built today, the Board should at least remand the case to DPS to examine the issue, rather than granting the County's motion.

Since DPS improperly issued a fence permit that is incompatible with the Zoning Ordinance, the County is not entitled, as a matter of law, for this appeal to be dismissed.

CONCLUSION

The Board should deny the County's motion to dismiss or, in the alternative, summary disposition.

October 20, 2025

Respectfully submitted,

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Case No. S-807

PETITION OF WASHINGTON ADVENTIST HOSPITAL, INC.
(Hearing held April 22, 1982)

OPINION OF THE BOARD

This is a petition filed for a special exception pursuant to Section 59-G-2.31 of the Zoning Ordinance (Chap. 59, Mont. Co. Code 1977, as amended) to permit construction of an addition for an ambulatory care center. The subject property is Block 51, B. F. Gilberts Addition to Takoma Park, at 7600 Carroll Avenue, Takoma Park, Maryland, in an R-60 Zone. (Previous Case Nos. S-238 and S-591 were granted.)

Decision of the Board: Special exception granted, subject to conditions enumerated herein.

Petitioner and spokesmen for the petitioner appeared and agreed to be bound by their testimony and evidence of record, as follows:

This special exception modification was submitted to the Board by Washington Adventist Hospital through its attorney. The purposes of the proposed modification, as amended, are to construct a new hospital ambulatory care center and to make several changes to the site with regard to surface parking, landscaping and lighting. An introductory statement entered into the record as Exhibit No. 15, describes the area surrounding the applicant's site, the project and the methods of operation. A letter from Robert G. Brewer, Jr., Esq., dated April 2, 1982, was entered in the record as Exhibit No. 14. A revised site plan and revised traffic analysis as well as the introductory statement were also submitted at that time and entered into the record.

Background of Amendment

This application for modification was originally filed in October 1981. It proposed the construction of the ambulatory care center and a large parking garage on the west (northwest) side of the hospital, and expressed the intention of the hospital to preserve the sanitarium building and utilize portions of it for physician examination areas. Subsequent to the filing of the application, considerable community concern was expressed regarding the proposed size of the ambulatory care center and parking garage, the locations of the proposed ambulatory care center and parking garage, the possible resulting concentration of traffic on the west side of the hospital, the use of the parking lot adjacent to Maple Avenue, and the hospital's lack of programs to encourage the use of car pooling

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for employees to reduce the need for on-site parking. In addition to these major concerns, many less significant concerns were also expressed.

In response to the community's request, the hospital obtained a postponement of the Board's hearing to permit continued community discussions and possible revision of the hospital's plan. Numerous meetings between interested community members and representatives of the hospital occurred during the past few months, in an effort to reach a plan for development which is mutually satisfactory to all. The amended proposal is a joint product of this effort. Petitioner has now deleted the parking garage and proposes a smaller ambulatory care center on the east side of the hospital. It proposes the elimination of an existing parking lot near several neighbors on Maple Avenue, the reduction of some lighting, the addition of more landscaping, the alteration of the facing of an existing retaining wall, and the promotion of a hospital car pooling program.

Requests by interested citizens and the City of Takoma Park to defer the instant hearing in order to have more time to study the revised proposal were denied by the Board on the ground that a lengthy continuance had already been granted. The Board kept the record open for four weeks to receive additional comments from the City of Takoma Park and interested citizens.

Description of Site and Area

The hospital occupies approximately 16.2 acres, which is almost half of Block 51 in Takoma Park. The balance of the block is occupied by the hospital's sister institution, Columbia Union College. The surrounding area is predominately residential. The hospital's southeastern boundary is Carrol Avenue, which is a busy thoroughfare between Langley Park and downtown Takoma Park. Sligo Creek Parkway and Maple Avenue constitute the southwestern and western boundaries, respectively. The eastern boundary of the hospital is the campus of Columbia Union College. Immediately across Carroll Avenue are several residences owned by the hospital or occupied by persons connected with the college or the hospital. The nothern boundary is Maplewood Avenue. The commercial centers of Langley Park, Takoma Park and Silver Spring are located within one or two miles, and the surrounding medium density residential area contains numerous other uses, such as extended care facilities, educational institutions, multiple-dwelling buildings and churches. The various applicable master plans advocate the continuation of a hospital in this location as a special exception use.

Description of the Hospital

The hospital currently is a 320 bed acute care facility located in Takoma Park, Maryland. It has been serving the health needs of

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Montgomery County for over 75 years. As a general community hospital, the hospital provides a full range of major clinical services, including out-patient care as needed by the community. Through the years several additions increased the size of the hospital and the growth of its programs serving the community. An addition was completed in 1973 (by way of special exception modification) and brought the hospital to a size of 366 beds in facilities that were constructed in 1907, 1940, 1950 and 1973. In December 1977, the Board approved another special exception modification for the addition of the 4th and 5th floors to the 1973 building, the construction of a two-story addition (only one floor above ground) adjacent to the 1973 building, the renovation of the 1950 building, the demolition of the sanitarium building, and the reduction in the number of the hospital beds from 366 to 300. The new construction is virtually completed and renovations to the 1950 building have commenced.

Since the initial development of the hospital in the community, the scope of the medical and related services it has offered has greatly expanded. The hospital provides not only medical, surgical, obstetrical and psychiatric services found in most community hospitals, but also has achieved an unusual degree of excellence in some specialty areas. The Departments of Cardiology, Pulmonary Medicine, Radiological Services, Radiation Therapy, and the Community Mental Health Center, the Family Health Center, the Ultrasound Unit, and the Detoxication Center, offer a high degree of sophistication and have gained community and state-wide recognition for excellence. The hospital continues to believe that it must place primary emphasis on satisfying the health care needs of the community, as long as any required new development to achieve that objective is not inconsistent with the land-use objectives of the community.

Ambulatory Care Center

The principal proposal of the hospital is to construct a new ambulatory care center. For several years, members of the medical staff of the hospital have complained of their inability to examine patients at facilities near the hospital. The physicians need facilities near the hospital since outpatient services offered by the hospital, including radiology, cardiology and laboratory services, are essential to the needs of diagnosis and patient care. Increased utilization of the hospital's ancillary services will help to make these services more economically self-sustaining. In addition, the availability of examination areas for the medical staff physicians next to the hospital will assure continued viability and utilization of other hospital facilities by members of the medical staff.

The ambulatory care center concept is a relatively new concept in the delivery of health care services by hospitals. Such centers have developed rapidly in other hospitals elsewhere in the United

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States in the past few years. The closest such center in this area is the ambulatory care building constructed adjacent to the Shady Grove Adventist Hospital in the Montgomery County Medical Center. Ambulatory care centers differ from traditional medical office buildings in that the functional services provided are more diverse and dependent upon the support of hospital facilities than traditional medical office buildings. Whereas medical office buildings are used by physicians who have all types of medical practices, ambulatory care centers are used by physicians who regularly admit patients to the hospital. Ambulatory care centers offer greater patient services than trational medical office buildings and integrate their service capabilities with the existing hospital facilities. Furthermore, the right to utilize the ambulatory care center will generally be limited by the hospital to physicians who maintain staff privileges at the hospital.

The hospital contends that the ambulatory care center clearly is a "hospital" within the meaning of the Montgomery County Zoning Ordinance, for the following reasons:

The ambulatory care center functions to follow out-patients to the rest of the hospital facilities for treatment as inpatients, just as the existing emergency department and out-patient clinic of the hospital do. It is inherently a part of the hospital, particularly a modern hospital, just as much as any other hospital department. Whether or not it is physically attached to the hospital buildings or separated by a few feet is logically and legally irrelevant. It certainly satisfies the medical care components of the definition of a hospital. The ambulatory care center is not a "medical clinic" primarily because of the inpatient services involved and the relationship to the hospital. In this case, however, there is no practical significance in the distinction, since all requirements associated with a medical clinic have been complied with.

The ambulatory care center is needed by the hospital to maintain its ability to serve the health care needs of the community. In recent years, as a result of the relative inability of physicians to be located near the hospital, the hospital has been unable to satisfy all the community's needs. To maintain a viable health care facility, the hospital must encourage active physicians to utilize the hospital, and the ambulatory care center will help to achieve this objective. The hospital has no present plans to add other hospital facilities in the near future. While its long-range (5 to 10 years) plans envision some modest new construction of replacement facilities adjacent to the existing hospital on the east side, there are no commitments to any definite plans. The ambulatory care center should satisy the hospital's building needs for at least several years.

The ambulatory care center will be situated between the main hospital building and the Carroll Avenue entrance and constructed

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as a detached building on the east side of the hospital, adjacent to an existing parking lot along Carroll Avenue. The ambulatory care center will be 4 floors in height (3 above grade with a partially exposed lower level); the total height will be less than the aggregate height of the existing hospital buildings. Initially, it will contain only approximately 48,000 square feet of space, which represents a reduction of 1/5th of the originally-proposed size. Access points will exist on the east and west sides of the building. The ambulatory care center was relocated to the east side to minimize visual intrusions upon the community and the possible alteration of internal traffic distribution within the site. It will displace very little existing parking and will be adjacent to ample-sized parking areas. The architectural style of the ambulatory care center will be consistent with the style of other hospital buildings. Construction may commence as early as late fall 1982.

The hospital anticipates that as many as 25-40 physicians will utilize the ambulatory care center. The center, like all other hospital facilities, will be available for use 24 hours a day, as necessary, but the primary hours of operation will be from 8:00 a.m. to 5:00 p.m., Monday thru Friday, with occasional operating hours on weekends. The number of employees will be based upon the staff needs of the physicians utilizing the services in the ambulatory care center.

The hospital does not anticipate that any special equipment will be utilized. Some physicians may utilize portable medical equipment to supplement facilities maintained or services available to the other hospital buildings; in all such cases, appropriate safeguards to protect the safety of the persons affected will be established. The hospital may establish a small auxilliary pharmacy on the first floor for patient use, but it will use no exterior signs or advertising. No food service facilities, except for vending machines, will be installed in this building. Customary security will be provided. The ambulatory care center may be constructed and managed by a private entity in accordance with the terms of a written agreement with the hospital. For tax and financing purposes, the building (but not the grounds) may be owned by the private entity; the ground will always be owned by the hospital and may be leased to the entity.

Additional testimony reveals that the ambulatory care center has a dependent relationship with the hospital. Principally staff physicians would use the center and it would augment diagnostic service, serve to strengthen medical staff, and the hospital will continue to offer the good services that it now does. Ambulatory surgery is now being practiced at the hospital.

The proposed center would be operated largely by surgeons and specialists who spend much of their time at the hospital. It would offer more accute and tertiary type care.

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Parking

The hospital's prior proposal to construct a parking garage for use by its employees, patients and visitors has been eliminated at the request of the community. It originally was opposed on the grounds that it would have been too big, would have caused excessive glare and fumes, and would have resulted in a shift in the distribution of traffic. Since the construction of a parking garage also is extremely expensive, it would have required the hospital to consider a paid parking system; the elimination of the present garage proposal will not require any paid parking at the present time.

In place of a parking garage, the hospital has attempted to resolve its parking needs by the use of surface parking. The hospital apparently has sufficient parking to satisfy the requirements of the Zoning Ordinance.* To satisfy the additional needs for the ambulatory care center, the hospital is proposing a modest increase in parking areas as shown on the architectural site plan. Upon conpletion of the proposed plan a total of 839 parking spaces will be provided, exceeding the requirement by 59 spaces. However, the hospital is not proposing to add more than is necessary and intends to reduce the present parking needs by encouraging carpooling and the use of public transit. Although the hospital has had a carpooling system for several years which offers preferential parking to employees who car pool, it is in the process of increasing the incentives to utilize the program by providing better parking areas and lowering the eligibility requirement for the program. Some existing surface parking areas will be expanded, but they will be bermed and landscaped to avoid any detrimental consequences. The landscaping will be of varying sizes and types (deciduous and non-deciduous). While the hospital may wish, in the future, to add various parking decks over existing surface lots and perhaps even construct a parking garage, it has no immediate plans to do so, and would of course be required to return to the Board with any such proposal.

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* Based on parking criteria of the Zoning Ordinance, using building square footage, number of resident and existing doctors, and employees on the major shift, and using a total building area of 368,817 square feet (discounting the 71,000 square foot sanitarium proposed for demolition) with 17 resident doctors, 140 existing staff doctors and 760 employees on the major shift, the required parking spaces equals 780 spaces.

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The site plan (Exhibit No. 16), shows removal of the Sanitarium building, presently located south of the parking area, between the main hospital building and the proposed ambulatory care center. Upon completing the demolition, the present parking area will be extended southward, with a landscaped perimeter just north of the Lisner building. Additional modifications to parking areas as proposed by the applicant include: (1) the elimination of a parking area located near the intersection of Maple and Maplewood Avenues, to be replaced by a landscaped area and (2) the leasing of a 104-space existing parking area from the adjoining college facilities. This paved parking area is located at the hospital's Carroll Avenue entrance and is less than 100 feet from the proposed ambulatory care center across from the primary access drive.

The existing and proposed lighting on the site is an attempt to reduce what some persons believe is excessive light on parking areas and roadways near residential areas. Modifications of the existing lighting include reduction in height and the change in fixtures from seven 25-foot high poles to 10 to 12-foot poles and the addition of 20 new lights at these reduced heights. The petitioner intends to add more landscaping at various points in response to community suggestions regarding the need to improve the appearance of some large expanses of macadam areas. As recommended by the Maryland-National Capital Park and Planning Commission (M-NCPPC), the petitioner will consider additional landscapping in the large parking lots and the use of landscaping material to help delineate pedestrian walks between the new building and the hospital. Testimony reveals that the petitioner intends to alter the exterior appearance of the facing of the retaining wall on the west side of the hospital to make it more asthetically attractive to the community and its visitors.

The hospital intends to stage construction so as to minimize interruption of hospital activities and to maximize the opportunity to make some improvements prior to the construction of the ambulatory care center. No problems are anticipated for accommodating the construction vehicles during the construction process or in the provision of adequate parking during construction.

Storm-water runoff will be contained on the subject property and will be handled before it gets to Sligo Creek. The amended proposal represents a 3 to 5% increase in impervious area over the previous proposal. In answer to a Board question in regard to types of pervious surfaces available, the Board received a letter dated May 18, 1982 (Exhibit No. 24), which stated " ... based upon the review by our engineers, we do not believe that porous paving would be feasible at this time. In addition to the significantly increased cost, the engineers believe that the uncertain effectiveness of the system does not warrant its use at this time. However, the Hospital remains receptive to installing such a system if it is determined to be feasible at the time of construction." The above

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mentioned letter also addresses the matter of storm-water management. It states " ... the Hospital is located along Sligo Creek. Based upon current policy by the Montgomery County Department of Environmental Protection, it is likely that a contribution to an off-site system will be required in lieu of construction of a large on-site system. However, according to Lew Williams of the Department of Environmental Protection, the Hospital will be required to construct adequate transmission and holding facilities from the parking area to Sligo Creek. Our engineer advises that this will consist of several catch basins in the parking area, with pipes down to the creekbed of Sligo Creek. Where the pipes exit to Sligo Creek, an appropriate outfall with velocity diminishing material will be constructed. This system will be adequate to handle all storm water generated by the proposed new construction."

A traffic study entered into the Record as Exhibit No. 17 and the testimony of an expert traffic planner and engineer concluded new parking areas would function in a safe and efficient manner. The new site layout locates only about 30-35% of the total parking in direct proximity to the Maple Avenue access and the expanded parking layout will not result in a shift to that location. In addition, the overall internal design of the hospital roadways and parking facilities will provide for safe and efficient movement of traffic throughout the site.

An impact study conducted for the hospital in 1977 when the bed capacity was scheduled to be reduced from 366 beds to 300 beds estimated that the evening peak-hour traffic associated with the 300 bed facility would be approximately 20% lower than that which existed in 1977. Carpooling arrangements have also reduced peak-hour traffic associated with the hospital. Adjacent roadway intersections will continue to operate within acceptable levels of service 'A' and 'B", the distribution of traffic will be more even and not concentrated at the Maple Avenue access and there should be no significant increase in traffic volume.

The intersection of Flower Avenue/Carroll Avenue is scheduled to be signalized in 1984 by the State Highway Administration, replacing 4-way stop signs. It will be easy for vehicles to pass through the location once it is signalized, and may even encourage vehicles to exit on the south of the hospital rather than use Maple Avenue and Maplewood Avenue. The signal installation should not have an adverse effect on the local street system which currently operates at acceptable levels of service.

Additional testimony revealed that the proposed special exception would be in conformity with the Takoma/Langley Park Master Plan; the very recently adopted Takoma/Langley Master Plan still designates the subject property in the R-60 zone; the use would exceed the setback requirements and the ambulatory care center would be lower than the maximum height permitted. The materials used for the proposed building (off-white split face brick and earth tones) would blend with existing buildings, trees,

EXHIBIT C

etc.; all parking areas would provide handicapped parking spaces and ramps; that the proposed use would not be a nuisance or a redundant use, and would be compatible with the existing facility and would be asthetically pleasing and should enhance the value of property. In addition, there would be no burning on site; the only noise that would be bothersome would be the noise of construction for approximately ten months, with none after that.

Two residents living at the corner of Maplewood and Maple Avenues across from the hospital parking lot on Maplewood asked the petitioner questions regarding plans for future expansion and the design and style of the ambulatory care center. Petitioner replied that they have made no commitment to future hospital expansion. However, it added that any planned future expansion would be consistent with what is now being proposed. It was also petitioner's opinion that the proposed building is compatible with the existing hospital building. The residents asked if the parking lot on Maple Avenue could be converted to green space in the summer of 1982 and petitioner replied that consistent with good horticultural practice, this could be done in September or October. In regard to light replacement, especially on the maintenance building lot, petitioner replied that this could be done this summer. In addition, petitioner stated that the lower lot could immediately be closed off from Maple Avenue. The two residents stated that they felt that the proposed changes to the hospital would not enhance their neighborhood but would not be detrimental either.

Aside from the testimony from the two nearby residents who were not opposed but only wanted to express their concern, no opposition evidence was adduced at the hearing.

Report of the Technical Staff of the Maryland National Capital Park and Planning Commission

In recommending conditional approval of the subject petition, the Technical Staff report (Exhibit No. 20) stated that the subject special exception "... has been reviewed in terms of its relationship to the final draft of the Takoma Park Master Plan." In this regard, the "...special exception use is in conformance with the master plan's land use recommendations in that the location is identified as being utilized for institutional purposes."

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In addition, the Technical Staff concluded that the revised plans conform with requirements of the special exception regarding building coverage, height limit, setbacks and parking.

The question whether the ambulatory care center constitutes an addition to the Hospital or is a medical clinic was addressed. The Staff, after reviewing the applicant's submitted statements and discussion of same with the County attorney's office, concludes that the proposal is, in fact, an addition to the Hospital.

The Montgomery County Planning Board recommended approval of the special exception with the conditions cited in its staff report (Exhibit No. 20).

The petitioner expressed willingness to accept the conditions recommended by the Technical Staff of the M-NCPPC.

Opposition

The Board kept the record of the hearing open for four weeks to receive comments from the City of Takoma Park. A letter from the City was received by the Board and entered in the record as Exhibit No. 26. It states that due to the fact that the amended site plan which encompasses significant changes in the proposal was introduced so abruptly, the City did not have the minimum time to adequately consider the full impact of the ambulatory care center on the community. The change in the location of the ambulatory care center poses such problems as increased traffic on Carroll Avenue, greater traffic impact at the intersection of Carroll and Flower Avenues due to this increased traffic, diminution of trees and green space, and the proposed demolition of the historic Washington Sanitarium. Absent the opportunity of the Mayor and Council to get together with the Hospital to negotiate these matters, the Mayor and Council felt they had no other alternative but to request denial of the proposed special exception.

A letter to the Board from the Long Branch-Sligo Citizens' Association was entered in the record as Exhibit No. 25. The letter states that the Citizens' Association is opposed to relocating the ambulatory care center from the west side of the property to the east side as long as significant issues arising from the amended proposal remained unaddressed or inadequately addressed. These issues are:

EXHIBIT C

(1) Utilization of the building. The Citizens' Association stated that a market study was not produced that conclusively demonstrated that an ambulatory care facility was needed in the Takoma Park area.

(2) The overall effects on traffic. The Association contends that the plans would result in increased traffic. In addition, ingress and egress to and from the Hospital property are already difficult and sometimes hazardous because of the street and Hospital layouts. The intersection of Carroll and Flower Avenues, they said, is one of the most heavily traveled intersections in the area. The proposed plans would create new traffic problems and exacerbate existing problems.

(3) The environmemtal damage resulting from construction of the proposed building on the east side of the hospital. The only landscaped area on the Hospital grounds is on the east or Carroll Avenue building side. In addition, construction will necessitate destruction of approximately 20 to 25 trees. An expanded parking lot will eliminate the little green space left.

(4) Financing of the project. The Association states that until such time as a developer has been retained and financial arrangements secured, the petitioner's application for a special exception is inappropriate.

The Association letter states the abrupt change of location of the ambulatory care center from the west to the east side of the Hospital by the petitioner and the reasons given are unpersuasive. The Association therefore remains unconvinced of the merits of the Hospital's application for the special exception and the Citizens' Association is opposed.

Rebuttal

A letter in reply to Long Branch-Sligo Citizens' Association from the attorney for the petitioner was received by the Board and entered into the record as Exhibit No. 27 . It states that all of the issues raised by the Citizens' Association were fully addressed at a public hearing held by the City; that the petitioner demonstrated the need for the Hospital to establish the Ambulatory Care Center (although the Zoning Ordinance does not require a finding of need), and that testimony of a traffic expert demonstrated the lack of traffic impact. Allegations that the "only landscaped area on the Hospital

EXHIBIT C

grounds will be destroyed" are refuted by the fact that the Hospital has ample green space, including four to five acres which exist as an easement for Sligo Creek Parkway. Lastly, the letter states the Hospital's financial considerations are not relevant to the special exception process.

In addition, the letter states that the Hospital's decision to move the Ambulatory Care Center to the east side of the property was neither abrupt nor unjustified. The change, which represents a total compromise by the Hospital for the benefit of its immediate neighbors, came as the result of months of meetings with the Citizens' Association and is supported by sound planning considerations. All interested persons were given copies of the revised site plan nearly a month prior to the Board's hearing, which was adequate time for review and comment. The comments in the Citizens' Association letter were received nearly a month after the Board's hearing and nearly two months after the plan was filed. (An attached letter to Mr. Messenger of the Long Branch-Sligo Citizens' Association outlined the chronology of events leading up to the special exception modification as proposed and attests to the fairness of the process.)

Findings of the Board

After considering all testimony, evidence and exhibits in the record, including testimony and exhibits binding upon the petitioner, the Board finds that the proposed use, as conditioned herein, meets all pertinent requirements of the Zoning Ordinance, including the general standards for the grant of the special exception (Section 59-G-1.21), the particular requirements for a hospital (Section 59-G-2.31), and the requirements of the R-60 Zone and parking requirements in Section 59-E-7.6.

The Board notes that the hospital use has long been established on this site and that the proposed Ambulatory Care Center will meet all building height, coverage and setback requirements of Section 59-G-2.31.

The Board is convinced by evidence in the record that the proposed use is consistent with the adopted area Master Plan, that existing facilities are adequate to serve the proposed use and that the proposed addition would have no adverse effect on adjacent or surrounding properties and would be in harmony with the Hospital, which is in harmony with the neighborhood.

EXHIBIT C

In addition, the Board is convinced that the Ambulatory Care Center constitutes an addition to the Hospital, rather than a medical clinic; that the proposed use would not generate a detrimental traffic impact; that the proposed facility is needed and would be operated mostly by doctors who presently use the Hospital; that the proposed plans meet the green space requirements and exceed the parking space requirements of the Zoning Ordinance. In regard to the Sanitarium building being an historic site, the Board is mindful of numerous unsuccessful attempts to have the building declared as an historic structure. Evidence in the record reveals that in Case No. S-591 granted in 1977, it was the Hospital's intention to demolish the Sanitarium building as a result of its inability to meet building and fire codes. This decision was sustained when, on February 18, 1982, the Hospital decided to retain its existing approval to demolish the Sanitarium building; in its judgment there is no use for the building which is consistent with the health care needs and objectives of the Hospital and its patients.

The Board is of the opinion that all parties to the proceedings were given more than ample time to review and comment on the amended plans for the Ambulatory Care Center. In fact, it is apparent that the petitioner went to great lengths to alleviate and resolve community concerns.

In regard to future expansion of the Hospital, the Board notes that any future modifications must be brought before the Board for approval.

Accordingly, the proposed special exception is granted, subject to the following conditions:

1. Construction shall be according to the revised site plan entered into the record as Exhibit No. 16 and according to architectural plans (Exhibit No. 18(b)).

2. The applicant shall, in consultation with the Technical Staff of M-NCPPC, institute a program encouraging employee use of public transit and carpool.

3. The applicant shall maintain the required number of parking spaces throughout the demolition of the buildings and construction of the Ambulatory Care Center.

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4. The entire special exception shall be subject to review by the Board annually until all phases of the Hospital development have reached completion.

5. The applicant shall submit a revised landscape and lighting plan addressing both on and off site effects. This plan shall be subject to the review and approval of the Technical Staff of the Maryland-National Capital Park and Planning Commission.

The Board adopted the following Resolution:

"BE IT RESOLVED by the County Board of Appeals for Montgomery County, Maryland, that the opinion stated above be adopted as the Resolution required by law as its decision on the above-entitled appeal."

The foregoing Resolution was proposed by Doris Lipschitz and concurred in by Joseph E. O'Brien, Jr., Chairman, Rita A. Morgan, Harry M. Leet and Wallace I. Babcock.

I do hereby certify that the foregoing Minutes were officially entered in the Minute Book of the County Board of Appeals this 28th day of July, 1982.

Dollie H. Kyte
Clerk to the Board

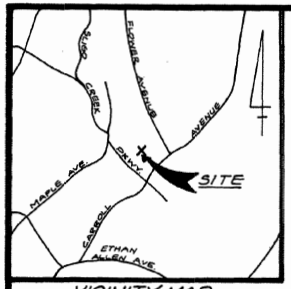
NOTE: See Section 59-A-4.53 of the Zoning Ordinance regarding the twelve-months' period within which the right granted by the Board must be exercised.

See Section 59-A-3.2 of the Zoning Ordinance regarding use and occupancy permit.

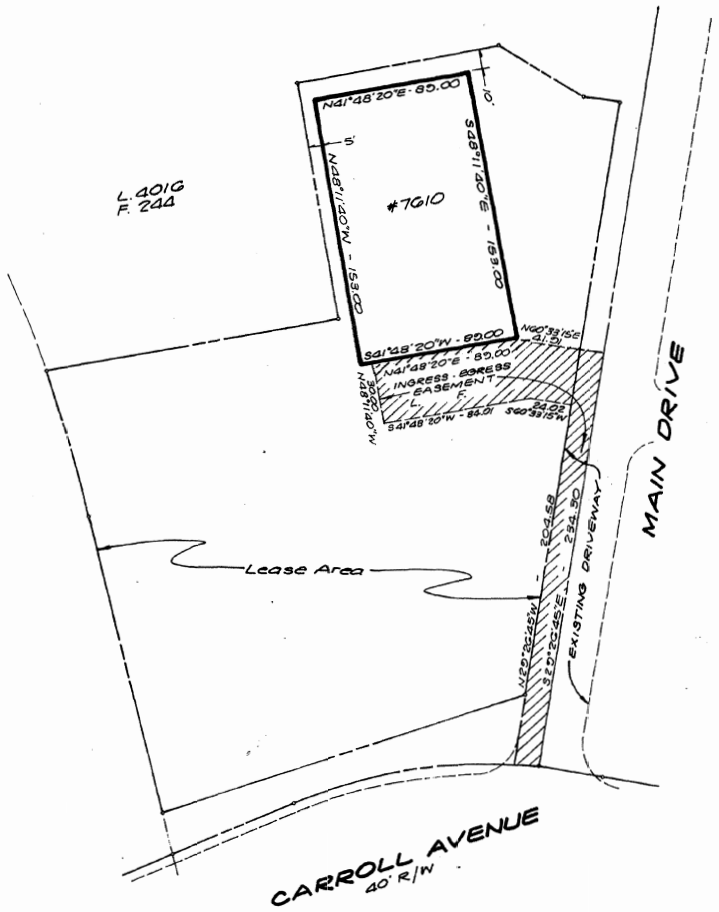
Any decision by the County Board of Appeals may, within thirty (30) days after the decision is rendered, be appealed by any person aggrieved by the decision of the Board and a party to the proceeding before it, to the Circuit Court for Montgomery County in accordance with the Maryland Rules of Procedure.

EXHIBIT C

PLAT No. 3300



VICINITY MAP
SCALE: 1" = 2000'



Note:
Lease Area and Ingress and Egress Easement area are not a part of this Condominium.

SURVEYOR'S CERTIFICATE

I certify that this plan of Condominium consisting of 5 pages is all of the land conveyed by the Washington Adventist Hospital Incorporated to Nu Dev Con, Inc. a Maryland Corporation by deed dated May 31, 1983 and recorded in Liber G127 Folio 830* among the Land Records of Montgomery County, Maryland.

I further certify that the position of all existing improvements have been established by accepted field practices and unless otherwise shown, there are no encroachments either way across the property line, and that these plats and plans together with the applicable wording of the Washington Adventist Ambulatory Care Center, a Condominium declaration is a correct representation of the Condominium described and indentification and location of each unit and common elements as constructed can be determined from them.

Date: May 14, 1984

Rodney L. Hanson
Rodney L. Hanson
Reg. Land Surveyor, Md. #3084

*as amended by Confirmatory Deed dated April 12, 1984 and recorded in L.G401 F.G26

OWNER'S DEDICATION

We, NUDEVCON, Inc., a Maryland Corporation by Boyd O. Bower, President, and Cornelius Davies, Secretary, owners of the property shown and described hereon hereby adopt this plan of Condominium Subdivision pursuant to the provisions and requirements of Title II, Real Property Article, Sections 11-101 et seq. of the Annotated Code of Maryland as amended.

June 20, 1984 NUDEVCON, INC.

Attest: Cornelius Davies By: Boyd O. Bower
Cornelius Davies, Secretary
Boyd O. Bower, President

FILED
JUN. 28 1984

CONDOMINIUM PLAT
WASHINGTON ADVENTIST AMBULATORY CARE CENTER A CONDOMINIUM
(NON-RESIDENTIAL)
13th ELECTION DISTRICT
MONTGOMERY COUNTY, MARYLAND
Scale: 1" = 50' Date: May, 1984

HANSON & DEN OUTER, LTD.
CIVIL ENGINEERS & LAND SURVEYORS
LAND PLANNING CONSULTANTS
172 ROLLINS AVE., ROCKVILLE, MD 20852
(301) 881-6770

Sheet 1 of 5 FILE NO. RP 7G3 JOB NO. 1185-C1

LIBER 6160 FOLIO 895

1983 AUG 23 AM 11:29

CLERK'S OFFICE
MONTGOMERY COUNTY, MD

LEASE

THIS LEASE (the "Lease") is made this 31st day of May, 1983, by and between Washington Adventist Hospital, Incorporated, a corporation organized and existing under the laws of the State of Maryland (the "Lessor"), and NuDevCon, Inc., a corporation organized and existing under the laws of the State of Maryland (the "Lessee").

WITNESSETH, that the Lessor, for and in consideration of the covenants, conditions, and agreements herein contained, and on the part of the Lessee to be paid, kept and performed, does hereby lease to the Lessee, and the Lessee does hereby lease from the Lessor, certain premises as outlined in red on the plat attached hereto as Exhibit A, consisting of 69,618 square feet of parking area as further described in Exhibit B (the "Property").

1. The Property. The Lessor does hereby [illegible] Property to the Lessee and the Lessee hereby leases the Property from the Lessor.

2. Term. This Lease shall be for a term of forty (40) years, commencing upon June 1, 1983.

3. Rent. The annual rent shall be Five Thousand and No/100 Dollars ($5,000.00) for the first three (3) years hereof, payable monthly in advance to the Lessor on the first day of each month, commencing on the first day of the first month after the date hereof, with a pro-rata payment of rent to be paid in advance for any period which is less than an entire calendar

EXHIBIT B

month from the date hereof until the first day of the first month from the date hereof. Beginning on the first day of the fourth lease year and on the first day of each lease year thereafter, the annual rent (then in effect) shall be increased and paid monthly by a percentage equal to seventy-five percent (75%) of the percentage by which the Consumer Price Index for Wage Earners and Clerical Workers, All Items, Washington, D.C. - Metropolitan area (1967 = 100) (hereinafter referred to as the "Index") for the last calendar month or calendar quarter (whichever is available) prior to the then current lease year in question exceeds the Index for the last full calendar month or calendar quarter (whichever is available) immediately prior to the month in which the Lease commences. Should said Index cease to be published, then the closest similar Index published by an agency of the United States Government shall be substituted. Should there be no such substitute, then the matter shall be determined by arbitration in accordance with the then prevailing rules of the American Arbitration Association, and judgment upon the award rendered shall be final and binding upon the parties and may be entered in any court of competent jurisdiction.

4. Late Charge. In the event Lessee shall fail to pay an installment of rent within ten (10) days from the date on which it is due and payable, Lessee shall pay Lessor, in addition to the rent, a late charge in the amount of five percent (5%) of the rent due. Such payment shall be payable as additional rent together with the rent then overdue and in arrears, and such payment is not a waiver of the fact that rent is due on the first of the month.

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5. Taxes. The parties understand that the Property is currently exempt from taxation. However, the Maryland State Department of Assessments and Taxation may, at some future date, revoke the tax exemption as the result of this Lease. If, as the result of such revocation, the Property is taxed, Lessee, or its assigns, shall pay all taxes and charges (but not including income taxes, if any, payable by the Lessors in respect to the rent) and any and all other assessments, levies and governmental or other charges now or hereafter assessed, levied or otherwise applicable to the Property and shall provide proof of payment thereof to Lessor. Anything to the contrary contained herein notwithstanding, the Lessee, however, may take the benefit of the provisions of any statute or ordinance permitting any assessment referred to herein to be paid over a period of time, except that all such assessments shall be fully paid by the end of the term of this Lease. The Lessee shall have the right to contest the legality or amount of any assessment of taxes and other public charges which it is required to pay under the provisions of this Lease, and may contest the legality or amount of such assessments in the name of the Lessor, provided that it indemnifies and saves harmless the Lessor from any and all expenses in connection therewith. Any such taxes, interest or penalties thereon paid by the Lessee under the provisions hereof which may thereafter be refunded to the Lessor shall be repaid promptly by the Lessor to the Lessee. The Lessee covenants and agrees that in the event it shall contest the legality or amount of any assessment of taxes or other public charges as herein provided which have not been paid, it will, upon written demand of the Lessor, deposit an amount of money equal to the amount of

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such tax or other public charge plus ten percent thereof in an escrow fund, such deposit to be held as security for the payment of such tax or other public charge in the event that the Lessee shall fail to pay such tax or other public charge after a final determination finding such tax or other public charges to be valid. Provided, however, that if any part of such tax or other public charge shall be declared to be invalid by such final determination and shall not constitute a lien, charge or imposition upon the Property or any part thereof, or the improvements thereon, then said part of such deposit shall be refunded to the Lessee.

6. Maintenance and Operation. Lessee shall pay all costs, charges and expenses associated with the maintenance and operation of the Property, and shall maintain the leased area in a good condition consistent with its approved use.

7. Access. The Lessor reserves a right of reasonable pedestrian access for its employees and visitors through the Property. However, it is agreed that parking by such employees or visitors on the Property is prohibited. The Lessor further reserves the right of access through the Property for emergency vehicles and for emergency purposes; it is understood and agreed that vehicular access to the Property may be controlled by way of gates, which may be removed or broken without liability in the event of an emergency.

8. Development Agreement. This Lease is made pursuant to and in connection with the terms and provisions of a Development

EXHIBIT B

Agreement, dated January 21, 1983, between Lessor and Lessee (the "Development Agreement").

9. Lessor's Title. Lessor covenants that it has fee simple title to the Property, subject only to the encumbrances set forth in Exhibit B attached hereto and incorporated herein by reference.

10. Use. Lessee shall use the Property for a parking lot and for no other purpose. The use shall be consistent with the Special Exception Opinion, attached as Exhibit D to the Development Agreement (the "Special Exception Opinion").

11. Alterations. Lessee shall have the right to make such changes, repairs or alterations to the Property as are consistent with and conform to the Special Exception Opinion.

12. Quiet Enjoyment. The Lessor covenants that the Lessee, its successors and assigns, upon paying the rent as specified herein and upon observing and performing all of the covenants herein contained on their part to be observed and performed, shall and may peaceably and quietly hold and enjoy the demised premises during the term of this Lease, without disturbance or ejection by the Lessor or by any person or persons lawfully claiming by, from or under them.

13. Easements. Lessee agrees to convey to Lessor, from time to time, upon request, such easements for utilities which the Lessor deems to be reasonably necessary, provided that such

EXHIBIT B

easements do not unreasonably interfere with Lessee's use or possession of the Property, and further provided that if creation of said easements causes damage to Lessee's property, or any part thereof, said damage shall be repaired to Lessee's satisfaction, at Lessor's expense.

14. Encumbrances and Liens. The Lessee shall not commit or suffer any act or neglect whereby the Property or any part thereof shall at any time during the term of the Lease become subject to any attachment, judgment, lien, charge or encumbrance whatsoever, and Lessee shall indemnify and hold the Lessor harmless from any loss, cost and expense with respect thereto.

15. Assignment. Lessee shall have the right to assign this Lease to the Condominium Association, as defined in the Development Agreement, without Lessor's consent, provided that the Lessee gives the Lessor written notice of such assignment. Lessee shall not assign the Lease to any other entity without the prior written consent of the Lessor, which consent will not be unreasonably withheld.

16. Liability Insurance. During the term of this Lease, the Lessee shall, at its own cost and expense, carry public liability insurance, which insurance shall have limits of not less than $1,000,000.00 for property damage and $3,000,000.00 for personal injuries and death and shall cover both the Lessor, its successors and assigns, and the Lessee, its successors and assigns, as their respective interests may appear. The insurance herein provided for shall be carried with some insurance company or companies approved in writing by the Lessor, which approval shall not be unreasonably withheld. Certificates of insurance or the original insurance policies shall at all times be deposited with the Lessor.

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17. Indemnity. Lessee shall indemnify and save harmless Lessor from and against any and all liability, damage, penalties, and judgments arising from injury to person or property sustained by anyone in and about the Property resulting from any act or acts or omission or omissions of Lessee or Lessee's officers, agents, servants, employees, licensees or contractors. Lessee shall, at its own cost and expense, defend any and all suits or actions (just or unjust) which may be brought against Lessor or in which Lessor may be impleaded with others upon any such above-mentioned matter, claim or claims, except as may result from the acts set forth in the following sentence. Except for its affirmative acts or negligence or the affirmative acts or negligence of its officers, agents, servants, employees or contractors, Lessor shall not be responsible or liable for any damage or injury to any property, fixtures, buildings or other improvements or to any person or persons at any time on the Property, including any damage or injury to Lessee or to any of Lessee's officers, agents, servants, employees, contractors, customers or sublessees.

18. Default. If the rent aforesaid or any installment thereof shall not be paid within thirty (30) days after the same becomes due and payable, as aforesaid, although no demand shall be made for the same, or if Lessee shall fail or neglect to keep and perform each and every one of the covenants, conditions and agreements contained herein or in the Development Agreement or in the Declaration of Covenants, Conditions and Restrictions made by the Hospital and dated May 31, 1983 , and on the part of the said Lessee, to be kept and performed, or if the

EXHIBIT B

same or any of them shall be broken, then, at the option of the Lessor after 30 days written notice to Lessee, during which time Lessee shall have the right to cure such breach, the Lessee's right of possession shall thereupon end and determine, and the Lessor shall be entitled to the possession of the Property and to re-enter the same without demand of rent or demand of possession of the Property and forthwith proceed to recover possession of the Property by process of law, and a notice to quit or of intention to exercise said option or to re-enter the same being hereby expressly waived by the Lessee. That, in the event of such re-entry by process of law or otherwise, Lessee nevertheless agrees to remain answerable for any and all damages, deficiency or loss of rent which the Lessor may sustain by such re-entry, and the Lessor reserves full power which is hereby acceded to by the Lessee to re-let the said premises for the benefit of the Lessee.

19. Recordation. If this Lease is recorded among the Land Records of Montgomery County, the recording party will bear the total costs of such recording and any stamps or other expenses arising therefrom.

20. Estoppel Certificate. Lessee agrees, at any time and from time to time, upon ten (10) days prior written request by Lessor, to execute, acknowledge and deliver to Lessor a statement in writing certifying that this Lease is unmodified and is full force and effect (or if there have been modifications that the same is in full force and effect as modified and stating the modifications), and the date to which

EXHIBIT B

the basic rent and other charges have been paid in advance, if any, and whether or not there is any existing default by Tenant or notice of default served by Lessor. Lessor is hereby constituted Attorney-in-Fact to execute any certificate on behalf of Lessee after five days written notice should Lessee fail to carry out the provisions hereof.

21. Surrender Upon Termination. The Lessee shall and will, on the last day of the term of this Lease, or upon any earlier termination thereof, surrender and deliver up the Property and the improvements (without any payment or allowance whatever to Lessee on account of or for the improvements or any part thereof), unto the possession and use of Lessor, without fraud or delay and in good order, condition and repair, ordinary wear and tear excepted, but free and clear of all liens and encumbrances. In the event Lessee fails to surrender the Property, Lessor may, without further notice (any notice to quit or intention to re-enter required by law being expressly waived by Lessee) re-enter upon the Property and possess itself thereof, by summary proceedings, ejectment, or otherwise, and may have, hold and enjoy the premises and improvements and have the right to receive all rents and other income of and from the same.

22. Holding Over by Lessee. If Lessee shall hold over the term hereof, such holding over shall be deemed a tenancy from month-to-month for one and one-half times rent herein provided and upon the same terms and conditions as are herein provided.

EXHIBIT B

23. Waiver. The failure of the Lessor to insist upon strict performance of any of the terms, covenants or conditions of this Lease or to exercise any option herein conferred in any one or more instances, shall not be construed as a waiver or relinquishment for the future of any such terms, covenants, conditions or option, but the same shall be and remain in full force and effect, and it is further agreed that the acceptance by the Lessor of rent from the Lessee, with knowledge of the existence of a breach of this Lease by Lessee, shall not constitute a waiver of such breach, nor a waiver of the right to insist upon Lessee's curing such breach or default of this Lease.

24. Notices. All notices shall be hand delivered or sent by certified United States Mail, return receipt requested, as follows (unless such address is changed by written notice to the other party):

If to Lessor	7600 Carroll Avenue Takoma Park, Maryland 20912 Attention: President
With a copy to:	Robert G. Brewer, Jr., Esquire Lerch, Early & Roseman, Chartered 7101 Wisconsin Avenue, Suite 1313 Bethesda, Maryland 20814
If to Lessee:	Wilmot, Bower & Associates 1350 Piccard Drive Rockville, Maryland 20850
With a copy to:	William P. Daisley, Esquire King & Nordlinger 1000 Connecticut Avenue Suite 311 Washington, D.C. 20036

25. Modification or Amendment. This Lease shall not be modified or amended, except by an agreement in writing signed by both parties.

EXHIBIT B

26. Captions. The captions of this Lease are for convenience and reference only and in no way define or limit the scope or intent of this Lease nor in any affect this Lease.

27. Gender and Number. Words of any gender used in this Lease shall be deemed to include any other gender, and words in the singular number shall be deemed to include the plural (and vice versa), when the context so requires.

28. Severability. If any clauses or provisions herein contained operate or would prospectively operate to invalidate this Lease in whole or in part, such clauses and provisions only shall be void, as though not herein contained, and the remainder of this Lease shall remain in full force and effect.

29. Governing Law. This Lease shall be interpreted and enforced in accordance with the laws of the State of Maryland.

IN WITNESS WHEREOF, the parties hereto have executed this Lease as of the day and year set forth above.

ATTEST:

LESSOR:

WASHINGTON ADVENTIST HOSPITAL, INCORPORATED

By: Herbert J. Schmidt, Pres.

LESSEE:

MUDEVCON, INC.

By: Boyd O. Fowler

LIBER 6160 FOLIO 906

STATE OF MARYLAND)
) ss:
COUNTY OF MONTGOMERY)

I HEREBY CERTIFY THAT on this 31st day of MAY, 1983, before the undersigned, a Notary Public of the State and County aforesaid, personally appeared HERBERT Z. SHIROMA, who acknowledged himself to be the President of Washington Adventist Hospital, Incorporated, a corporation, and that he, as such officer, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by himself as President.

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

Notary Public
CONSTANCE C. MAY

My commission expires: 7/1/86

CONSTANCE C. MAY NOTARY PUBLIC MONTGOMERY COUNTY, MD.

STATE OF MARYLAND)
) ss:
COUNTY OF MONTGOMERY)

I HEREBY CERTIFY THAT on this 31st day of MAY, 1983, before the undersigned, a Notary Public of the State and County aforesaid, personally appeared BOYD BOWER, who acknowledged himself to be the President of NuDevCon, Incorporated, a corporation, and that he, as such officer, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by himself as President.

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

Notary Public
CONSTANCE C. MAY

My commission expires: 7/1/86

CONSTANCE C. MAY NOTARY PUBLIC MONTGOMERY COUNTY, MD.

LEWIS, EARLY & BRENNAN CHARTERED

EXHIBIT B

LIBER 6160 PAGE 907

DEVELOPMENT CONSULTANTS GROUP, INC.

Exhibit A

[redacted]

DESCRIPTION OF PART OF
THE PROPERTY OF WASHINGTON ADVENTIST HOSPITAL
LIBER 4016 FOLIO 244
LEASE AREA
1.5982 ACRES

Being all that piece or parcel of land, situate, lying and being in Takoma Park, 13th Election District, Montgomery County, Maryland, also being part of the land conveyed from the Washington Sanitarium and Hospital, Inc. to Washington Sanitarium and Hospital, Inc. by deed dated November 6, 1970 and recorded in Liber 4016 at Folio 244 among the Land Records of Montgomery County, Maryland and being more fully described as follows:

Beginning at a point at the beginning of the 15th or South 52° 02' 00" East, 193.59 foot line of the 2.8629 acre parcel of land conveyed to the Maryland National Capital Park and Planning Commission by deed recorded in Liber 558 at Folio 272, thence running with part of the 14th line of said deed

1) 85.86 feet along the arc of a curve to the left, having a radius of 890.95 feet and chord bearing and distance of North 54° 47' 38" West, 85.82 feet to a point, thence running to cross and include a part of said conveyance
2) North 41° 48' 20" East, 167.94 feet to a point, thence
3) North 48° 11' 40" West, 133.00 feet to a point, thence
4) North 41° 48' 20" East, 115.00 feet to a point, thence
5) North 82° 41' 03" East, 54.93 feet to a point, thence
6) North 60° 33' 15" East, 20.00 feet to a point, thence
7) South 29° 26' 45" East, 335.70 feet to a point, thence
8) South 34° 18' 27" West, 216.08 feet to a point on the aforesaid 15th line, thence with said line

PARCEL IDENTIFIER No. 13-25-1050256

EXHIBIT B

3) North 52° 02' 00" West, 170.59 feet to the place of beginning, containing 1.9108 acres of land.

Saving and excepting therefrom the 0.3126 acre Building Parcel described as follows:
Beginning at a point North 24° 06' 01" East, 181.69 feet from the beginning point of the 1.9108 acre parcel described above, thence running to include a part thereof
1) North 48° 11' 40" West, 153.00 feet to a point, thence
2) North 41° 48' 20" East, 89.00 feet to a point, thence
3) South 48° 11' 40" East, 153.00 feet to a point, thence
4) South 41° 48' 20" West, 89.00 feet to the place of beginning, containing 0.3126 acres of land.
Leaving a net area of 1.5982 acres of land in the Leano Area.

Subject to any and all easements and rights-of-way of record.

EXHIBIT B

GOROVE SLADE
Transportation Planners and Engineers

TECHNICAL MEMORANDUM

To: Soo Lee-Cho — Bregman, Berbert, Schwartz & Gilday, LLC

From: Blake Hakimian, EIT
Maribel Donahue
Katie Wagner, PE, PTOE

Date: October 17, 2025

Subject: 7610 Caroll Avenue Parking Memo

Our review of the current parking layout at 7610 Carroll Avenue indicates that while approximately 112 parking spaces appear to be in some state of striping in the parking lot to the south and along the main drive aisle immediately adjacent to the east of the building, only a portion of these spaces meet Montgomery County Zoning Ordinance requirements for minimum drive aisle width and parking space dimensions.

Based on our preliminary assessment, 41 spaces meet the applicable standards and are considered zoning-compliant and functional. The remaining spaces are either undersized, encumbered by obstructions, or located within aisles that do not meet County width requirements. It should be noted that an additional 11 spaces provide adequate drive aisle width but are currently experiencing overgrowth encumbering the space.

In addition, the existing pavement markings are faded further limiting functionality and visibility of the parking layout.

Parking Supply

For practical purposes, the site currently provides 52 zoning compliant parking spaces. This total includes 15 spaces located along the main drive aisle and 11 spaces in the lot to the south that are experiencing overgrowth, but which could potentially be counted within the zoning-compliant supply.

Next Steps

Parking utilization observations are ongoing. Once complete, a detailed utilization summary will be provided to confirm demand patterns and to identify opportunities for restriping, reconfiguration, or minor improvements to increase the number of compliant spaces.

Friday, October 17, 2025 at 2:06:57 PM Eastern Daylight Time

Subject: Fw: [EXTERNAL]Fwd: Temporary Fencing Adjustment - Adventist HealthCare Property
Date: Friday, October 10, 2025 at 1:01:52 PM Eastern Daylight Time
From: William Rogers
To: John Grimm
Attachments: Outlook-zwzmblpr.jpeg, Approved_FencePlan_parkingcount_10-10.pdf, Outlook-100.png

BBS&G Attorneys
William J. Rogers
(Admission Pending in Maryland)
BREGMAN, BERBERT, SCHWARTZ & GILDAY, LLC
7315 Wisconsin Avenue, Suite 800 West
Bethesda, Maryland 20814
301-656-2707 x5918 **PHONE**
Email: wrogers@bregmanlaw.com
https://www.bregmanlaw.com/

From: Lavanya Sithanandam <lavanyasith@gmail.com>
Sent: Friday, October 10, 2025 12:59 PM
To: Soo Lee-Cho <sleecho@bregmanlaw.com>; Cindy Hoes <choes@ala-inc.com>; William Rogers <wrogers@bregmanlaw.com>
Subject: [EXTERNAL]Fwd: Temporary Fencing Adjustment - Adventist HealthCare Property

Please see this email below which was just sent by Geoff Morgan:

Lavanya Sithanandam, MD
Owner| Medical Director
Park Pediatrics & Park Travel Clinic

Begin forwarded message:

From: Geoffrey Morgan <GMORGAN@adventisthealthcare.com>
Date: October 10, 2025 at 12:52:49 PM EDT
To: lavanyasith <lavanyasith@gmail.com>
Cc: Jaynie Riel <JRiel@adventisthealthcare.com>, Karmen Brown <KBrown7@adventisthealthcare.com>, Javorka Saracevic <JSaracevic@adventisthealthcare.com>
Subject: Temporary Fencing Adjustment - Adventist HealthCare Property

Dea Dr. Sithanandam,

It was a pleasure to meet you in person at the Condo Board meeting earlier this week. I am hopeful that this initial face-to-face introduction will serve as a foundation for developing a trusting relationship between the Condo Board and Adventist HealthCare, ultimately facilitating a good faith negotiation of a renewed ground lease. Following the meeting, Adventist HealthCare received a request from the City of Takoma Park to delay fencing its property for a few weeks to allow the Condo Board to complete its parking study. Please consider this message as a formal response to the City's request and a demonstration of Adventist HealthCare's commitment to acting in good faith.

Adventist HealthCare (AHC) plans to install a campus fence imminently to proceed with the demolition of the vacant buildings without further delay. The fence will be placed in the locations indicated in the letter delivered to the Condominium on October 7, 2025. However, at the City of Takoma Park's request, AHC is willing to modify the extent of the fencing installation to allow parking along the main driveway from Carroll Avenue to just past the southern entrance to the former Washington Adventist Hospital's physicians' parking lot, thereby providing access to an additional parking area, and temporarily providing a total of 183 parking spaces, far exceeding the 112 provided spaces provided in the original ground lease.

To the extent described in this email, AHC will configure the fencing to allow continued access and utilization of the southern half of the former Washington Adventist Hospital's physicians' parking lot for the use of the Condominium (see attached exhibit). The northern half of this parking lot will be fenced off for use by the demolition contractor. This forbearance from fencing the entirety of the former Washington Adventist Hospital's physicians' parking lot will be in effect through October 31, 2025. If the Condominium and AHC have not negotiated a new parking lease for a suitable amount of parking at commercially fair market value rental rates by that date, AHC reserves the right to fence off the entirety of the former Washington Adventist Hospital physicians' parking lot and revoke the permission granted by this letter to the Condominium for its use. Otherwise, the described fencing will remain throughout the former Washington Adventist Hospital campus for the duration of the demolition process.

Best regards,

Geoffrey Morgan

Geoffrey A. Morgan
Vice President, Chief Facilities & Real Estate Officer

820 W. Diamond Avenue

Suite 600

Gaithersburg, MD 20878

301.315.3374

gmorgan@adventisthealthcare.com
www.adventisthealthcare.com

Maryland

After 112 years, Takoma Park's Washington Adventist Hospital departs for White Oak

August 22, 2019 More than **6 years ago**

By Rebecca Tan

Washington Adventist Hospital is moving from its birthplace in Takoma Park to a $400 million campus in White Oak on Sunday, ending more than a decade of protracted, sometimes contentious negotiations about the future of the 112-year-old institution.

Local officials say the relocation of the community hospital — its largest employer — will be a significant loss, particularly because the hospital has reneged on an earlier pledge to retain several key medical services in the Montgomery County suburb.

But hospital executives and Maryland state regulators say the move is a necessary sacrifice that will allow the institution to leave behind an outdated facility and adapt to changing regional health-care needs as well as broad industry pressures that have threatened the sustainability of hospitals nationwide.

"The county and state are very excited for it, but for us here, it's a loss," Takoma Park Mayor Kate Stewart said.

"You can hear about something for years, but you don't believe it till you see it," added Suzanne Ludlow, the city manager. "Now it's happening, and good or bad, we're all going to be affected."

When the hospital was first opened by Seventh-day Adventist Church leaders in 1907, it served as a sanitarium for D.C. residents seeking an escape from the nation's capital. But in the century since,

sanitarium for D.C. residents seeking an escape from the nation's capital. But in the century since, physicians say, urban bustle has moved into and around Takoma Park, exerting pressure on its aging infrastructure.

It is common to find visitors wandering on the wrong floor of the hospital, which after years of ad hoc extensions, is organized like "a series of boxes held together by a series of corridors," said Christopher Magee, an orthopedic surgeon.

The operating rooms are so small, he added, that during surgeries, nurses occasionally have to run out and around the corner to retrieve equipment that cannot be stored in the room because of a lack of space.

"I've had wonderful memories there, but to be honest with you, it's kind of a relief to move," Magee said.

The White Oak facility is more than twice as large as the one in Takoma Park, with 180 private rooms, compared with about 178 beds — about half in shared rooms — in the old hospital. The private rooms will not cost more than the shared ones in Takoma Park, Adventist representatives said.

More important, state regulators say, the new facility provides easier access to patients not just in Montgomery County, but also in neighboring Prince George's County, which has been plagued for years by a shortage of high-quality health care. (A separate regional medical center is under construction about 20 miles away in Prince George's County, in the Largo Town Center.)

Visitors to the Takoma Park hospital must travel through a narrow, two-lane road that offers little space to cars and emergency vehicles. The new facility, located six miles away, is just off Cherry Hill Road near Route 29, close to Interstate 95, and accessible by two public buses.

Ben Steffen, executive director of the Maryland Health Care Commission, an independent agency that approved Washington Adventist's application to move, said state regulators "think long and hard about relocating a hospital," but decided ultimately that this would allow more Maryland residents, and specifically those from Prince George's, to access a high-quality general hospital.

When Washington Adventist Hospital first sought state approval to move in 2015, President Erik Wangsness pledged to retain "a robust array of health services" in Takoma Park, including a behavioral health unit that provides mental health care and a prenatal clinic serving women without health insurance.

But in 2018, hospital officials applied for state permission to move most of these services out of the city as well, leaving just an urgent-care facility. Local officials, who said at the time that they were "stunned and dismayed" by the news, protested the change to the Maryland Health Care Commission but were unsuccessful.

"We had to ensure that these services were sustainable long term, and part of that was to co-locate them with the acute care services in White Oak," said Robert Jepson, the hospital's vice president of business development. Leaving the stand-alone behavioral health unit in Takoma Park, he said, would have made it difficult for the hospital to receive full reimbursement from public and private insurers.

This decision is part of a larger trend, said Gerard Anderson, director of the Johns Hopkins Center for Hospital Finance and Management. In recent years, for-profit hospitals nationwide have worked to

absorb smaller providers and consolidate market share with the aim of strengthening their negotiating power with large insurers.

In 2017, the consulting company Kaufman Hall recorded 115 transactions among hospitals and health systems in the United States, the highest since it began tracking the numbers in 2000.

Although Adventist HealthCare is a nonprofit network of providers, it is operating in an industry that includes strong financial incentives for providers to consolidate entities and services, Anderson said.

“We’re very sensitive to the fact that there is a loss, but we have to do what we have to do,” Jepson said. “It’s unfortunate, but the challenge for any health-care organization now is how one sustains services in a changing environment.”

At 7 a.m. Sunday, the hospital, renamed Adventist HealthCare White Oak Medical Center, will close its emergency department and most services in Takoma Park.

Starting Monday, a 24/7 urgent-care facility will open at that location to treat minor illnesses such as the flu. Patients with more serious conditions such as chest pains or seizures should go to the emergency department at White Oak, or to Holy Cross Hospital in Silver Spring, officials said.

LIBER 6127 FOLIO 830

PROPERTY IDENTIFIER NO 13-25-1650256

DEED

THIS DEED is made this 31st day of May, 1983, by and between Washington Adventist Hospital, Incorporated, a corporation existing under the laws of Maryland, (the "Hospital") and NuDevCon, Inc., a corporation existing under the laws of Maryland, ("NuDevCon").

WITNESSETH, that in consideration of Eighty-One Thousand and No/100 Dollars ($81,000.00), the Hospital does grant and convey unto NuDevCon, its successors and assigns, in fee simple all of that piece or parcel of land situate, lying and being in Montgomery County, Maryland, as more particularly described in Exhibit A attached hereto and incorporated herein by reference (the "Property"); together with a non-exclusive easement for vehicular and pedestrian access to the Property and for use of general Hospital facilities over the real property retained by the Hospital, of which the Property conveyed hereby is a part, provided, however, that said easement shall not include parking rights except for property which is specifically leased to NuDevCon, its successors and assigns, as a parking lot.

AND the Hospital covenants that it will warrant specially the Property hereby conveyed and that it will execute such further assurances of the Property as may be requisite.

The grant made by this Deed is not part of a transaction in which there is a sale, lease, exchange or other transfer of all or substantially all of the property and assets of the Hospital.

IN WITNESS WHEREOF, the Hospital has caused these presents to be signed in its corporate name by Herbert Z. Shiroma, its President, and attested by Ronald D. Marx, its Secretary, and its corporate seal to be hereunto affixed; and does hereby constitute and appoint Herbert Z. Shiroma, its true and lawful Attorney-in-Fact, for it and in its name to acknowledge and deliver these presents as its act and deed.

WASHINGTON ADVENTIST HOSPITAL, INCORPORATED

(Corporate Seal)

By: [signature]
Herbert Z. Shiroma, President

Attest:

[signature]
Ronald D. Marx, Secretary

AGRICULTURAL TRANSFER TAX IN THE AMOUNT OF $ N/A
SIGNATURE JSY

STATE OF MARYLAND)
) ss:
COUNTY OF MONTGOMERY)

I, Constance C. May, a Notary Public in and for the State and County aforesaid do hereby certify that Herbert Z. Shiroma, who is personally well known to me as (or proved by the oath of credible witnesses to be) the person named as attorney in fact in the foregoing Deed, bearing date on the 31st day of

1983 JUL 18 AM 9 55

CLK.CT.M.C. PAID 5 4 9 6 DED—ECK 15.00

CLK.CT.M.C. PAID 5 4 9 7 —STYECK 356.00

CLK.CT.M.C. PAID 5 4 9 8 —ST ECK 405.00

LERCH, EARLY & ROSTMAN CHARTERED

APPROVED ASSESSMENTS DEPT. DRAFTING SECT 7/15/83

EXHIBIT A

MAY, 1983, and hereto annexed, personally appeared before me in said State and County and as Attorney in fact as aforesaid by virtue of the power vested in him by said Deed, acknowledged the same to be the act and deed of said Corporation for the purposes therein contained.

Notary Public

My Commission expires: 7/1/86

(NOTARY PUBLIC seal — MONTGOMERY COUNTY, MD.)

I, RONALD D. MARX, Secretary of said Corporation do hereby certify that the foregoing Deed was executed in strict conformity with a resolution of the Board of Directors of the said Corporation, organized under the laws of Maryland passed at a duly called meeting of said Corporation, at which a quorum was present, the 16th day of December, 1982.

(Corporate Seal)

Ronald D. Marx, Secretary

This is to certify that this instrument has been prepared under the supervision of the undersigned, an attorney duly admitted to practice before the Court of Appeals of Maryland.

Robert G. Brewer, Jr.

Parcel I.D. No.	13-25-1080256
Property Address:	7600 Carroll Avenue Takoma Park, Maryland 20912
Grantor's Address	7600 Carroll Avenue Takoma Park, Maryland 20912
Grantee's Address:	1350 Piccard Drive Rockville, Maryland 20850
Title Insurer:	None.

DEED RECEIVED FOR RECORD on the day of , A.D. 19 , at o'clock .M., and recorded in Liber No. at Folio , one of the Land Records for Montgomery County, Maryland.

Recorder or Clerk

Return to:

LERCH, EARLY & ROSEMAN, CHARTERED
7101 Wisconsin Avenue, Suite 1313
Bethesda, Maryland 20814
(301) 986-1300
08023

JUL 18 1983
13-25-1080256
Tax Exempt

$ 810 TRANSFER TAX PAID
MONTGOMERY COUNTY, MARYLAND
BY

... THIS PROPERTY HAS BEEN ... THE MONTGOMERY COUNTY ...
... 04/09
TRANSFER CLERK, ASSESSMENT DEPARTMENT

EXHIBIT A

LIBER 6127 FOLIO 832

DEVELOPMENT CONSULTANTS GROUP, INC.

Exhibit A

12408 ROUTE 108 #
CLARKSVILLE MD 21029
301 596 9080
301 988 8830

5316 CRESTEDGE LANE
ROCKVILLE MD 20852
301 460 3826

DESCRIPTION OF PART OF
THE PROPERTY OF WASHINGTON ADVENTIST HOSPITAL
LIBER 4016 FOLIO 244
BUILDING PARCEL
0.3126 ACRES

Being all that piece or parcel of land, situate, lying and being in Takoma Park, 13th Election District, Montgomery County Maryland, also being part of the land conveyed from the Washington Sanitarium and Hospital, Inc. to Washington Sanitarium and Hospital, Inc. by deed dated November 6, 1970 and recorded in Liber 4016 at Folio 244 among the Land Records of Montgomery County, Maryland and being more fully described as follows:

Beginning at a point North 24° 06' 01" East, 181.69 feet from the beginning of the 15th or South 52° 02' 00" East, 193.59 feet line of the 2.8629 acre parcel of land conveyed to the Maryland National Capital Park and Planning Commission by deed recorded in Liber 558 at Folio 272, thence running to include a part thereof

1) North 48° 11' 40" West, 153.00 feet to a point, thence
2) North 41° 48' 20" East, 89.00 feet to a point, thence
3) South 48° 11' 40" East, 153.00 feet to a point, thence
4) South 41° 48' 20" West, 89.00 feet to the place of beginning, containing 0.3126 acres of land.

Subject to any and all easements and rights-of-way of record.

EXHIBIT A

LIBER 6401 FOLIO 626

CONFIRMATORY DEED PARCEL IDENTIFIER NO 13-25-231781 3

THIS CONFIRMATORY DEED is made this 12th day of April, 1984, by WASHINGTON ADVENTIST HOSPITAL, INCORPORATED, a corporation existing under the laws of the State of Maryland (the "Hospital").

VOID NOT 25.00

WHEREAS, the Hospital executed a Deed to NUDEVCON, INC., (also known of record as NuDevCon, Inc.) a corporation existing under the laws of the State of Maryland ("NUDEVCON"), dated May 31, 1983, and recorded in the Land Records for Montgomery County, Maryland, on July 18, 1983, in Liber 6127, at Folio 830 (the "Deed"); and

DEED 25.00
MISC. 1.00

WHEREAS, the description of the property set forth in Exhibit A attached to the Deed was incorrect; and

WHEREAS, the Hospital desires to correct the error in the property description and confirm all other provisions in the Deed.

NOW, THEREFORE, in consideration of the sum of Ten Dollars ($10.00) and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Hospital declares the following:

1. The Recitals are incorporated herein by reference.

2. The description of the property conveyed by the Deed shall be corrected to read as set forth in Exhibit A attached hereto and incorporated herein by reference (the "Property"). The Hospital does hereby grant, confirm and convey unto NUDEVCON, its successors and assigns, in fee simple all of that piece or parcel of land situate, lying and being in

1984 MAY 18 AM 11:07
MAY 18 11:07
CLERK'S OFFICE
MONTGOMERY COUNTY, MD

55.00

N/A

Verified By:

EXHIBIT A

Montgomery County, Maryland, as more particularly described in Exhibit A, together with a non-exclusive easement for vehicular and pedestrian access to the Property and for use of general Hospital facilities over the real property retained by the Hospital, of which the Property conveyed hereby is a part, provided, however, that said easement shall not include parking rights except for property which is specifically leased to NUDEVCON, its successors and assigns, as a parking lot.

3. All other provisions of the Deed shall remain in full force and effect.

4. The Hospital certifies under the penalties of perjury that there is no consideration requiring the payment of transfer taxes involved with this Confirmatory Deed.

IN WITNESS WHEREOF, the Hospital has caused these presence to be signed by its corporate name by Ronald D. Marx, its President, and attested by its Secretary, and its Corporate Seal to be hereunto affixed; and does hereby constitute and appoint Ronald D. Marx its true and lawful attorney in fact, for it and in its name to acknowledge and deliver these presents as its act and deed.

WASHINGTON ADVENTIST HOSPITAL, INCORPORATED

By: R. D. Marx
Ronald D. Marx, President

ATTEST:

Asst. Secretary

(Corporate Seal)

EXHIBIT A

NUDEVCON, INC. consents to this Confirmatory Deed and has caused this Confirmatory Deed to be duly executed on its behalf by Boyd O. Bower, President and attested by its Secretary, and its Corporate Seal to be hereunto affixed, in order to confirm the original intent to convey the Property to NUDEVCON, INC. and to acknowledge the original instrument was defective as to the real property conveyed and does not reflect the parties' intent at the time it was executed with respect to the property conveyed.

ATTEST:

Secretary
Cornelius Davis

NUDEVCON, INC.

By: Boyd O. Bower
Boyd O. Bower, President

(Corporate Seal)

STATE OF MARYLAND)
) ss:
COUNTY OF MONTGOMERY)

On this 12th day of April, 1984, before me, the undersigned officer personally appeared RONALD D. MARX, who acknowledged himself to be the President of WASHINGTON ADVENTIST HOSPITAL, a corporation, and that he, as such President, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by himself as President.

In Witness Whereof, I hereunto set my hand and official seal.

Suzanne A. Queen
Notary Public

My Commission expires: July 1, 1986.

STATE OF MARYLAND)
) ss:
COUNTY OF MONTGOMERY)

On this 12th day of April, 1984, before me, the undersigned officer personally appeared BOYD O. BOWER, who acknowledged himself to be the President of NUDEVCON, INC., a corporation, and that he, as such President, being authorized so

EXHIBIT A

to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by himself as President.

In Witness Whereof, I hereunto set my hand and official seal.

KATHLEEN G. HUBBARD, NOTARY PUBLIC
PRINCE GEORGE'S COUNTY
My Commission Expires July 1, 1986

Notary Public

My Commission expires: July 1, 1986.

THIS IS TO CERTIFY that this instrument has been prepared under the supervision of the undersigned, an attorney duly admitted to practice before the Court of Appeals of Maryland.

Cindi E. Cohen

Parcel I.D. No.:	13-25-2317813 Formerly - 13-25-1080256
Property Address:	7610 Carroll Avenue Formerly - 7600 Carroll Avenue Takoma Park, Maryland 209
Grantor's Address:	7600 Carroll Avenue Takoma Park, Maryland 20912
Grantee's Address:	1350 Piccard Drive Rockville, Maryland 20850
Title Insurer:	None.

#1047
04094/5

MAY 18 1984

13-25-2317813

All taxes on assessments certified to the Collector of Montgomery County ... have been paid ...

TRANSFER WITHOUT CONSIDERATION

... MONTGOMERY COUNTY

12242

... ASSESSMENT DEPARTMENT

EXHIBIT A

DEVELOPMENT CONSULTANTS GROUP, INC.

12408 ROUTE 108
CLARKSVILLE, MD. 21029
301-596-9080
301-588-9530

5316 CRESTEDGE LANE
ROCKVILLE, MD. 20853
301-460-3826
301-854-0157

EXHIBIT A

Being all that piece or parcel of land, situate, lying and being in Takoma Park, 13th Election District, Montgomery County Maryland, also being part of the land conveyed from the Washington Sanitarium and Hospital, Inc. to Washington Sanitarium and Hospital, Inc. by deed dated November 6, 1970 and recorded in Liber 4016 at Folio 244 among the Land Records of Montgomery County, Maryland and being more fully described as follows:

Beginning at a point North 23° 05' 18" East, 172.19 feet from the beginning of the 15th or South 52° 02' 00" East, 193.59 feet line of the 2.8629 acre parcel of land conveyed to the Maryland National Capital Park and Planning Commission by deed recorded in Liber 558 at Folio 272, thence running to include a part thereof

1) North 48° 11' 40" West, 153.00 feet to a point, thence
2) North 41° 48' 20" East, 89.00 feet to a point, thence
3) South 48° 11' 40" East, 153.00 feet to a point, thence
4) South 41° 48' 20" West, 89.00 feet to the place of beginning containing 0.3126 acres of land.

Subject to any and all easements and rights-of-way of record.

EXHIBIT A

LIBER 6442 FOLIO 367

DECLARATION

OF

WASHINGTON ADVENTIST AMBULATORY CARE CENTER, A CONDOMINIUM

(Non-Residential)

LAW OFFICES
LERCH, EARLY, ROSEMAN & FRANKEL
CHARTERED
SUITE 1313
7101 WISCONSIN AVENUE
BETHESDA, MARYLAND 20814-4862
(301) 986-1300

239.00
30

Verified By: CB

TABLE OF CONTENTS

DECLARATION

OF

WASHINGTON ADVENTIST AMBULATORY CARE CENTER, A CONDOMINIUM

(Non-Residential)

THIS DECLARATION, (the "Declaration") is made and entered into this 7th day of June, 1984, by NUDEVCON, INC., a corporation organized and existing under the laws of the State of Maryland, hereinafter and in the Exhibits hereto sometimes called the "Declarant":

WHEREAS, the Declarant is the owner in fee simple of certain land and premises located in the County of Montgomery, State of Maryland, and more particularly described on "EXHIBIT A" attached hereto and incorporated herein by reference; and,

WHEREAS, the Declarant is the owner of certain buildings and other improvements constructed upon the aforesaid premises, which property constitutes a "condominium" pursuant to Title 11, Real Property Article, Section 11-101, et seq., of the Annotated Code of Maryland (1981 Repl. Vol. and 1983 Supp.) and it is the desire and intention of the Declarant to divide said property and the improvements thereon into condominium units and to sell and convey the same subject to the covenants, restrictions, uses, limitations, obligations, easements, equitable servitudes, charges and liens, hereinafter set forth, each of which is for the benefit of said property and the subsequent owners thereof; and,

WHEREAS, prior to the recordation hereof, the Declarant has filed for record in the office of the Clerk of Court for the Circuit Court for Montgomery County, Maryland, a certain Plat, hereinafter referred to as the "Condominium Plat", which Condominium Plat, consisting of 5 sheet(s), is recorded in Condominium Plat Book 34, beginning at plat 3600-3604; and,

WHEREAS, the Declarant desires and intends by the recordation of the Condominium Plat and this Declaration, to submit the property described on "EXHIBIT A" attached hereto, together with the improvements heretofore or hereafter constructed thereon, and all appurtenances thereto, to the provisions of Title 11, Real Property Article, Section 11-101, et seq., of the Annotateu Code of Maryland (1981 Repl. Vol. and 1983 Supp.) as a condominium:

NOW, THEREFORE, the Declarant hereby declares that all of the property described on "EXHIBIT A" attached hereto, together with all improvements heretofore or hereafter constructed thereon, and all appurtenances thereto, shall be held, conveyed, divided or subdivided, leased, rented and occupied, improved, hypothecated and encumbered subject to the covenants, restrictions, uses, limitations, obligations, easements, equitable servitudes, charges and liens (hereinafter sometimes referred to as "covenants and restrictions") hereinafter set forth, including the provisions of the By-Laws of the Council of Unit Owners of the condominium, attached hereto as "EXHIBIT B" and incorporated herein by reference, all of which are declared and agreed to be in aid of a plan for improvement of said property, and the division thereof into

LAW OFFICES
LERCH EARLY ROSEMAN & FRANKEL
CHARTERED
SUITE 1111
7101 WISCONSIN AVENUE
BETHESDA, MARYLAND 20814-4882
(301) 986-1300

condominium units and common elements, and shall be deemed to run with and bind the land, and shall inure to the benefit of and be enforceable by the Declarant, its successors and assigns, and any person acquiring or owning an interest in said property and improvements, including, without limitation, any person, group of persons, corporation, partnership, trust or other legal entity, or any combination thereof, who holds such interest solely as security for the performance of an obligation.

ARTICLE I

Section 1. Definitions.

(a) "The Act" or "the Condominium Act" means Title 11, Section 11-101, et seq., Real Property Article, Annotated Code of Maryland (1981 Repl. Vol. and 1983 Supp.) and shall include any revisions thereof and amendments and supplements thereto which are enacted subsequent to the date of this Declaration and which are not inconsistent with the provisions hereof.

(b) "Board of Directors" means the Board of Directors of Washington Adventist ACC Condominium Association, Inc.

(c) "Common elements" means both general common elements and limited common elements, as hereinafter and on the Condominium Plat described and identified, and shall include all of the Condominium except the condominium units.

(d) "Common expenses and common profits" means the expenses and profits of the Council of Unit Owners.

(e) "Condominium" or "the condominium project" means the property subjected to the condominium regime pursuant to this Declaration.

(f) "Council of Unit Owners" means all of the unit owners in association, comprising the Washington Adventist ACC Condominium Association, Inc.

(g) "Mortgagee" means the holder of any recorded mortgage, or the party secured or beneficiary of any recorded deed of trust, encumbering one or more of the condominium units in the Condominium. "Mortgage", as used herein, shall include deed of trust. "First mortgage" as used herein, shall mean a mortgage with priority over all other mortgages. As used in this Declaration, the term "mortgagee" shall mean any mortgagee and shall not be limited to institutional mortgagees.

(h) "Property" means the land described on "Exhibit A", together with the improvements heretofore or hereafter constructed thereon, as more particularly described on the Condominium Plat.

(i) "Unit" or "condominium unit" means a three dimensional area, as hereinafter and on the Condominium Plat described and identified, and shall include all improvements contained within that area except those excluded in this Declaration.

(j) "Unit owner" or "owner" means any person, group of persons, corporation, partnership, trust or other legal entity,

or any combination thereof, who holds legal title to a unit within the Condominium; provided, however, that any person, group of persons, corporation, partnership, trust or other legal entity, or any combination thereof, who holds such interest solely as security for the performance of an obligation shall not be a unit owner by reason only of such interest.

Section 2. Other Definitions. Unless it is plainly evident from the context that a different meaning is intended, all other terms used herein shall have the same meaning as they are defined to have in the By-Laws of the Council of Unit Owners or in Title 11, Section 11-101, et seq., Real Property Article, Annotated Code of Maryland (1981 Repl. Vol. and 1983 Supp.).

Section 3. Name. The name by which the Condominium is to be identified is as follows: Washington Adventist Ambulatory Care Center, a Condominium.

ARTICLE II

Section 1. Property Subject to Declaration. The property which is, and shall be, held, conveyed, divided or subdivided, hypothecated or encumbered, sold, leased, rented, used, occupied, and improved subject to this Declaration and the provisions of the Condominium Act is located in the County of Montgomery, State of Maryland, and is more particularly described on "EXHIBIT A" attached hereto and incorporated herein by reference, together with improvements now existing and to be constructed thereon.

Section 2. Condominium Plat. The Condominium Plat is incorporated herein by reference.

ARTICLE III

Section 1. The Condominium Units. The general description and number of each condominium unit in the Condominium, including its perimeters, approximate dimensions, floor area, identifying number or letter, location and such other data as may be sufficient to identify it with reasonable certainty, is set forth on the Condominium Plat.

(a) The lower boundary of any condominium unit in the Condominium is a horizontal plane (or planes) the elevation of which coincides with the elevation of the upper surface of the unfinished concrete subfloor or slab thereof (to include any finished flooring materials within the condominium unit), extended to intersect the lateral or perimetrical boundaries thereof. The upper boundary of any condominium unit in the Condominium is a horizontal plane, (or planes) the elevation of which coincides with the lower surface of the steel open web joists thereof, to exclude such joists from that condominium unit but to include the suspended ceiling thereof (including T-bars, hanger wires and primary runner channels as well as the suspended ceiling materials themselves), extended to intersect the lateral or perimetrical boundaries thereof. The lateral or perimetrical boundaries of any condominium unit are as follows: (1) for a unit with lateral or perimetrical boundaries between itself and other condominium units, those boundaries shall be the vertical planes which coincide with the centerline of the

party walls which divide that unit from adjacent units, as shown on the Condominium Plat, extended to intersect the upper and lower boundaries thereof and to intersect the other lateral or perimetrical boundaries of that condominium unit; (2) for a unit with boundaries on outside walls of the Condominium Building, those lateral or perimetrical boundaries are vertical planes which coincide with the unexposed (i.e., unfinished) surfaces of the perimeter drywall thereof, to include the perimeter drywall and plenums, if any, trim, windows and doors thereof, (but where the outer building wall is fifty percent (50%) or more of glass, the lateral or perimetrical boundaries are vertical planes which coincide with the inside surface of such glass area) extended to intersect the upper and lower boundaries thereof and to intersect the other lateral or perimetrical boundaries of that condominium unit; and (3) for a unit with boundaries bordering corridors constituting common elements or limited common elements, those lateral or perimetrical boundaries are vertical planes which coincide with the finished surface of the corridor side of the corridor partition.

(b) Equipment and appurtenances located within any condominium unit and designed or installed to serve only that unit to the exclusion of all other units, including, without limiting the generality of the foregoing, exhaust fans and other air-handling and air-conditioning equipment, mechanical equipment, appliances, non-bearing partition walls, lath, furring, drywall or wallboard, plasterboard, plaster, paneling, wallpaper, paint, plenums, windows, doors and trim, lighting fixtures, flooring materials, tile, carpets, T-bars, hanger wires, primary runner channels, suspended ceiling materials and devices, electrical receptacles and outlets, plumbing fixtures and outlets and other plumbing apparatus, fixtures, cabinets and the like, shall be considered a part of that condominium unit and not a part of the common elements. Equipment and appurtenances located outside the boundaries of any condominium unit but designed or installed in a manner to serve only a particular condominium unit to the exclusion of all others, including without limiting the generality of the foregoing, heat pumps, furnaces, condensors, compressors, air-handling equipment, air-conditioning equipment, compressor pads, ducts, pipes, tubes, and the like shall be considered a part of the condominium unit which they are designated or designed to serve and shall not be considered a part of the common elements.

Section 2. Easements. Any and all pipes, ducts, flues, chutes, conduits, cables, wires and wire outlets, utility lines and the like located within or accessible only from any particular unit, but which are designed or installed to serve all units are common elements. Each condominium unit shall be subject to an easement to the owners of all of the other condominium units to and for the unobstructed and uninterrupted use of such pipes, ducts, flues, chutes, conduits, cables, wires and wire outlets, utility lines and the like, and any other common elements located within or accessible only from any particular condominium unit, and for support.

ARTICLE IV

Section 1. Limited Common Elements. The limited common elements of the Condominium are those common elements designated as such on the Condominium Plat and such other common elements as are agreed upon by all of the unit owners to be reserved for the exclusive use of one or more, but less than all of the unit owners. Any area designated on the Condominium Plat as a limited common element is reserved for the exclusive use of the owner or owners of the condominium unit or units to which such area is adjacent or to which such area is declared to be appurtenant by appropriate designation on the Condominium Plat.

Section 2. General Common Elements. The general common elements are the real property described on "EXHIBIT A" and consist of all of the Condominium except the condominium units and the limited common elements.

Section 3. Covenant Against Partition. The common elements, both general and limited, shall remain undivided. No owner of any condominium unit or any other person shall bring any action for partition or division thereof except as may be provided for in the Condominium Act.

Section 4. Easements. The common elements of the Condominium shall be subject to mutual rights of support, access, use and enjoyment by all of the unit owners; provided, however, that any portion of the common elements designated as limited common elements is reserved for the exclusive use of the owner or owners of the condominium unit or units to which it is adjacent or to which it is declared to be appurtenant by appropriate designation on the Condominium Plat.

ARTICLE V

Section 1. The Condominium Units. Each condominium unit in the Condominium shall have all of the incidents of real property.

Section 2. Undivided Percentage Interests in Common Elements. Each unit owner shall own an undivided percentage interest in the common elements of the Condominium equal to that set forth on "EXHIBIT C" attached hereto and incorporated herein by reference. The undivided percentage interest in the common elements set forth on "EXHIBIT C" shall have a permanent character and, except as specifically provided in the Condominium Act, may not be changed without the written consent of all of the unit owners and the holders of all mortgages on the condominium units. The undivided percentage interests in the common elements set forth on "EXHIBIT C" may not be separated from the condominium unit to which they appertain. Any instrument, matter, circumstance, action, occurrence or proceeding in any manner affecting a condominium unit also shall affect, in like manner, the undivided percentage interest in the common elements appertaining to such unit, whether or not such percentage interest is expressly described or mentioned.

Section 3. Percentage Interest in Common Expenses and Common Profits. Each unit owner shall have a percentage interest in the common expenses and common profits of the Condominium equal

to that set forth on "EXHIBIT D". The undivided percentage interests in the common expenses and common profits set forth on "EXHIBIT D" shall have a permanent character and, except as specifically provided in the Condominium Act, may not be changed without the written consent of all of the unit owners and the holders of all mortgages on the condominium units. The undivided percentage interests in the common expenses and common profits set forth on "EXHIBIT D" may not be separated from the condominium unit to which they appertain. Any instrument, matter, circumstance, action, occurrence or proceeding in any manner affecting a condominium unit also shall affect, in like manner, the undivided percentage interests in the common expenses and common profits appertaining to such unit, whether or not such percentage interest is expressly described or mentioned.

Section 4. Voting Rights. At any meeting of the Council of Unit Owners, each unit owner shall be entitled to cast one vote on each question at any meeting of the Council of Unit Owners for each square foot contained in his condominium unit as defined in accordance with definitions utilized by the Washington Board of Realtors as of the date hereof, a copy of which definitions are attached hereto as "Exhibit E" and incorporated herein by reference.

ARTICLE VI

Section 1. Party Walls. Each wall which is built as a part of the original construction of the Condominium and placed upon the dividing line between two condominium units, or partly within one condominium unit and partly within another condominium unit, all as may be shown on the Condominium Plat, shall constitute a party wall and, to the extent not inconsistent with the other provisions of this Declaration, the general rules of law regarding party walls and of liability for property damage due to negligent or willful acts or omissions shall apply thereto; provided, however, that structural load-bearing columns shown on the Condominium Plat are part of the general common elements of the Condominium and are not a part of the condominium units.

Section 2. Repairs and Maintenance. The cost of reasonable repairs and maintenance of a party wall shall be shared by the unit owners who make use of the party wall, in equal shares. Nothing shall be done by any unit owner which impairs the structural integrity of any party wall or which diminishes or is calculated to diminish the fire protection afforded by any party wall. No unit owner shall use any party wall for any purpose which creates a hazard or nuisance for any other unit owner who makes use of that party wall.

Section 3. Destruction by Fire or Other Casualty. In the event a party wall is destroyed or damaged by fire or other casualty, and in the event that the restoration thereof is not accomplished by the Council of Unit Owners, any unit owner who has used the party wall may restore it; and if the other unit owners thereafter make use of the party wall, then they shall contribute to the cost of restoration thereof in proportion to such use without prejudice, however, subject to the right of any unit owner to call for a larger contribution from the other unit owners under any rule of law regarding liability for negligent or willful acts or omissions.

Section 4. Weatherproofing. Notwithstanding any other provision of this Declaration, any unit owner who by his negligent or willful act, causes a party wall to be exposed to the elements shall bear the entire cost of furnishing the necessary protection against the elements.

Section 5. Right to Contribution Runs With Land. The right of any unit owner to contribution from any other unit owner under this Article VI shall be appurtenant to the condominium unit and shall pass to that unit owner's successors and assigns.

ARTICLE VII

Section 1. Encroachments. In the event any portion of the common elements encroaches upon any condominium unit, or in the event any condominium unit encroaches upon any other condominium unit or any common element, as a result of settlement, shifting, or the duly authorized construction or repairs, a valid easement for the encroachment and for the maintenance of the same shall exist so long as the building stands. In the event any portion of the Condominium is partially or totally damaged or destroyed by fire or other casualty, or as a result of condemnation or eminent domain proceedings, and then repaired or reconstructed as authorized in the By-laws of the Council of Unit Owners and the Condominium Act, encroachments of any portion of the common elements upon any condominium unit or of any condominium unit upon any other condominium unit or upon any portion of the common elements due to such repair or reconstruction shall be permitted, and valid easements for such encroachments and the maintenance of the same shall exist so long as the building stands. For all purposes incident to the interpretation of deeds, the Condominium Plat and all other instruments of title relating to any condominium unit in the condominium project, the existing physical boundaries of any condominium unit constructed or reconstructed in substantial conformity with the Condominium Plat shall be conclusively presumed to be its boundaries, regardless of the shifting, settling or lateral movement of any building and regardless of minor variations between the physical boundaries shown on the Condominium Plat and those of any condominium unit.

Section 2. Easement to Declarant. There is hereby reserved to the Declarant, its employees, agents, contractors and invitees, a non-exclusive easement and right-of-way over all of the common elements of the Condominium for purposes of ingress, egress, regress, vehicular parking, the storage of building supplies, materials and equipment and without limitation, for any and all purposes reasonably related to the completion of the marketing, sale, inspection, construction, rehabilitation, restoration, repair and management of the Condominium and the condominium units. As used in this Section 2 of this Article VII, and anything contained in this Declaration to the contrary notwithstanding, the expression "Declarant" shall include and mean those successors and assigns of the Declarant to whom the Declarant shall specifically assign the easement reserved in this Section 2, and shall include and mean the respective employees, agents, contractors and invitees of such successors and assigns. This easement shall terminate one year from the recordation of this Declaration or upon the termination of the Condominium.

Section 3. Easements for Ingress and Egress. There is hereby reserved to all persons having any interest of record in title to the land and premises described on "Exhibit A", attached to this Declaration, and to their respective agents, employees and tenants, a non-exclusive easement and right-of-way over all driveways and parking areas constructed upon the general common elements of the Condominium or leased to the Declarant or the Council of Unit Owners for purposes of ingress and egress to and from the land and premises described on "Exhibit A" attached to the Declaration and the adjacent public streets.

ARTICLE VIII

Section 1. Rights of WSSC. In the event that any sewer or water use charge, or front foot benefit charge, or sewer charge, or ad valorem or other tax, imposed upon the entire Condominium pursuant to the Washington Suburban Sanitary District Act is not paid by the Council of Unit Owners when due, then the Washington Suburban Sanitary Commission shall have the right, within the time provided by that Act or the Regulations of said Commission, to terminate sewer and water service to all of the condominium units. There is hereby reserved to the Washington Suburban Sanitary Commission and to the Agency which is a successor to the functions of the Washington Suburban Sanitary Commission, and to their respective agents, employees and contractors, a non-exclusive easement over all of the general common elements of the Condominium for any and all purposes reasonably related to the construction, reconstruction, maintenance or repair of any and all water and sewer lines, meters, vaults and the like located upon the common elements of the Condominium.

ARTICLE IX

Section 1. Duty to Maintain. Except for maintenance requirements herein imposed upon the Council of Unit Owners, the owner of any condominium unit shall, at his own expense, maintain the interior of his condominium unit and any and all equipment, appliances or fixtures therein situate, and its other appurtenances (including such appurtenances designated herein or in the Declaration or the Condominium Plat as limited common elements reserved for exclusive use by the owner of that particular condominium unit, and including all mechanical equipment and appurtenances located outside such unit which are designed, designated or installed to serve only that unit), in good order, condition and repair, and in a clean and sanitary condition, and shall do all redecorating, repairs, painting and the like which may at any time be necessary to maintain the good appearance of his condominium unit. In addition to the foregoing, the owner of any condominium unit shall, at his own expense, maintain, repair, replace any plumbing and electrical fixtures, plenums, heating and air-conditioning equipment, lighting fixtures, and other equipment that may be in or declared to be appurtenant to such condominium unit. The owner of any condominium unit shall also, at his own expense, keep any other limited common elements reserved for his exclusive use in a clean, orderly and sanitary condition.

Section 2. Windows and Doors. The owner of any condominium unit shall, at his own expense, clean and maintain both the interior and exterior surfaces of all windows of such

condominium unit and shall, at his own expense, clean and maintain both the interior and exterior surfaces of all doors of the condominium unit. Notwithstanding the provisions of this Section, the Board of Directors may resolve to clean the exterior surfaces of all windows and doors in the Condominium at common expense in accordance with a schedule to be determined by the Board of Directors.

Section 3. Parking - General Requirements. Except for those parking areas designated on the Condominium Plat as limited common elements, if any, all parking areas within the Condominium or leased to the Declarant or the Council of Unit Owners outside of the boundaries of the Condominium shall be considered part of the general common elements. Parking upon the general common areas may be regulated by the Board of Directors of the Council of Unit Owners.

Section 4. Access at Reasonable Times. The Council of Unit Owners shall have an irrevocable right and an easement to enter condominium units for the purpose of making repairs to the common elements. Except in cases involving manifest danger to public safety or property, the Council of Unit Owners shall make a reasonable effort to give notice to the owner of any condominium unit to be entered for the purpose of such repairs. No entry by the Council of Unit Owners for the purpose specified in this Section may be considered a trespass.

Section 5. Easement for Utilities and Related Purposes. Subject to any limitations provided for in the Condominium Act, the Council of Unit Owners is authorized and empowered to grant (and shall from time to time grant) such licenses, easements and rights-of-way over the general common elements for sewer lines, water lines, electrical cables, telephone cables, gas lines, storm drains, overhead or underground conduits and such other purposes related to the provision of public utilities to the Condominium as may be considered necessary and appropriate by the Board of Directors for the orderly maintenance, preservation and enjoyment of the common elements or for the preservation of the heath, safety, convenience and welfare of the owners of the condominium units or the Declarant.

ARTICLE X

Section 1. Notice to Board of Directors. Any owner of any condominium unit in the Condominium who mortgages such unit shall promptly notify the Board of Directors of the name and address of his mortgagee and, if requested so to do, shall file a conformed copy of such mortgage with the Board of Directors. The Board of Directors shall maintain suitable records pertaining to such mortgages.

Section 2. Notice of Meetings. Any institutional mortgagee of any condominium unit in the Condominium who desires notice of the annual and special meetings of the Council of Unit Owners shall notify the Secretary of the Council to that effect by Certified Mail-Return Receipt Requested. Any such notice shall contain the name and post office address of such institutional mortgagee and the name of the person to whom notice of the annual and special meetings of the Council of Unit Owners should be addressed. The Secretary of the Council of Unit Owners shall

maintain a roster of all institutional mortgagees from whom such notices are received and it shall be the duty of the Secretary to mail or otherwise cause the delivery of a notice of each annual or special meeting of the Council of Unit Owners to each such institutional mortgagee, in the same manner, and subject to the same requirements and limitations as are provided for notice to the members. Any such institutional mortgagee shall be entitled to designate a representative to attend any annual or special meeting of the Council of Unit Owners and such representative may participate in the discussion at any such meeting and may, upon his request made to the Chairman in advance of the meeting, address the unit owners present at any such meeting. Such representative shall have no voting rights at any such meeting. Such representative shall be entitled to copies of the minutes of all meetings of the unit owners upon request made in writing to the Secretary of the Council.

Section 3. Consents. Any other provision of the Bylaws or of this Declaration to the contrary notwithstanding, neither the unit owners, the Board of Directors nor the Council of Unit Owners shall, by act or omission, take any of the following actions without the prior written consent and approval of the holders of all first mortgages of record on the condominium units:

(a) abandon or terminate the Condominium except for abandonment or termination provided in the Condominium Act in the case of substantial damage or destruction of the Condominium by fire or other casualty or in the case of a taking by condemnation or eminent domain; or

(b) modify or amend this Declaration or the Bylaws so as to change the percentage interests of the unit owners in the common elements of the Condominium, the percentage interests of the unit owners in the common expenses and common profits of the Condominium or the voting rights of the unit owners; or

(c) modify the method of determining and collecting common expense assessments or other assessments as provided in Article VIII of the Bylaws; or

(d) abandon, partition, subdivide, encumber, sell or transfer any of the common elements of the Condominium; provided, however, that the granting of easements and rights-of-way for public utilities or for other public purposes consistent with the continued use of the common elements by the unit owners shall not be deemed a transfer within the meaning of this subparagraph (d); or

(e) transfer any or all of their interest in the leasehold estate for parking from Washington Adventist Hospital, Incorporated to Declarant, as assigned by Declarant to the Council of Unit Owners.

(f) resolve to use the proceeds of casualty insurance for any purpose other than the repair, replacement or reconstruction of the Condominium.

Section 4. Subdivision or Partition. No condominium unit in the Condominium shall be subdivided or partitioned without the

prior written approval of the holder of any first mortgage on such condominium unit.

Section 5. Casualty Losses. In the event of damage or destruction of any Condominium unit or any part of the common elements of the Condominium the Board of Directors of the Council of Unit Owners shall give prompt written notice of such damage or destruction to the holders of all first mortgages of record on the condominium units. No provision of the Declaration or these Bylaws shall entitle any unit owner to any priority over the holder of any first mortgage of record on his condominium unit with respect to the distribution to such unit owner of any insurance proceeds.

Section 6. Condemnation or Eminent Domain. In the event any condominium unit or any part of the common elements of the Condominium is made the subject matter of any condemnation or eminent domain proceeding, or is otherwise sought to be acquired by any condemning authority, then the Board of Directors of the Council of Unit Owners shall give prompt written notice of any such proceeding or proposed acquisition to the holders of all mortgages of record on the condominium units. No provision of this Declaration or the Bylaws shall entitle any unit owner to any priority over the holder of any mortgage of record on his condominium unit with respect to the distribution to such unit owner of the proceeds of any condemnation award of settlement.

ARTICLE XI

Section 1. Amendment. Except as otherwise provided in the Condominium Act, and in this Declaration, this Declaration may be amended only with the written consent of all of the unit owners and the holders of all mortgages on the condominium units in the Condominium. Any such amendment shall be effective only upon the recordation of a Declaration of Amendment among the Land Records for Montgomery County, Maryland.

Section 2. Termination and Waiver. The condominium regime established by the recordation of this Declaration and the Condominium Plat may be terminated by Deed of Termination executed by all of the unit owners and, in a manner to indicate their consent to such termination, by all persons with recorded encumbrances, including judgment lienors, on the condominium units in the Condominium, all in the manner provided in the Condominium Act. Any such termination shall be effective only upon the recordation of a Deed of Termination among the Land Records for Montgomery County, Maryland.

ARTICLE XII

Section 1. Construction and Enforcement. The provisions hereof shall be liberally construed to facilitate the purpose of creating a uniform plan for the creation and operation of a condominium. Enforcement of these covenants and restrictions and of the Bylaws attached hereto shall be by any proceeding at law or in equity against any person or persons violating or attempting to violate any covenant or restriction, either to restrain or enjoin violation or to recover damages, or both, and against any condominium unit to enforce any lien; and the failure or forebearance by the Council of Unit Owners or the

owner of any condominium unit to enforce any covenant or restriction herein contained shall in no event be deemed a waiver of the right to do so thereafter. There shall be and there is hereby created and declared to be a conclusive presumption that any violation or breach or any attempted violation or breach of any of the within covenants or restrictions cannot be adequately remedied by action at law or exclusively by recovery of damages.

Section 2. Severability. Invalidation of any one of these covenants or restrictions by judgment, decree or order shall in no way affect any other provisions hereof, each of which shall remain in full force and effect.

Section 3. Captions. The captions contained in this Declaration are for convenience only and are not a part of this Declaration and are not intended in any way to limit or enlarge the terms and provisions of this Declaration.

IN WITNESS WHEREOF, NUDEVCON, INC., a corporation organized and existing under the laws of the State of Maryland, has caused these presents to be executed in its name by Boyd O. Bower, President, the year and day first above written.

ATTEST: NUDEVCON, INC.

Cornelius Davies Secretary

By: Boyd O. Bower, President

STATE OF MARYLAND)
) ss:
COUNTY OF MONTGOMERY)

I HEREBY CERTIFY THAT on this 21st day of June, 1984, before the undersigned, a Notary Public of the State and County aforesaid, personally appeared BOYD O. BOWER, who is personally well known to me (or satisfactorily proved) to be the person who executed the foregoing instrument as President of NuDevCon, Inc., who acknowledged himself to be President of NuDevCon, Inc., and that he, as President, being authorized so to do, executed the foregoing instrument for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

Notary Public

My Commission Expires:

KATHLEEN G. HUSSARD, NOTARY PUBLIC
PRINCE GEORGES COUNTY
My Commission Expires July 1, 1986

THIS IS TO CERTIFY that the within instrument was prepared under the supervision of the undersigned, an attorney duly admitted to practice before the Court of Appeals of Maryland.

Cindi E. Cohen

Parcel Identifier: 13-25-2317813

Address of Declarant: 1350 Piccard Drive
Rockville, Maryland 20850

Property Address: 7610 Carroll Avenue
Takoma Park, Maryland

Title Insurer: None

#0085
06264/14

DEVELOPMENT CONSULTANTS GROUP, INC.

12408 ROUTE 108
CLARKSVILLE, MD. 21029
301-596-9080
301-988-9830

5316 CRESTEDGE LANE
ROCKVILLE, MD. 20853
301-460-3826
301-854-0157

EXHIBIT A

Being all that piece or parcel of land, situate, lying and being in Takoma Park, 13th Election District, Montgomery County Maryland, also being part of the land conveyed from the Washington Sanitarium and Hospital, Inc. to Washington Sanitarium and Hospital, Inc. by deed dated November 6, 1970 and recorded in Liber 4016 at Folio 244 among the Land Records of Montgomery County, Maryland and being more fully described as follows:

Beginning at a point North 23° 05' 18" East, 172.19 feet from the beginning of the 15th or South 52° 02' 00" East, 193.59 feet line of the 2.8629 acre parcel of land conveyed to the Maryland National Capital Park and Planning Commission by deed recorded in Liber 558 at Folio 272, thence running to include a part thereof

1) North 48° 11' 40" West, 153.00 feet to a point, thence
2) North 41° 48' 20" East, 89.00 feet to a point, thence
3) South 48° 11' 40" East, 153.00 feet to a point, thence
4) South 41° 48' 20" West, 89.00 feet to the place of beginning containing 0.3126 acres of land.

Subject to any and all easements and rights-of-way of record.

CLERK'S NOTATION
Document submitted for record in a condition not permitting satisfactory photographic reproduction.

"EXHIBIT B"

BYLAWS

WASHINGTON ADVENTIST ACC

CONDOMINIUM ASSOCIATION, INC.

(Non-Residential)

LAW OFFICES
LERCH, EARLY, ROSEMAN & FRANKEL
CHARTERED
SUITE 1300
7101 WISCONSIN AVENUE
BETHESDA, MARYLAND 20814-4892

(301) 986-1300

TABLE OF CONTENTS

"EXHIBIT B"

BYLAWS

WASHINGTON ADVENTIST ACC

CONDOMINIUM ASSOCIATION, INC.

(Non-Residential)

ARTICLE I

Section 1. Name and location. The name of the Council of Unit Owners is as follows:

WASHINGTON ADVENTIST ACC CONDOMINIUM ASSOCIATION, INC.

Its principal office and mailing address is initially as follows:

c/o NuDevCon, Inc.
1350 Piccard Drive, Ste. 200
Rockville, Maryland 20850

ARTICLE II
Definitions

Section 1. Declaration. "Declaration", as used herein, means that certain Declaration made the day of , 1984 by the Declarant therein identified, pursuant to Title 11, Real Property Article, Annotated Code of Maryland (1981 Repl. Vol.) and as amended, by which certain described premises (including land) are submitted to a condominium property regime and which Declaration is recorded among the Land Records for Montgomery County, Maryland, immediately prior hereto and to which these Bylaws are appended as an Exhibit.

Section 2. Mortgagee. "Mortgagee", as used herein, means the holder of any recorded mortgage, or the party secured or beneficiary of any recorded deed of trust, encumbering one or more of the condominium units in the Condominium. "Mortgage", as used herein, shall include deed of trust. "First mortgage" as used herein, shall mean a mortgage with priority over all other mortgages. As used in these Bylaws, the term "mortgagee" shall mean any mortgagee and shall not be limited to institutional mortgagees. As used in these Bylaws, the term "institutional mortgagee" or "institutional holder" shall include banks, trust companies, insurance companies, mortgage insurance companies, savings and loan associations, trusts, mutual savings banks, credit unions, pension funds, mortgage companies, Federal National Mortgage Association ("FNMA"), Government National Mortgage Association ("GNMA"), Federal Home Loan Mortgage Corporation ("FHLMC"), all corporations and any agency or department of the United States Government or of any state or municipal government.

Section 3. Other Definitions. Unless it is plainly evident from the context that a different meaning is intended, all other terms used herein shall have the same meaning as they are defined to have in the Declaration or in Title 11, Real Property Article, Annotated Code of Maryland (1981 Repl. Vol.).

LAW OFFICES
LEACH, EARLY, ROSEMAN & FRANKEL
CHARTERED
SUITE 1300
7101 WISCONSIN AVENUE
BETHESDA, MARYLAND 20814-4882
(301) 986-1300

ARTICLE III
Membership

Section 1. Members. Every person, group of persons, corporation, partnership, trust or other legal entity, or any combination thereof, who holds legal title to a unit within the Condominium shall be a member of the Council of Unit Owners; provided, however, that any person, group of persons, corporation, partnership, trust or other legal entity, or any combination thereof, who holds such interest solely as security for the performance of an obligation shall not be a member of the Council of Unit Owners by reason only of such interest.

Section 2. Membership Certificates. In the event the Board of Directors considers it necessary or appropriate to issue membership certificates or the like, then each such membership certificate shall state that the Council of Unit Owners is organized under the laws of the State of Maryland, the name of the registered holder or holders of the membership represented thereby, and shall be in such form as shall be approved by the Board of Directors. Membership certificates shall be consecutively numbered, bound in one or more books, and shall be issued therefrom upon certification as to the transfer of title to the condominium unit to which such membership is appurtenant. Every membership certificate shall be signed by the President or a Vice President and the Secretary or an Assistant Secretary of the Council of Unit Owners and shall be sealed with the seal of the Council of Unit Owners, if any. Such signatures and seal may be original or facsimile.

Section 3. Lost Certificates. The Board of Directors may direct a new certificate or certificates to be issued in place of any certificate or certificates previously issued by the Council of Unit Owners and alleged to have been destroyed or lost, upon the making of an affidavit of that fact by the unit owner claiming the membership certificate to be lost or destroyed. When authorizing such issuance of a new certificate or certificates, the Board of Directors may, in its discretion, and as a condition precedent to the issuance thereof, require the registered holder or holders of such lost or destroyed certificate or certificates, or his legal representative, to advertise the same in such manner as the Board of Directors shall require and to give the Council of Unit Owners a bond in such sum as the Board of Directors may require as indemnity against any claim that may be made against the Council of Unit Owners.

ARTICLE IV
Meetings of Unit Owners

Section 1. Place of Meeting. Meetings of the unit owners shall be held at the principal office of the Council of Unit Owners or at such other suitable place within the State of Maryland reasonably convenient to the unit owners as may from time to time be designated by the Board of Directors.

Section 2. Annual Meetings. The first annual meeting of the unit owners shall be held at such time as the Board of Directors shall determine but, in any event, within sixty (60) days after fifty percent (50%) of the percentage interests in the

Condominium have been sold and title to the same has been conveyed by the Declarant or within six (6) months following the recordation of the Declaration, whichever shall first occur. Thereafter the annual meetings of the unit owners shall be held during the month of September of each succeeding year. At such meeting there shall be elected by ballot of the unit owners a Board of Directors in accordance with the requirements of Article V of these Bylaws. The unit owners may also transact such other business of the Council of Unit Owners as may properly come before them.

Section 3. Special Meetings. It shall be the duty of the President to call a special meeting of the unit owners as directed by resolution of the Board of Directors or upon a petition signed by unit owners representing at least twenty percent (20%) of the total votes of the unit owners having been presented to the Secretary; provided, however, that, except upon resolution of the Board of Directors, no special meeting of the unit owners shall be called prior to the first annual meeting of unit owners as hereinabove provided for. The notice of any special meeting shall state the time and place of such meeting and the purpose thereof. No business shall be transacted at a special meeting except as specifically stated in the notice.

Section 4. Roster of Unit Owners. The Council of Unit Owners shall maintain a current roster of the names and addresses of each unit owner to which written notice of meetings of the Council of Unit Owners shall be delivered or mailed. Each unit owner shall furnish the Council of Unit Owners with his name and current mailing address. No unit owner may vote at any meeting of the Council of Unit Owners until this information is furnished.

Section 5. Notice of Meetings. It shall be the duty of the Secretary to mail or otherwise deliver a notice of each annual and special meeting of the Council of Unit Owners, stating the purpose thereof as well as the time and place where it is to be held, to each unit owner at his address as it appears on the roster of unit owners maintained by the Council of Unit Owners, or if no such address appears, at his last known place of address or at his condominium unit, at least ten (10) but not more than ninety (90) days prior to such meeting. Notice by either such method shall be considered as notice served and proof of such notice shall be made by the affidavit of the person giving such notice. Attendance by a unit owner at any annual or special meeting shall be a waiver of notice by him of the time, place and purpose thereof. Notice of any annual or special meeting of the unit owners may also be waived by any unit owner either prior to, at or after any such meeting.

Section 6. Quorum. The presence, either in person or by proxy, of unit owners representing at least fifty percent (50%) of the total votes of the Council of Unit Owners shall be requisite for, and shall constitute a quorum for the transaction of business at all meetings of members.

Section 7. Adjourned Meetings. If any meeting of unit owners cannot be organized because a quorum has not attended, another meeting of the members may be called for the same purpose if: (1) the notice of the meeting stated that the procedure

authorized by this section might be invoked; and (2) by majority vote, the members present in person or by proxy call for the additional meeting. Fifteen days notice of the time, place and purpose of the additional meeting shall be given by advertisement in a newspaper published in the county where the principal office of the Condominium is located. The notice shall contain the quorum and voting provisions contained herein. At the additional meeting, the members present in person or by proxy constitute a quorum. A majority of the members present in person or by proxy may approve or authorize the proposed action at the additional meeting and may take any other action which could have been taken at the original meeting if a sufficient number of members had been present.

Section 8. Voting. At every meeting of the unit owners, each of the unit owners shall have the right to cast the number of votes appurtenant to his unit, as established in the Declaration, on each question. The votes of the unit owners representing fifty-one percent (51%) of the votes of the unit owners present and voting, in person or by proxy, shall decide any question brought before such meeting, unless the question is one upon which, by express provision of the Condominium Act, or of the Articles of Incorporation of the Council of Unit Owners, or of the Declaration or of these Bylaws, a different vote is required, in which case such express provision shall govern and control. The vote for any condominium unit which is owned by more than one person may be exercised by any of them present at any meeting unless any objection or protest by any other owner of such condominium unit is noted at such meeting. In the event all of the co-owners of such condominium unit who are present at any meeting of the unit owners are unable to agree on the manner in which the vote for such condominium unit shall be cast on any particular question, then such vote shall not be counted for purposes of deciding the question. In the event any condominium unit is owned by a corporation, then the vote appurtenant to such condominium unit shall be cast by a person designated in a certificate signed by the president or any vice president and attested by the secretary or an assistant secretary of such corporation and filed with the Secretary of the Council of Unit Owners at or prior to the meeting. Any such certificate shall remain valid until revoked or superseded in writing. The vote appurtenant to any condominium unit which is owned by a trust or partnership may be exercised by any trustee or partner thereof, as the case may be, and, unless any objection or protest by any other trustee or partner is noted at such meeting, the Chairman of such meeting shall have no duty to inquire as to the authority of the person casting such vote or votes. No unit owner shall be eligible to vote, either in person or by proxy, or to be elected to the Board of Directors if the Council of Unit Owners has recorded a Statement of Condominium Lien on his unit and the amount necessary to release the lien has not been paid at the time of the meeting.

Section 9. Proxies. A unit owner may appoint any other natural person as his proxy. Any proxy must be in writing and must be filed with the Secretary in form approved by the Board of Directors at or before the appointed time of each meeting. Unless limited by its terms, any proxy shall continue until revoked by a written notice of revocation filed with the Secretary or by the death of the unit owner; provided, however,

that no proxy is effective for a period in excess of one hundred eighty (180) days unless granted to a mortgagee or lessee of the condominium unit to which the votes are appurtenant.

Section 10. Rights of Mortgagees. Any institutional mortgagee of any condominium unit in the Condominium who desires notice of the annual and special meetings of the unit owners shall notify the Secretary to that effect by Certified Mail-Return Receipt Requested. Any such notice shall contain the name and post office address of such institutional mortgagee and the name of the person to whom notice of the annual and special meetings of the unit owners should be addressed. The Secretary of the Council of Unit Owners shall maintain a roster of all institutional mortgagees from whom such notices are received and it shall be the duty of the Secretary to mail or otherwise cause the delivery of a notice of each annual or special meeting of the unit owners to each such institutional mortgagee, in the same manner, and subject to the same requirements and limitations as are provided in this Article for notice to the members. Any such institutional mortgagee shall be entitled to designate a representative to attend any annual or special meeting of the unit owners and such representative may participate in the discussion at any such meeting and may, upon his request made to the Chairman in advance of the meeting, address the unit owners present at any such meeting. Such representative shall have no voting rights at any such meeting. Such representative shall be entitled to copies of the minutes of all meetings of the unit owners upon request made in writing to the Secretary.

Section 11. Order of Business. The order of business at all annual meetings of the unit owners of the Council of Unit Owners shall be as follows:

(a) Roll call and certification of proxies.
(b) Proof of notice of meeting or waiver of notice.
(c) Reading and disposal of minutes of preceding meetings, if any.
(d) Reports of officers, if any.
(e) Reports of committees, if any.
(f) Election or appointment of inspectors of election.
(g) Election of directors.
(h) Unfinished business.
(i) New Business.
(j) Adjournment.

In the case of special meetings, items (a) through (d) shall be applicable and thereafter the agenda shall consist of the items specified in the notice of the meeting.

Section 12. Rules of Order and Procedure. The rules of order and all other matters of procedure at all annual and special meetings of the unit owners shall be determined by the Chairman of such meeting.

Section 13. Inspectors of Election. The Board of Directors may, in advance of any annual or special meeting of the unit owners appoint an uneven number of one or more inspectors of election to act at the meeting and at any adjournment thereof. In the event inspectors are not so appointed, the Chairman of

any annual or special meeting of unit owners shall appoint such inspectors of election. Each inspector so appointed, before entering upon the discharge of his duties, shall take and sign an oath faithfully to execute the duties of inspector of election at such meeting. The oath so taken shall be filed with the Secretary of the Council of Unit Owners. No officer or director of the Council of Unit Owners, and no candidate for Director of the Council of Unit Owners, shall act as an inspector of election at any meeting of the unit owners if one of the purposes of such meeting is to elect Directors.

ARTICLE V
Directors

Section 1. Number and Qualification. The affairs of the Council of Unit Owners shall be governed by a Board of Directors composed of an uneven number of at least three (3) natural persons and not more than five (5) natural persons, a majority of whom (after the first annual meeting of unit owners hereinabove provided for) shall be unit owners. For the purposes of this section, any principal or officer of any entity that is a unit owner shall be deemed to be a unit owner. Prior to the first annual meeting of unit owners, the number of Directors shall be determined, from time to time, by a vote of the initial Directors. Thereafter, the number of Directors shall be determined by a vote of the unit owners at the first annual meeting of unit owners and the number of Directors may be changed by a vote of the unit owners at any subsequent annual or special meeting of the unit owners; provided, however, that (a) the limitations of this Section shall continue to apply; and (b) no such change shall operate to curtail or extend the term of any incumbent Director. A sale by any member of the Board of Directors of all units in the Condominium owned by such member, shall constitute such member's resignation from the Board of Directors.

Section 2. Initial Directors. The initial Directors shall be selected by the Declarant and need not be unit owners. The names of the Directors who shall act as such from the date upon which the Declaration is recorded among the Land Records for Montgomery County, Maryland, until the first annual meeting of the unit owners are as set forth in the Articles of Incorporation of the Council of Unit Owners.

Section 3. Powers and Duties. The Board of Directors shall have all the powers and duties necessary for the administration of the affairs of the Council of Unit Owners and the Condominium and may do all such acts and things as are not by law or by these Bylaws directed to be exercised and done by the unit owners. The powers and duties of the Board of Directors shall include, but not be limited to, the following:

(a) care, upkeep and surveillance of the Condominium and its general and limited common elements and services in a manner consistent with law and the provisions of these Bylaws and the Declaration; and

(b) establishment, collection, use and expenditure of assessments and carrying charges from the unit owners and for the assessment, the filing and enforcement of Statement of Condominium Liens therefore in a manner consistent with law and the provisions of these Bylaws and the Declaration; and

(c) designation, hiring and dismissal of a Management Agent and such personnel necessary for the good working order of the Condominium and for the proper care of the common elements and to provide services for the project in a manner consistent with law and the provisions of these Bylaws and the Declaration; and

(d) promulgation and enforcement of such rules and regulations and such restrictions on or requirements as may be deemed proper respecting the use, occupancy and maintenance of the Condominium and the use of the general and limited common elements and as are designated to prevent unreasonable interference with the use and occupancy of the Condominium and of the general and limited common elements by the unit owners and others, all of which shall be consistent with law and the provisions of these Bylaws and the Declaration; and

(e) authorization, in their discretion, of the payment of patronage refunds from residual receipts or common profits when and as reflected in the annual report; and

(f) to enter into agreements whereby the Council of Unit Owners acquires leaseholds, memberships and other possessory or use interests in real or personal property for the purpose of promoting the enjoyment or welfare of the unit owners and to declare expenses incurred in connection therewith to be common expenses of the Council of Unit Owners; and

(g) to purchase insurance upon the Condominium in the manner provided for in these Bylaws; and

(h) to repair, restore or reconstruct all or any part of the Condominium after any casualty loss in a manner consistent with law and the provisions of these Bylaws and to otherwise improve the Condominium; and

(i) to lease, grant licenses, easements, rights-of-way and other rights of use in all or any part of the common elements of the Condominium; and

(j) to purchase condominium units in the Condominium and to lease, mortgage or convey the same, subject to the provisions of these Bylaws and the Declaration; and

(k) to appoint the members of the Architectural and Environmental Control Committee provided for in Article X of these Bylaws and to appoint the members of such other committees as the Board of Directors may from time to time designate.

Section 4. Management Agent. The Board of Directors shall employ for the Council of Unit Owners a management agent or manager (the "Management Agent"), which Management Agent shall be approved by Washington Adventist Hospital, Incorporated, at a rate of compensation established by the Board of Directors to perform such duties and services as the Board of Directors shall from time to time authorize in writing. The Council of Unit Owners shall not undertake "self-management" or otherwise fail to employ a professional management agent or manager without the prior written approval of all of the institutional holders of all first mortgages on the condominium units in the Condominium.

Any management agreement entered into by the Council of Unit Owners shall provide, inter alia, that such agreement may be terminated for cause upon thirty (30) days written notice thereof. The term of any such management agreement shall not exceed three (3) years; provided, however, that the term of any such management agreement may be renewable by mutual agreement of the parties.

Section 5. Election and Term of Office. The term of the initial Directors shall expire when their successors have been elected at the first annual meeting of unit owners and are duly qualified. The election of Directors shall be by ballot, unless balloting is dispensed with by the unanimous consent of the unit owners present at any meeting, in person or by proxy. There shall be no cumulative voting. At the first annual meeting of the unit owners, the term of office of the Director receiving the greatest number of votes shall be fixed for three (3) years. The term of office of the Director receiving the second greatest number of votes shall be fixed for two (2) years and the term of office of the other Director or Directors shall be fixed for one (1) year. At the expiration of the initial term of office of each respective Director, his successor shall be elected to serve a term of three (3) years.

Section 6. Vacancies. Vacancies in the Board of Directors caused by any reason other than the removal of a Director by a vote of the membership shall be filled by vote of the majority of the remaining Directors, even though they may constitute less than a quorum; and each person so elected shall be a Director until a successor is elected by the unit owners at the next annual meeting to serve out the unexpired portion of the term.

Section 7. Removal of Directors. At an annual meeting of unit owners, or at any special meeting duly called for such purpose (but only at or after the first annual meeting of unit owners, as hereinabove provided for) any Director may be removed with or without cause by the affirmative vote of the majority of the votes of the unit owners present and voting, in person or by proxy, and a successor may then and there be elected to fill the vacancy thus created. Any Director whose removal has been proposed by the unit owners shall be given an opportunity to be heard at the meeting. The term of any Director who becomes more than sixty (60) days delinquent in payment of any assessments or carrying charges due the Council of Unit Owners may be terminated by resolution of the remaining Directors and the remaining Directors shall appoint his successor as provided in this Article.

Section 8. Compensation. No compensation shall be paid to Directors for their services as Directors. After the first annual meeting of the unit owners, no remuneration shall be paid to any Director who is also a unit owner for services performed by him for the Council of Unit Owners in any other capacity unless a resolution authorizing such remuneration shall have been adopted by the Board of Directors before such services are undertaken. Directors may be reimbursed for their actual out-of-pocket expenses necessarily incurred in connection with their services as Directors.

Section 9. Organizational Meeting. The first meeting of a newly elected Board of Directors shall be held within ten (10) days of election at such place as shall be fixed by the Directors at the meeting at which such Directors were elected, and no notice shall be necessary to the newly elected Directors in order legally to constitute such meeting, provided a majority of the whole Board of Directors shall be present at such first meeting.

Section 10. Regular Meetings. Regular meetings of the Board of Directors may be held at such time and place as shall be determined, from time to time, by a majority of the Directors, but at least four (4) such meetings shall be held during each fiscal year. Notice of regular meetings of the Board of Directors shall be given to each Director, personally or by mail, telephone or telegraph, at least six (6) days prior to the day named for such meeting.

Section 11. Special Meetings. Special meetings of the Board of Directors may be called by the President on three (3) days' notice to each Director, given personally or by mail, telephone or telegraph, which notice shall state the time, place and purpose of the meeting. Special meetings of the Board of Directors shall be called by the President or Secretary in like manner and on like notice on the written request of at least one-third (1/3) of the Directors.

Section 12. Waiver of Notice. Before, at or after any meeting of the Board of Directors, any Director may, in writing, waive notice of such meeting and such waiver shall be deemed equivalent to the giving of such notice. Attendance by a Director at any meeting of the Board of Directors shall be a waiver of notice by him of the time, place and purpose thereof. If all the Directors are present at any meeting of the Board of Directors, no notice shall be required and any business may be transacted at such meeting.

Section 13. Quorum. At all meetings of the Board of Directors, a majority of the Directors shall constitute a quorum for the transaction of business, and the acts of the majority of the Directors present at any meeting at which a quorum is present shall be the acts of the Board of Directors. If at any meeting of the Board of Directors there be less than a quorum present, the majority of those present may adjourn the meeting. At any such adjourned meeting, any business which might have been transacted at the meeting as originally called may be transacted at a later meeting without further notice.

Section 14. Action Without Meeting. Any action by the Board of Directors required or permitted to be taken at any meeting may be taken without a meeting if all of the members of the Board of Directors shall individually or collectively consent in writing to such action. Such written consent or consents shall be filed with the minutes of the proceedings of the Board of Directors.

Section 15. Fidelity Bonds. The Board of Directors shall require that all officers, Directors and employees of the Council of Unit Owners regularly handling or otherwise responsible for the funds of the Council of Unit Owners shall

furnish adequate fidelity bonds or equivalent insurance against acts of dishonesty in accordance with the requirements of Article XI of these Bylaws. The premiums on such bonds or insurance shall be paid by the Council of Unit Owners.

ARTICLE VI
Officers

Section 1. Designation. The principal officers of the Council of Unit Owners shall be a President, a Vice President, a Secretary, and a Treasurer, all of whom shall be elected by the Board of Directors. Prior to the first annual meeting of unit owners, the officers of the Council of Unit Owners need not be unit owners. Thereafter, except for the President, the officers of the Council of Unit Owners need not be unit owners. For the purposes of this section, any principal or officer of an entity which is a unit owner shall be deemed to be a Unit Owner. The Directors may appoint an assistant secretary and an assistant treasurer and such other officers as in their judgment may be necessary. The offices of Secretary and Treasurer may be filled by the same person.

Section 2. Election of Officers. The officers of the Council of Unit owners shall be elected annually by the Board of Directors at the organizational meeting of each new Board and shall hold office at the pleasure of the Board of Directors.

Section 3. Removal of Officers. Upon an affirmative vote of a majority of the members of the Board of Directors, any officer may be removed either with or without cause, and his successor elected at any regular meeting of the Board of Directors, or at any special meeting of the Board of Directors called for such purpose.

Section 4. President. The President shall be the chief executive officer of the Council of Unit Owners. He shall preside at all meetings of the unit owners and of the Board of Directors. He shall have all of the general powers and duties which are usually vested in the office of president of a corporation, including, but not limited to, the power to appoint such committees from among the unit owners from time to time as he may, in his discretion, decide are appropriate to assist in the conduct of the affairs of the Council of Unit Owners.

Section 5. Vice President. The Vice President shall take the place of the President and perform his duties whenever the President shall be absent or unable to act. If neither the President nor the Vice President is able to act, the Board shall appoint some other member of the Board to do so on an interim basis. The Vice President shall also assist the President generally and shall perform such other duties as shall from time to time be delegated to him by the Board of Directors.

Section 6. Secretary. The Secretary shall keep the minutes of all meetings of the Board of Directors and the minutes of all meetings of the unit owners for the recording of the resolutions of the Council of Unit Owners. The Secretary shall give notice of all annual and special meetings of the unit owners in conformity with the requirements of these Bylaws. The Secretary shall have custody of the seal of the Council of Unit Owners, if

any. The Secretary shall have charge of the membership transfer books and of such other books and papers as the Board of Directors may direct and he shall, in general, perform all of the duties incident to the office of Secretary.

Section 7. Treasurer. The Treasurer shall have responsibility for funds and securities of the Council of Unit Owners and shall be responsible for keeping, or causing to be kept, full and accurate accounts of all receipts and disbursements in books belonging to the Council of Unit Owners. He shall be responsible for causing the deposit of all monies and other valuable effects in the name, and to the credit, of the Council of Unit Owners in such depositories as may from time to time be designated by the Board of Directors.

ARTICLE VII
Liability and Indemnification of Officers and Directors

Section 1. Liability and Indemnification of Officers and Directors. The Council of Unit Owners shall indemnify every officer and Director of the Council of Unit Owners against any and all expenses, including counsel fees, reasonably incurred by or imposed upon any officer or Director in connection with any action, suit or other proceeding (including the settlement of any such suit or proceeding if approved by the then Board of Directors of the Council of Unit Owners) to which he may be made a party by reason of being or having been an officer or Director of the Council of Unit Owners, whether or not such person is an officer or Director of the Council of Unit Owners at the time such expenses are incurred. The officers and Directors of the Council of Unit Owners shall not be liable to the unit owners for any mistake of judgment, negligence, or otherwise, except for their own individual willful misconduct or bad faith. The officers and Directors of the Council of Unit Owners shall have no personal liability with respect to any contract or other commitment made by them, in good faith, on behalf of the Council of Unit Owners or the Condominium (except to the extent that such officers or Directors may also be owners of condominium units) and the Council of Unit Owners shall indemnify and forever hold each such officer and Director free and harmless against any and all liability to others on account of any such contract or commitment. Any right to indemnification provided for herein shall be in addition to and not exclusive of any other rights to which any officer or Director of the Council of Unit Owners, or former officer or Director of the Council of Unit Owners may be entitled.

Section 2. Common or Interested Directors. The Directors shall exercise their powers and duties in good faith and with a view to the interests of the Council of Unit Owners and the Condominium. No contract or other transaction between the Council of Unit Owners and one or more of its Directors, or between the Council of Unit Owners and any corporation, firm or association (including the Declarant) in which one or more of the Directors of the Council of Unit Owners are directors or officers or are pecuniarily or otherwise interested, is either void or voidable because such Director or Directors are present at the meeting of the Board of Directors or any committee thereof which authorizes or approves the contract or transaction, or because his or their votes are counted for such

purpose, if any of the conditions specified in any of the following subparagraphs exist:

(a) the fact of the common directorate or interest is disclosed or known to the Board of Directors or a majority thereof or noted in the minutes, and the Board of Directors authorizes, approves, or ratifies such contract or transaction in good faith by a vote sufficient for the purpose; or

(b) the fact of the common directorate or interest is disclosed or known to the unit owners, or a majority thereof, and they approve or ratify the contract or transaction in good faith by a vote sufficient for the purpose; or

(c) the contract or transaction is commercially reasonable to the Council of Unit Owners at the time it is authorized, ratified, approved or executed.

Common or interested Directors may be counted in determining the presence of a quorum of any meeting of the Board of Directors or committee thereof which authorizes, approves or ratifies any contract or transaction, and may vote to authorize any contract or transaction with like force and effect as if he were not such director or officer of such other corporation or not so interested.

ARTICLE VIII
Assessments and Carrying Charges for Common Expenses

Section 1. Annual Assessments and Carrying Charges. Each unit owner shall pay to the Council of Unit Owners, in advance, a monthly sum (hereinelsewhere sometimes referred to as "assessments" or "carrying charges") equal to one-twelfth (1/12) of the unit owner's proportionate share (determined in accordance with the percentage interests in common expenses and common profits of the Condominium set forth in the Declaration) of the sum required by the Council of Unit Owners, as estimated by its Board of Directors, to meet its annual expenses, including, but in no way limited to, the following:

(a) the cost of all operating expenses of the Condominium and services furnished, including, without limitation, charges by the Council of Unit Owners for facilities and services furnished by it; and

(b) the cost of necessary management and administration, including fees paid to any Management Agent; and

(c) the amount of all taxes and assessments levied against the Council of Unit Owners or upon any property which it may own or which it is otherwise required to pay, if any; and

(d) the cost of fire and extended coverage and liability insurance on the Condominium and the cost of such other insurance as the Council of Unit Owners may effect; and

(e) the cost of furnishing water, electricity, heat, gas, garbage and trash collection and other utilities, to the extent furnished by the Council of Unit Owners; and

(f) the cost of funding contributions to the "Paid-in-Surplus" account of the Council of Unit Owners and the cost of funding all reserves established by the Council of Unit Owners, including, when appropriate, a general operating reserve and a reserve for replacements; and

(g) the estimated cost of repairs, maintenance and replacements of the common elements of the Condominium to be made by the Council of Unit Owners.

The Board of Directors shall determine the amount of the assessments at least annually, but may do so at more frequent intervals should circumstances so require. Upon resolution of the Board of Directors, installments of annual assessments may be levied and collected on a quarterly, semiannual or annual basis rather than on the monthly basis hereinabove provided for.

The Board of Directors of the Council of Unit Owners shall make reasonable efforts to fix the amount of the assessment against each condominium unit for each annual assessment period at least thirty (30) days in advance of the commencement of such period and shall, at that time, prepare a roster of the condominium units and assessments applicable thereto which shall be kept in the office of the Council of Unit Owners and shall be open to inspection by the owner or mortgagee of any condominium unit and by their respective duly authorized agents and attorneys, upon reasonable notice to the Board of Directors. Written notice of the assessments shall thereupon be sent to the unit owners. The omission of the Board of Directors, before the expiration of any annual assessment period, to fix assessments for that or the next such period shall not be deemed a waiver or modification in any respect of the provisions of this Article, or a release of any unit owner from the obligation to pay the assessment, or any installment thereof, for that or any subsequent assessment period; but the assessment fixed for the preceding period shall continue until a new assessment is fixed. No unit owner may exempt himself from liability for assessments or carrying charges by a waiver of the use or enjoyment of any of the common elements or by abandonment of any condominium unit belonging to him.

Section 2. Budget. The Board of Directors, with the assistance and counsel of the Management Agent, shall prepare and adopt a budget for each annual assessment period which shall include estimates of the funds required by the Council of Unit Owners to meet its annual expenses for that period. The budget herein required to be prepared and adopted by the Board of Directors shall be in a format consistent with the classification of the accounts of the Council of Unit Owners, as hereinafter in these Bylaws provided for, and shall provide for sufficient estimates on a monthly basis, to permit comparison to and analysis of deviations from the various periodic reports of the actual results of operations and the actual financial condition of the Council of Unit Owners, on both a current basis and for prior corresponding periods, all in accordance with generally accepted accounting practices, consistently applied. Copies of the budget shall be forwarded to Declarant's construction lender and shall be available for examination by the unit owners and by their duly authorized agents and attorneys, and to the institutional holder of any first mortgage

on any condominium unit in the condominium and by their duly authorized agents and attorneys during normal business hours for purposes reasonably related to their respective interests.

Section 3. Special Assessments. In addition to the regular assessments authorized by this Article, the Council of Unit Owners may levy in any assessment year a special assessment or assessments, applicable to that year only, for the purpose of defraying, in whole or in part, the cost of any construction or reconstruction, unexpected repair or replacement of a described capital improvement located upon the Condominium, including the necessary fixtures and personal property related thereto, or for such other purpose as the Board of Directors may consider appropriate; provided, however, that any such special assessment in excess of ten percent (10%) of the then current budget shall have the assent of the unit owners representing two-thirds (2/3) of the total votes of the Council of Unit Owners. A special meeting of the unit owners shall be duly called for this purpose.

Section 4. Reserve for Replacements. The Council of Unit Owners shall establish and maintain a reserve fund for replacements by the allocation and payment monthly to such reserve fund of an amount to be designated from time to time by the Board of Directors. Such fund shall be conclusively deemed to be a common expense. Such fund shall be deposited in a special account with a lending institution the accounts of which are insured by an agency of any state or an agency of the United States of America or may, in the discretion of the Board of Directors, be invested in obligations of, or fully guaranteed as to principal by, any state or the United States of America. The reserve for replacements may be expended only for the purpose of effecting the replacement of the common elements and equipment of the Condominium and for start-up costs and operating contingencies of a nonrecurring nature. The proportionate interest of any unit owner in any reserve for replacements and any other reserves established by the Council of Unit Owners shall be considered an appurtenance of his condominium unit and shall not be separately withdrawn, assigned or transferred or otherwise separated from the condominium unit to which it appertains and shall be deemed to be transferred with such condominium unit.

Section 5. Non-Payment of Assessments - Statement of Condominium Lien. Any assessment levied pursuant to the Declaration or these Bylaws, and any installment thereof, which is not paid on the date when due shall be delinquent and shall entitle the Council of Unit Owners to claim the amount of such assessment, together with interest thereon and the actual costs of collection thereof, as a lien on the condominium unit against which it is assessed; provided, however, that such lien shall be effective only after a Statement of Condominium Lien is recorded among the Land Records for the jurisdiction where the Declaration was originally recorded, stating the description of the condominium unit, the name of the unit owner of record, the amount due and the period for which the assessment is due. Any such Statement of Condominium Lien shall be in substantially the following form or as may otherwise be required by the Condominium Act:

STATEMENT OF CONDOMINIUM LIEN

This is to certify that , owner(s) of Unit No. in Washington Adventist Ambulatory Care Center, a Condominium, (is) (are) indebted to the Council of Unit Owners, in the amount of $, as of , 19 , for (his) (their) proportionate share of the common expenses of the Condominium for the period from , 19 to , 19 , plus interest thereon at the rate of percent (%), costs of collection and reasonable attorney's fees.

WASHINGTON ADVENTIST ACC
CONDOMINIUM ASSOCIATION, INC.

By_____
Officer's Title (or Agent)
Address
Telephone

I HEREBY AFFIRM under penalties of perjury that the information contained in the foregoing Statement of Condominium Lien is true and correct to the best of my knowledge, information and belief.

_____
Officer (or Agent)

The Statement of Condominium Lien shall be signed and verified as required in the Condominium Act by any officer of the Council of Unit Owners, or by the Management Agent or any duly authorized representative thereof, or by any agent, attorney or other person duly authorized by the Board of Directors of the Council of Unit Owners for such purposes.

Upon recordation of the Statement of Condominium Lien as aforesaid, the lien shall bind the condominium unit described in the Statement of Condominium Lien in the hands of the unit owner, his heirs, devisees, personal representatives and assigns. The personal obligation of the unit owner to pay the assessment shall, however, remain his personal obligation for the statutory period and a suit to recover a money judgment for non-payment of any assessment levied pursuant to the Declaration or these Bylaws, or any installment thereof, may be maintained without foreclosing or waiving the lien established by the Statement of Condominium Lien to secure payment of such assessment. Upon full payment of the amount for which the lien is claimed the unit owner shall be entitled to a recordable satisfaction of the lien. Any assessment levied pursuant to the Declaration or these Bylaws, and any installment thereof, which is not paid when due may, upon resolution of the Board of Directors, subject the unit owner obligated to pay the same to the payment of a "late charge" of $15.00 or one tenth (1/10th) of the total amount of any delinquent assessment or installment, whichever is greater, and the Council of Unit Owners may bring an action at law against the unit owner personally obligated to pay the same and may, after the recordation of the Statement of

Condominium Lien provided for in this Article and in the Condominium Act, foreclose the lien against the condominium unit or units then belonging to said unit owner in the same manner, and subject to the same requirements, now or hereafter provided for the foreclosure of mortgages or deeds of trust in the State of Maryland containing a power of sale or an assent to a decree; in either of which events interest at the rate of eighteen percent (18%) per annum, actual costs or collection and reasonable attorney's fees of not less than twenty percent (20%) of the sum claimed shall be added to the amount of each assessment. Suit for any deficiency following foreclosure may be maintained in the same proceeding. No suit may be brought to foreclose the lien except after ten (10) days' written notice to the unit owner given by registered mail - return receipt requested to the address of the unit owner shown on the roster of unit owners maintained by the Council of Unit Owners. In the event of a foreclosure sale, upon compliance by the purchaser with the terms of such sale, and upon judicial approval as may be required by law, the Council of Unit Owners shall convey the Condominium Unit in fee simple to and at the cost of the purchaser. The Board of Directors may post a list of members who are delinquent in the payment of any assessment or other fees which may be due the Council of Unit Owners, including any installment thereof which becomes delinquent, in any prominent location within the Condominium.

Section 6. Priority of Lien. The lien established by the recordation of a Statement of Condominium Lien, as in this Article provided, shall have preference over any other assessments, liens, judgments or charges of whatever nature, except the following:

(a) general and special assessments for ad valorem real estate taxes on the condominium unit; and

(b) the lien of any bona fide deed of trust, mortgage or other encumbrance duly recorded on the condominium unit prior to the recordation of the Statement of Condominium Lien, or duly recorded on the condominium unit after receipt by the holder of any such mortgage (or the holder of the indebtedness or note secured thereby) of a certificate or statement in writing signed by an officer or agent of the Council of Unit Owners stating the payments on account of all assessments levied by the Council of Unit Owners against the condominium unit were current as of the date of recordation of such deed of trust, mortgage instrument or other encumbrance. The lien established by the recordation of a Statement of Condominium Lien, as in this Article provided, shall be subordinate to the lien of any deed of trust, mortgage or other encumbrance duly recorded on the condominium unit and made in good faith and for value received; provided, however, that such subordination shall apply only to assessments, and installments thereof, which have become due and payable prior to a sale or transfer of the condominium unit pursuant to a foreclosure or any deed, assignment or other proceeding or arrangement in lieu of foreclosure. Any holder of any deed of trust, mortgage or other encumbrance duly recorded on the condominium unit and made in good faith and for value received who comes into possession of the condominium unit pursuant to a foreclosure or any deed, assignment or other proceeding or arrangement in lieu of foreclosure, and any other purchaser at a

foreclosure sale, shall take the condominium unit free of any claims for unpaid common expense assessments and carrying charges levied against the condominium unit which accrue prior to the time such holder comes into possession of the condominium unit or prior to the foreclosure sale, except for claims for a proportionate share of such unpaid common expense and carrying charges resulting from a reallocation of such unpaid common expense assessments or carrying charges among all of the condominium units in the Condominium. Such foreclosure, deed, assignment or other proceeding or arrangement in lieu of foreclosure shall not relieve the mortgagee in possession or the purchaser at any foreclosure sale from any liability for any common expense assessments and carrying charges thereafter becoming due, or from the lien established by the recordation of a Statement of Condominium Lien with respect to any common expense assessments and carrying charges thereafter becoming due. No amendment to this Section shall affect the rights of the holder of any such deed of trust, mortgage or other encumbrance recorded prior to the recordation of such amendment unless the holder of such deed of trust, mortgage or other encumbrance shall join in the execution of such amendment.

Section 7. Additional Rights of Mortgagees - Notice. The Council of Unit Owners shall promptly notify the holder of the first mortgage on any condominium unit for which any assessment levied pursuant to the Declaration or these Bylaws, or any installment thereof, becomes delinquent for a period in excess of thirty (30) days and the Council of Unit Owners shall promptly notify the holder of the first mortgage on any condominium unit with respect to which any default in any provision of the Declaration or these Bylaws remains uncured for a period in excess of thirty (30) days following the date of such default. Any failure to give any such notice shall not affect the priorities established by this Article, the validity of any assessment levied pursuant to the Declaration or these Bylaws or the validity of any lien to secure the same. No suit or other proceeding may be brought to foreclose the lien for any assessment levied pursuant to the Declaration or these Bylaws except after the (10) days' written notice to the holder of the first mortgage on the condominium unit which is the subject matter of such suit or proceeding.

Section 8. Acceleration of Installments. Upon default in the payment of any one or more monthly installments of any assessment levied pursuant to the Declaration or these Bylaws, or any other installment thereof, the entire balance of said assessment may be accelerated at the option of the Board of Directors and be declared due and payable in full.

Section 9. Assessment Certificates. The Council of Unit Owners shall, within twenty (20) days following receipt of any written demand, furnish to any unit owner liable for any assessment levied pursuant to the Declaration or these Bylaws (or any other party legitimately interested in the same) a certificate in writing signed by an officer or agent of the Council of Unit Owners, setting forth the status of said assessment, i.e., whether the same is paid or unpaid. Such certificate shall be conclusive evidence of the payment of any installment of any assessment therein stated to have been paid. A charge not to exceed Thirty Dollars ($30.00) may be levied in

advance by the Council of Unit Owners for each certificate so delivered, except that no charge shall be levied against any institutional mortgagee of any condominium unit in the Condominium who requests such a certificate.

Section 10. Additional Default. Any recorded first mortgage secured on a condominium unit in the Condominium shall provide that any default by the mortgagor in the payment of any assessment levied pursuant to the Declaration or these Bylaws, or any installment thereof, shall likewise be a default in such mortgage (or the indebtedness or note secured thereby). Such mortgages shall also provide that, in the event of any default thereunder, the mortgagee shall have the right, at its option exercised by notice in writing to the mortgagor and the Secretary of the Council of Unit Owners, to cast the votes appurtenant to the condominium unit which is security for the repayment of the mortgage debt at all meetings of the unit owners. Failure to include such provisions in any such mortgage shall not affect the validity or priority thereof and the protection extended to the holder of such mortgage (or the holder of the indebtedness or note secured thereby) by reason of the provisions of this Article shall not be altered, modified, or diminished by reason of any such failure.

ARTICLE IX
Use Restrictions

Section 1. Use. All condominium units in the Condominium shall be used for the tendering of customary medical services, health care, and other incidental services in a manner consistent with the limitations of law, these Bylaws, the Declaration of Covenants, Conditions and Restrictions made by Washington Adventist Hospital, Incorporated (the "Hospital") and recorded among the land records for Montgomery County on June 9, 1983 in liber 6095 at folio 612 (the "Covenants"), any and all restrictions, conditions and covenants of record and the rules, regulations, resolutions and orders of all governmental or quasi-governmental authorities having or claiming jurisdiction over the Condominium, including without limitation, the requirements of special exception Case No. 5-807 granted by the County Board of Appeals for Montgomery County, Maryland. No activity shall be carried on within the Condominium or its individual units which interferes unreasonably with the maintenance and functions of the surrounding property of the Hospital. No condominium unit shall be used for residential purposes. Each unit owner shall obtain and maintain all use and occupancy permits and other permits and approvals required in connection with the use and occupancy of his condominium unit.

Section 2. Leasing. Any owner of any condominium unit who shall lease such unit or any portion thereof shall, promptly following the execution of any such lease, forward a conformed copy thereof to the Board of Directors. All leases shall be in writing. Any such lease shall contain a provision to the effect that the rights of the tenant to use and occupy the condominium unit shall be subject and subordinate in all respects to the provisions of the Declaration, these Bylaws, the Covenants, and to such other reasonable rules and regulations relating to the use of the common elements, or other "house rules", as the Board of Directors may from time to time promulgate and shall provide,

further, that any failure by the tenant to comply with the provisions of such documents shall be a default under the lease. Each lease shall provide that the Board of Directors shall have the right and authority, in the event of a default under such lease, to enforce all provisions of the lease in the event such enforcement is not undertaken by the lessor within a reasonable time after notice of such default. The provisions of this subsection shall not apply to any institutional first mortgagee of any condominium unit who comes into possession of the unit by reason of any remedies provided by law or in such mortgage or as a result of a foreclosure sale or other judicial sale or as a result of any proceeding, arrangement, assignment or deed in lieu of foreclosure, except that all such institutional first mortgagees shall be bound by all covenants and restrictions of record.

Section 3. Prohibited Uses and Nuisances. Except for the activities of the Declarant and its agents, employees, contractors and invitees in connection with the construction and marketing of the Condominium, and except as may be otherwise reasonable and necessary in connection with the maintenance, improvement, repair or reconstruction of any portion of the Condominium by the Declarant or the Council of Unit Owners:

(a) No unlawful trade or activity and no activity inconsistent with the permitted use shall be carried on within any condominium unit, nor shall anything be done therein or thereon which may be or become an unreasonable source of annoyance to the other unit owners. No nuisances shall be permitted within the Condominium, nor shall any use or practice be permitted which is or becomes an unreasonable source of annoyance to the unit owners or which unreasonably interference with the peaceful use and possession thereof by the unit owners.

(b) There shall be no obstruction of any of the general common elements. Nothing shall be stored upon any of the general common elements, excepting those areas designated for storage of personal property by the owners of the condominium units. The Board of Directors shall have the right to adopt reasonable rules regarding the time and manner for the delivery and removal of heavy or bulky equipment.

(c) Nothing shall be done or maintained in any condominium unit or upon any of the common elements which will increase the rate of insurance on any condominium unit or the common elements, or result in the cancellation thereof, without the prior written approval of the Board of Directors. Nothing shall be done or maintained in any condominium unit or upon the common elements which would be in violation of any law. No waste shall be committed upon any of the common elements.

(d) No structural alteration, construction, addition or removal of any condominium unit or the common elements shall be commenced or conducted except in strict accordance with the provisions of these Bylaws and the Condominium Act. No exterior structural alteration, addition or deletion may be made to or on the Condominium Building without the prior approval of any applicable governmental entities and the Hospital, whose approval shall not be unreasonably withheld.

(e) Occupancy of the individual condominium units shall be limited to physicians, dentists and psychologists who are duly licensed in the State of Maryland and who are members of the medical staff of the Hospital, (or eligible to be members of the medical staff, as defined by the Hospital Medical Staff By-laws), licensed pharmacists, and the non-physician employees and visitors of such physicians, dentists and pharmacists.

(f) Competing Services shall be defined as any and all medical services now or subsequently offered by the Hospital, including, but not limited to the following: Pulmonary Function Laboratory, Arterial Blood Gas Laboratory, Bronchoscopy Suite, Ultrasound, Nuclear Medicine, Computed Tomography, Superficial X-ray, Strontium-90, Electrodiagnostic Studies, Evoked Potential Testing, Physical Therapy, Occupational Therapy, Speech Pathology, Pain Clinic, and Clinical Laboratory. No Competing Service shall be offered at the Condominium without the prior written approval of the Hospital, which approval shall not be unreasonably withheld, in order to avoid duplication of services offered by and available at the Hospital; the foregoing shall not be construed to prevent occupants from maintaining or providing private, non-commercial and customary laboratory and radiological service or equipment for the use of such occupant's patients. Any proposed service which has been submitted to the Hospital for review and which has not been approved or rejected within five (5) business days shall be deemed to be approved.

(g) For as long as Unit 120, as shown on the Condominium Plat, is used primarily for pharmacy purposes, no other Unit in the condominium shall be used for pharmacy purposes. However, this subsection shall not be construed to prohibit the use of Unit 120 for purposes other than a pharmacy, provided that such other use is in compliance with the terms of the Declaration and these By-laws.

(h) No major food service shall be provided at the Condominium. Vending machines and sales of limited quantities and types of convenience foods by any pharmacist shall be permitted, however, the Hospital shall have the right to restrict the types of food sold in accordance with the principles of the Seventh-day Adventist religion.

(i) In accordance with the principles of the Seventh-day Adventist religion, occupants of the Condominium shall restrict their hours of rendering services to a minimum on Saturdays.

(j) Water closets and other plumbing apparatus within the Condominium shall be used only for the purposes for which they are designed and such plumbing apparatus shall not be used for the disposal of sweepings, trash, rubbish, chemicals, paint or the like.

(k) Except for such signs as may be posted by the Declarant or the Council of Unit Owners for promotional or marketing purposes, traffic control or the like, and except for interior signs necessary to advise of the existence and location of Units used for pharmacy purposes, no signs of any character shall be erected, posted or displayed upon, in, from or about any condominium unit or the common elements without the prior consent in writing of the Architectural and Environmental Control Committee and under such conditions as it may establish. The Architectural and Environmental Control Committee is hereby authorized to adopt and promulgate rules and regulations regarding the size, color, location and content of all signs to be erected, posted or displayed upon, in, from or about any condominium unit or the common elements, including the described pharmacy related signs.

(l) No unit owner shall permit a floor load within his condominium unit in excess of 60 pounds per square foot upon the framed or suspended steel floors of the condominium units, including an allowance of 20 pounds per square foot for partition loads. No unit owner shall permit a floor load within his condominium unit in excess of 80 pounds per square foot upon concrete slabs on grade, including an allowance of 20 pounds per square foot for partition loads. No unit owner shall permit floor loads in excess of the stated design loads for the Condominium, nor shall any unit owner permit concentrated loads of any sort (e.g., for safes, library stacks, filing systems or other heavy equipment) unless and until the adequacy of the structure to support such floor loads is verified by a structural engineer to the satisfaction of the Architectural and Environmental Control Committee under such reasonable conditions and circumstances as it may require.

(m) No burning of any trash and no unreasonable or unsightly accumulation or storage of litter, new or used building materials, or trash of any other kind shall be permitted within any condominium unit or upon any of the general common elements. All refuse shall be deposited with care in containers designated for such purpose during such hours as may from time to time be designated by the Board of Directors.

(n) No bell, loudspeaker, sound amplifier, lights or lighting devices, whistle, horn, bell siren or other similar device shall be installed upon the exterior of any condominium unit or upon the common elements except in connection with such security systems as may be maintained by the unit owners as approved by the Architectural and Environmental Control Committee.

(o) No outside television or radio aerial or antenna, or other aerial or antenna, for reception or transmission, shall be maintained upon any condominium unit or upon any of the common elements except with the prior written consent of the Architectural and Environmental Control Committee and under such reasonable limitations and conditions as it may establish.

(p) No unlawful use shall be made of any condominium unit or any portion of the common elements and all laws, zoning and other ordinances, regulations of governmental and other municipal bodies and the like shall be observed at all times.

(q) No unit owner shall engage or direct any employee of the Council of Unit Owners or the Management Agent on any private business of the unit owner during the hours such employee is employed by the Council of Unit Owners or the Management Agent nor shall any member direct, supervise or in any manner attempt to assert control over any such employee.

(r) There shall be no violation of any rules for the use of the common elements, or other "house rules", which may from time to time be adopted by the Board of Directors and promulgated among the unit owners by them in writing, and the Board of Directors is hereby and elsewhere in these Bylaws authorized to adopt and promulgate such rules.

As used in this Section 3 of this Article IX, and any other provision of these Bylaws to the contrary notwithstanding, the expression "Declarant" shall include and mean those of the successors and assigns of the Declarant to whom the Declarant

may specifically assign the privileges and exemptions reserved to the Declarant in this Section III.

ARTICLE X
Architectural Control

Section 1. Architectural and Environmental Control Committee. Except for the construction of the Condominium by the Declarant or its successors and assigns, and their respective employees, agents and contractors, and except for any improvements to any condominium unit or to the common elements accomplished concurrently with said original construction, and except for purposes of proper maintenance and repair or as otherwise in the Condominium Act or these Bylaws provided, it shall be prohibited for any unit owner to make any change or otherwise alter (including any alteration in color) in any manner whatsoever the exterior of any condominium unit, or to remove or alter any window or exterior doors of any condominium unit, or to make any change or alteration within any condominium unit which will alter the structural integrity of any building or otherwise affect the property, interest or welfare of any other unit owner, materially increase the cost of operation or insuring the Condominium or impair any easement, until the complete plans and specifications, showing the location, nature, shape, change (including, without limitation, any other information specified by the Board of Directors or its designated committee) shall have been submitted to and approved in writing as to safety, the effect of any such alterations on the costs of maintaining and insuring the Condominium and harmony of design, color and location in relation to surrounding structures and topography, by the Board of Directors of the Council of Unit Owners, or by an Architectural and Environmental Control Committee designated by the Board of Directors.

Section 2. Architectural and Environmental Control Committee Operation. The Architectural and Environmental Control Committee shall be composed of an uneven number of three (3) or more natural persons designated from time to time by the Board of Directors of the Council of Unit Owners and such persons shall serve at the pleasure of the Board of Directors. In the event the Board of Directors fails to appoint an Architectural and Environmental Control Committee, then the Board of Directors shall constitute the Committee. The affirmative vote of a majority of the members of the Architectural and Environmental Control Committee shall be required in order to adopt or promulgate any rule or regulation, or to make any finding, determination, ruling or order, or to issue any permit, consent, authorization, approval or the like, pursuant to the authority contained in this Article.

Section 3. Approvals, etc. Upon approval of the Architectural and Environmental Control Committee of any plans and specifications submitted pursuant to the provisions of this Article, a copy of such plans and specifications, as approved, shall be deposited among the permanent records of such Committee and a copy of such plans and specifications bearing such approval, in writing, shall be returned to the applicant submitting the same. In the event the Architectural and Environmental Control Committee fails to approve or disapprove any plans and specifications which may be submitted to it

pursuant to the provisions of this Article within sixty (60) days after such plans and specifications (and all other materials and information required by the Architectural and Environmental Control Committee) have been submittted to it in writing, then approval will not be required and this Article will be deemed to have been fully complied with.

Section 4. Limitations. Construction or alterations in accordance with plans and specifications approved by the Architectural and Environmental Control Committee pursuant to the provisions of this Article shall be commenced within six (6) months following the date upon which the same are approved by the Architectural and Environmental Control Committee (whether by affirmative action or by forebearance from action, as in Section 3 of this Article provided), and shall be substantially completed within twelve (12) months following the date of commencement, or within such longer period as the Architectural and Environmental Control Committee shall specify in its approval. In the event construction is not commenced within the period aforesaid, then approval of the plans and specifications by the Architectural and Environmental Control Committee shall be conclusively deemed to have lapsed and compliance with the provisions of this Article shall again be required. There shall be no deviations from plans and specifications approved by the Architectural and Environmental Control Committee without the prior consent in writing of the Architectural and Environmental Control Committee. Approval of any particular plans and specifications or design shall not be construed as a waiver of the right of the Architectural and Environmental Control Committee to disapprove such plans and specifications, or any elements or features thereof, in the event such plans and specifications are subsequently submitted for use in any other instance.

Section 5. Certificate of Compliance. Upon the completion of any construction or alteration or other improvements or structure in accordance with plans and specifications approved by the Architectural and Environmental Control Committee in accordance with the provisions of this Article, the Architectural and Environmental Control Committee shall, at the request of the owner thereof, issue a certificate of compliance which shall be prima facie evidence that such construction, alteration or other improvements referenced in such certificate have been approved by the Architectural and Environmental Control Committee and constructed or installed in full compliance with the provisions and requirements of these Bylaws as may be applicable.

Section 6. Rules and Regulations, etc. The Architectural and Environmental Control Committee may from time to time adopt and promulgate such rules and regulations regarding the form and content of plans and specifications to be submitted for approval and may publish such statements of policy, standards, guidelines and establish such criteria relative to architectural styles or details, or other related matters, as it may consider necessary or appropriate. No such rules, regulations, statements, criteria or the like shall be construed as a waiver of the provisions of this Article or any other provision or requirement of these Bylaws. The Architectural and Environmental Control Committee may charge and collect a reasonable fee for the

examination of any plans and specifications submitted for approval pursuant to the provisions of this Article. The decisions of the Architectural and Environmental Control Committee shall be final except that any unit owner who is aggrieved by any action or forebearance from action by the Architectural and Environmental Control Committee may appeal the decision of the Architectural and Environmental Control Committee to the Board of Directors of the Council of Unit Owners and, upon the request of such unit owner, shall be entitled to a hearing before the Board of Directors.

Section 7. Additions, Alterations or Improvements by Board of Directors. Except in cases of bona fide emergencies involving manifest danger to life, safety or property, or the interruption of essential services to the Condominium, whenever in the judgment of the Board of Directors the common elements of the Condominium shall require additions, alterations or improvements requiring the expenditure of funds of the Council of Unit Owners in excess of Twenty-five Thousand and No/100 Dollars ($25,000), such additions, alterations or improvements shall not be made until the same shall have been approved by (a) unit owners representing a majority of the total votes of the Council of Unit Owners at a meeting of the unit owners duly called for such purpose; and (b) the institutional holder of any mortgages or other obligations secured by any condominium unit or units in the aggregate principal sum of more than $150,000.00, which approval shall be in writing and which approval shall not be unreasonably withheld or delayed.

ARTICLE XI
Insurance

Section 1. Insurance. The Board of Directors of the Council of Unit Owners shall obtain and maintain to the extent reasonably available, at least the following:

(a) Casualty or physical damage insurance in an amount equal to the full replacement value (i.e., 100% of "replacement cost" exclusive of land, foundation and excavation) of the Condominium (including all building service equipment and the like) with an "Agreed Amount Endorsement" or its equivalent, a "Demolition Endorsement" or its equivalent, an "Increased Cost of Construction Endorsement" or its equivalent a "Condominium Replacement Cost Endorsement" or its equivalent, and a "Contingent Liability from Operation of Building Laws Endorsement" or its equivalent, without deduction or allowance for depreciation, as determined annually by the Board of Directors with the assistance of the insurance company affording such coverage, such coverage to afford protection against at least:

(i) Loss or damage by fire and other hazards covered by the standard extended coverage endorsement; and

(ii) such other risks as shall customarily be covered with respect to projects similar in construction, location and use, including, but not limited to, sprinkler leakage, debris removal, cost of demolition, vandalism, malicious mischief, windstorm, water damage, boiler and machinery explosion or damage, and such other insurance as

(ii) the Board of Directors may from time to time determine; and

(b) comprehensive public liability insurance, including medical payments insurance, with a "Severability of Interest Endorsement" or its equivalent in such amounts and in such forms as may be considered appropriate by the Board of Directors (but not less than One Million and No/100 Dollars ($1,000,000.00) covering all claims for bodily injuries and/or property damage arising out of a single occurrence) including, but not limited to, legal liability, hired automobile liability, non-owned automobile liability, liability for property of others, and such other risks as shall customarily be covered with respect to projects similar in construction, location and use, including any and all other liability incident to the ownership and use of the Condominium or any portion thereof.

(c) workmen's compensation insurance to the extent necessary to comply with applicable Maryland law; and

(d) a "Legal Expense Indemnity Endorsement", or its equivalent, affording protection for the officers and Directors of the Council of Unit Owners for expenses and fees incurred by any of them in defending any suit or settling any claim, judgment or cause of action to which any such officer or Director shall have been made a party by reason of his or her services as such; and

(e) such other policies of insurance, including insurance for other risks of a similar or dissimilar nature and fidelity coverage as required by Section 15 of Article V of these Bylaws, as are or shall hereafter be considered appropriate by the Board of Directors. The Board of Directors shall maintain such fidelity coverage as it deems adequate to protect against dishonest acts on the part of officers and Directors of the Council of Unit Owners, trustees for the Council of Unit Owners and such employees and agents of the Council of Unit Owners who handle or are responsible for the handling of funds of the Council of Unit Owners.

Section 2. Limitations. Any insurance obtained pursuant to the requirements of this Article shall be subject to the following provisions:

(a) all policies shall be written or reinsured with a company or companies licensed to do business in the State of Maryland and holding a rating of "Class X" or better in the current edition of Best's Insurance Reports.

(b) exclusive authority to negotiate losses under said policies shall be vested in the Board of Directors of the Council of Unit Owners, as a trustee for the owners of the condominium units, or its authorized representative, including any trustee with which the Council of Unit Owners may enter into any Insurance Trust Agreement, or any successor trustee, each of which shall be hereinelsewhere referred to as the "Insurance Trustee".

(c) in no event shall the insurance coverage obtained and maintained pursuant to the requirements of this Article be

brought into contribution with insurance purchased by the owners of the condominium units or their mortgagees, as herein permitted, and any "no other insurance" or similar clause in any policy obtained by the Council of Unit Owners pursuant to the requirements of this Article shall exclude such policies from consideration.

(d) such policies shall contain no provision relieving the insurer from liability because of loss occurring while the hazard is increased in the building, whether or not within the control or knowledge of the Board of Directors and shall contain no provision relieving the insurer from liability by reason of any breach of warranty or condition caused by the Board of Directors or any owner of any condominium unit, or their respective agents, employees, tenants, mortgagees or invitees or by reason of any act or neglect or negligence on the part of any of them.

(e) all policies shall provide that such policies may not be cancelled or substantially modified (including cancellation for non-payment of premium) without at least thirty (30) days prior written notice to any and all insureds named thereon, including any and all mortgagees of the condominium units.

(f) all policies of casualty insurance shall provide that notwithstanding any provisions thereof which give the carrier the right to elect to restore damage in lieu of making a cash settlement, such option shall not be exercisable without the prior written approval of the Board of Directors (or any Insurance Trustee) or when in conflict with the provisions of any Insurance Trust Agreement to which the Council of Unit Owners may be a party, these Bylaws or the provisions of the Condominium Act.

(g) all Policies shall contain a waiver of subrogation by the insurer as to any and all claims against the Council of Unit Owners, the Board of Directors, the owner of any condominium unit and their respective agent, employees or tenants, and of any defenses based upon co-insurance or invalidity.

(h) All policies of casualty insurance shall contain the standard mortgagee clause except that any loss or losses payable to named mortgagees shall be payable in the manner set forth in Article XII of these Bylaws. Such mortgagee clause shall provide for notice in writing to the mortgagee of any loss paid as aforesaid.

Section 3. Individual Policies - Recommendation of Declarant - Notice to Board of Directors. The owner of any condominium unit (including the holder of any mortgage thereon) may obtain additional insurance (including a "Condominium Unit-Owner's Endorsement" or its equivalent, for improvements and betterments to the condominium unit made or acquired at the expense of the owner) at his own expense. Such insurance may be written by the same carrier as that from which insurance is purchased by the Board of Directors pursuant to this Article or shall provide that it shall be without contribution as against the same. Such insurance shall contain the same waiver of subrogation provision as that set forth in Section 2(g) of this Article. The Declarant recommends that each owner of a

condominium unit in the Condominium obtain, in addition to the insurance hereinabove provided to be obtained by the Board of Directors, a plateglass damage policy and insurance against loss or damage to personal property used or incidental to the occupancy of the condominium unit, business interruption, vandalism or malicious mischief, theft, personal liability and the like. Such insurance should cover losses to improvements and betterments to the condominium unit made or acquired at the expense of the unit owner. Copies of all such policies shall be filed with the Secretary. The owner of any condominium unit shall notify the Board of Directors in writing of any and all improvements and betterments made to the condominium unit at the expense of such unit owner, the value of which is in excess of Ten Thousand and No/100 Dollars ($10,000.00).

Section 4. Endorsements, etc. The Board of Directors, at the request of any owner of any condominium unit in the Condominium or at the request of the mortgagee of any such condominium unit, shall promptly obtain and forward to such owner or mortgagee (a) an endorsement to any of the policies aforementioned in this Article showing the interest of such unit owner or mortgagee as it may appear; and (b) certificates of insurance relating to any of such policies; and (c) copies of any such policies, duly certified by the insurer or its duly authorized agent.

ARTICLE XII
Casualty Damage - Reconstruction or Repair

Section 1. Use of Insurance Proceeds. In the event of damage or destruction to the Condominium by fire or other casualty, the same shall be promptly repaired or reconstructed in substantial conformity with the original plans and specifications for the Condominium with the proceeds of insurance available for that purpose, if any.

Section 2. Proceeds Insufficient. In the event that the proceeds of insurance are not sufficient to repair damage or destruction by fire or other casualty or in the event such damage or destruction is caused by any casualty not insured against, then the repair or reconstruction of the damage shall be accomplished promptly by the Council of Unit Owners at its common expense, pursuant and subject to such conditions and subject to such controls as the mortgagee, as defined in Section 4 of this Article, may require. The ratable share of the expense of such repairs or reconstruction may be assessed against the owners of all the condominium units in the same proportion as that established in the Declaration for ownership of appurtenant undivided interests in the common elements and, in the event any Statement of Condominium Lien is recorded with respect to any such assessments, then the lien shall have all the priorities provided for in Article VIII of these Bylaws. In the event that the proceeds of casualty insurance are paid to any Insurance Trustee pursuant to the requirements of Section 4 of this Article, then all funds collected from the unit owners of the condominium units pursuant to this Section 2 shall likewise be paid over to such Insurance Trustee and shall be disbursed by such Insurance Trustee in accordance with the provisions of Section 4 of this Article.

Section 3. Restoration Not Required. In the event the Condominium is damaged or destroyed by fire or other casualty to

the extent of two-thirds (2/3) of the full replacement value of the Condominium, as estimated by the Board of Directors and the insurer pursuant to the requirements of Section 1(a) of Article XII of these Bylaws for the period during which such loss was sustained, and the unit owners to which eighty percent (80%) of the votes in the Council of Unit are allocated do not promptly resolve to proceed with repair or reconstruction, then and in that event the Condominium shall be terminated in accordance with the terms and provisions of Title 11, Section 11-123 of the Real Property Article of the Annoted Code of Maryland.

Section 4. Insurance Trustee. In the event the cost of reconstruction or repair (as estimated by the Board of Directors) shall exceed an amount equal to two and one-half percent (2-1/2%) of the full replacement value of the Condominium, as estimated by the Board of Directors and the insurer pursuant to the requirements of Section 1(a) of Article XII of these Bylaws for the period during which such loss was sustained, and the institutional holder or holders of any mortgages or other obligations secured by any condominium unit or units in the aggregate principal sum of more than $250,000.00 (hereinafter in this Section 4 called the "mortgagee") shall so require, all proceeds of insurance shall be paid over to a trust company or bank (the "Insurance Trustee") having trust powers and authorized to engage in trust business in the jurisdiction wherein the Condominium is located, selected by the Board of Directors with the approval of the mortgagee, and shall be paid out from time to time as the reconstruction or repair progresses in accordance with the provisions of an Insurance Trust Agreement satisfactory in form and substance to the mortgagee and which shall contain, inter alia, the following provisions:

(a) the reconstruction or repair shall be in the charge of an architect or engineer, who may be an employee of the Council of Unit Owners, satisfactory to the mortgagee, and hereinafter in this Section 4 called the "architect".

(b) prior to the commencement of the reconstruction or repair, other than such work as may be necessary to protect the Condominium from further damage,the mortgagee shall have approved the plans and specifications for such reconstruction or repair, which approval shall not be unreasonably withheld or delayed.

(c) unless otherwise required by the mortgagee, each request for an advance of the proceeds of insurance shall be made to the mortgagee at least ten (10) days prior to delivery

to the Insurance Trustee and shall be accompanied by a certificate from the architect to the effect that (i) all work then completed has been performed in accordance with the plans and specifications and all building codes or similar governmental requirements; and (ii) the amount requested to be advanced is required to reimburse the Council of Unit Owners for payments previously made by the Council of Unit Owners or is due to the contractor responsible for the restoration or repair, or to subcontractors, materialmen, laborers, engineers, architects or to other persons responsible for services or materials in connection with such restoration or repair or for fees or the like necessarily incurred in connection with the same; and (iii) when added to amounts previously advanced by the Insurance Trustee, the amount requested to be advanced does not unreasonably exceed the value of the work done and materials delivered to the date of such request; and (iv) funds remaining available to the Insurance Trustee for the purpose are sufficient to complete the reconstruction or repair.

(d) each request for an advance of the proceeds of insurance shall, if required by the mortgagee, be accompanied by satisfactory waivers of liens covering that portion of the repair or reconstruction for which payment or reimbursement is being requested, together with appropriate evidence from a title insurance company or the like to the effect that there has not been filed with respect to the Condominium any mechanic's or other lien, or notice of intention to file the same, which has not been dismissed or satisfied of record.

(e) the fees and expenses of the Insurance Trustee, as agreed upon by the Board of Directors and the Insurance Trustee, shall be paid by the Council of Unit Owners as a common expense, and such fees and expenses may be deducted from any insurance proceeds in the hands of the Insurance Trustee, pro rata as the reconstruction or repair progresses.

(f) such other provisions not inconsistent with the provisions hereof as the Board of Directors, the Insurance Trustee or the mortgagee may reasonably require.

Upon completion of the reconstruction or repair and payment in full of all amounts due on account thereof, any proceeds of insurance then in the hands of the Insurance Trustee shall be paid to the Council of Unit Owners and shall be considered as one fund and shall be divided among the owners of all of the condominium units in the same proportion as that established in the Declaration for ownership of appurtenant undivided interests in the common elements, after first paying out of the share of the owner of any condominium unit, to the extent such payment is required by any lienor and to the extent the same is sufficient for the purpose, all liens upon said condominium unit in accordance with the priority of interest in each unit.

ARTICLE XIII
Fiscal Management

Section 1. Fiscal Year. The fiscal year of the Council of Unit Owners shall begin on the first day of January every year, except for the first fiscal year of the Council of Unit Owners which shall begin at the date of recordation of the Declaration

among the Land Records of Montgomery County, Maryland. The commencement date of the fiscal year herein established shall be subject to change by the Board of Directors should the practice of the Council of Unit Owners subsequently dictate.

Section 2. Principal Office - Change of Same. The principal office of the Council of Unit Owners shall be as set forth in Article I of these Bylaws. The Board of Directors, by appropriate resolution, shall have the authority to change the location of the principal office of the Council of Unit Owners from time to time; provided, however, that no such change shall become effective until a certificate evidencing such change shall have been made by the Secretary or any Assistant Secretary of the Council of Unit Owners and recorded, in the name of the Council of Unit Owners, among the Land Records for the jurisdiction where the Declaration was originally recorded or with the Maryland State Department of Assessments and Taxation.

Section 3. Books and Accounts. Books and accounts of the Council of Unit Owners shall be kept under the direction of the Treasurer in accordance with generally accepted accounting practices, consistently applied. The same shall include books with detailed accounts, in chronological order, of the receipts and of the expenditures and other transactions of the Council of Unit Owners and its administration and shall specify the maintenance and repair expenses of the common elements of the Condominium, services provided with respect to the same and any other expenses incurred by the Council of Unit Owners. The amount of any assessment required for payment of any capital expenditures or reserves of the Council of Unit Owners may be credited upon the books of the Council of Unit Owners to the "Paid-in-Surplus" account as a capital contribution by the members. The receipts and expenditures of the Council of Unit Owners shall be credited and charged to other accounts under at least the following classifications:

(a) "Current Operations" which shall involve the control of actual expenses of the Council of Unit Owners, including reasonable allowances for necessary contingencies and working capital funds in relation to the assessments and expenses herein provided for; and

(b) "Reserves for Deferred Maintenance" which shall involve the control of monthly funding and maintenance of such deferred maintenance costs and reserves as are approved by the Board of Directors from time to time; and

(c) "Reserves for Replacement" which shall involve the control of such reserves for replacement as are provided for in these Bylaws and as may from time to time be approved by the Board of Directors; and

(d) "Other Reserves" which shall involve the control over funding and charges against any other reserve funds which may from time to time be approved by the Board of Directors; and

(e) "Investments" which shall involve the control over investment of reserve funds and such other funds as may be deemed suitable for investment on a temporary basis by the Board of Directors; and

(f) "Betterments" which shall involve the control over funds to be used for the purpose of defraying the cost of any construction or reconstruction, unanticipated repair or replacement of a described capital improvement and for expenditures for additional capital improvements or personal property made or acquired by the Council of Unit Owners with the approval of the Board of Directors.

Section 4. Auditing. At the close of each fiscal year, the books and records of the Council of Unit Owners shall be audited by an independent Certified Public Accountant whose report shall be prepared and certified in accordance with generally accepted auditing standards, consistently applied. Based upon such report, the Council of Unit Owners shall furnish the unit owners and any mortgagee requesting the same with an annual financial statement, including the income and disbursements of the Council of Unit Owners, within ninety (90) days following the end of each fiscal year.

Section 5. Inspection of Books. The books and accounts of the Council of Unit Owners, vouchers accrediting the entries made thereupon and all other records maintained by the Council of Unit Owners shall be available for examination by the unit owners and their duly authorized agents or attorneys, and to the institutional holder of any first mortgage on any condominium unit and its duly authorized agents or attorneys, during normal business hours and for purposes reasonably related to their respective interests and after reasonable notice.

Section 6. Execution of Corporate Documents. With the prior authorization of the Board of Directors, all notes and contracts shall be executed on behalf of the Council of Unit Owners by either the President or a Vice President, and all checks shall be executed on behalf of the Council of Unit Owners by such officers, agents or other persons as are from time to time so authorized by the Board of Directors.

Section 7. Seal. The Board of Directors may provide a suitable corporate seal containing the name of the Council of Unit Owners, which seal shall be in the charge of the Secretary. If so directed by the Board of Directors, a duplicate seal may be kept and used by the Treasurer or any assistant secretary or assistant treasurer.

ARTICLE XIV
Physical Management

Section 1. Management and Common Expenses. The Council of Unit Owners, acting by and through its Board of Directors, shall manage, operate and maintain the condominium units and, for the benefit of the condominium units and the unit owners, shall enforce the provisions hereof and shall pay out of the common expense fund herein provided for the cost of managing, operating and maintaining the Condominium, including, without limitation, the following:

(a) the cost of providing water, sewer, garbage and trash collection and electrical, gas and other necessary utility services for the common elements and, to the extent that the same are not separately metered or billed to each condominium unit, for the condominium units; and

(b) the cost of fire and extended liability insurance on the Condominium and the cost of such other insurance as the Council of Unit Owners may effect; and

(c) the cost of the services of a person or firm to manage the Condominium to the extent deemed advisable by the Council of Unit Owners consistent with the provisions of these Bylaws, together with the services of such other personnel as the Board of Directors of the Council of Unit Owners shall consider necessary for the operation of the Condominium; and

(d) the cost of providing such legal and accounting services as may be considered necessary by the Board of Directors for the operation of the Condominium; and

(e) the cost of repairs, maintenance, service and replacement of leased areas associated with the Condominium and the common elements of the Condominium, including, without limitation, the cost of painting, maintaining, replacing, repairing and landscaping the common elements and such furnishings and equipment for the common elements as the Board of Directors shall determine are necessary and proper; provided, however, that nothing herein contained shall require the Council of Unit Owners to repair, replace, or otherwise maintain the interior of any condominium unit or any fixtures, appliances, equipment or the like located therein; and

(f) the cost of any and all other materials, supplies, labor, services, maintenance, repairs, taxes, assessments or the like, which the Council of Unit Owners is required to secure or pay for by law, or otherwise, or which in the discretion of the Board of Directors shall be necessary or proper for the operation of the Condominium; provided, however, that if any of the aforementioned are provided or paid for the specific benefit of a particular condominium unit or units, the cost thereof shall be specially assessed to the owner or owners thereof in the manner provided in this Article; and

(g) the cost of the maintenance or repair of any condominium unit in the event such maintenance or repair is reasonably necessary in the discretion of the Board of Directors to protect the common elements or to preserve the appearance or value of the Condominium, or is otherwise in the interest of the general welfare of all of the unit owners; provided, however, that, except in cases involving emergencies or manifest danger to safety of person or property, no such maintenance or repair shall be undertaken without a resolution by the Board of Directors and not without reasonable written notice to the owner of the condominium unit proposed to be maintained and, provided further, that the cost thereof shall be assessed against the condominium unit for which such maintenance or repair is performed and, when so assessed, a statement for the amount thereof shall be rendered promptly to the then owner of said condominium unit at which time the assessment shall become due and payable and a continuing obligation of said unit owner in all respects as provided in Article VIII of these Bylaws; and

(h) any amounts necessary to discharge any lien or encumbrance levied against the Condominium, or any portion thereof, which may, in the opinion of the Board of Directors, constitute

a lien against any of the common elements rather than the interest of the owner of any individual condominium unit, including taxes.

Section 2. Council of Unit Owners as Attorney-in-Fact. The Council of Unit Owners is hereby irrevocably appointed as the attorney-in-fact for the owners of all the condominium units in the Condominium, and for each of them, to manage, control and deal with the interests of such unit owners in the common elements of the Condominium so as to permit the Council of Unit Owners to fulfill all of its powers, functions and duties under the provisions of the Condominium Act, the Declaration and the Bylaws, and to exercise all of its rights thereunder and to deal with the Condominium upon its destruction and the proceeds of any insurance indemnity, as hereinelsewhere provided. The foregoing shall be deemed to be a power of attorney coupled with an interest and the acceptance by any person or entity of any interest in any condominium unit shall constitute an irrevocable appointment of the Council of Unit Owners as attorney-in-fact as aforesaid.

Section 3. Management Agent. The Council of Unit Owners may by contract in writing delegate any of its ministerial duties, powers or functions to the Management Agent. The Council of Unit Owners and the Board of Directors shall not be liable for any omission or improper exercise by the Management Agent of any such duty, power of function so delegated.

Section 4. Limitation of Liability. The Council of Unit Owners shall not be liable for any failure of water supply or other services to be obtained by the Council of Unit Owners or paid for out of the common expense funds, or for injury or damage to person or property caused by the elements or resulting from electricity, water, snow or ice which may leak or flow from any portion of the common elements or from any wire, pipe, drain, conduit, appliance or equipment. The Council of Unit Owners shall not be liable to the owner of any condominium unit for loss or damage, by theft or otherwise, of articles which may be stored upon any of the common elements. No diminution or abatement of common expense assessments, as herein provided, shall be claimed or allowed for inconvenience or discomfort arising from the making of repairs or improvements to the common elements, or to any condominium unit, or from any action taken by the Council of Unit Owners to comply with any law or ordinance or with the order or directive of any governmental authority.

ARTICLE XV
Parking

Section 1. General Requirements. All parking areas within the Condominium or leased to the Declarant or the Council of Unit Owners shall be considered part of the general common elements. Parking may be regulated by the Board of Directors. No vehicle belonging to any unit owner, or to any guest or employee of any unit owner, shall be parked in a manner which unreasonably interferes with or impedes ready vehicular access to any other parking spaces. Nothing shall be stored upon any parking space nor shall the same be permitted to accumulate trash or debris. Each unit owner shall comply in all respects

with such supplementary rules and regulations which are not inconsistent with the provisions of these Bylaws which the Board of Directors may from time to time adopt and promulgate with respect to parking and traffic control within the Condominium and the Board of Directors is hereby, and elsewhere in these Bylaws authorized to adopt such rules and regulations.

ARTICLE XVI
Amendment

Section 1. Amendments. These Bylaws may be amended by the affirmative vote of unit owners representing sixty-seven percent (67%) of the total votes of the Council of Unit Owners, at any meeting of the unit owners duly called for such purpose, in accordance with the provisions and requirements of these Bylaws and Title 11, Real Property Article, of the Annotated Code of Maryland (1981 Repl. Vol.). Any amendment to these Bylaws shall be effective only upon the recordation of such amendment among the Land Records for Montgomery County, Maryland, together with a certificate in writing of the President of the Council of Unit Owners stating that the amendment was approved as aforesaid.

Section 2. Proposal of Amendments. Amendments to these Bylaws may be proposed by the Board of Directors of the Council of Unit Owners or by petition signed by unit owners representing at least twenty-five percent (25%) of the total votes of the Council of Unit Owners, which petition shall be delivered to the Secretary. A description of any proposed amendment shall accompany the notice of any annual or special meeting of the unit owners at which such proposed amendment is to be considered and voted upon.

ARTICLE XVII
Mortgages - Notice - Other Rights of Mortgagees

Section 1. Notice to Board of Directors. Any owner of any condominium unit in the Condominium who mortgages such unit shall promptly notify the Board of Directors of the name and address of his mortgagee and, if requested so to do, shall file a conformed copy of such mortgage with the Board of Directors. The Board of Directors shall maintain suitable records pertaining to such mortgages.

Section 2. Consents. Any other provision of these Bylaws or of the Declaration to the contrary notwithstanding, neither the unit owners, the Board of Directors nor the Council of Unit Owners shall, by act or omission, take any of the following actions without the prior written consent and approval of the holders of all first mortgages of record on the condominium units:

(a) abandon or terminate the Condominium except for abandonment or termination provided in the Condominium Act in the case of substantial damage or destruction of the Condominium by fire or other casualty or in the case of a taking by condemnation or eminent domain; or

(b) modify or amend the Declaration or these Bylaws so as to change the percentage interests of the unit owners in the common elements of the Condominium, the percentage interests of

the unit owners in the common expenses and common profits of the Condominium or the voting rights of the unit owners; or

(c) modify the method of determining and collecting common expense assessments or other assessments as provided in Article VIII of these Bylaws; or

(d) abandon, partition, subdivide, encumber, sell or transfer any of the common elements of the Condominium; provided, however, that the granting of easements and rights-of-way for public utilities or for other public purposes consistent with the continued use of the common elements by the unit owners shall not be deemed a transfer within the meaning of this subparagraph (d); or

(e) resolve to use the proceeds of casualty insurance for any purpose other than the repair, replacement or reconstruction of the Condominium.

Section 3. Subdivision or Partition. No condominium unit in the Condominium shall be subdivided or partitioned without the prior written approval of the holder of any first mortgage on such condominium unit.

Section 4. Casualty Losses. In the event of damage or destruction of any Condominium unit or any part of the common elements of the Condominium the Board of Directors of the Council of Unit Owners shall give prompt written notice of such damage or destruction to the holders of all first mortgages of record on the condominium units. No provision of the Declaration or these Bylaws shall entitle any unit owner to any priority over the holder of any first mortgage of record on his condominium unit with respect to the distribution to such unit owner of any insurance proceeds.

Section 5. Condemnation or Eminent Domain. In the event any condominium unit or any part of the common elements of the Condominium is made the subject matter of any condemnation or eminent domain proceeding, or is otherwise sought to be acquired by any condemning authority, then the Board of Directors of the Council of Unit Owners shall give prompt written notice of any such proceeding or proposed acquisition to the holders of all first mortgages of record on the condominium units. No provision of the Declaration or these Bylaws shall entitle any unit owner to any priority over the holder of any first mortgage of record on his condominium unit with respect to the distribution to such unit owner of the proceeds of any condemnation award of settlement.

ARTICLE XVIII
Compliance - Interpretation - Miscellaneous

Section 1. Compliance. These Bylaws are set forth in compliance with the requirements of Title 11, Real Property Article, Annotated Code of Maryland (1981 Repl. Vol.).

Section 2. Conflict. These Bylaws are subordinate and subject to all provisions of the Declaration and to the provisions of Title 11, Real Property Article, Annotated Code of Maryland (1981 Repl. Vol.), as amended, provided however that

Sections 11-111 and 11-113 of such Article are hereby negated and superseded by the terms and provisions of the Declaration and these By-Laws. All of the terms hereof, except where clearly repugnant to the context, shall have the same meaning as in the Declaration or the aforesaid statute. In the event of any conflict between these Bylaws and the Declaration, the provisions of the Declaration shall control; and in the event of any conflict between the aforesaid Declaration and Title 11, Real Property Article, Annotated Code of Maryland (1981 Repl. Vol.), the provisions of the statute shall control.

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EXHIBIT C

PERCENTAGE INTEREST IN COMMON ELEMENTS

UNIT	SIZE	PERCENTAGE INTEREST
7610-100	1,135 sq. ft.	2.82
7610-110	1,410 sq. ft.	3.50
7610-120	1,678 sq. ft.	4.17
7610-200	1,584 sq. ft.	3.93
7610-220	1,426 sq. ft.	3.54
7610-230	4,230 sq. ft.	10.51
7610-240	871 sq. ft.	2.16
7610-260	883 sq. ft.	2.19
7610-270	1,510 sq. ft.	3.75
7610-280	1,275 sq. ft.	3.17
7610-300	8,054 sq. ft.	20.00
7610-380	4,095 sq. ft.	10.17
7610-400	7,598 sq. ft.	18.87
7610-460	1,467 sq. ft.	3.64
7610-470	2,136 sq. ft.	5.31
7610-480	913 sq. ft.	2.27

EXHIBIT D

PERCENTAGE INTEREST IN PROFITS AND EXPENSES

UNIT	SIZE	PERCENTAGE INTEREST
7610-100	1,135 sq. ft.	2.82
7610-110	1,410 sq. ft.	3.50
7610-120	1,678 sq. ft.	4.17
7610-200	1,584 sq. ft.	3.93
7610-220	1,426 sq. ft.	3.54
7610-230	4,230 sq. ft.	10.51
7610-240	871 sq. ft.	2.16
7610-260	883 sq. ft.	2.19
7610-270	1,510 sq. ft.	3.75
7610-280	1,275 sq. ft.	3.17
7610-300	8,054 sq. ft.	20.00
7610-380	4,095 sq. ft.	10.17
7610-400	7,598 sq. ft.	18.87
7610-460	1,467 sq. ft.	3.64
7610-470	2,136 sq. ft.	5.31
7610-480	913 sq. ft.	2.27

EXHIBIT E

Washington Board of Realtors Method

Single Tenancy Floors

The net rentable area of a single tenancy floor shall be the area with the outside walls computed by measuring from the inside surface of the outer masonry building wall to the inside surface of the opposite outer masonry building wall, but where the outer building wall consists of 50% or more of glass, the rentable area shall be measured from the inside surface of such glass area to the inside surface of opposite outer masonry building wall or the opposite glass area, whichever is applicable, including columns and projections necessary to the building and the following accessory areas when within and exclusively serving only that floor, with their enclosing walls: toilets, janitors' closets, slop sinks, electrical closets, telephone closets, air-conditioning rooms, fan rooms.

But excluding the following when serving more than one floor, with their enclosing walls: public stairs, fire towers, public elevator shafts, flues, vents, stacks, pipe shafts, vertical ducts.

Divided Floors

The net rentable area of an individual office or a portion of a divided floor shall be the area computed by measuring from the inside surface of the outer masonry building wall (but where the outer building wall is 50% or more of glass, the rental area shall be measured from the inside surface of such glass area) *to the finished surface of the corridor side of corridor partition*, and from the center of the partitions that separate the premises from adjoining rentable areas, including columns and projections necessary to the building and a pro-rata share of any accessory areas such as public corridors and elevator lobbies, toilets, janitors' closets, slop sinks, electrical closets, telephone closets, air-conditioning rooms and fan rooms, with their enclosing walls serving the divided floor as described above.

EXHIBIT I

Adventist HealthCare

Washington Adventist Hospital Demolition Update

April 28, 2025

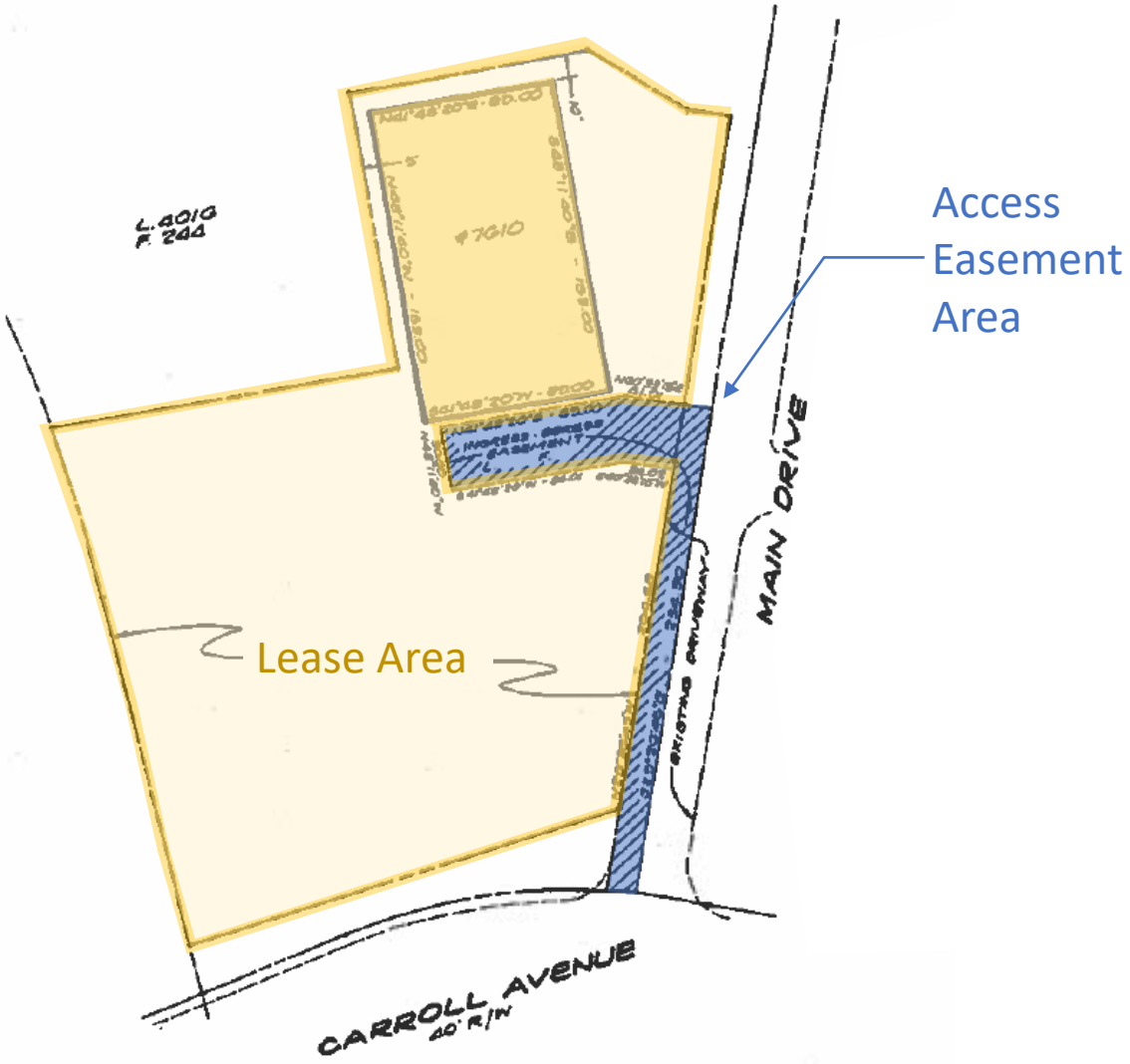
Exhibit 7(i)

Agenda

- Property Lines
- Areas of Demolition
- Demolition Fence Plan
- Schedule
- Review Ground Lease

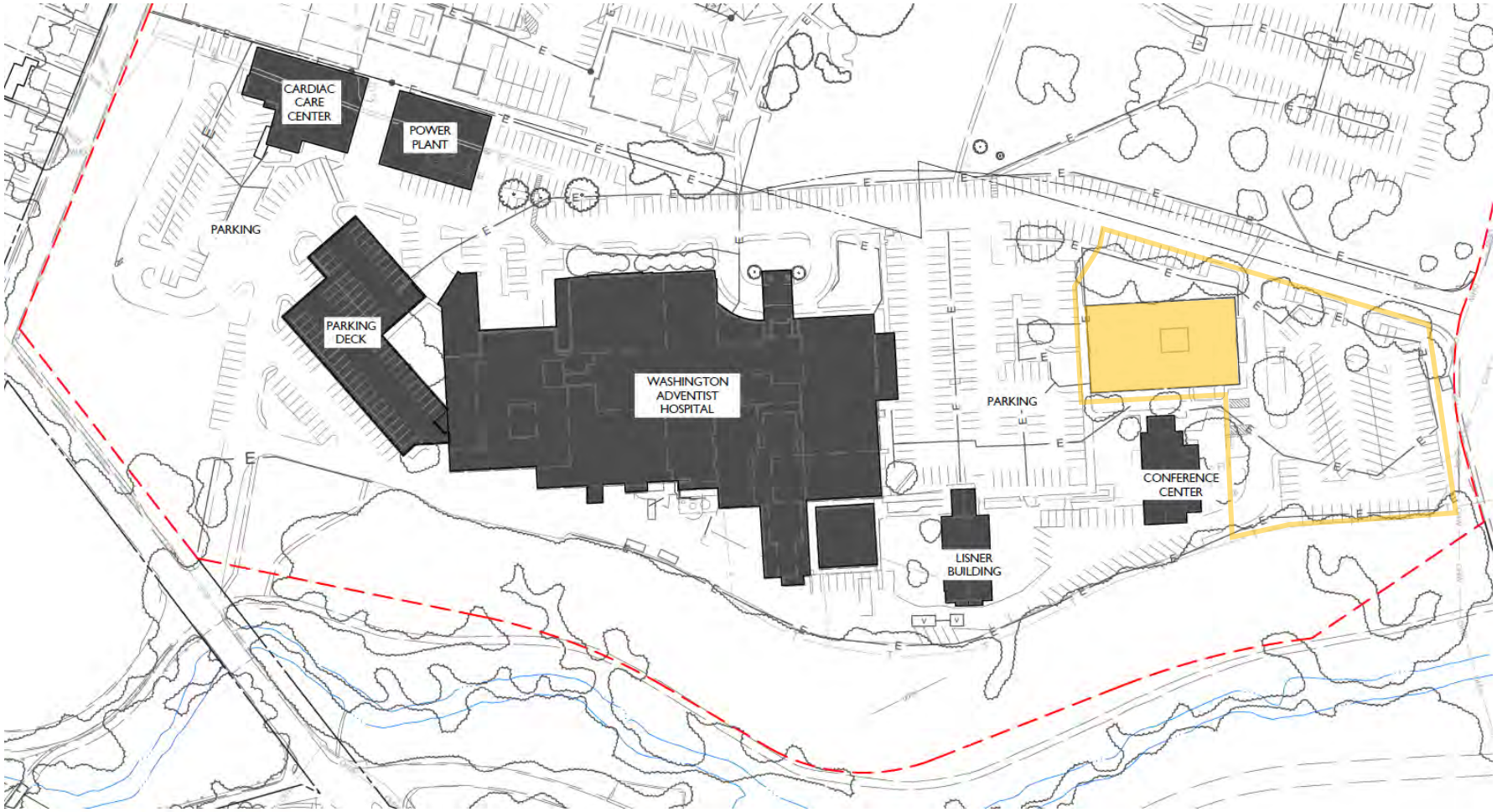
Adventist HealthCare

Property Lines – Leased Area



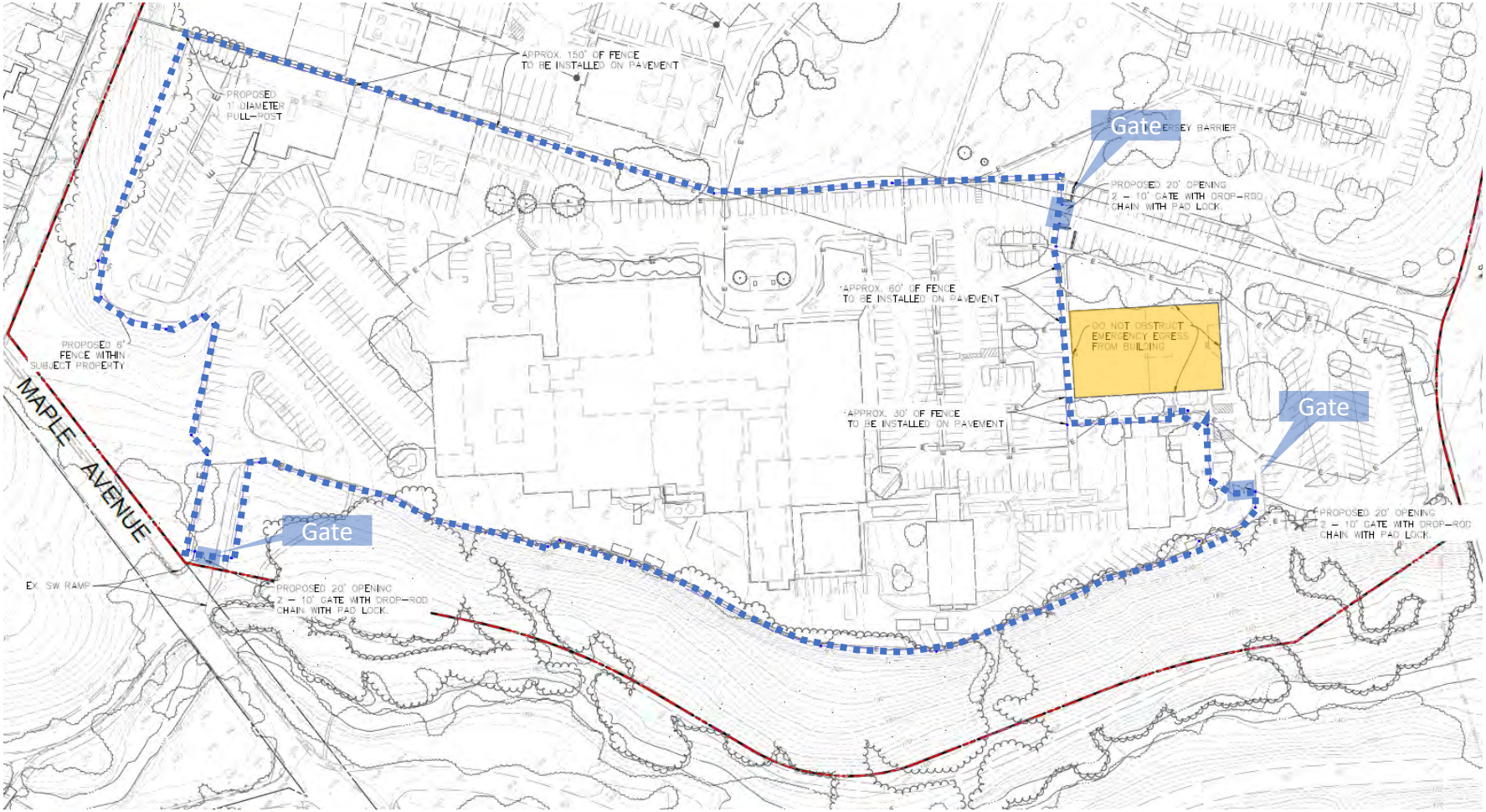
Adventist HealthCare

Areas of Demolition



Adventist HealthCare

Demolition Fence Plan

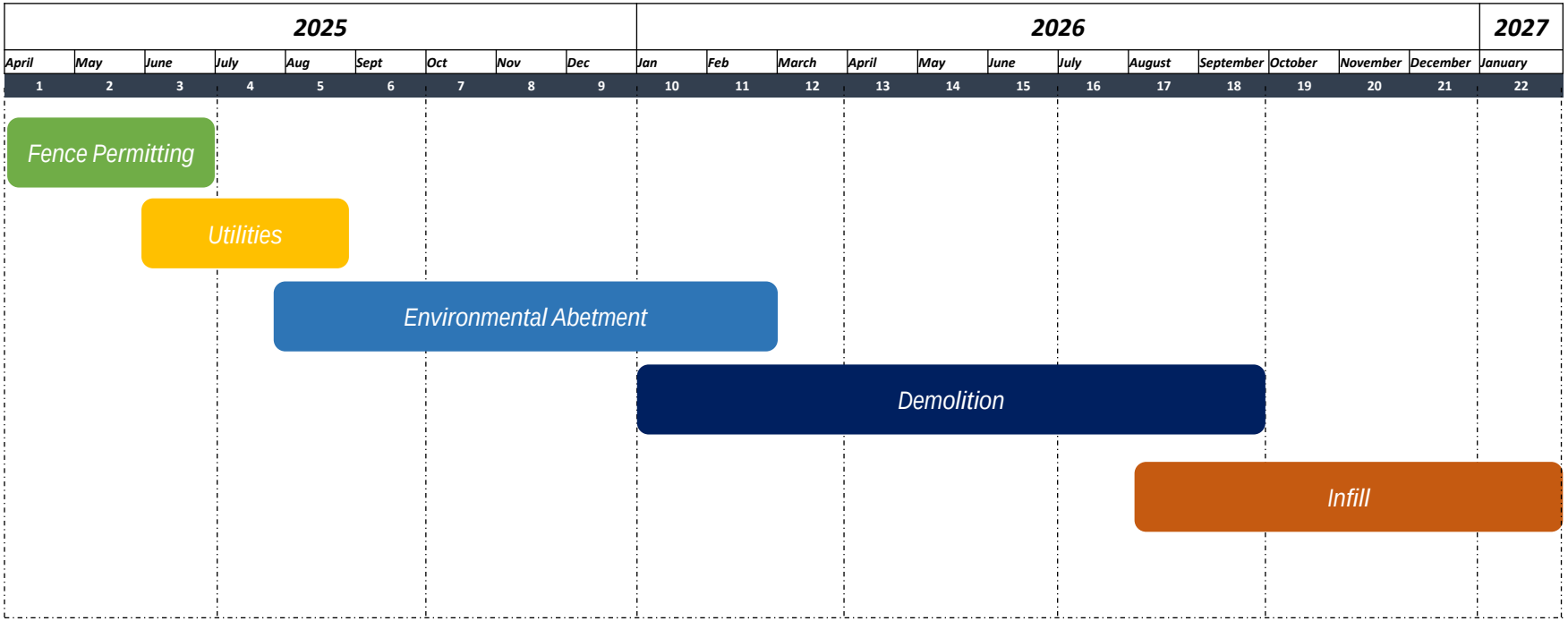


Adventist HealthCare

Demolition Fence Plan

Adventist HealthCare

High Level Schedule



Adventist HealthCare

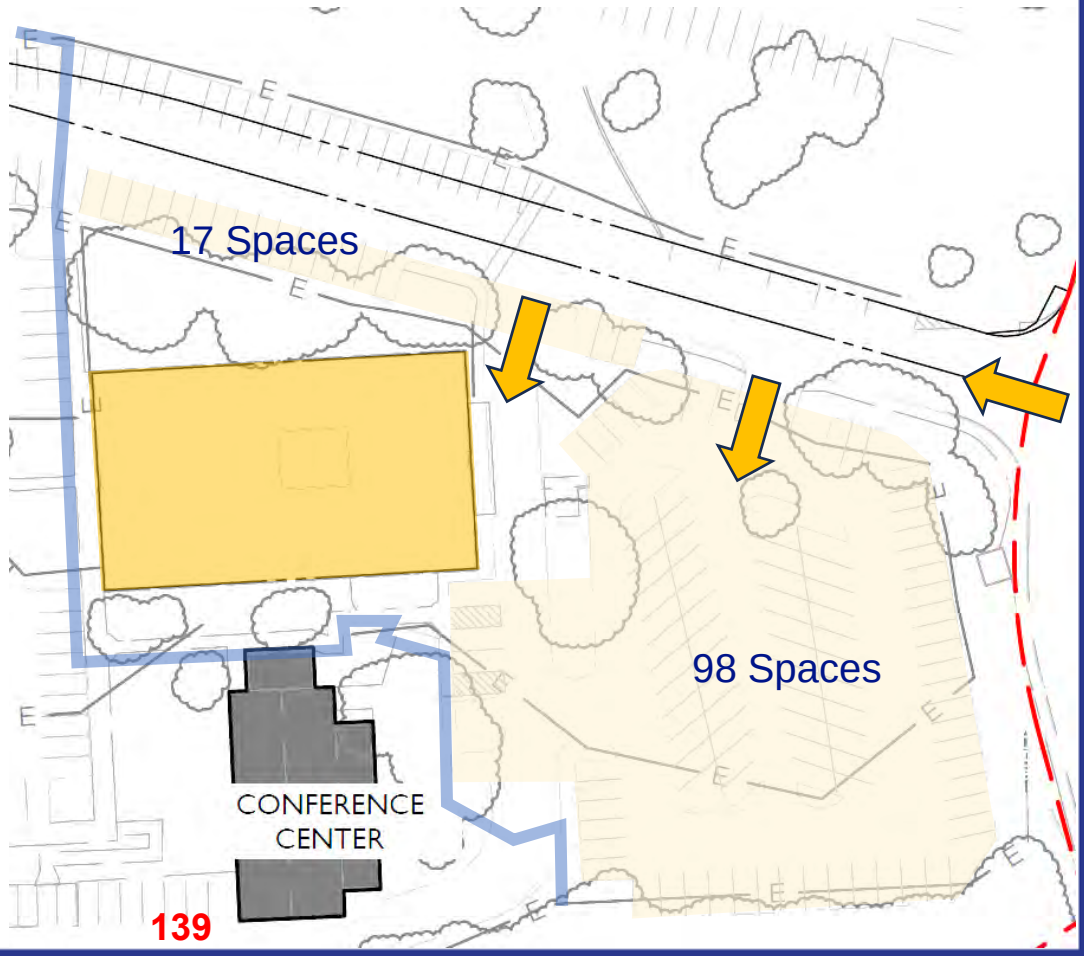
Review of Ground Lease T & C

Access to the site/building

- Unobstructed access from Carrol Avenue
- Access from Maple Avenue closed

Use of parking

- Front lot – 98 spaces
- Access Road – 17 spaces



Adventist HealthCare

Review of Ground Lease T & C (cont.)

Parking Agreement

- Parking Agreement created 5/31/83 expired 5/31/23 - 40 year term.
- Parking rent noted in paragraph 3 was to be $5000/month with annual CPI increases.
- No record of rent paid.
- Paragraph 22 addresses permits holdover on month-to-month basis upon payment of 150% of the rent.

Ongoing maintenance of site access and parking areas

- Paragraph 6 states Lessee shall pay all expenses for maintenance of the property and keep in good condition.

Adventist HealthCare

Review of Ground Lease T & C (cont.)

Utilities

- All utilities to be separate
  - Power (Pepco)
    - Pepco accounts already separate from the Hospital
    - AHC to separate Parking Lot lighting and connect to Professional Building electrical panel
  - Water/sewer (WSSC)
    - WSSC accounts to be separated between the Hospital and Professional Building
      - AHC will install new infrastructure (pipes and meter) for separation
      - May require filing to WSSC by both Owners

Adventist HealthCare

Washington
Adventist Hospital
A Member of Adventist HealthCare

Application for Certificate of Need

October 4, 2013

Washington Adventist Hospital

7600 Carroll Ave.

Takoma Park, MD 20912

301-891-7600

www.AdventistHealthCare.com

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MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

HOSPITALS
APPLICATION FOR CERTIFICATE OF NEED

ALL PAGES THROUGHOUT THE APPLICATION, ATTACHMENTS AND EXHIBITS SHOULD BE NUMBERED CONSECUTIVELY.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. a. Adventist HealthCare, Inc. d/b/a Washington Adventist Hospital
Legal Name of Project Applicant (ie. Licensee or Proposed Licensee)

   b. 820 West Diamond Avenue
Street

   c. Gaithersburg 20878 Montgomery
City Zip County

   d. 301-315-3030
Telephone

   e. William G. "Bill" Robertson
Name of Owner/Chief Executive

2. a. _____
Legal Name of Project Co-Applicant (ie. if more than one applicant)

   b. _____
Street

   c. _____
City Zip County

   d. _____
Telephone

   e. _____
Name of Owner/Chief Executive

3. a. Washington Adventist Hospital
Name of Facility

   b. 12100 Plum Orchard Drive
Street (Project Site)

   c. Silver Spring 20904 Montgomery
City Zip County

4. _____
Name of Owner (if different than applicant)

5. a. _____
Representative of Co-Applicant

   b. _____
Street

   c. _____
City Zip County

   d. _____
Telephone

6. **Person(s) to whom questions regarding this application should be directed:** ***(Attach sheets if additional persons are to be contacted)***

a. Robert Jepson, Vice President Business Development
Name and Title

b. 820 West Diamond Avenue
Street

c. Gaithersburg 20878 Montgomery
City Zip County

d. 301-315-3042
Telephone No.

e. 301-315-3043
Fax No.

f. RJepson@adventisthealthcare.com
E-mail Address

a. Geoffrey A. Morgan, Vice President Washington Adventist Hospital
Name and Title

b. 12041 Bournefield Way
Street

c. Silver Spring 20904 Montgomery
City Zip County

d. 301-592-4458 or 301-891-6214
Telephone No.

e. 301-891-5991
Fax No.

f. GMorgan@adventisthealthcare.com
E-mail Address

a. Joyce Newmyer, President Washington Adventist Hospital
Name and Title

b. 7600 Carroll Avenue
Street

c. Takoma Park 20912 Montgomery
City Zip County

d. 301-891-5651
Telephone No.

e. 301-891-5991
Fax No.

f. JNewmyer@adventisthealthcare.com
E-mail address

a. Howard Sollins, Attorney Ober|Kaler
Name and Title

b. 100 Light Street
Street

c. Baltimore 21202-1643 Baltimore City
City Zip County

d. 410-347-7369
Telephone No.

e. 443-263-7569
Fax No.

f. hlsollins@ober.com
E-mail address

7. **Brief Project Description** ***(for identification only; see also item #14)*:**

APPLICANT RESPONSE:

Adventist HealthCare proposes the construction of a 201-bed replacement hospital facility on 48.86 acres in the White Oak area of Silver Spring ("White Oak campus"). Behavioral health services, including 40 acute psychiatric beds, will remain in renovated space inside the current Washington Adventist Hospital facility on the Takoma Park campus ("Takoma Park campus"). Outpatient services will be available on both the White Oak campus and the Takoma Park campus.

8. **Legal Structure of Licensee *(check one from each column):***

a.		b.		c.	
Governmental	___	Sole Proprietorship	___	To be Formed	___
Proprietary	___	Partnership	___	Existing	X
Nonprofit	X	Corporation	X		
		Subchapter "S"	___		

9. **Current Physical Capacity and Proposed Changes:** ***(Staff will also provide separately a detailed spreadsheet on which the applicant will display current and proposed physical bed capacity by location.)***

Service	Current Physical Beds	Beds to be Added or Reduced	Total Beds if Project is Approved	Comments (WO = White Oak, TP = Takoma Park)
M/S/G/A	157 Beds	-5	152	WO
Pediatrics	0 Beds	n/a	n/a	
Obstetrics	21 Beds	0	21	WO
ICU/CCU Care	34 Beds	-6	28	WO
Psychiatry	40 Beds	0	40	TP
Rehabilitation	n/a Beds	n/a	n/a	n/a
Chronic	0 Beds	n/a	n/a	n/a
Other (Specify	n/a Beds	n/a	n/a	n/a
TOTAL BEDS	252	-11	241	WO + TP

10. **Project Location and Site Control:**

A. **Site Size** 48.86 acres

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

C. **Site Control:**

(1) **Title held by:** Adventist HealthCare, Inc.

(2) **Options to purchase held by:** _____

(i) **Expiration date of option** _____

(ii) **Is option renewable?** _____ **If yes, please explain**

_____

_____

(iii) **Cost of Option** _____

(3) **Land Lease held by:** Adventist HealthCare, Inc.

(i) **Expiration date of lease** _____

(ii) **Is lease renewable** _____ **If yes, please explain**

_____

_____

(iii) **Cost of Lease** _____

(4) **Option to lease held by:** _____

(i) **Expiration date of option** _____

(ii) **Is option renewable?** _____ **If yes, please explain**

_____

_____

(iii) **Cost of option** _____

(5) **If site is not controlled by ownership, lease, or option, please explain how site control will be obtained** _____

_____

APPLICANT RESPONSE:

The proposed replacement hospital will be built in White Oak on a 48.86 acre parcel of land that is wholly owned by Adventist HealthCare Holdings 1, LLC where Adventist HealthCare, Inc. (AHC) is the sole member. Renovations will occur in Takoma Park, on the existing campus of Washington Adventist Hospital, also wholly owned by Adventist HealthCare, Inc.

(INSTRUCTION: IN COMPLETING ITEMS 11, 12 & 13, PLEASE NOTE APPLICABLE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

11. Project Implementation Target Dates (for construction or renovation projects):

APPLICANT RESPONSE:

PHASE 1 – Early Site Work at Washington Adventist Hospital at White Oak Campus

A. Obligation of Capital Expenditure: <1 month from approval date.
B. Beginning Construction: <1 month from capital obligation.
C. Pre-Licensure/First Use: 6 months
D. Full Utilization: N/A

PHASE 2 – Base Building and Fit-out at Washington Adventist Hospital White Oak Campus

A. Obligation of Capital Expenditure: <1 month from completion of immediately preceding phase of construction
B. Beginning Construction: 2 months from capital obligation.
C. Pre-Licensure/First Use: 29 months from capital obligation.
D. Full Utilization: 4 months from First Use.

PHASE 3 – Renovations at Takoma Park Campus

A. Obligation of Capital Expenditure: 2 months from completion of immediately preceding phase of construction
B. Beginning Construction: 2 months from capital obligation.
C. Pre-Licensure/First Use: 20 months from capital obligation.
D. Full Utilization: 3 months from First Use.

Phase 1 of the proposed project consists of the early site work on the White Oak campus that is required for commencement of the replacement building foundations and footings. This includes clearing and grubbing, relocation of existing utilities, site access roads and staging areas. In order to deliver a cost-effective project in as short a time frame as possible, Adventist HealthCare will begin Phase 1 construction as soon as possible following award of the CON utilizing existing capital funds (cash) to be reimbursed from the bond proceeds after placement of the construction financing. The design for this work has already been completed and permitted.

Phase 2 of the project consists of fit-out and remainder of site work not required for commencement of the building construction on the White Oak campus, such as final grading, paving, landscaping and site lighting. Because phase 2 will include 428,400 square feet of base building construction, full interior fit-out and equipment installation on a site with complex on-site utilities, extensive on-site circulation and complicated hillside construction, Washington Adventist Hospital is requesting that the Commission authorize 29 months from Capital Obligation to Pre-licensure/First Use for Phase 2 of the project.

This request is respectfully made in recognition that the size and complexity of Phase 2 is equal to or greater than all but the largest single-phase projects approved by the Commission, as well as supported by COMAR 10.24.01.12C. (i) "For a multiphased plan of construction, the Commission, upon a showing of good cause by an applicant, may authorize: (i) Obligation for each approved phase of construction of a specified portion of the capital expenditure that is less than 51 % of the

approved capital expenditure for the entire project; and (ii) Up to 36 months to complete each approved phase.

Phase 3 consists of renovations at the existing Takoma Park campus including a renovated behavioral health unit, new and renovated outpatient clinics, renovation to the Emergency Department and demolition of certain existing interior construction to create leasable space for physician offices and instructional use space by Washington Adventist University.

12. Project Implementation Target Dates *(for projects not involving construction or renovations)*:

A. Obligation of Capital Expenditure ___n/a___ months from approval date.
B. Pre-Licensure/First Use __n/a____ months from capital obligation.
C. Full Utilization _n/a_____ months from first use.

13. Project Implementation Target Dates (for new service projects not involving a capital expenditure):

A. Obligation of Capital Expenditure __n/a____ months from approval date.
B. Pre-Licensure/First Use __n/a____ months from capital obligation.
C. Full Utilization __n/a___ months from first use.

14. Project Description:

Describe the project's construction and renovation plan, and all services to be provided following completion of the project.

APPLICANT RESPONSE:

PROPOSED PROJECT

Washington Adventist Hospital proposes building a replacement inpatient facility on a 48.86 acre site in the White Oak area of Silver Spring, Maryland. The new campus at 12100 Plum Orchard Drive, ("White Oak campus") is located in the existing primary service area for Washington Adventist Hospital and is within a Maryland state priority funding area. (See Exhibit 1 - Priority Funding Area Map). The replacement hospital would include all existing services except for behavioral health services and Adventist Rehabilitation Hospital of Maryland/Takoma Park, both of which will stay permanently in Takoma Park ("Takoma Park campus"). The Takoma Park campus will also retain a Federally Qualified Healthcare Center (FQHC) operated by Community Clinic, Inc., the maternity clinic for low-income women physician offices, diagnostic services (laboratory and imaging), wound care services, various clinics and office space for administrative staff of Adventist HealthCare. The Takoma Park campus would also include more than 55,000 square feet of space to be leased to Washington Adventist University, a growing college with an adjoining campus. (See Exhibit 2- Letter of Intent with Washington Adventist University).

This plan addresses the need for new facilities in an accessible location, continued health care services for the community around the existing Takoma Park campus, and reflects the changing dynamics of health care.

White Oak Facility Description

The project will begin with the development of a full service acute care facility on the White Oak campus, which will then house the current hospital units at Takoma Park with the exception of behavioral health services, which will remain on the Takoma Park campus. The White Oak facility will have a 428,400 square foot gross area and be comprised of eight stories above grade and one below grade, cellar level. The hospital will include 201 private patient rooms.

The White Oak hospital will include the following components:

1) An Emergency Department with 35 treatment bays

2) 8 Operating Rooms (5 for general surgery, 2 for cardiac surgery, 1 hybrid/specialty surgery)

3) 2 Endoscopy Rooms

4) 1 Cystoscopy Room

5) 6 Cardiac/Vascular Angiography suites

6) 32 bed Telemetry Unit

7) 28 bed Critical Care Unit

8) Maternity Unit (21 post-partum rooms, 7 Labor and Delivery Rooms, 2 C-Section)

9) 20 Short Stay Observation Beds (8 in a dedicated unit in the patient tower, 12 adjacent to the ED)

10) Approximately 750 surface parking spaces

The development of the central plant for the facility will be out-sourced to a third party that will provide services to the facility on an ongoing basis.

Once the White Oak hospital opens the existing Takoma Park campus will be partially renovated and modified. In addition, portions of the hospital that will be vacant once services are moved to the White Oak campus will be renovated, mothballed, or leased for alternate uses.

Site Layout and Organization

The White Oak site is oriented generally north-south and slopes from east down to west toward the retention pond. The plan design considered characteristics of the site to incorporate and maximize access, feasibility of future growth and aesthetics.

The building axis is aligned with the site to permit multiple entry points. Site circulation is separated by functions with separate entrances for emergency vehicles, and for the public to access the Emergency Department, the main hospital and the main parking area. This site arrangement improves circulation and access by allowing vehicles to be separated by type of visit. Parking is distributed over the site with multiple points of ingress and egress. Parking functions are also separated according to their associated hospital services with is a dedicated lot for visitors directly in front of the Emergency Department.

The site slope is used to best advantage in the site planning of the campus from both a practical and aesthetic approach. The difference in height is used to expose a back-of-house loading area at the cellar level with a separate entrance and limited visibility and access from patient and public areas. In addition, because the aesthetics of the hospital location and site are criteria in the Washington Adventist Hospital selection process, the sloping site permits less aesthetic site utility functions such as the medical gas storage facility, electrical transformers, generators, central plant and cooling towers to be hidden as much as possible from the street view, improving the view of the hospital from the street. A retaining wall along the west side of the hospital provides additional opportunity for utility functions behind the hospital and an "overlook" south of the hospital.

The sloping site permits access to the lower service level with less excavation than if the entire site were flat and the cellar required major site excavation and manipulation. The intent of the site development will be to balance the excavation and fill required so there is minimal requirement for export or import of soil. This reduces waste and cost and aligns with the project's concept of sustainable development.

Given the constriction and difficulty of expansion at the existing Takoma Park campus, this White Oak site was selected and planned to allow for logical and feasible future growth. The main hospital facility is located in the center of the site with sufficient space for expansion, if necessary, to the north, south, and west. The site plan shows these expansion areas.

The site plan also considers the view of the woods and pond to maximize the aesthetics of the property for the enjoyment of the maximum number of staff, patients, family and visitors. For example, whenever possible, patient rooms will have windows that look out over the pond and woods. The landscape design will include a path around the pond for the use of patients, visitors and staff, with the woodlands retained to the fullest extent possible.

Building Organization, Efficiency and Patient Safety

The hospital is organized to maximize patient safety and efficiency with a patient tower of five Medical-Surgical floors on a "base" with Emergency, Radiology, Surgery, Cardiac, and Maternity services. A cellar level will house support spaces such as Lab, Central Sterile Processing, Dietary, Maintenance, Information Technology and Mechanical-Electrical.

Because the elevators are critical to hospital circulation for patients, visitors, and staff, they form the primary organizing vertical element that also helps differential horizontal functions. Elevator functions are segregated with one bank for the public and a separate bank for service/patients. Both banks are located in the center of the building, to maximize efficiency and provide easy access to all floors and functions. As an organizing element, the central elevator cores provide a functional separation between the patient areas (bed units) north of the elevators and clinical services such as Surgery and Obstetrics which are located south of the elevators.

The hospital design is compact and efficient. The current design has a ratio of 2,031 (GSF) per patient room. Recent hospital constructions considered "efficient" are typically 2,000-2,200 GSF/patient room, making this design on the low (more efficient) end of the spectrum. Efficient buildings are less costly to construct and operate, easier for visitors and staff to navigate, and retain more site for future expansion.

Unit sizes are organized and located to improve efficiency. The Emergency Department is directly below Critical Care and Surgery. Operating rooms are accessible by corridor (Critical Care) or patient transfer elevator (Emergency Department). Maternity and Obstetrics are on one floor. Patient floors are stacked and each patient floor has a similar layout for building function and to simplify construction by stacking services and utilities. Patient rooms are located along the

perimeter for access to natural light and views. Exterior windows will also be provided in the public areas of the unit at the corridors to bring natural light into the unit for staff and visitors. Patient bathrooms are located against the exterior wall to improve staff access to and visibility of patients and minimize travel distance for nurses. The patient rooms are designed around the "family care" model and will contain dedicated areas for family members in each room.

Performance Characteristics and Sustainable Features

Washington Adventist Hospital has set a priority to exceed the minimum threshold of LEED certification that is set as a Montgomery County requirement for a LEED Certified Project. In response, the project design meets a higher standard than that necessary for LEED certification.

Sustainable features of the building include:

- Energy efficiency: the design has set a goal to be more than 14% better than code requirements.
- Envelope efficiency: the design will incorporate an efficient envelope to maximize light while minimizing heat gain.
- Efficient lighting will reduce energy use and improve interior environment quality.
- The project will be commissioned and will employ sophisticated control systems and measuring sensors to ensure the operation meets the design intent.
- Site selection: the site is close to public transportation.
- Stormwater design: the project will control for both quality and quantity within the site.
- Light roofs will reduce the heat island effect.
- Shielded lights will reduce light pollution.
- Water-efficiency will include efficient landscaping with native and low water-use planting and low-flow plumbing fixtures to reduce domestic water use.
- Construction waste will be diverted from landfill, and materials will use recycled content and regional materials to reduce transportation and related environment impact.
- Low-emitting materials, sealants, and finishes will provide a clean interior environment.

Takoma Park Campus

After the completion of the White Oak hospital, the next phase will be the re-development of the Takoma Park campus. As most of the hospital services move to White Oak, the Takoma Park site will change its focus to lower-intensive services more suited to the community and campus conditions.

In this respect, the proposed project makes the best use of an aging campus by changing some functions from clinical to non-clinical uses. Replacing high-intensity clinical services with low-

intensity occupancies will reduce the strain on the infrastructure and utilities so that areas such as behavioral health can remain at Takoma Park with only moderate upgrades and expansions. As explained in the Availability of More Cost Effective Alternatives section the existing infrastructure is not capable of supporting a full building program of modern, high-intensity clinical spaces.

The re-development of the Takoma Park campus includes:

- Behavioral health services will remain in place at Takoma Park and form the core of the inpatient services on that campus. As part of the modernization of this department, a portion of the existing 1990s building will be renovated to accommodate the conversion of semi-private rooms to private, fulfilling one of Washington Adventist Hospital's primary objectives. This will connect to the existing unit via the existing corridor, making one larger behavioral health department. The existing patient rooms will then be converted from semi-private rooms to private rooms.

- The existing Emergency Department will be converted into outpatient clinic space providing a community service and most logical re-use of the existing space. In response to the Takoma Park community, some clinic services will initially operate 24/7 and future hours of operation will depend upon how much the service is utilized by the community. The layout of the clinic space is similar to an emergency department, except that the required infrastructure (including utilities such as air flow) is not as demanding. The ingress and egress of the Emergency Department along with the close proximity of the existing parking make this program change from Emergency Department to clinic space straightforward and logical.

- Existing hospital support functions such as Laboratory, Dietary, Storage, Plant Operations, Pharmacy, and Radiology will remain in their current configuration. They will continue to support the new programs at Takoma Park and the most cost-effective utilization of these spaces is to retain them as is.

- A Federally Qualified Healthcare Center.

- The maternity clinic serving low income women.

- Adventist Rehabilitation Hospital of Maryland/Takoma Park

The balance of the Takoma Park campus will be re-purposed for occupancies and services that make the most sense given the building condition and constraints. Building space will be renovated to house offices for physicians, and Washington Adventist Hospital will lease space to the adjacent Washington Adventist University. Adventist Rehabilitation Hospital of Maryland/Takoma Park will remain in its current space. The reasons for this are as follows:

- These occupancies have less stringent mechanical and plumbing requirements and have lower Energy Use Intensity so they will result in a net reduction of energy use and heating/cooling for the campus. This will in turn free up capacity in the existing utilities to upgrade services to the existing inpatient services which will remain.

- The ceiling heights in the existing Takoma Park buildings are low by current health care standards (refer to "Takoma Park On-Campus Alternative" (Option B). Building new inpatient units in these buildings would be tremendously challenging. It is more

logical to change the occupancies in these areas to uses that will not be as challenging for the building. Commercial office spaces do not have the same ductwork density or sizes that health care occupancies require. As a result, the ceiling height issues are mitigated.

The services in Takoma Park will meet the needs of the community while at the same time making the best use of the existing buildings. The combination of a new facility in White Oak, complete with inpatient and outpatient services within the hospital's primary service area, along with behavioral health services, an FQHC, outpatient clinics, doctor's offices and other services in Takoma Park, provide additional points of access to care for the community.

Project Cost

The total project cost for the development of the White Oak facility and renovations to the Takoma Park campus is $373 million including interest and an allowance for inflation. This includes $294.1M for the construction, and capital costs related to construction of the White Oak hospital facility and $31.787M for the renovations and capital costs related to facilities/services on the Takoma Park campus.

Project Schedule

The total duration of the project from CON submission through to completion of the final phase is estimated at 78 months, including 24 months of planning, CON review, design, permitting and financing and 54 months of site and building construction and occupancy. The project itself is divided into three main phases.

Phase 1 consists of the early site work required for commencement of the building foundations and footings such as clearing and grubbing, relocation of existing utilities, site access roads and staging areas. In order to deliver a cost-effective project in as short a time frame as possible, Adventist HealthCare plans to begin phase 1 as soon as possible following award of the CON utilizing existing capital funds to be reimbursed from the bond proceeds after placement of the construction financing. The design for this work has already been completed and permitted and the site contractor will be selected prior to award of the CON.

Phase 2 will immediately follow phase 1 and consists of the new hospital building construction, fit-out and remainder of site work not required for commencement of the building construction such as final grading, paving, landscaping and site lighting.

Phase 3 is the renovation of the existing Takoma Park hospital including an enhanced behavioral health unit, clinic space and demolition of certain existing interior construction to create leasable space for physician offices and for instructional use by Washington Adventist University. Design, permitting, financing and procurement will begin as the White Oak hospital approaches completion with a target of beginning the construction portion of phase 3 within four months after the White Oak facility construction is completed.

FDA Memorandum of Understanding

Finally, it is important to note that Washington Adventist Hospital has a signed Memorandum of Understanding (MOU) with the Federal Food and Drug Administration, located adjacent to the proposed Washington Adventist Hospital campus in White Oak. The MOU, attached as Exhibit 3, outlines a collaborative relationship between the two entities. "By sharing resources and talents, the two organizations can open up new areas of discovery, funding and cooperation that are critically important for keeping both organizations on the leading edge and for protecting and

promoting our nation's public health." Washington Adventist Hospital and the FDA have already begun collaborating on several initiatives regarding major FDA regulatory program areas and the collaborative relationship will grow when the hospital moves to White Oak.

15. Project Drawings:

Projects involving renovations or new construction should include architectural drawings of the current facility (if applicable), the new facility (if applicable) and the proposed new configuration. These drawings should include, as applicable:

1) the number and location of nursing stations,

2) approximate room sizes,

3) number of beds to a room,

4) **number and location of bath rooms,**

5) **any proposed space for future expansion, and**

6) **the "footprint" and location of the facility on the proposed or existing site.**

APPLICANT RESPONSE:

Project drawings are attached as Exhibit 4 (White Oak Campus) and Exhibit 5 (Takoma Park Campus.

16. Features of Project Construction:

A. Please Complete "CHART 1. PROJECT CONSTRUCTION CHARACTERISTICS AND COSTS" describing the applicable characteristics of the project, if the project involves new construction or renovation.

(Chart 1 begins on following page).

Chart 1. Project Construction Characteristics and Costs		
Base Building Characteristics	Complete if Applicable	
	New Construction	Renovation
Class of Construction		
Class A	A	n/a
Class B	n/a	B
Class C	n/a	n/a
Class D	n/a	n/a
Type of Construction/Renovation	n/a	n/a
Low	n/a	n/a
Average	n/a	Average
Good	Good	n/a
Excellent	n/a	n/a
Number of Stories	8	4[1]
Total Square Footage	428,412	126,910[2]
Basement	70,836	42,240
First Floor	81,794	67,770
Second Floor	64,430	15,900
Third Floor	51,948	1,000
Fourth Floor	43142	n/a
Fifth Floor	28,289	n/a
Sixth Floor	28,289	n/a
Seventh Floor	28,289	n/a
Eighth Floor	28,289	n/a
Penthouse Floor	3,105	n/a
Perimeter in Linear Feet		n/a, Interior Renovation
Basement	1482	n/a
First Floor	1581	n/a
Second Floor	1510	n/a
Third Floor	1297	n/a
Fourth Floor	1159	n/a
Fifth Floor	913	n/a
Sixth Floor	913	n/a
Seventh Floor	913	n/a
Eighth Floor	913	n/a
Penthouse Floor	438	n/a
Wall Height (floor to eaves)		Varies by bldg.[3]
Basement	21	11 (Typical)
First Floor	18	11 (Typical)
Second Floor	18	11 (Typical)
Third Floor	15	11 (Typical)
Fourth Floor	15	n/a
Fifth Floor	15	n/a
Sixth Floor	15	n/a
Seventh Floor	15	n/a
Eighth Floor	15	n/a
Elevators		
Type *Passenger* *Freight*		
Number 6 6	6 for public 6 service for hospital transport	n/a, Existing to Remain
Sprinklers (Wet or Dry System)	Wet	Wet
Type of HVAC System	Mechanically Ventilated	Mechanically Ventilated
Type of Exterior Walls	Precast Concrete Panel, CMU, Curtainwall, Unitized metal panels	n/a, Existing to Remain

NOTES: Values for renovation work include only renovated floors and areas of existing building. Floors and areas designated as existing to remain are excluded

1 Number of stories for renovation work at Takoma Park includes only floors on which renovations are taking place. Floors designated as existing to remain are excluded.

2 Total square footage values for renovation work at Takoma Park includes only renovated areas of the existing building. Areas designated as existing to remain are excluded

3 Wall heights at the existing Takoma Park campus vary. Wall height for renovation indicates the typical condition.

Chart 1. Project Construction Characteristics and Costs (cont.)		
	Costs	Costs
Site Preparation Costs	$10,400,000	$0
Normal Site Preparation	1,350,000	n/a
Demolition	100,000	n/a
Storm Drains	1,500,000	n/a
Rough Grading	1,200,000	n/a
Hillside Foundation	300,000	n/a
Terracing	0	n/a
Pilings	0	n/a
Offsite Costs	$3,850,000	$0
Roads	2,500,000	n/a
Utilities	600,000	n/a
Jurisdictional Hook-up Fees	750,000	n/a
Signs	$150,000	$0
Landscaping	$1,000,000	$0

B. Explain any plans for bed expansion subsequent to approval which are incorporated in the project's construction plan.

There are no current plans for bed expansion subsequent to approval as part of the construction plan.

C. Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities.

APPLICANT RESPONSE:

C. Availability of Utilities

Water, electricity, sewage and other utilities for the proposed project are available or will be obtained as follows:

Public Water & Sewer:

Water service is available via an existing 10" WSSC main on Plum Orchard Drive (SEP Contract # 83-5831- A).

Sewer service is available via an existing 12" WSSC main on Plum Orchard Drive (SEP Contract #83-5831-A).

Currently, Washington Adventist Hospital is proposing 3 new public water connections and 2 new public sewer connections to service the site. In addition, an existing public sewer line crossing the site will be relocated to create two public connections that will accommodate the new site layout. A WSSC application, plan and profiles, will be required for the Public SEP process; taking approximately 9 months from initial submission to permitting.

Approximately 2,111 ft. of public 12" S and approximately 1257ft. of public 10" W is being proposed to service the site.

Additionally, approximately 1,315 ft. of public 10" W is proposed through the site to connect to public 10" W in Bournefield Way to provide redundancy service to the site.

Site Utility Water & Sewer:

Site Utility (previously referred to as "On-Site") water & sewer is required on site to accommodate the new building demands. A WSSC application, plan, and profiles will be required for the Regulatory Systems Group process; taking approximately 6 months from initial submission to permitting.

Approximately 3,230 ft of private 10" W and approximately 920 ft. of private 8"S is being proposed to service this site.

Storm Drain

All existing and proposed drainage is conveyed to a regional SWM pond located on the site. There are 3 existing public storm drain lines running through our site. Currently, Washington Adventist Hospital is proposing to relocate these 3 existing public storm drain lines to accommodate the new layout as well as an on-site private storm drain to safely convey runoff conditions created by the new layout. A MCDPS application, plan, and profiles, will be required for processing. This will take approximately 6 months from initial submission to permitting.

Approximately 2,410 ft. of public Storm Drain is being proposed to service the site.

Stormwater Management

The existing site is mainly wooded and drains entirely to a regional SWM pond located on our site. Currently, a waiver has been received for recharge, quantity and roof top quality requirements for the proposed condition with an active Sediment Control Permit (covering SWM requirements) for the project site. The current Sediment Control Permit requires quality control for the remaining site provided via underground SWM structural devices. Due to recent changes in SWM regulation, the quality and quantity control must be provided to Environmental Site Design (ESD) facilities. A MCDPS application, plan, and profiles, will be required for processing. This will take approximately 6 months from initial submission to permitting.

Natural Gas

Washington Gas has existing gas lines located in Plum Orchard Drive that will be extended onto the proposed hospital campus to service the proposed hospital building. Gas service will enter the hospital near the Boiler Room.

Electric Power

Based upon the proposed loads of the hospital that have been submitted to PEPCO, the utility service has proposed a plan to provide the required electrical service from the existing Fairland utility substation. Under this plan PEPCO will provide two sources of electricity from existing feeders 15,899 and 15,900 out of the Fairland substation. Both feeds are required to meet the proposed hospital electric

requirements. The PEPCO feeds will be extended from the Fairland substation approximately 3/4 of a mile in a combination of overhead cable along Calverton Road and buried cable in conduit along Broadbirch Road and Plum Orchard Drive. Once on the site, the electrical feeders will be installed in buried conduit from the property line to the utility substation room in the basement of the hospital.

Telephone and Data

Telephone and data services will be extended through the existing cable plant along Plum Orchard Drive to Broadbirch Drive. Redundant services can also be routed in the opposite direction along Plum Orchard Drive to Cherry Hill Road. Alternately, existing fiber on Bournefield Way can be tapped which could provide connection to several data service providers. These services will be extended onto the hospital campus to the entrance facility in the hospital cellar.

PART II - PROJECT BUDGET

(INSTRUCTION: All estimates for 1.a.-d., 2.a.-h., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. Use of Funds

		Phase 1 & 2 White Oak	Phase 3 Takoma Park	Total
1.	Capital Costs			
a.	New Construction			
(1)	Building & Fixed Equipment	$ 136,300,000	-	$ 136,300,000
(2)	Fixed Equipment (Included above)	-	-	$ -
(3)	Land Purchase	11,000,000	-	$ 11,000,000
(4)	Site Preparation - Land Improvements	10,400,000	-	$ 10,400,000
(5)	Architect/Engineering Fees	13,200,000	-	$ 13,200,000
(6)	Permits, (Building, Utilities, Etc.)	700,000	-	$ 700,000
	SUBTOTAL	$ 171,600,000	$ -	$ 171,600,000
b.	Renovations			
(1)	Building demolition	$ -	$ 1,200,000	$ 1,200,000
(2)	Renovations	-	10,100,000	$ 10,100,000
(3)	Fixed Equipment (Not Included in Construction)	-	-	$ -
(4)	Architect/Engineering Fees	-	1,100,000	$ 1,100,000
(5)	Permits, (Building, Utilities, Etc.)	-	100,000	$ 100,000
	SUBTOTAL	$ -	$ 12,500,000	$ 12,500,000
c.	Other Capital Costs			
(1)	Major Movable Equipment	20,400,000	400,000	$ 20,800,000
(2)	Minor Movable Equipment	13,600,000	200,000	$ 13,800,000
(3)	Contingencies	11,300,000	700,000	$ 12,000,000
(4)	Other (Specify)			$ -
	a. Furniture	10,200,000	200,000	$ 10,400,000
	b. Interior & Exterior Signage	1,400,000	-	$ 1,400,000
	c. IS/Comm	13,600,000	300,000	$ 13,900,000
	d. Security system	2,000,000	-	$ 2,000,000
	e. Relocation expense	2,700,000	100,000	$ 2,800,000
	f. Certifications, inspections, etc.	1,000,000	100,000	$ 1,100,000
	g. Takoma Park Capital Facility Upgrades	-	14,300,000	$ 14,300,000
		-	-	-
	TOTAL CURRENT CAPITAL COSTS (a - c)	$ 247,800,000	$ 28,800,000	$ 276,600,000
d.	Non Current Capital Cost			
(1)	Interest (Gross)	50,288,600	1,691,800	51,980,400
(2)	Inflation Allowance (2.0% per year to midpoint of each construction phase)	9,400,000	1,300,000	10,700,000
	TOTAL PROPOSED CAPITAL COSTS (a-d)	$ 307,488,600	$ 31,791,800	$ 339,280,400
2.	Financing Cost and Other Cash Requirements:			
a.	Loan Placement Fees	5,260,600	299,600	5,560,200
b.	Bond Discount			
c.	Legal Fees (CON Related)	223,970	26,030	250,000
d.	Legal Fees (Other)			
e.	Printing			
f.	Consultant Fees	129,280	15,020	144,300
	CON Application Assistance			
	Other (Specify)			
g.	Liquidation of Existing Debt			
h.	Debt Service Reserve Fund	26,303,000	1,498,000	27,801,000
i.	Principal Amortization Reserve Fund			
j.	Other (Specify)			
	TOTAL (a - j)	$ 31,916,850	$ 1,838,650	$ 33,755,500
3.	Working Capital Startup Costs			
	TOTAL USES OF FUNDS (1 - 3)	**$ 339,405,450**	**$ 33,630,450**	**$ 373,035,900**

B. Sources of Funds for Project:

		Phase 1 & 2 White Oak	Phase 3 Takoma Park	Total
1	Cash	53,366,656	7,094,044	60,460,700
2	Pledges: Gross, less allowance for uncollectables=Net			
3	Gifts, bequests	20,000,000		20,000,000
4	Interest income (gross)	3,334,935	230,265	3,565,200
5	Authorized Bonds	251,703,859	26,306,141	278,010,000
6	Mortgage			
7	Working capital loans			
8	Grants or Appropriation			
	(a) Federal			
	(b) State			
	(c) Local			
9	Other (Specify) (Land)	11,000,000		11,000,000
	TOTAL SOURCES OF FUNDS (1-9)	**$ 339,405,450**	**$ 33,630,450**	**$ 373,035,900**

PART III - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

(INSTRUCTION: Each applicant must respond to all criteria included in COMAR 10.24.01.08G(3), listed below.)

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

List each applicable standard from each appropriate chapter of the State Health Plan and provide a direct, concise response explaining the project's consistency with that standard. In cases where standards require specific documentation, please include the documentation as a part of the application. *(Copies of the State Health Plan are available from the Commission. Contact the Staff of the Commission to determine which standards are applicable to the Project being proposed.)*

COMAR 10.24.10, the Acute Inpatient Services Chapter (the "Acute Care Chapter"), COMAR 10.24.12, the Acute Hospital Inpatient Obstetric Services Chapter (the "OB Chapter") and COMAR 10.24.07 (the "Psychiatric Services Chapter") of the State Health Plan are discussed below.

COMAR 10.24.10 - Acute Hospital Services

.04 Standards

A. General Standards

The following general standards encompass Commission expectations for the delivery of acute care services by all hospitals in Maryland. Each hospital that seeks a

Certificate of Need for a project covered by this Chapter of the State Health Plan must address and document its compliance with each of the following general standards as part of its Certificate of Need application. Each hospital that seeks a Certificate of need exemption for a project covered by this Chapter of the State Health Plan must address and demonstrate consistency with each of the following general standards as part of its exemption request.

(1) Information Regarding Charges.

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

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;
(b) Procedures for promptly responding to individual requests for current charges for specific/ procedures; and
(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

APPLICANT RESPONSE:

Policy 3.19.2 Public Disclosure of Charges (Exhibit 6) details the Adventist HealthCare, Inc. policy and procedure for the provision of information regarding hospital services and policies to the public. Quarterly updates to the Representative List of Services and Charges are made and posted to the hospital internet web site (http://www.washingtonadventisthospital.com/app/files/public/467/pdf-WAH-Billing-HospitalCharges.pdf) and are available on request to the public. The Patient Access Department of Washington Adventist Hospital ensures that requests made for current charges for specific procedures are provided in a timely manner. The Patient Access Department provides staff training on this and other policies on a regular basis.

(2) Charity Care Policy

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

(a) This policy shall provide:

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

(ii) Minimum Required Notice of Charity Care Policy.

1. **Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;**
2. **Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas with the hospital; and**
3. **Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.**

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

APPLICANT RESPONSE:

Adventist HealthCare, Inc. maintains written policies in English and Spanish pertaining to the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. Policy number AHC 3.19 Charity Care Policy, and Policy 3.19.1 Charity Care Policy, Spanish Language Version apply to all Adventist HealthCare-affiliated facilities in Maryland which include Washington Adventist Hospital. (Exhibits 7 and 8). These policies are summarized and included on the website of Adventist HealthCare, Inc. and Washington Adventist Hospital (http://www.washingtonadventisthospital.com/WAH/patientsvisitors/patients/billing/charity-care/).

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

Public notice of nondiscrimination policy and access to care regardless of ability to pay is posted annually in The Gazette Newspapers. The most recent posting was made on July 10 and 11, 2013 and appeared in the following Montgomery County editions: Gaithersburg, Germantown, Damascus, Rockville, Bethesda, Potomac, Silver Spring, and Olney; and in both the Northern and Southern Prince George's County editions (Exhibit 9).

In 2012, Washington Adventist Hospital provided a total community benefit of 15.08% of its total operating expenses, as reported in the July 10, 2013 Maryland Hospital Community Benefit Report FY 2012 (http://www.hscrc.state.md.us/documents/HSCRC_Initiatives/CommunityBenefits/cb-fy12/hscrc-fy-12-cbr-final.pdf) is 15.08%. This ranks the hospital as providing the 7th highest amount of community benefit for all hospitals in Maryland, with an average for all hospitals of 10.19%.

(3) Quality of Care

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;
(ii) Accredited by the Joint Commission; and
(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

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

APPLICANT RESPONSE:

Washington Adventist Hospital is in possession of Maryland Department of Health and Mental Hygiene, Office of Health Care Quality License Number 15-031 issued on October 1, 2010 through January 1, 2014 (Exhibit 10). Hospital License Number 15369 effective December 30, 2012 through December 30, 2013 was issued by the Health and Human Services Licensure and Regulatory Services of Montgomery County (Exhibit 11). Applications for renewal of the licenses are in process.

Washington Adventist Hospital is accredited by the Joint Commission and earned a "Gold Plus Get with the Guidelines – Stroke" quality award in 2013 (Exhibit 12). The last full survey by the Joint Commission successfully concluded on August 16, 2013.

The hospital is in compliance with the conditions of participation of the Medicare and Medicaid programs.

According to the Maryland Hospital Performance Evaluation Guide posted on June 28, 2013, of 23 applicable measures, Washington Adventist Hospital ranked at or above average on 21 measures. The hospital achieved 100% in 8 of the measures. For the measure, "Surgery patients who received treatment at the appropriate time to help prevent blood clots" Washington Adventist Hospital achieved a 97% rating compared to a 98% state average. Washington Adventist Hospital was above the 90% level of compliance on all measures.

Washington Adventist was 47 minutes beyond the standard for the measure, "Median Time from Emergency Department Arrival to Emergency Department Departure for Admitted Patients," and 33 minutes beyond the standard for "Admission Decision Time to Emergency Department Departure Time for Admitted Emergency Department Patients."

When considering emergency department measures, it is important to note that Washington Adventist Hospital's Emergency Department is configured to accommodate 30,000 visits annually. However, more than 50,000 patients were treated in 2012, a 12.5% increase over the prior year.

Throughput times are also negatively affected by the low number of private rooms available since most of the hospital was built with semi-private rooms. As a result, the second bed in a semi-private room is unavailable for admissions if the first bed is a patient with a communicable disease. Similar limitations occur to avoid placing male and female patients in the same room. Delays in throughput times may also be attributed to an overall rise in hospital diversions times throughout Montgomery County.

Washington Adventist Hospital is working to improve performance on the measure Admission Decision Time to Emergency Department Departure Time for Admitted Emergency Department Patients.

Implementation of this improvement plan begins by identifying when an inpatient bed is available. At that notification, patients immediately are moved from the Emergency Department to an inpatient bed. The admitting physician (typically the hospitalist) assesses the patient and orders diagnostic testing after the patient is on the inpatient unit. In the past, the assessment and testing was performed in the Emergency Department contributing to the delays in the time to admission.

The hospital length of stay is on average 10% greater than the state average, contributing to a lack of beds for admitted patients. To address this, Washington Adventist Hospital has contracted a consultant, IMA. The consultant is on site at the hospital and is working with physicians and staff to improve the length of stay. When length of stay reaches the state average, there will be an average of 15-20 beds open and available each day. This will allow a timely movement of admitted patients.

Lastly, the Emergency Department has been working to improve staffing and turnaround times for testing. These changes will allow for quicker assessment and treatment of patients leading up to the decision to admit.

B. Project Review Standards.

(1) Geographic Accessibility

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

APPLICANT RESPONSE:

Washington Adventist Hospital is proposing an acute care general hospital to be replaced on a new site that will optimize accessibility and travel time for its likely service area population. This includes optimal travel time for general medical/surgical and intensive/critical care services within 30 minutes under normal driving conditions for 90 % of the population in its likely service area; inpatient pediatric services are not part of the current or new hospital services.

Washington Adventist Hospital analyzed travel times for Zip codes within its likely service area to the current Takoma Park location and to the proposed White Oak location. The result of the analysis, outlined below, indicates that travel time for general medical/surgical, intensive/critical care services will be within 30 minutes under normal driving conditions for more than 90% of the population in the likely service area.

Process and Results Used

Washington Adventist Hospital established the PSA and a Secondary Service Area (SSA) using Zip codes in the Washington region. Exhibits 13 and 14 detail the estimated drive times under normal driving conditions from Washington Adventist Hospital's PSA (highlighted in green) and SSA (highlighted in blue).

The Travel Time Table (Exhibit 13) shows the normal drive time distances from various areas within the Zip codes that represent PSA and SSA for the hospital with following detail:

a) Zip codes

b) Distance from Takoma Park campus and distance from White Oak campus

c) Travel time from various locations within the PSA

The Service Area Map (Exhibit 14) details the location of both the existing Takoma Park facility and the proposed White Oak hospital.

Travel points located within the Zip codes were selected both on the perimeter of the Zip code and in the centroid area of the Zip code. Due to size, some zip codes contain more travel points than others.

Overall, the optimal travel time for general medical/surgical and intensive/critical care services are within 30 minutes under normal driving conditions for more than 90% of the population in Washington Adventist Hospital's likely service area.

Additional Accessibility Considerations

As previously noted, health care services will be maintained on the Takoma Park campus. The White Oak site addresses serious accessibility issues that exist at the current campus. The hospital is presently located in a residential area and is only accessible by narrow, two-lane residential streets, making it difficult for ambulances, patients, physicians, employees and others to access the hospital. Public transportation options are limited as regional Metrobus system does not access the Takoma Park campus, creating a hardship for residents who rely on this mode of travel.

Access challenges continue once on the narrow, linear campus squeezed between Washington Adventist University and Sligo Creek. Ambulances, cars, pedestrians and buses all compete for right-of-way on the main campus roadway, which also serves as a parking area and walkway, an unsafe confluence of traffic that delays ambulances.

An important objective supporting the proposed relocation is site accessibility. Core medical/surgical services will be relocated to a site located on a 48.86 acre parcel on the west side of Plum Orchard Drive, west of its intersection with Cherry Hill Road in the Fairland/White Oak section of Montgomery County and in the center of its service area. This site is located approximately 6.6 miles from the existing Takoma Park campus of Washington Adventist Hospital. Drive time between the two campuses is approximately 16 minutes according to MAPQUEST©.

Additionally, the site is accessible to major interconnecting roadways, such as I-95, New Hampshire Avenue (MD 650), US 29 and Cherry Hill Road. Metrobus provides access to the new site and Montgomery County plans to extend its Ride-On bus service (Montgomery County operated transit system) to the White Oak campus. Hospital representatives are working with

Metrobus to enhance service connections to existing routes originating in Prince George's County. The Maryland Intercounty Connector (ICC) has a major interchange just one mile north of the proposed White Oak campus located along US 29 and I-95.

Washington Adventist Hospital, through its Montgomery County Special Exception and Site Plan approvals, will also provide an employee shuttle bus service between the Takoma Park and White Oak campuses. Washington Adventist Hospital has agreed to make this shuttle bus service available to hospital patients, visitors and others for a modest fee. The "Shuttle Program" will consist of two buses that will operate from 6:00 a.m. until 6:00 p.m. Monday through Friday. The Shuttle Program will operate for a minimum of 10 years, allowing for the development and enhancement of regional public transportation systems.

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

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

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

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

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

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

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

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

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

APPLICANT RESPONSE:

The minimum jurisdictional gross bed need projection for Montgomery County, in 2018 is 995 MSGA beds. The maximum jurisdictional bed need is 1,193 MSGA beds. As of July 1, 2013, there were 1,022 licensed MSGA beds located in the five acute care general hospitals of Montgomery County and 75 beds approved in 2011 at Holy Cross Germantown, as shown below:

Licensed MSGA Beds in Montgomery County (FY2013)	
Hospital	**Licensed & Approved MSGA Beds**
Holy Cross Hospital of Silver Spring	282
Holy Cross - Germantown	75
MedStar Montgomery Medical Center	100
Shady Grove Adventist Hospital	250
Suburban Hospital	199
Washington Adventist Hospital	191
Total	**1,097**

Source: Maryland Health Care Commission, Acute Care Bed Inventory (Fiscal Year 2013)

The replacement hospital project proposes 180 MSGA beds, a reduction of 11 MSGA beds. All 180 of the MSGA beds will be located in private rooms. There are no additional MSGA beds proposed in the replacement project for Washington Adventist Hospital. The table below demonstrates that the proposed beds indicate a net bed need from -91 to 107 beds for Montgomery County.

Projected Minimum and Maximum
Bed Need
Montgomery County

	Gross Bed Need (1)	Licensed & Approved Beds (2)	Proposed Beds	Net Bed Need
Date	**2018**	**FY 2013**		2018
Minimum	995	1,097	1,086	-91
Maximum	1,193	1,097	1,086	107

(1) Estimates from the Maryland Register (Volume 37, Issue 7, p.589-591) dated March 26, 2010
(2) Based on Licensed Acute Care Beds (Fiscal Year 2013) Includes 75 CON approved beds at Holy Cross Hospital - Germantown

The Washington Adventist Hospital project is well within the bed need projection for Montgomery County.

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

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

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

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

APPLICANT RESPONSE:

This standard is not applicable to the proposed project.

(4) Adverse Impact

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

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

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

APPLICANT RESPONSE:

Part (a) of the standard references Average Age of Plant. According to the most recent HSCRC annual filing, Washington Adventist Hospital's average age of plant is 22.7 years, second highest among 47 hospitals in the State of Maryland.

In response to part (a), Washington Adventist Hospital did not assume a rate increase in the financial projections included in the application. Therefore, there is no unwarranted impact on hospital charges related to this project.

In response to part (b), Washington Adventist Hospital has developed a project that enhances its facilities and services while ensuring continued access to health care for all in its service area. While the hospital is reducing 11 MSGA beds, the efficiency gained by moving to all private rooms offsets the loss of those beds. The prevalence of semi-private rooms in the current facility creates capacity limitations with infectious disease patients and the sharing of rooms by male and female patients.

More importantly, this project improves the availability of, and access to, services in the Washington Adventist Hospital service area and especially to low-income patients for whom public transportation may be the only option. Patients will have access to a 21st century facility on a comprehensive medical campus of inpatient and outpatient services in White Oak in addition to substantial health care services in Takoma Park including the existing 40-bed behavioral health unit; an FQHC; physician offices; imaging and other ancillary services; the maternity clinic for low income patients; a wound care clinic; and outpatient primary care clinic and other health care services. The Adventist Rehabilitation Hospital of Maryland/Takoma Park will remain on the Takoma Park campus. The services in White Oak and Takoma Park provide additional points of access for the community.

Takoma Park Campus Access

The current Takoma Park hospital campus is challenging from both an access standpoint and for the delivery of care. From access to the campus, to traffic flow and parking on campus, to limited space, to an aging infrastructure, to small room sizes, to a limited number of private rooms, the challenges are many. The proposed project is designed to remove barriers to accessing care and enhance access to facilities and services.

Washington Adventist Hospital's current campus is surrounded by narrow, two-lane residential streets on which traffic backups occur regularly. Emergency vehicles must compete with normal vehicular and bus traffic for access to the hospital campus. The main hospital entrance off of Carroll Avenue is located near an aging arched bridge, scheduled for State Highway Administration repair in the next few years. The back entrance to the hospital is at the confluence of three small roads, Maple Avenue, Maplewood Avenue and Sligo Creek Parkway.

Public transportation options are limited. MetroBus, the region-wide bus system in the Washington metropolitan area, does not travel to the hospital campus. The only bus access is from the local Montgomery County RideOn system, creating an additional hurdle for residents who seek and receive care at the hospital.

Access challenges continue once on campus where ambulances, automobiles, pedestrians and buses compete for right-of-way. The facility sits on a 13-acre campus of which only nine acres are buildable. Parking is severely limited with only 645 spaces on campus for patients, visitors, employees, volunteers and physicians.

The proposed project seeks to address these and other barriers to care.

Site Accessibility and the Level of Impact in Relocation

To determine the level of impact from the relocation, it is important to understand how people currently access the campus and what options are available in the future. A Campus Arrival Study completed by The Traffic Group (Exhibit 15), demonstrated that 98% of people arrive to the current Takoma Park campus by private automobile or taxi. The data collected in 2013 confirms previous studies performed in 2007 and 2011.

For others, the following means are used:

(a) Emergency Medical Services ambulance after a 911 call;

(b) Private, nonemergency ambulance such as from area nursing homes;

(c) Helicopter transport (the hospital is a designated back up for other hospitals providing emergency and nonemergency cardiac interventions including primary and non-primary PCI but without an onsite cardiac surgery program),

(d) Metro Access which "provides services for disabled persons who are unable to use the regular transit systems and have been certified eligible to use Special Transportations service";

(e) The Montgomery County "Call 'N' Ride Program. http://www.montgomerycountymd.gov/tsvtmpl.asp?url=/content/dot/transit/seniors.asp#call, which provides subsidized taxi trips for low-income persons with disabilities and seniors;" and

(f) The Montgomery County Ride On bus system.

Each of these options remains available with the relocation of the main hospital facility to White Oak.

The Traffic Group gathered its data by counting automobiles and placing observers where Ride-On buses stopped and noted the direction in which individuals walked. It counted individuals coming to and leaving from the hospital. It did not have a basis to distinguish between patients, visitors, physicians or other clinicians or staff. It was not able to identify which of these individuals arrived and left during the same 12-hour period and therefore might be double-counted in the tally. Neither did it have a basis to know the point of origin for each individual whether arriving by car or the starting point from which a bus traveler departed from home or elsewhere. The Traffic Group campus arrival study confirms 98% of persons coming to the Takoma Park campus travel by automobile.

White Oak Campus Access

The proposed White Oak campus enhances transportation access in a number of important ways:

- The White Oak hospital facility will be directly accessible to individuals using MetroBus. The White Oak campus will also be accessible by the Montgomery Ride-On bus system;

- Emergency ambulances will have direct access to the Emergency Department without competing with all other traffic to and on the campus;

- Nonemergency ambulances will have more convenient access to both the hospital and medical office building on the new campus;

- Helicopter access will be available to a site that is not located in a residential neighborhood, enhancing Washington Adventist Hospital's own emergency access as well as supporting its role as a cardiac surgery PCI backup hospital;

- MetroAccess will continue to be available;

- Call N' Ride taxi access will continue to be available;

- Staff will have additional access via a shuttle from an existing hospital satellite parking lot that will travel to the White Oak campus. This shuttle will be available for the general public as well for a modest fee.

Private automobile access to the Washington Adventist Hospital campus in White Oak will improve significantly with access from multiple major roads and highways.

To further assess the impact of proposed relocation, The Traffic Group also conducted a travel time analysis (Exhibit 16) of where residents live within Washington Adventist Hospital's existing primary and secondary service areas. Most residents electing to travel to a particular hospital will have a shorter travel time to the hospital in White Oak than to other hospitals. (A number of other hospitals are located within, near or overlap Washington Adventist Hospital's service areas).

The report identifies the point beyond which the White Oak campus is a shorter or longer drive time than the Takoma Park campus. The same process was completed for several other hospitals including Holy Cross Hospital, Laurel Regional Hospital, Medstar Montgomery Medical Center, Shady Grove Adventist Hospital, Prince George's Hospital Center, Doctor's Community Hospital and Medstar Southern Maryland Hospital Center. Separate maps were created identifying those dividing lines based on travel for residents in Washington Adventist Hospital's service area.

The Travel Time Proximity Map (Exhibit 17) uses this data to outline in a consolidated manner the area within which it is a shorter distance to White Oak than to another hospital. The Travel Time Proximity Map shows the area within Washington Adventist Hospital's service area where residents would find a shorter drive time to White Oak than to any one of multiple other hospitals. This same consolidated map shows the area within Washington Adventist Hospital's service area where it is a shorter drive time to another hospital than to the proposed facility in White Oak.

The Traffic Group further identifies the load capacities of the roads to and from Takoma Park and White Oak. The roads to White Oak and the driving times demonstrate that White Oak is a superior site for automotive accessibility than Takoma Park. The combination of improved automobile access, better public transportation options, and health care services at two locations significantly improves access to health care services for residents in the hospital's service area.

The only individuals who would experience a longer non-automotive transportation trip to White Oak are those who currently live along a Ride-On route that travels directly to the Washington Adventist Hospital campus in Takoma Park, and who would need to take Ride-On and transfer either to another Ride-On route or to MetroBus to get to the replacement hospital campus in White Oak.

From the survey referenced above, the total number of persons who use Ride-On to access the current Washington Adventist Hospital campus is very small in relation to the total number of individuals coming to the campus, and only a subset of those presumably would not have access to a direct bus route to the White Oak campus. This number of individuals is smaller than the population who lives in the Washington Adventist Hospital service area, both now and after the relocation to White Oak, who will have convenient MetroBus access to Washington Adventist Hospital for the first time.

The travel time for those in the service area who currently must travel by MetroBus and transfer to Ride-On to get to the residential community where Washington Adventist Hospital is located will be diminished. The attached Traffic Group report and associated maps show the far greater access to MetroBus associated with communities in the Washington Adventist Hospital service area in White Oak. This provides shorter non-automotive access for a greater population than the individuals who currently live along a Ride-On route going to the Takoma Park campus, lack proximity to MetroBus and may need to transfer from Ride-On to another bus route to get to the White Oak location.

The availability of health services at the Takoma Park campus means that a portion of the population who currently take Ride-On to that campus for certain services will continue to do so.

From a cost perspective, Ride On monthly passes are available for $45 at current rates. Disabled persons have access for free Monday through Friday from 9:30 a.m. to 3 p.m. and pay half fare all other times. Ride On offers free rides for Metro Access certified riders and one companion traveling with the disabled person. A one-week MetroBus pass is $16.

There is no additional cost for transfers if the rider uses a Smart Trip card and transfers within 2 hours between buses.

Travel options are also improved for Washington Adventist Hospital employees. Those who drive will be able to park at the White Oak campus while other travel options include MetroBus and Ride-On services. The hospital will provide a shuttle bus for employees from the current satellite lot near the Takoma Park campus to the White Oak facility.

To assist bus service to the White Oak campus, Washington Adventist will construct a special bus layover facility at the main entrance to the hospital along Plum Orchard Road as part of its site preparation work. There will be a dedicated bus pull off area that will service three buses at the same time with a 100 foot long bus shelter for staff and patients arriving from throughout the Montgomery County and Prince George's County region. Additionally, there will be dedicated bus stops along Plum Orchard Road and a dedicated bus stop at the medical office building at the north end of the White Oak campus.

The Montgomery County Department of Transportation Transit Division has recognized that bus service to the White Oak Campus is extremely important and, as a result, the hospital has worked with the department to ensure that all of the amenities for bus passengers will exist along Plum Orchard Road. When the Department of Transportation is prepared to install a "Next Bus" system, the hospital will install the system inside the facility for patients and staff and also inside the bus shelters along Plum Orchard Road. The transit service and accessibility to transit will be dramatically enhanced at the White Oak campus as compared to the existing options at the Takoma Park campus. Due to limited right-of-way and other private property, the area around the Takoma Park campus does not allow for the pull-off and layover area that will exist in White Oak.

As further support for The Traffic Group's conclusions about greater accessibility presented by the White Oak campus than exists at the Takoma Park campus, attached as Exhibit 18 is the Montgomery County Planning Department's White Oak Science Gateway recommended draft Master Plan update. It addresses the comprehensive master plan amendment for the southern portion of eastern Montgomery County.

(5) Cost-Effectiveness

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

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

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

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

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

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

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:

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

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

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

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

APPLICANT RESPONSE:

The Board of Trustees for Adventist HealthCare held a special meeting regarding Washington Adventist Hospital and developed 19 objectives to consider in selecting the best option for the hospital's future. The 19 objectives, which board members identified as critical to making an informed decision, are divided into the 7 categories listed below:

Financial Considerations

1. Financial feasibility
2. Financial viability

Facility: Size, Scope and Description

3. Improves Access
4. Sufficient Parking
5. Improve Campus and Building Aesthetics
6. Improve Effectiveness and Efficiency of Building Utility Systems

Regulatory Implications

7. Improve Patient Flow/Staff Efficiency
8. Improve Private Bed Capacity
9. Ability to Achieve Regulatory Approval

Clinical Experience

10. Opportunity for Future Inpatient Capacity
11. Increases Outpatient Capacity/Accessibility
12. Increases Physician Recruitment Opportunities

Community Implications

13. Impact on Community

Adventist HealthCare Impacts

14. Minimizes Impact on Current Operations
15. Ability to Achieve Project Completion
16. Impact on AHC and its Services
17. Ensures Long Term Future of Washington Adventist Hospital

Adaptability to Market Changes

18. Potential to Expand
19. Provides Flexibility for a Dynamic Market, Now and in the Future

Using these objectives, the board further directed the executive team to evaluate options for the future of Washington Adventist Hospital that included two options for staying on the Takoma Park campus and two for relocating to White Oak on a site within the hospital's existing primary service area.

The four options considered are as follows:

Options

A. Limited capital project on the existing Takoma Park campus, maintaining the current buildings;

B. More significant capital project on the existing Takoma Park campus;

C. Smaller facility in White Oak with non-rate regulated health care services in Takoma Park;

D. Similar sized facility in White Oak with some rate regulated acute care services in Takoma Park.

Adventist HealthCare then began working to develop the scope and viability of the various options, and a scoring matrix was developed to aid in the decision making process. The scoring matrix, included as Exhibit 19, identifies the degree to which each option met the 19 objectives established by the Board.

Option A, the limited capital project in Takoma Park, was removed from consideration early in the decision making process because it failed to materially address pressing facility infrastructure challenges or access issues. It maintained the status quo including the current, outdated buildings, providing no opportunity to enhance facilities and services for the community, and did not ensure the long term future of Washington Adventist Hospital. This plan represented what amounted to a do nothing approach with the hospital and the campus.

For the remaining three options, scope, programming, budget, and development schedule were developed for each alternative. The details for option B are included below and in the response to the Availability of More Cost Effective Alternatives standard. Information regarding Option C is included below. Information for Option D is included throughout the application and below.

For option B, an effort to try and fully achieve all of the 19 objectives identified by the Adventist HealthCare Board would be an immense challenge given the characteristics of the campus, the aging infrastructure, disruption of ongoing operations during construction, and other issues. Fully re-developing the Takoma Park site consistent with the 19 objectives and what could be

accomplished with a new full sized replacement facility at a new site in White Oak would take 12-15 years of intense construction and demolition and would be cost prohibitive.

Accordingly, Adventist HealthCare evaluated a more reasonable option that meets some of the 19 objectives identified by the Board. Option B would involve a significant reinvestment in the existing hospital with a multi-phased program of demolition and construction at the Takoma Park campus. The resulting hospital in Takoma Park would take six and one half years to complete beginning with site preparation and demolition, instead of 12-15 years. It also would involve replacing portions of the buildings on campus and have a realistic end point. To achieve the objectives of this option while operating a fully functional hospital, the modernization of the hospital is divided into two separate phases of construction and corresponding phases of demolition.

The first phase of the project is the development of a new bed tower, garage and central plant on an existing parking lot to the south of the existing hospital. Phase 1 of construction would take 24 months. With the completion of Phase 1 of construction, services from the oldest portion of the existing hospital will be moved to the new tower and the vacated portion of the hospital will be demolished to make way for Phase 2 of construction. The transition period will last 6 months including survey, relocation and demolition to prepare for Phase 2. Phase 2 will immediately follow the demolition of the existing building and will have an expected duration of 24 months.

Completion of Phase 1 of this project would provide the following programs/departments:

- A new cardiac care unit
- New maternity unit, including postpartum, labor and delivery and diagnostics
- New laboratory, pharmacy, and respiratory areas.
- New heart center
- New medical same day unit
- New central utility plant
- New lobby

Completion of Phase 2 would provide the following programs/departments:

- New 36-bed medical surgical unit
- New 32-bed medical surgical unit
- New surgical suite
- New G.I. endoscopy suite
- New emergency department
- New admitting and radiology areas
- New cafeteria

Upon the completion of the construction of Phase 2, Washington Adventist Hospital will relocate the existing physician's offices in the MOB at the north end of the site into the body of the hospital and construct a 600-car parking structure on the location of the existing MOB. The capital expenditure for this project would be $339.7 million. (See the Capital Budget chart in the response to the COMAR 10.24.01.08G(3)(c)-Availability of More Cost Effective Alternatives standard on page 125 of this application).

Option C, a proposal to build a smaller facility in White Oak, was also considered by Adventist HealthCare. This proposal would downsize the hospital from 252 inpatient beds to 180 beds while developing a more limited range of non-hospital, non-rate regulated community based services in Takoma Park. All existing acute care hospital services would relocate to White Oak but some

services would be downsized. Under Option C, the White Oak hospital would have all private rooms except for a few semi-private rooms in the behavioral health unit. The White Oak campus would have a 750-car surface parking lot. The Takoma Park campus in this option would include non-acute, community-based services. The construction timeline for this option would be 69 months, including 24 months for planning, CON review, design, and 45 months of building construction and occupancy. The capital expenditure for Option C would be $349.4 million (Exhibit 20- Project Sources and Uses of Option C).

Option D is the development of a replacement facility with all private rooms on a 48.86-acre campus in White Oak while retaining the existing Takoma Park campus for various health care services including the hospital's behavioral health services, an FQHC, the services of Adventist Rehabilitation Hospital of Maryland/Takoma Park, the maternity partnership prenatal clinic and other outpatient clinics, as well as lab, radiology and other ancillary services. Washington Adventist University has signed a letter of intent to lease more than 55,000 square feet of space on the Washington Adventist Hospital Takoma Park campus. The new facility in option D would have 11 fewer inpatient beds and a total cost for option D, including renovations on the Takoma Park campus, is $373 million.

As noted in the options scoring matrix (Exhibit 19), Option D received the highest score, followed by Option C and then Option B.

An analysis of the options against one another makes delineates why Option D is the most cost effective choice.

Option B, the on campus alternative, creates challenges by encumbering the organization with significant debt without addressing the serious challenges patients, physicians and others have in negotiating narrow residential streets to get to the hospital or the more limited public transportation options that exist. (See Exhibit 21- Sources and Uses Option B). This is why, for example, Option B received the lowest score, a "1", for the objective Improves Access while Option D received a "5" for the same objective. Although the project delivers an effective modernization of many patient care spaces, Option B does not modernize the entire facility and significant portions of older structures, such as portions of the 1970s, 1980s and 1990s buildings, remain. Thus, Option B received a score of "3" on the scoring grid for both Improve Campus and Building Aesthetics and Improve Effectiveness and Efficiency of Building Utility Systems, in contrast to a higher score for Option D. In addition, Option B is implemented in the midst of current hospital operations and presents a series of major disruptions that endure over a prolonged period of time, presenting a host of unfavorable impacts and challenges to financial viability and to the quality of care delivered during the construction and renovation periods. Option B received a score of "2" Impact on Current Operations versus a "4" for Option D.

Most significantly, Option B does not earn a positive financial margin within 5 years and thus would require a substantial, ongoing subsidy from Adventist HealthCare. This project would not ensure the long term future of Washington Adventist Hospital and would negatively impact the entire Adventist HealthCare organization. Note the ratings of a "1" for the objectives Financial Viability, Impact On Adventist HealthCare and Ensures Long Term Future of Washington Adventist Hospital as opposed to much higher marks for Option D on those objectives.

Like Option B, Option C does have some positive attributes including a new facility in White Oak on a sizeable, more accessible medical campus within the hospital's existing primary service area. However, the financial viability of Option C is weak. Option C does not earn a positive financial margin five years after opening. Option C earned a "3" on Financial Viability due to its loss in year 5 versus a higher mark for Option D. (Option B scored the lowest on Financial Viability given its much more significant losses by year 5). Substantive, accessible and viable health care services on the

Takoma Park campus are important to the community. Yet, the services on the Takoma Park campus are far less comprehensive under Option C than Option D. Since the entire hospital is moved in Option C, hospital-based behavioral and outpatient services in HSCRC rate-regulated clinics would not be available in Takoma Park. This would limit the scope of services and the amount of charity care available to the local community since the services there would not be hospital based. This also means that these health care services on the Takoma Park campus would contribute significantly less to the financial pro forma for the Takoma Park campus with a resulting negative impact on Adventist HealthCare. Hence, Option C rated a "2" for the Impact on Community objective.

The point about impact to Adventist HealthCare is an important one. Projected income statements and Adventist Healthcare, Inc. financial ratios for each of the options evaluated can be found at Exhibit 22. While meeting the current bond covenants required for the Adventist HealthCare Obligated Group, Option B loses money and would require an ongoing subsidy, placing a tremendous strain on the resources on Adventist HealthCare. Likewise, Option C meets the current bond covenants required for the Obligated Group but loses money, would require an ongoing subsidy and would strain the resources of Adventist HealthCare

Option D provides the best alternative for ensuring the long term future of Washington Adventist Hospital and is the most cost effective. Option D is the only option that earns a positive financial margin by the fifth year and would not require ongoing subsidy by Adventist HealthCare. Further, Option D provides a new facility in White Oak and significant health care services on the Takoma Park campus where hospital-based outpatient services would be rate regulated, ensuring the viability of the campus and an ability to provide charity care for the community. Thus, Option D is more financial viable and financially feasible than the other two alternatives.

Finally, Option D positions the organization well for emerging changes in health care with an expansion of outpatient services, more accessible care for the community at two campuses and, as a result, ensures Washington Adventist Hospital is best positioned to meet the needs of patients well into the future.

The table below summarizes the capital expense and the margin in the fifth year after opening each option.

Comparison of Each Option

OPTION	CAPITAL EXPENSE	MARGIN IN FIFTH YEAR
Option B	$ 339.7 million	-3.1%
Option C	$ 349.4 million	-0.7%
Option D	$ 373 million	1.9%

Site Selection Process

Along with real estate consulting assistance, the Washington Adventist Hospital and Adventist HealthCare leadership teams worked through a thorough process to evaluate potential sites for the replacement of the hospital. n total, five possible sites were evaluated according to specific criteria and were scored against a variety of characteristics. Of the five potential sites:

- All but one were located in Silver Spring
- Only one was within a mile of the existing site
- Only one was available for purchase and full ownership
- Only one was available through private ownership

Although five potential sites were identified for the relocation and replacement of Washington Adventist Hospital, they were carefully evaluated and scored against the following twelve criteria:

1. Accessibility/Location (major interconnecting roadways)
2. Available Acreage (to accommodate full master plan & associated structures)
3. Purchase to Own (site control)
4. Zoning (proper zoning and entitlements)
5. Existing Public Transportation (bus, train)
6. Feasibility (ease of transaction)
7. Within Existing Primary Service Area
8. Within Montgomery County
9. Area Compatibility (harmony with surrounding development)
10. Ease of Development (site or other constraints)
11. Natural Setting for Healing Environment (close adjacency to natural elements (trees, water, gardens)
12. Access to Science and Technology Organizations(s) (proximity to FDA, University of Maryland, science and technology affiliates)

As demonstrated by the "Site Selection Decision Grid," Exhibit 23, the selected location (Site #5) scored well above the other four options and is the only property that allowed for complete site control through purchase and full ownership.

Priority Funding Area

Part (c) of this standard makes reference to a Priority Funding Area. The White Oak campus of Washington Adventist Hospital is located in a Priority Funding Area as identified in the map. (See Exhibit 1).

(6) Burden of Proof Regarding Need

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

APPLICANT RESPONSE:

Washington Adventist Hospital acknowledges that it has the burden of proof regarding need. Please see COMAR 10.24.01.08G(3)(b) where the need for MSGA beds, psychiatric beds,

obstetrical beds and emergency department space are discussed. Please see COMAR 10.24.11.05B(2) where the need for operating rooms is discussed.

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

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

APPLICANT RESPONSE:

The proposed cost of the hospital construction project is reasonable and consistent with current industry cost experience in Maryland, evidenced by the Marshall Valuation Service (MVS) analysis of construction costs for this project set forth in Exhibits 24 through 29. The MVS analysis addresses the cost of the new hospital at White Oak and the cost of renovation work at Takoma Park. All construction costs are expressed in current (October 2013) dollars and only those costs applicable to the MVS definitions of construction costs for a standard acute care general hospital are included.

Construction Interest and Other Capital Costs – New Construction at White Oak

MVS states that the costs contain "normal interest on only the building funds during the period of construction and processing fee." For this reason, the estimated capitalized interest costs on the project for the construction of the hospital has been adjusted from $47,943,000 to $17,764,000, which reflects the allocation of interest costs to "only the building funds" and to include equity contribution. In other words, no interest cost is carried on the portion of funding to be provided from Adventist HealthCare equity.

The estimated costs of major and minor moveable equipment and other capital cost items that are not specifically included in the design and construction contracts for the new hospital have been excluded, as has the cost of construction interest on these line items. Cost items that are excluded from the MVS calculation are as follows:

- Interest related to above-MVS site development, such as relocation of existing utilities
- Interest related to off-site improvements
- Interest related to Montgomery County land use costs

- Interest related to other extraordinary above-MVS adjustments
- Interest related to major and minor medical equipment
- Interest related to furniture and signage costs
- Interest related to IT and security costs
- Interest related to relocation costs
- Interest related to infrastructure improvements at Takoma Park
- Interest related to renovations at Takoma Park is not carried in the MVS cost for new hospital construction, but it is carried in the MVS analysis of renovation cost described below
- Interest related to Adventist HealthCare's equity contribution

Extraordinary Above-MVS Costs – New Construction at White Oak

Where certain costs to prepare the White Oak site and build the replacement facility for Washington Adventist Hospital are not included in the MVS standard, these are noted and explanations are provided in Exhibit 24. Among the extraordinary cost items excluded from the analysis are: Montgomery County land use costs; off-site road improvements; relocation of existing utility mains and new storm drains; site retaining walls; landscaping, surface parking and construction interest on these line items.

Adjusted Project Cost – New Construction at White Oak

As adjusted, the estimated cost per square foot of building the replacement facility for Washington Adventist is approximately $365.92 as shown below and in Exhibit 25.

MVS Calculations to Build a Good Quality Class A Hospital in Montgomery County
October 2013

	Unadjusted	Extraordinary	Total Cost
New Construction, Incl. Fixed Equipment	$136,300,000	$10,400,000	$132,600,000
Site Preparation	$10,400,000	$9,050,000	$1,350,000
A/E & Consultant Fees	$13,200,000	n/a	$13,200,000
Permits	$700,000	n/a	$700,000
Capitalized Construction Interest	$17,764,000	$2,152,000	$15,612,000
TOTAL	$178,364,000	$ 21,602,000	$156,762,000
	TOTAL SQUARE FEET		428,400
	COST PER SQUARE FOOT		**$365.92**

The project includes a basement and 8 upper floors. According to the MVS calculations summarized below, the Washington Adventist Hospital replacement facility of Class A, Good construction quality should cost approximately $384.64/SF in October 2013 dollars. The complete calculations are found at Exhibit 26. Adjustments for construction cost differentials by department have been included in the calculations as found at Exhibit 27.

MVS Cost Estimate for Construction of the Washington Adventist Hospital at White Oak

	GSF	$ / GSF	Total Cost
Basement	70,836	$191.28	$ 13,549,268
1st - 2nd Floors	146,224	$445.99	$ 65,149,530
3rd - 4th Floors	95,090	$430.39	$ 42,946,078
5th – 8th Floors	116,250	$371.16	$ 43,129,089
TOTAL	**428,400**	**$380.11**	**$164,778,506**

Comparison to MVS Standard – New Construction At White Oak

As the calculations indicate and as reflected in Exhibit 25, the estimated cost of the new hospital construction in White Oak is approximately $18.71/SF or 4.9% below the applicable MVS standard. In addition, the cost of renovations at Takoma Park reduces the net cost per square foot substantially as described below.

MVS Analysis For Renovations At Takoma Park

The existing hospital at Takoma Park is being renovated to provide a portion of the regulated services under this CON as well as clinic services, physician offices and leased space for Washington Adventist University. The physician offices and leased space for Washington Adventist University are addressed under Construction Cost of Non-Hospital Space. Medical equipment, furniture, signage, IT, communication and security are included in Other Capital Costs. For budgeting purposes, various levels of renovations have been identified, ranging from $250/SF to $100/SF. These are construction costs only. The renovation categories include:

- Full clinical renovation for a new use (i.e. tenant space is gutted, all new interior construction and branch utility lines, core and shell features to remain include structure, building envelope and central utility services) - $250/SF;
- Full clinical renovation for the same or similar use (similar to renovation for new use except that major utility distribution and some clinical areas may remain) - $200/SF;
- Moderate clinical renovation or non-clinical renovation for new use (most walls and branch utility distribution remain) - $150/SF; and
- Minor clinical renovation or non-clinical renovation for same use (minor wall changes if any, lighting, floor, wall and ceiling finishes replaced) - $100/SF.

Cost Estimate for Renovation of Washington Adventist Hospital In Takoma Park

FUNCTION	TOTAL AREA	RENO AREA	LEVEL OF RENOVATION	COST
Outpatient Clinic Space	6,400 SF	6,400 SF	Full Clinical, Similar Use	$1,300,000
Psychiatric Unit	30,600 SF[1]	12,500 SF	Moderate Clinical Renovation	$1,860,000
Psychiatric Unit		2,400 SF	Minor Clinical Renovation	$240,000
AREA	37,000 SF	21,300 SF	CONSTRUCTION COST	$3,400,000
Site Prep, Design Fees, Permits, Interest (See Exhibit 28)				$ 727,000
RENOVATED AREA		**21,300 SF**	**TOTAL PROJECT COST**	**$4,127,000**
PROJECT COST PER SF				**$193.76**

NOTES

1. The 30,600 SF Psychiatric Unit includes 15,700 SF of existing space to remain and 14,900 SF of renovated space.

The renovations at Takoma Park include work on the Lower Level and 2nd floor. According to the MVS calculations summarized below, the renovations at Washington Adventist Hospital/ Takoma Park of Class B, Average construction quality should cost approximately $315.62/SF in October 2013 dollars. The complete calculations are found at Exhibit 29.

MVS Cost Estimate for Renovation of Washington Adventist Hospital at Takoma Park

	GSF	$ / GSF	Total Cost
Lower Level 1	6,400	$236.08	$ 1,510,887
2nd Floor	14,900	$349.78	$ 5,211,785
TOTAL	**21,300**	**$315.62**	**$ 6,772,672**

Comparison To MVS Standard – Renovations At Takoma Park

As the calculations indicate and as reflected in Exhibit 28, the estimated cost for the renovation of Washington Adventist Hospital/Takoma Park is approximately $121.86/SF or 38.6% below the applicable MVS standard.

Net Cost Of Construction For Washington Adventist Hospital - Including Existing Space To Remain, Renovations And New Construction

Many of the existing support spaces at Washington Adventist Hospital/Takoma Park are being re-used or re-purposed with no required renovations as shown below. This increases the cost-effectiveness of the project and reduces the net cost per square foot as compared to a project including new construction only.

Renovation of Washington Adventist Hospital In Takoma Park

FUNCTION	TOTAL AREA	RENO AREA	LEVEL OF RENOVATION
Outpatient Clinics	6,400 SF	6,400 SF	Full Clinical, Similar Use
Plant Operations	1,200 SF	N/A	Existing Space to Remain
Building Engineering	4,500 SF	N/A	Existing Space to Remain
Housekeeping	1,000 SF	N/A	Existing Space to Remain
Dietary	9,200 SF	N/A	Existing Space to Remain
Biomed Engineering	600 SF	N/A	Existing Space to Remain
Morgue	200 SF	N/A	Existing Space to Remain
Materials Mgmt.	2,800 SF	N/A	Existing Space to Remain
Laboratory	3,700 SF	N/A	Existing Space to Remain
Wound Care	1,500 SF	N/A	Existing Space to Remain
Radiology	4,800 SF	N/A	Existing Space to Remain
Pharmacy	1,700 SF	N/A	Existing Space to Remain
Central Registration	1,000 SF	N/A	Existing Space to Remain
Psychiatric Unit	30,600 SF	12,500 SF	Moderate Clinical Renovation
Psychiatric Health Unit	2,400 SF		Minor Clinical Renovation
TOTAL AREA	**69,200 SF**	**21,300 SF**	

Including the renovation cost for services to remain at Takoma Park, the cost for new hospital construction and renovation is $160,162,000. Total program area is 497,600, resulting in an effective cost per square foot of $321.87 for the combined program at White Oak and Takoma Park. This is approximately $62.77 or 16.3% below the MVS standard for new construction only.

(8) Construction Cost of Non-Hospital Space.

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

APPLICANT RESPONSE:

The budget for the Washington Adventist Hospital replacement project includes allowances for demolition of the areas in Takoma Park which are to be converted to leased space for physician offices and Washington Adventist University, for work in the public corridors to create accessible, demisable tenant spaces within the existing hospital and for fit-up of the leased spaces. These are the only non-hospital spaces included in the project.

Values for the fit-up allowances were determined based upon comparison to recent leases executed by Adventist HealthCare for comparable spaces. The allowance values, including escalation, are as follows:

Fit-up allowance for Washington Adventist University space (i.e. renovate to leasable condition) - $84/SF;

Demolition allowance for Washington Adventist University space (i.e. demolish walls, ceilings, lighting, and branch MEP distribution, including demolition of existing OR's to create a leasable space) - $17/SF;

Fit-up allowance for physician office space (i.e. renovate to leasable condition) - $50/SF;

Demolition allowance for physician office space (i.e. demolish walls, ceilings, lighting, and branch mechanical, electrical, plumbing, (MEP) distribution to create a leasable space) - $11/SF;

Allowance for finishes, zoning and security in public corridors (i.e. new finishes, lighting and demising walls as required to create tenant space) - $84/SF.

Cost Budget for Non-Hospital Spaces In Takoma Park

TENANT SPACE	LEASE AREA	ALLOWANCE	COST
Washington Adventist University	56,770 SF	Demolition/Prep	$970,000
Washington Adventist University	Same	Fit-up	$4,770,000
Physician Offices	28,840 SF	Demolition/Prep	$320,000
Physician Offices	Same	Fit-up	$1,440,000
Public Corridors	14,000 SF	Finishes, zoning and security	$1,180,000
TOTAL NON-HOSPITAL SPACE	**99,610 SF**		**$8,680,000**
AVERAGE CONSTRUCTION COST PER SQUARE FOOT, INCL. DEMOLITION			$87.14

As stated, these costs are consistent with fit-out allowances included in recent leases for medical office and related space.

(9) Inpatient Nursing Unit Space.

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

APPLICANT RESPONSE:

None of the space for inpatient units in the project exceeds 500 square feet per bed.

Square Feet/Bed built for inpatient nursing units in the Project is shown below:

Proposed Bed Distribution (White Oak)

Unit Name	Unit Description	No. Beds in the Project	Unit Size (SF)	Square Feet / Bed
Floor 2	ICU / CCU	28	13,766	491.64
Floor 3	Cardiac	32	11,778	368.06
Floor 4	Post Partum/Ante Partum / MSGA	21	9,418	448.48
Floor 5	Med / Surg	32	11,061	345.66
Floor 6	Med / Surg	32	11,061	345.66
Floor 7	Med / Surg	32	11,061	345.66
Floor 8	Med / Surg	24	8,296[4]	345.66
.	Total =	201		

4 This floor contains observation beds which are excluded from the calculation.

Proposed Bed Distribution (Takoma Park)

Unit Name	Unit Description	No. Beds in the Project	Unit Size (SF)	Square Feet / Bed
Floor 2 (Takoma Park)	Behavioral Health / Psych (Takoma Park)	40	19,214	480.35

The department area was determined by summing the interior room areas for each departmental unit, including all patient rooms, support spaces and family support rooms within that department. The tabulation excluded corridor circulation, stairs, elevators, shafts, utility rooms, structural columns, shear walls and exterior wall enclosure. As an example, below is the summary table for the 2North ICU/CCU Unit:

ROOM SCHEDULE BY DEPARTMENT - ICU / CCU

Level	Department	Room Name	Area (sf)
LEVEL 2	CRITICAL CARE	ALCOVE	12
LEVEL 2	CRITICAL CARE	ALCOVE	12
LEVEL 2	CRITICAL CARE	ALCOVE	14
LEVEL 2	CRITICAL CARE	ALCOVE	14
LEVEL 2	CRITICAL CARE	ANTE ROOM	129
LEVEL 2	CRITICAL CARE	ANTE ROOM	129
LEVEL 2	CRITICAL CARE	CHARTING	318
LEVEL 2	CRITICAL CARE	CHARTING STATION	319
LEVEL 2	CRITICAL CARE	CLEAN EQUIPMENT HOLD	453
LEVEL 2	CRITICAL CARE	CLEAN SUPPLY	144
LEVEL 2	CRITICAL CARE	CLEAN SUPPLY	169
LEVEL 2	CRITICAL CARE	CORRIDOR	1,107
LEVEL 2	CRITICAL CARE	DECONTAM	126
LEVEL 2	CRITICAL CARE	EQUIPMENT STORAGE	219
LEVEL 2	CRITICAL CARE	EQUIPMENT STORAGE	297
LEVEL 2	CRITICAL CARE	FAMILY WAITING	253
LEVEL 2	CRITICAL CARE	HK	34
LEVEL 2	CRITICAL CARE	ICU 01	293
LEVEL 2	CRITICAL CARE	ICU 02	272
LEVEL 2	CRITICAL CARE	ICU 03	283
LEVEL 2	CRITICAL CARE	ICU 04	283
LEVEL 2	CRITICAL CARE	ICU 05	272
LEVEL 2	CRITICAL CARE	ICU 06	293
LEVEL 2	CRITICAL CARE	ICU 07	311
LEVEL 2	CRITICAL CARE	ICU 08	327
LEVEL 2	CRITICAL CARE	ICU 09	271
LEVEL 2	CRITICAL CARE	ICU 10	283
LEVEL 2	CRITICAL CARE	ICU 11	283
LEVEL 2	CRITICAL CARE	ICU 12	272
LEVEL 2	CRITICAL CARE	ICU 13	293
LEVEL 2	CRITICAL CARE	ICU 14	290
LEVEL 2	CRITICAL CARE	ICU 15	296
LEVEL 2	CRITICAL CARE	ICU 16	293

Level	Department	Room Name	Area (sf)
LEVEL 2	CRITICAL CARE	ICU 17	272
LEVEL 2	CRITICAL CARE	ICU 18	283
LEVEL 2	CRITICAL CARE	ICU 19	283
LEVEL 2	CRITICAL CARE	ICU 20	271
LEVEL 2	CRITICAL CARE	ICU 21	327
LEVEL 2	CRITICAL CARE	ICU 22	311
LEVEL 2	CRITICAL CARE	ICU 23	293
LEVEL 2	CRITICAL CARE	ICU 24	272
LEVEL 2	CRITICAL CARE	ICU 25	283
LEVEL 2	CRITICAL CARE	ICU 26	283
LEVEL 2	CRITICAL CARE	ICU 27	272
LEVEL 2	CRITICAL CARE	ICU 28	297
LEVEL 2	CRITICAL CARE	LEAD THERAPIST	162
LEVEL 2	CRITICAL CARE	LOCKERS	56
LEVEL 2	CRITICAL CARE	MED	81
LEVEL 2	CRITICAL CARE	MEDICATION	76
LEVEL 2	CRITICAL CARE	NOURISH	59
LEVEL 2	CRITICAL CARE	NOURISH	61
LEVEL 2	CRITICAL CARE	OFFICE	70
LEVEL 2	CRITICAL CARE	OFFICE	71
LEVEL 2	CRITICAL CARE	OFFICE	84
LEVEL 2	CRITICAL CARE	OFFICE	84
LEVEL 2	CRITICAL CARE	PAT TLT	23
LEVEL 2	CRITICAL CARE	PHYSICIAN WORK ROOM	124
LEVEL 2	CRITICAL CARE	SOILED UTILITY	135
LEVEL 2	CRITICAL CARE	SOILED UTILITY	124
LEVEL 2	CRITICAL CARE	STAFF LOUNGE / LOCKERS	401
LEVEL 2	CRITICAL CARE	STAFF ROOM	111
LEVEL 2	CRITICAL CARE	STF TLT	56
LEVEL 2	CRITICAL CARE	STF TLT	42
LEVEL 2	CRITICAL CARE	TEAM ROOM	135
		Total Area (SF)	13,766
		Patient Rooms	28
		Area per Patient Room	491.6

(10) Rate Reduction Agreement.

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

APPLICANT RESPONSE:

This standard is inapplicable because the rate reduction agreements contemplated by the standard have been replaced by automatic rate reductions.

(11) Efficiency.

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

(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in which the planning and design of the project took efficiency improvements into account; and

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

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

APPLICANT RESPONSE:

The Washington Adventist Hospital design team has consistently incorporated performance features into the design of the replacement proposed for the White Oak site in order to perform efficiently. The current design for the proposed replacement hospital retains the following efficiencies in an efficient building footprint.

- Centrally located supply rooms on the patient floors to minimize nurse travel distances.
- Optimized movements between patient care departments and critical support amenities or services will result in greater efficiency for staff providing care and patients receiving care.
- On the cellar level, several key support departments are located with easy access to both the clean dock and the staff/service elevators.
- The main public and staff elevator banks are centrally located.
- Pharmacy is located on the cellar level in close proximity to service elevator core.
- Information Services and Health Information are adjacent to provide better dock access for support service departments with daily dock use.
- Relocation of Patient Care Equipment adjacent to Central Sterile Processing for more efficient circulation and cleaning of equipment.
- Complementing departments are located adjacent to each other, such as Nursing Administration/Public Access and Occupational Health/Human Resources.

- The building has only one patient tower so the vertical circulation is more direct and the distances between matching services such Labor and Delivery adjacent to the Post-Partum Unit is shorter.

- Maternity layout minimizes the distance from the service elevators to the C-Section suites and places the Nursery within the Post-Partum Unit suite.

- Optimal elevator quantity and configuration of elevator banks for better building circulation.

- Centralize public access areas to improve wayfinding and security.

- Include line-of-sight wayfinding from main public entrance to public areas such as gift shop, retail pharmacy, cafeteria, elevators.

Washington Adventist Hospital, along with its architect and engineers, will continue this effort in the design phases to provide the best value for the associated design and/or construction costs. Additional energy-saving suggestions (LED lighting. more-efficient equipment. etc.,) will also be explored in later phases of design.

Efficiencies in Staffing

As described in this proposal to relocate Washington Adventist Hospital, full time equivalents (FTEs) per Adjusted Occupied Bed (AOB) will improve in the replacement facility and will continue to improve as volumes grow as projected. Specifically, in Year 1 in the new facility, FTEs/AOB ratios will improve to 4.20 from 4.34 projected for 2014 in the existing facility. As volume grows according to the projection, FTEs/AOB will further reduce to 3.93 by 2023. The increases in efficiency are related to the programmed improvements in patient flow and management built into the design of the replacement Hospital facility. Specific improvements in efficiency are the result of: 1) consolidating the critical care service into one nursing unit, 2) reduction in patient transport positions due to better adjacencies between departments, 3) improvements in the patient admissions function, and 4) overall reductions in average length of stay. Without these gains in efficiencies, the hospital would incur additional manpower expenses above those associated with the modest increases in volumes forecasted for the proposed relocation of Washington Adventist Hospital.

Building

The overall organization of the new hospital will also improve operations. Unlike the existing facility which requires multiple elevator locations that serve specific areas of the hospital and often mix public, staff, and service traffic, the new design is organized around centrally located, segregated public and staff/service elevator cores that service the entire building thereby reducing confusion, congestion and travel time. A Patient Transfer elevator will allow for the movement of patients from the Emergency Department to Critical Care, Maternity, and Intermediate Care units.

Departments

- Hospital Administration - All functions co-located on a single floor

- Nursing Units - All private rooms increase utilization, reduces moves. Nursing workstations are located outside of patient rooms.

- Critical Care - Co-located in 7-bed zones to allow for fluctuation in census as well as sharing support services. Co-located with Respiratory Therapy.

- Surgical Suite - Central Clean Core with direct elevator access to Central Processing. Designed for switch to case cart system.

- Endoscopy - Co-located with Surgery for shared support.

- Cardiology - All Cardiology (invasive and non-invasive) co-located on one floor with adjacent telemetry unit.

- Maternity - Unlike the current department, a distinct Triage Suite and C-section prep/recovery suite is provided to preclude the need to use LDR's for this purpose.

- Nursery - Respite Nursery co-located with Intermediate Care Nursery for shared support.

- Behavioral Health Unit - To remain in Takoma Park and will undergo renovations to increase private beds and capacity and increase staff efficiency by developing units based on acuity.

- Emergency - Universal enclosed exam/treatment rooms and zoned configuration to allow flexibility in use and adjustments with changes in census. CT and Radiographic rooms in close proximity to Diagnostic Imaging. Satellite Collections Lab provided. Additionally, the 12 adjacent observation beds will facilitate cohorting short-stay patients where care will be managed more efficiently, avoiding inefficient transfers.

- Dialysis - Dialysis Unit located on Nursing Unit Floor

- Rehab - Rehab Suite located on Nursing Unit Floor

- Throughput at the current site is hampered by the number of semi-private rooms. Rooms are blocked when a patient has isolation restrictions due to infection. The replacement facility will have all private rooms improving patient flow and treatment.

Summary

The proposed replacement Washington Adventist Hospital is designed to operate efficiently and, as described above, has incorporated many design features that explicitly address this objective.

(12) Patient Safety.

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

APPLICANT RESPONSE:

Evidence-based architectural methods have been employed in the hospital design to improve patient outcomes, safety, and satisfaction. Additionally, these design methods also improve staff efficiency, satisfaction, and staff retention. The design is consistent with national or jurisdictional codes and guidelines established for hospital design and construction and include those found at Exhibit 30.

All patient rooms will be private, including all of the rooms for Maternity, Medical/Surgical and Intensive Care Unit patients. Therefore, the replacement hospital will eliminate infection risks inherent in semi-private rooms occupied by two patients. In addition, hand washing stations will be located both directly inside the entry door to each patient room as well as along the corridor to further reduce the risk of infection.

Within each patient room, the risk of patient falls is reduced due to the close proximity of the washroom door to the patient's bed and the amount of light provided. Family space is also provided in the room to encourage patient and family involvement in care. Individual computer access is provided in each room to facilitate the communication of concerns that patients or family members might have.

Computer stations are included in both the alcoves and at the patient bedside for staff access to electronic medical records and medication bar coding, potentially reducing errors.

In the Emergency Department, the Triage and Fast Track areas both have separate waiting areas from the main Emergency Department waiting room and all exam spaces are private enclosed rooms, reducing the risk of infection. Within the Emergency Department, the Behavioral Health Assessment Area has a secured suite of rooms with an outside entry for patients.

Upon analysis of its patient population, Washington Adventist Hospital will identify and designate locations where ceiling mounted patient lifts will be placed in order to provide for the safe transfer of bariatric and other similarly incapacitated patients. These areas will also incorporate other safety features to include floor mounted toilets, wider doors, as well as furniture and equipment designed for this population.

At the Washington Adventist Hospital-Takoma Park campus the behavioral health unit will be expanded to provide all private beds and safer conditions. T he current configuration of Behavioral Health at Takoma Park comprises only 5 private rooms. This will be revised to 40 private beds in 2 units: a high-functioning unit and a low-functioning unit. The 2nd floor of the existing 1990's era building (known as building 2500 on the Takoma Park campus) will be renovated to a the low-functioning 20-bed unit with a corridor connection to the existing unit. In addition, renovations to the existing unit will provide better visibility and larger common areas.

At the White Oak campus, a discrete examination/assessment suite is provided within the Emergency Department and is designed to permit segregation of disruptive patients while allowing for visual control by staff. This suite can be accessed directly from the ambulance entrance area.

Where appropriate, various radio frequency identification systems will be utilized to track patient flow during their treatment. Such systems will particularly enhance the safety of patients being treated in the Surgical Suite and the Emergency Department as their progress through the department will be constantly monitored. Infants on the maternity floor will also be protected through the use of these systems which will include automatic alarm and lock down. Tracking of critical equipment through these systems will also be reviewed and implemented to ensure that they are located and available when urgently needed for patient care.

Consistent with its heritage, Washington Adventist Hospital seeks to create a hospital that holistically serves its future patients and staff. Through evidence-based design methods and principles, the replacement hospital is designed to promote healing in a safe and effective physical environment.

(13) Financial Feasibility.

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

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

(b) Each applicant must document that:

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

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

(iii) **Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals; and**

(iv) **The hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate that overall hospital financial performance will be positive and that the services will benefit the hospital's primary service area population.**

APPLICANT RESPONSE:

A comprehensive table of the revenue and expense assumptions that were used in the financial projections can be found in Exhibit 31.

All of the projections of future utilization of the hospital prior to the opening of the new facility have been based on historical trends in the utilization of these services by the service area population of the hospital. (Exhibit 32). Future utilization of the hospital after opening of the new facility have been based on the utilization of those services by the service area population need projections as shown in the need and market share projection on pages 140 and 143 of this application under COMAR 10.24.01.08G(3)(f)(Impact on Existing Providers).

Revenue estimates are based on current allowable charge levels and incorporate the current reimbursement methodologies employed by the HSCRC (i.e. Charge per Episode methodology for inpatient cases and outpatient fee for service with an 85% variable cost factor for all services except clinic which is subject to 50%). However, Washington Adventist Hospital has entered into discussions with the HSCRC staff to evaluate a new reimbursement mechanism with a probable effective date of January 1, 2014 that will serve to help stabilize Washington Adventist Hospital during the transition period to build a new and efficient hospital which will allow the hospital to meet the objectives of the evolving healthcare delivery model.

Staffing and expenditure levels as shown in Exhibit 31 are based on current expenditure levels but take into account the necessary reductions currently underway that are responsive to the current volume levels and reimbursement/financial challenges.

As shown in Exhibit 31, the hospital will generate excess revenues over expense in the fourth year following the opening of the new facility.

Attached as Exhibit 33 is a letter from Adventist Health Care's investment banker, Ziegler Capital Markets, which endorses the feasibility of the project.

(14) Emergency Department Treatment Capacity and Space.

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

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

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

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

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

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

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

APPLICANT RESPONSE:

Washington Adventist Hospital proposes an emergency department to be located within the replacement hospital on the White Oak campus, and clinic space to be located on the Takoma Park campus. Together, this approach reflects the dynamics of moving an existing emergency department to an adjusted service area and the projected effect of providing clinic services on the existing campus. The plan reflects Washington Adventist Hospital's analysis and projections based on the projected changes to the adjusted service area and changes to market share, current utilization rates and trends in the relocated hospital's service area, the projected population for the new service area, and the existing hospital's utilization trends.

As referenced above, this response addresses the program and design characteristics for the emergency department proposed for the White Oak campus, and, as stated previously, assume the presence of clinic service availability on the Takoma Park campus. The White Oak campus is easier for emergency vehicles to reach and provides safer landing access for helicopters. It is located in an area with a large senior population and is accessible for low income residents in Hyattsville, Langley Park and other communities. The current hospital emergency department on the Takoma Park campus houses 26 treatment bays, which do not provide a desirable level of privacy or dignity for patients and caregivers. The emergency department in White Oak will contain 35 treatment rooms, 2 Mental Health Evaluation rooms, and an adjacent area with 12 short stay observation beds.

Comparing the proposed design at White Oak with the ACEP standards and parameters, the proposed emergency department program and space comfortably meets the projected volumes and provides a plan for expansion should volumes increase as projected. The current design, 35 treatment bays and 12 observation beds in 24,987 DGSF, is within the high and low range parameters (see table below). In addition, Washington Adventist Hospital believes that the current design is appropriately sized to the projected volumes with some ability to expand yearly visits with improvements in efficiency or minor changes in room mix. Further, the 12-bed observation unit

provides flexibility in the emergency department program to meet anticipated future needs. Finally, should future volumes increase beyond the projections, the hospital design includes emergency department expansion capability directly to the north. The DGSF area for the current design is smaller than the ranges noted in the ACEP guidelines because these ranges usually include a radiology program. The current design shows the Radiology Department immediately adjacent to the emergency department with direct access to Radiology and quick access to the CT and MRI. As a result, that program area is included in the overall Radiology Services DGSF.

Washington Adventist Hospital considered the ACEP guidelines for determining the number of treatment spaces and the total program area for the design of the emergency department on the White Oak campus. The table below provides Washington Adventist Hospital's responses to the ACEP parameters.

Parameters Determining Size for Emergency Department

Low Range Parameter	**Applies to Washington Adventist Hospital**
ALOS for all ED patients <2.5 hours	NO
Observation /Evaluation Beds located outside ED	YES
Time to admit <60 minutes after disposition	YES
Average turnaround time for diagnostic test results <30 minutes	NO
Less than 18% of patients are admitted to the Hospital	NO
Non-urgent patients outnumber urgent patients by more than 10 %	NO
Less than 20% of patients are age 65+	NO
Minimal Need for offices or teaching spaces	NO
Imaging studies are not performed within the department	NO
No specialty components or departments	NO
Flight/trauma services support areas not included	YES
ALOS for all ED patients >3.5 hours	YES
Observation/evaluation beds will be located within the ED	YES
Time to admit >90 minutes after disposition	NO
Average turnaround time for diagnostic test results in >60 minutes	YES
More than 23% of patients are admitted to the Hospital	NO
Need for offices or teaching spaces, such as a university teaching hospital	NO
Imaging studies are performed within the department	YES
Specialty components or departments (pediatric ED, large number of psychiatric patients)	YES – psychiatric Patients, geriatric
Flight/trauma services support areas included	NO

Shown below are the low ranges and high ranges of emergency department areas and bed quantities, including patient spaces for observation/clinical decision. The high range includes beds for "observation/clinical decision." These estimates are shown below:

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

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

Service Area

Based on CY2012 internal operating data, the current service area for emergency department visits at Washington Adventist Hospital Takoma Park was analyzed.

In CY2012, the Washington Adventist Hospital PSA for the Emergency Department consisted of 8 zip codes, 5 located in Montgomery County, and 3 located in Prince George's County, with the primary number of Emergency Department visits coming from zip code 20783 (Hyattsville). Within the Washington Adventist Hospital Takoma Park PSA, Holy Cross Hospital is the only other emergency department service provider.

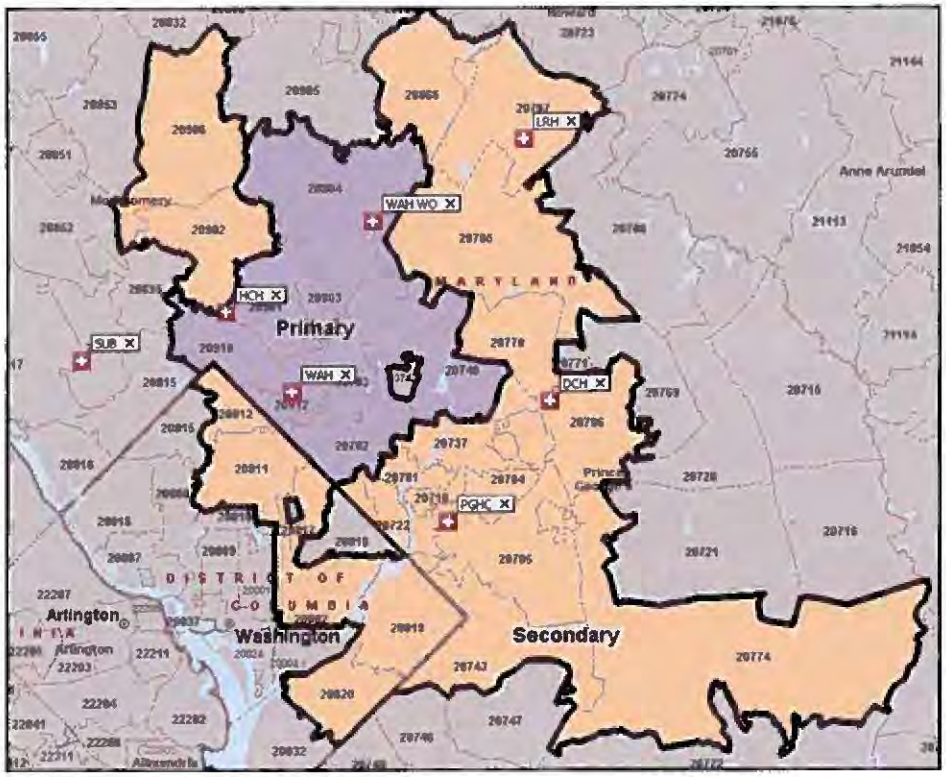
The Washington Adventist Hospital Takoma Park PSA is comprised of 30 zip codes, 8 located in Montgomery County, 16 located in Prince George's County, and 6 located in the District of Columbia, listed below.

Zip Code	City	Service Area	ED Visits
20783	Hyattsville	Primary	9,107
20912	Takoma Park	Primary	5,840
20782	Hyattsville	Primary	4,268
20903	Silver Spring	Primary	3,667
20901	Silver Spring	Primary	2,445
20904	Silver Spring	Primary	2,170
20910	Silver Spring	Primary	2,070
20740	College Park	Primary	1,315
20011	Washington, D.C.	Secondary	1,245
20737	Riverdale	Secondary	1,095
20705	Beltsville	Secondary	964
20902	Silver Spring	Secondary	911
20770	Greenbelt	Secondary	852
20781	Hyattsville	Secondary	778
20906	Silver Spring	Secondary	768
20712	Mount Rainier	Secondary	740
20012	Washington, D.C.	Secondary	630
20706	Lanham	Secondary	612
20784	Hyattsville	Secondary	600

Zip Code	City	Service Area	ED Visits
20722	Brentwood	Secondary	442
20785	Hyattsville	Secondary	426
20707	Laurel	Secondary	323
20019	Washington, D.C.	Secondary	281
20002	Washington, D.C.	Secondary	273
20743	Capitol Heights	Secondary	272
20866	Burtonsville	Secondary	263
20774	Upper Marlboro	Secondary	260
20020	Washington, D.C.	Secondary	257
20017	Washington, D.C.	Secondary	247
20710	Bladensburg	Secondary	245

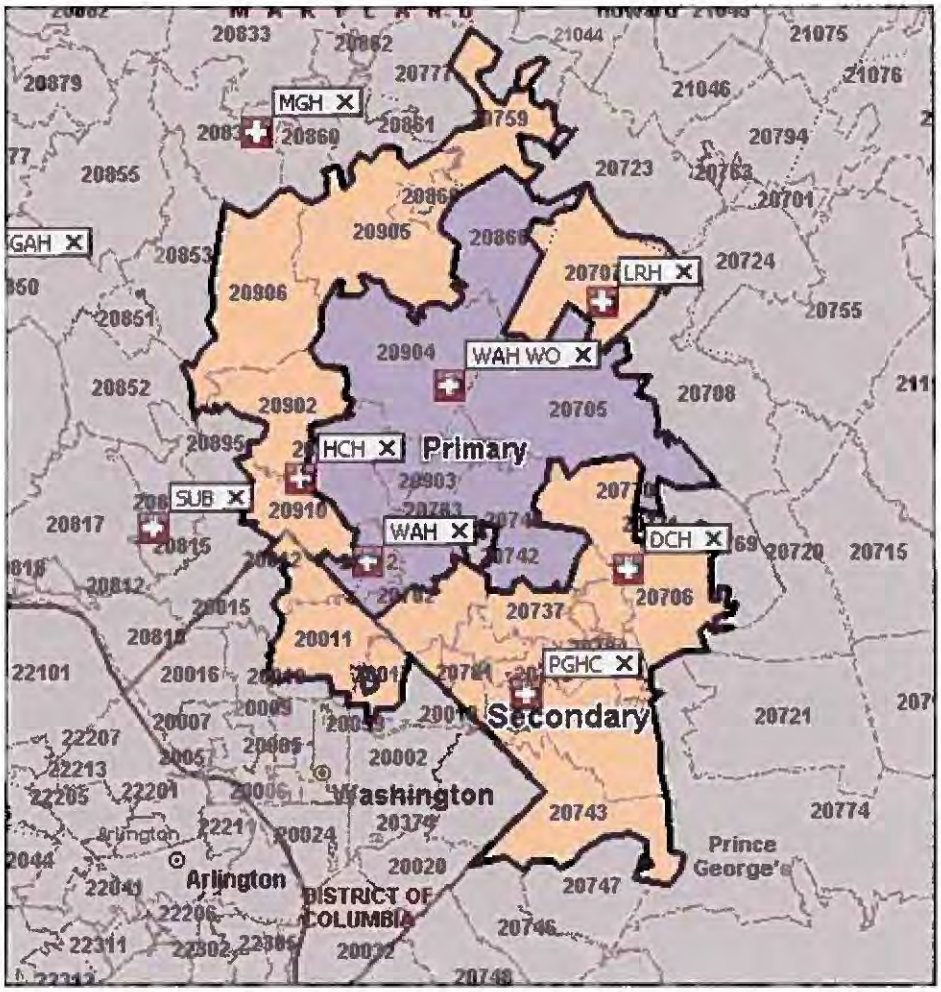
CY2012 Washington Adventist Hospital Takoma Park

Primary and Secondary Service Area for ED Visits



The White Oak TSA was identified based on Emergency Department admissions from contiguous zip codes to the proposed White Oak location because convenience and/or proximity is a critical factor in emergency department use. Travel times of less than 15 minutes to both the proposed White Oak location and the current Takoma Park campus were analyzed to identify the primary service area and secondary service area. The Takoma Park campus is considered relevant in this analysis defining the TSA because primary care clinics will be providing services at that campus to reduce the number of low acuity visits and unnecessary emergency level visits at Washington Adventist Hospital White Oak and surrounding hospital emergency departments. See the map below.

Proposed Washington Adventist Hospital White Oak Primary and Secondary Service Area for Emergency Department



The following chart shows the emergency room visits for all hospitals in Montgomery and Prince George's counties from CY 2008 until CY 2012. Overall emergency department visits grew 9% over the last five years. Washington Adventist Hospital experienced higher than average emergency room growth of 12.6% since 2008.

ED Visits for Montgomery and Prince George Hospitals - Calendar Years 2008-2012

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	45,167	46,257	44,823	48,189	50,840	12.6%
Holy Cross	84,998	93,801	86,627	90,582	92,761	9.1%
Montgomery General	34,200	36,100	36,325	39,091	40,339	18.0%
Shady Grove Adventist	74,457	75,973	71,984	72,113	78,575	5.5%
Suburban Hospital Center	43,138	44,491	43,063	44,219	45,851	6.3%
Laurel Regional Hospital	35,444	37,461	35,147	35,268	36,041	1.7%
Prince Georges Hospital Ctr	43,753	47,761	47,205	51,312	53,126	21.4%
Southern Maryland	-	-	-	-	6,953	N/A
Fort Washington Hospital	43,507	47,302	44,424	44,749	46,366	6.6%
Doctors Community Hospital	57,007	60,047	59,150	57,116	52,398	-8.1%
Total	461,671	489,193	468,748	482,639	503,250	9.0%

The following tables identify current utilization for the Emergency Department at Washington Adventist Hospital Takoma Park.

Emergency Department Payor Mix at Washington Adventist Hospital Takoma Park based on Gross Charges

Payor	2008	2009	2010	2011	2012	Change
COMMERCIAL	31.2%	30.7%	29.1%	27.9%	26.7%	-4.5%
MEDICAID	15.9%	21.6%	23.2%	24.6%	26.1%	10.2%
MEDICARE	22.8%	22.5%	24.8%	21.9%	22.0%	-0.8%
CHARITY	0.2%	0.1%	0.0%	0.0%	0.1%	-0.1%
OTHER	3.1%	2.7%	1.5%	1.6%	1.9%	-1.3%
SELF PAY	26.7%	22.5%	21.3%	23.9%	23.3%	-3.4%

Additionally, the percentage of uninsured population is higher in Montgomery County and Prince George's counties compared to the state of Maryland. Further, representative of the current payor mix at Washington Adventist Hospital, it serves a disproportionate number of the uninsured and underinsured population compared to other area providers.

Insurance Coverage Amongst Civilian Noninstitutionalized Population - CY2012

	No Health Insurance	
Montgomery County	118,148	11.9%
Prince George's County	135,901	15.6%
Maryland	597,554	10.3%

Source: 2012 American Community Survey

The Washington Adventist Hospital emergency department and acute care staff and physicians have been intentionally focused on appropriate utilization and the placement of patients to more appropriate settings for care. The model of care proposed by this plan is informed by and responds to current efforts and the existence of various partnerships directed at caring for the populations Washington Adventist Hospital serves in the best and most appropriate setting. Although the emergency department to be located in White Oak will continue to see a variety of patients from the identified service area, the complement of services to be located in Takoma Park will be available to current populations seeking care for lesser acuity conditions.

The complement of services in Takoma Park will be comprised of clinic services to be provided by the hospital or in affiliation with the hospital, such as CCI, Inc. and the maternity clinic. In fact, CCI will commence with providing Federally Qualified Health Services on the Takoma Park campus by the end of 2013 and the maternity clinic will continue to provide antenatal services as it has for many years at the Takoma Park campus. These efforts taken by the hospital have and will continue to have a favorable impact on the utilization of emergency services. Along with the plan to relocate the emergency department to White Oak, the plan for clinic based services to remain in Takoma Park is focused on ensuring that populations in the adjusted service area have access to the appropriate level of service when it is needed.

In addition to the emergency department and clinic services proposed in this application, population health programs have been implemented during the past two years to lower the rate of non-acute emergency room use and readmissions to the hospital. During the first 24 months of operation of these programs, the readmission rate (excluding one-day stays) has ranged from a high of 9.39%

early in the program to record lows of 6.2% achieved twice in the past 10 months. The program components are:

- A partnership with Walgreens to provide Bedside Prescription Delivery Service to patients ensuring that they have all required medications in hand before leaving the hospital, regardless of their ability to pay. Patients discuss their medications with pharmacists before discharge and again within 48-72 hours post discharge. This program has increased the level of medication compliance and as a result, improved health status and fewer emergent needs among hospital patients.

- WellTransitions Program also in partnership with Walgreens is in place for patients identified as high risk for readmission. Pharmacists make follow-up calls to these patients three times during the 30-day post discharge period. Home medications and prescribed hospital medications, side effects, dosing and other health questions are discussed during these calls.

- 340B Drug Pricing Program, one year after beginning the Bedside Prescription Delivery Service, the hospital and Walgreens initiated this program to ensure funding for prescription medications for the underserved patients discharging from the hospital.

- Early in 2013, the hospital added two Transitional Care positions within the Case Management Department to implement My Health Place® at Washington Adventist Hospital. This program in collaboration with Conifer Health Solutions identifies high risk patients before they leave the hospital and make sure they have follow-up appointments with a physician. Follow-up calls are also made to patients in the program who receive a My Health Place® Passport booklet. The booklet lists their physician name and appointment time, as well as phone numbers to call if they have questions. The Passport is issued in the patient's preferred language, and at present is available in Spanish, French and Amharic in addition to English.

- Washington Adventist Hospital has developed programs in conjunction with other community resources at two housing facilities to provide care for patients before a health condition becomes more serious and requires hospitalization. Programs at Victory Towers in Takoma Park and Holly Hall in Silver Spring are respectively serving seniors living on fixed incomes and seniors and disabled individuals who are aging in place with inadequate resources.

Washington Adventist Hospital, in cooperation with Adventist HealthCare's health and wellness activities, currently collaborates with multiple organizations to improve the health and wellbeing of the communities served by Washington Adventist Hospital. These partnerships support the initiatives described above and further enhance Washington Adventist Hospital's efforts to ensure appropriate utilization of ED services and improved access to the appropriate level of care. These partnerships include:

- Partnering with Mary's Center for Maternal and Child Care at its primary care center in the Long Branch area of Montgomery County. Mary's Center, with 20 years of experience in serving the indigent in Washington, demonstrates how improved access to family medical care, coupled with sensitivity to culture and language, lead to healthy families and safer communities.

- Partnering with MobileMed in the operation of mobile clinic sites and the development and recent fixed-site clinics. Currently MobileMed provides clinic services at: Arcola Towers, Wheaton; Casa de Maryland, Silver Spring; Community Vision at Progress Place, Silver Spring; Crusader Church, Rockville, East Montgomery County Regional Services Center, Silver Spring; Elizabeth House, Silver Spring; Gaithersburg/Ascension House, Gaithersburg; Gude Drive Men's Shelter, Rockville; Holly Hall, Silver Spring; Ibn Sina Clinic, Potomac; Kammsa Clinic, Gaithersburg; La Clinique L'A.M.I., Silver Spring; Lincoln Park Community Center, Rockville; Long Branch Community Center, Silver Spring; Pan Asian Volunteer Health Clinic, Silver Spring; Rockville Senior Center, Rockville; Shepherd's Table, Silver Spring; and Sophia House Women's Shelter.

- Providing ancillary and other support services, including comprehensive health screenings, for patients treated at Mercy Health Clinic in Gaithersburg. Mercy Health Clinic is a free, non-profit, non-sectarian, community-based, primary healthcare provider serving uninsured, low-income adult residents of Montgomery County.

- Maternity clinics at Washington Adventist Hospital and Shady Grove Adventist Hospital as part of the Montgomery County Maternity Partnership Program, providing prenatal health services and education for the low-income and uninsured population.

- Adventist HealthCare partners with Casa de Maryland to provide health care and community services for the immigrant communities in Montgomery County and Prince George's County. The partnership includes the provision of primary medical care for uninsured residents, collaboration on ways to encourage immigrants to pursue a career in health care and a variety of other community services including language assistance and job training.

- Adventist HealthCare's Health Ministry Outreach works with more than 19 faith-based community organizations and some 140 congregations of all faiths, helping them through classes and health events to train and support Faith Community (Parish) Nurses who will directly provide support and care at the local community level.

(15) <u>Emergency Department Expansion.</u>

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

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

injuries, and conditions, to lower cost alternative facilities or programs;

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

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

APPLICANT RESPONSE:

Washington Adventist Hospital is proposing an emergency department design for its White Oak hospital that effectively sizes the program to meet the demand of the projected population it will serve in the new location (see response to "Emergency Department Treatment Capacity and Space and the response provided to standard 10.24.01.08G(3)(b). Need). The program and design for the White Oak emergency department is informed by ACEP guidelines as evidenced in the response to the previous standard. Additionally, the design and program reflect the projected volume of patients that will require hospital based emergency services, which assumes a portion of lower acuity visits that will occur in the clinics on the Takoma Park campus. Together, the proposal for emergency services and clinic services in Takoma Park will result in accessible and appropriate medical services for the populations identified in the service area.

The Washington Adventist Hospital emergency department and acute care staff and physicians have been intentionally focused on appropriate utilization and the placement of patients to more appropriate settings for care. The model of care proposed by this plan is informed by and responds to current efforts and the existence of various partnerships directed at caring for the populations Washington Adventist Hospital serves in the best and most appropriate setting. Although the emergency department to be located in White Oak will continue to see a variety of patients from the identified service area, the complement of services to be located in Takoma Park will be available to current populations seeking care for lesser acuity conditions.

The complement of services in Takoma Park will be comprised of clinic services to be provided by the hospital or in affiliation with the hospital, such as CCI, Inc. and the maternity clinic. In fact, CCI will commence with providing Federally Qualified Health Services on the Takoma Park campus by the end of 2013 and the maternity clinic will continue to provide antenatal services as it has for many years at the Takoma Park campus. These efforts taken by the hospital have and will continue to have a favorable impact on the utilization of emergency services. Along with the plan to relocate the emergency department to White Oak, the plan for robust clinic based-services to remain in Takoma Park is focused on ensuring that populations in the adjusted service area have access to the appropriate level of service when it is needed.

In addition, Washington Adventist Hospital will continue to promote and provide a wide array of health and wellness programs in the community designed to help individuals lead healthy lives. These additional community focused services are available today and will continue to be provided by the hospital and Adventist HealthCare.

Following are examples of the extensive offering of health programs offered by Washington Adventist Hospital and Adventist HealthCare:

- The low-income breast cancer program provides free mammography and education to more than 2,500 women annually. The Breast Cancer Screening Program at Washington Adventist Hospital helps low-income, uninsured women ages 40 and older in Montgomery and Prince George's counties fight and defeat breast cancer. In partnership with the Montgomery County Women's Cancer Control Program and the State of Maryland Breast and Cervical Diagnosis and Treatment Program, the Breast Cancer Screening Program offers a continuum of care to patients including screenings and individual patient education, instruction on breast self-examinations and access to treatment. All patients diagnosed with breast cancer are case managed from diagnosis through treatment and beyond. Diagnosed patients are also recommended to the support group at Washington Adventist Hospital as well as the Look Good Feel Better Program.

- The Cardiac & Vascular Outreach program is committed to supporting Washington Adventist Hospital's mission by providing programming and screenings that will both educate, enable, and empower individuals to better understand and manage their risk factors and to make lifestyle changes with the goal of lowering their risk of heart disease. Cardiac outreach has touched many lives through Washington Adventist Hospital and Adventist HealthCare's Heart Healthy Screening Programs by striving to help eliminate the health disparities that exist among populations in our community.

- The Colorectal Cancer Screening Program, supported by the Cigarette Restitution Fund, provides education, outreach, and free screenings to eligible men and women residing in Montgomery County. The goal of the Colorectal Cancer Screening Program is to target men and women who are considered to be "at-risk" for colorectal cancer. This includes individuals who are aged 50 and over, medically uninsured or underinsured, and who are low income. African Americans and Hispanic/Latinos have been identified as target populations as data reveal high colorectal cancer diagnosis rates for these groups. Program Coordinators for the screening program are continually out in the community promoting the program and providing outreach in faith-based settings (churches and synagogues), soup kitchens, area shelters, community centers, and work sites. t is our goal to increase awareness within the community of the cancer risk and the benefits of early detection and screening.

- Community Health Education uses a variety of strategies to improve the health status of the community by providing classes and programs that are both educational and fun. This includes an array of classes such as nutrition and self-improvement, as well as fitness classes, which include land and water activities. Also offered are CPR and First Aid classes. In addition to providing community health classes, we actively participate in health fairs where health screenings and flu shot clinics are held.

Adventist HealthCare's pioneering Center for Health Disparities, assisted by its Blue Ribbon Advisory Panel of community leaders, has three areas of focus: increased services for underserved populations; a research program to identify and promote best practices of healthcare for the underserved; and an education initiative to improve the ability of caregivers to provide culturally competent care. Progress continues on a number of the panel's recommendations including an annual health disparities report card, a Maternal Services Center, a Patient Advocacy Program/Linguistic Access and Disparities Awareness Program, and cultural training programs for physicians and staff.

Washington Adventist Hospital and Adventist HealthCare continue to effectively engage the community by providing extensive educational and clinical opportunities through partnerships with 29 universities and specialty schools. Of special note is the relationship with Montgomery College for nursing students to do their clinical rotations. Many of the Adventist HealthCare facilities (Washington Adventist Hospital, Shady Grove Adventist Hospital, Adventist Rehabilitation Hospital of Maryland and Adventist Behavioral Health) provide clinical rotations for nursing students.

Adventist Healthcare also collaborates with multiple organizations including Adventist Community Services, American Cancer Society, American Heart Association, American Lung Association, Avon Foundation, Susan G. Komen Foundation, Montgomery County Health and Human Services, Montgomery County Fire and Rescue, Healthy Kids Campaign, Sister to Sister Foundation and GROWS (Grass Roots Organizations for Well-being of Seniors).

Other specific partnership examples which further extend care into the community, and seek to prevent illness and disease, as well as reduce unnecessary emergency department utilization,

- Partnering with Mary's Center for Maternal and Child Care at its primary care center in the Long Branch area of Montgomery County. Mary's Center, with 20 years of experience in serving the indigent in Washington, demonstrates how improved access to family medical care, coupled with sensitivity to culture and language, lead to healthy families and safer communities.

- Partnering with MobileMed in the operation of mobile clinic sites and fixed-site clinics. Currently MobileMed provides clinic services at: Arcola Towers, Wheaton; Casa de Maryland, Silver Spring; Community Vision at Progress Place, Silver Spring; Crusader Church, Rockville, Eastern Montgomery County Regional Services Center, Silver Spring; Elizabeth House, Silver Spring; Gaithersburg/Ascension House, Gaithersburg; Gude Drive Men's Shelter, Rockville; Holly Hall, Silver Spring; Ibn Sina Clinic, Potomac; Kammsa Clinic, Gaithersburg; La Clinique L'A.M.I., Silver Spring; Lincoln Park Community Center, Rockville; Long Branch Community Center, Silver Spring; Pan Asian Volunteer Health Clinic, Silver Spring; Rockville Senior Center, Rockville; Shepherd's Table, Silver Spring; and Sophia House Women's Shelter ICBS, Rockville.

- Providing ancillary and other support services, including comprehensive health screenings, for patients treated at Mercy Health Clinic in Gaithersburg. Mercy Health Clinic is a free, non-profit, non-sectarian, community-based, primary healthcare provider serving uninsured, low-income adult residents of Montgomery County.

- Maternity clinics at Washington Adventist Hospital as part of the Montgomery County Maternity Partnership Program, providing prenatal health services and education for the low-income and uninsured population.

- Adventist HealthCare partners with Casa de Maryland to provide health care and community services for immigrant communities in Montgomery County and Prince George's County. The partnership includes the provision of primary medical care for uninsured residents, collaboration on ways to encourage immigrants to pursue a career in health care and a variety of other community services including language assistance and job training.

- Adventist HealthCare Health Ministry Outreach works with more than 19 faith-based community organizations and more than 140 congregations of all faiths, helping them with classes and health events to train and support Faith Community (Parish) Nurses who will directly provide support and care at the local community level.

Washington Adventist Hospital is and will continue to be a valuable community asset and a major healthcare provider in the region, committed to fulfilling its mission and serving the general community. In addition to these partnerships and as mentioned, Washington Adventist Hospital proposes to continue providing care in Takoma Park with services directed to meet community needs.

(16) Shell Space.

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

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

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

(ii) Considers the time frame projected for finishing the space; and

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

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

(d) The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Services Cost Review Commission.

APPLICANT RESPONSE:

The current design does not include shell space.

COMAR 10.24.12—Acute Hospital Inpatient Obstetric Services Standards

Section .04 Review Standards – The standards in this section are intended to guide Certificate of Need and CON exemption reviews involving acute hospital inpatient obstetric services, existing services proposed to be relocated to newly constructed space, and existing services proposed to be located in renovated space. Standards (1) through (6) apply to all applicants. Standards (7) through (14) apply only to applicants for a new perinatal service. Standard (15) applies only to applicants with an existing obstetric service.

Section .04(1) Need. All applicants must quantify the need for the number of beds to be assigned to the obstetric service, consistent with the approach outlined in Policy 4.1. Applicants for a new perinatal service must address Policy 4.1.

APPLICANT RESPONSE:

Please see response to COMAR 10.24.01.08G(3)(b)(Need) where the need for obstetrical beds is discussed.

Since Washington Adventist Hospital is not proposing to establish a new perinatal service, Policy 4.1 does not apply.

Section .04(2) The Maryland Perinatal System Standards. Each applicant shall demonstrate the ability of the proposed obstetric program and nursery to comply with all essential requirements of Maryland's Perinatal System Standards, as defined in the perinatal standards, for either a Level I or Level II perinatal center.

APPLICANT RESPONSE:

Washington Adventist Hospital is committed to the Level IIB Perinatal Center that is currently serving our community and intends to maintain or exceed the Maryland Perinatal System Standards on the White Oak campus. A site visit conducted by the Maryland Department of Health and Mental Hygiene in November 2012 found Washington Adventist Hospital in compliance with all Level IIB Perinatal System Standards.

1.1 Organization

a. Exhibit 34 documents the Board resolution on September 10, 2013 agreeing to meet the Maryland Perinatal System Standards as a Level IIB Center.

b. Washington Adventist Hospital participates in the Maryland Perinatal System and submits patient care data to the Maryland Department of Health and Mental Hygiene and the Maryland Institute for Emergency Medical Services Systems, as appropriate for system and quality management.

c. All perinatal patients at Washington Adventist Hospital receive the medical care commensurate with a Level IIB Perinatal Program.

d. Exhibit 34 documents the Board resolution, bylaws, contracts, budgets specific to the perinatal program committing the appropriate physical resources and infrastructure necessary to support the Level IIB Perinatal Program.

1.2 Washington Adventist Hospital holds license number 15-031 as an acute general hospital from the Maryland Department of Health and Mental Hygiene, and license number 15369 from Montgomery County.

1.3. Washington Adventist Hospital is accredited by the Joint Commission and completed a successful survey August 16, 2013.

1.4 Washington Adventist Hospital does not currently have, nor is it pursuing the creation of a NICU.

1.5 Washington Adventist Hospital owns and maintains current equipment and technology to support optimal perinatal care for the Level IIB designation.

1.6 Washington Adventist Hospital does not accept neonatal or maternal transports other than transports of patients who were referred elsewhere and now returning to the hospital (back transports).

1.7. As a Level IIB Neonatal Program, Washington Adventist Hospital is not governed by this standard.

2.1 Obstetrical Unit Capabilities

Washington Adventist Hospital is capable of providing uncomplicated and complicated obstetrical care and has the following written standards, protocols and guidelines:

a. Unexpected obstetrical care problems policy High Risk policy, Policy WWS 9510, attached as Exhibit 35.

b. Fetal monitoring, including internal scalp electrode monitoring, Policy WWS 9509 and WWS 9507 attached as Exhibit 36.

c. Initiating a cesarean delivery within 30 minutes of the decision to deliver, Washington Adventist Hospital follows the ACOG guidelines (Exhibit 37); however this standard has changed, according to the Guidelines for Perinatal Care, 7th Edition (October 2012).

d. Selection and management of obstetrical patients at a maternal risk level appropriate to its capability, is covered under Policy WWS 9534. (Exhibit 38).

2.2 Washington Adventist Hospital is capable of providing critical care services appropriate for obstetrical patients as demonstrated by having a critical care unit and a board-certified critical care specialist as an active member of the medical staff.

2.3. Washington Adventist Hospital has written plans for initiating maternal transports to an appropriate level at Shady Grove Adventist Hospital. (Exhibit 39- Policy WWS 9170).

2.4 Washington Adventist Hospital does not accept maternal transports from other institutions.

3.1 Neonatal Capabilities

a. Washington Adventist Hospital Policy WAH 5736 (Exhibit 40) includes sections on the resuscitation and stabilization of unexpected neonatal problems all nursing personnel in the L&D and Nursery must be certified by the Neonatal Resuscitation Program.

b. Selection and management of neonatal patients at a neonatal risk level appropriate to its capability is demonstrated in WWS 9302. (Exhibit 41).

c. Because Washington Adventist Hospital is a Level IIB Neonatal Program, this standard does not apply.

4. Obstetric Personnel

4.1 As a Level IIB Neonatal Program, Washington Adventist Hospital is not governed by this standard.

4.2 Washington Adventist Hospital has obstetrics/gynecology board certified physician(s) as members of the medical staff who have responsibility for programmatic management of obstetrical services.

4.3 Washington Adventist Hospital has maternal-fetal medicine board-certified physicians who are members of the medical staff and have responsibility for programmatic management of high-risk obstetrical services.

4.5 Washington Adventist Hospital has a maternal-fetal medicine physician on the medical staff, in active practice and available 24 hours a day seven days per week.

4.6 Washington Adventist Hospital does not accept maternal transports, therefore this standard is not applicable.

4.7 As a Level IIB Neonatal Program, Washington Adventist Hospital meets the higher standard 4.8.

4.8 Washington Adventist Hospital has a physician board-certified or an active candidate for board-certification in obstetrics/gynecology or family medicine (with obstetrical privileges) readily available to the delivery area when a patient is in active labor.

4.9 A physician board-certified or an active candidate for board-certification in obstetrics/gynecology is present in-house 24 hours a day and immediately available to the delivery area when a patient is in active labor.

4.10 Washington Adventist Hospital has a physician present at all deliveries.

4.11 Washington Adventist Hospital has a physician board-certified (or active candidate for board-certification) in anesthesiology as a member of the medical staff who is responsible for programmatic management of obstetrical anesthesia services.

5. Pediatric Personnel

5.1 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

5.2 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

5.3 Washington Adventist Hospital has physician(s) board-certified or active candidate for board-certification in neonatal-perinatal medicine on the medical staff who have full-time responsibility for neonatal special care or intensive care unit services.

5.4 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

5.5 Neonatal Resuscitation Program (NRP) trained professional(s) with experience in acute care of the depressed newborn and skilled in neonatal endotracheal intubation and resuscitation are immediately available to the delivery and neonatal units at Washington Adventist Hospital.

5.6 Washington Adventist Hospital has a physician who has completed postgraduate pediatric training, with privileges for neonatal care appropriate to the level of the nursery (Level IIB) shall be immediately available when an infant requires Level II neonatal services such as FiO2>40%, assisted ventilation, or cardiovascular support.

5.7 Washington Adventist Hospital has a physician who has completed postgraduate pediatric training appropriate to the Level IIB nursery immediately available 24 hours a day.

5.8 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

5.9 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

Neonatal Subspecialty Care

5.10 Washington Adventist Hospital has written consultation and referral agreements in place with pediatric cardiology, pediatric surgery, and ophthalmology with experience and expertise in neonatal retinal examination.

5.11 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

5.12 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

5.13 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

5.14 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

6. Other Personnel

6.1 Washington Adventist Hospital has a physician board-certified or an active candidate in anesthesiology available so that cesarean delivery may be initiated per hospital protocol as stated in Standard 2.1c.

6.2 Washington Adventist Hospital has a physician board-certified or an active candidate in anesthesiology readily available to the delivery area when a patient is in active labor.

6.3 Washington Adventist Hospital has a physician board-certified or an active candidate for board certification in anesthesiology present in-house 24 hours a day, readily available to the delivery area.

6.4 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

6.5 Washington Adventist Hospital has a physician on the medical staff with privileges for providing critical interventional radiology services for obstetrical patients, and neonatal patients. The hours for this service are Monday through Friday from 8:00 a.m. to 5:00 p.m.

6.6 Washington Adventist Hospital has obstetric and neonatal diagnostic imaging available 24 hours a day, with interpretation by physicians with experience in maternal and neonatal disease and its complications.

6.7 Washington Adventist Hospital has a registered dietician with knowledge of and experience in adult and neonatal parenteral/enteral high—risk management on staff.

6.8 Washington Adventist Hospital has an International Board Certified Lactation Consultant on full-time staff who has programmatic responsibility for lactation support services which include education and training of additional hospital staff members in order to ensure availability seven days per week of dedicated lactation support.

6.9 As a Level IIB Neonatal Program, Washington Adventist Hospital meets standard 6.10.

6.10 Washington Adventist Hospital has a licensed social worker with a master's degree a Licensed Certified Social Worker (LCSW) and experience in psychosocial assessment and intervention with women and their families dedicated to the perinatal service.

6.11 As a Level IIB Neonatal Program, Washington Adventist Hospital meets standard 6.10.

6.12 Washington Adventist Hospital has respiratory therapists skilled in neonatal ventilator management who are available when an infant is receiving assisted ventilation and present in-house 24-hours a day.

6.13 Washington Adventist Hospital has an agreement with Maternal and Fetal Medicine to provide genetic diagnostic and counseling.

6.14 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

6.15 Washington Adventist Hospital's perinatal program has on its administrative staff a registered nurse with a master's degree in nursing and experience in high-risk obstetric and neonatal nursing who shall have programmatic responsibility for the obstetrical and neonatal nursing services.

6.16 Washington Adventist Hospital's perinatal program has nurses with special expertise in obstetrical and neonatal nursing identified for staff education.

6.17 The Level IIB Perinatal Program at Washington Adventist Hospital has:

a. A registered nurse skilled in the recognition and nursing management of complications of labor and delivery readily available if needed to the labor and delivery unit 24 hours a day.

b. A registered nurse skilled in the recognition and management of complications in women and newborns readily available to the obstetrical unit 24 hours a day.

c. A registered nurse with demonstrated training and experience in the assessment, evaluation and care of patients in labor present at all deliveries.

d. A registered nurse with demonstrated training and experience in the assessment, evaluation, and care of newborns readily available to the neonatal unit 24 hours a day.

6.18 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

6.19 Washington Adventist Hospital has a written plan which assures registered nurse/patient ratios as per current *Guidelines for Perinatal Care*. The AWHOON Guidelines are presented in Exhibit 42.

7. Laboratory

7.1 The programmatic leaders of the Washington Adventist Hospital perinatal service in conjunction with the hospital laboratory have established laboratory processing and reporting times to ensure that these are appropriate for samples drawn from obstetric and neonatal patients with specific consideration for the acuity of the patient and the integrity of the samples. As a practice all laboratory specimens sent from the obstetrical service or newborn nursery are sent STAT. (Exhibit 43- Policy LAB.L2-1).

7.2 Washington Adventist Hospital's laboratory is capable of immediately receiving, processing, and reporting urgent/emergent obstetric and neonatal laboratory requests.

7.3 Washington Adventist Hospital's laboratory has a process to report critical results to the obstetric and neonatal services. (See Exhibit 44- Policy 5204).

7.4 Laboratory results from standard maternal antepartum testing are available to the providers caring for the mother and the neonate prior to discharge from Washington Adventist Hospital. If test results are not available or if testing was not performed prior to admission, such testing shall be performed during the hospitalization of the mother and results available prior to discharge of the newborn.

7.5 Washington Adventist Hospital has the capacity to conduct rapid HIV testing 24 hours a day.

7.6 Washington Adventist Hospital has a laboratory capable of performing the following tests 24 hours a day:

a) fetal scalp blood pH is not considered standard of care and is not used at Washington Adventist Hospital

b) fetal lung maturity tests

7.7 Washington Adventist Hospital has available the equipment and trained personnel to perform newborn hearing screening prior to discharge on all infants born at the hospital as required by the Universal Newborn Hearing Screening, Diagnosis, and Intervention Guidelines.

7.8 Blood bank technicians are present in-house at Washington Adventist Hospital 24 hours a day.

7.9 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

8. Diagnostic Imaging Capabilities

8.1 Washington Adventist Hospital has portable obstetric ultrasound equipment, with the services of appropriate staff, present in the delivery area.

8.2 As a Level IIB Neonatal Program, Washington Adventist Hospital meets standard 8.1.

8.3 Washington Adventist Hospital has portable x-ray equipment with the services of appropriate staff, available to the neonatal units.

8.4 Washington Adventist Hospital has portable head ultrasound for newborns, with the services of appropriate staff, available to the neonatal units.

8.5 Washington Adventist Hospital has computerized tomography (CT) capability, with the services of appropriate staff, available on campus.

8.6 Washington Adventist Hospital has magnetic resonance imaging (MRI) capability, with the services of appropriate staff, available on campus.

8.7 Washington Adventist Hospital has neonatal echocardiography equipment and an experienced technician available on campus as needed with interpretation by pediatric cardiologist.

8.9 Washington Adventist Hospital has equipment for performing interventional radiology services for obstetrical patients

9. Equipment

9.1 Washington Adventist Hospital has all of the following equipment and supplies immediately available for existing patients and for the next potential patient:

a) O2 analyzer, stethoscope, intravenous infusion pumps

b) radiant heated bed in delivery room and available in the neonatal units

c) oxygen hood with humidity

d) bag and masks capable of delivering a controlled concentration of oxygen to the infant

e) orotracheal tubes

f) aspiration equipment

g) laryngoscope

h) umbilical vessel catheters and insertion tray

i) cardiac monitor

j) pulse oximeter

k) phototherapy unit

l) Doppler blood pressure for neonates

m) cardioversion/defibrillation capability for mothers and neonates

n) resuscitation equipment for mothers and neonates

o) individual oxygen, air, and suction outlets for mothers and neonates

p) emergency call system

9.2 Washington Adventist Hospital has a neonatal intensive care unit bed set up and equipment available at all times for an emergency admission.

9.3 Washington Adventist Hospital has fetal diagnostic testing and monitoring equipment for:

a) non-stress and stress testing

b) ultrasound examinations

c) amniocentesis

9.4 Washington Adventist Hospital has the capability to monitor neonatal intra-arterial pressure.

9.5 As a Level IIB Perinatal Program Washington Adventist Hospital is not required to meet this standard.

9.6 Washington Adventist Hospital has a full range of invasive maternal monitoring available to the delivery area, including equipment for central venous pressure and arterial pressure monitoring.

9.7 Washington Adventist Hospital has appropriate equipment (including back-up equipment) for neonatal respiratory care as well as protocols for the use and maintenance of the equipment as required by the Level IIB status. (Exhibit 45-Policies 5736, 219, 901, 601, 903 and Appendix R).

10. Medications

10.1 Washington Adventist Hospital has Emergency medications, as listed in the *Neonatal Resuscitation Program* of the American Academy of Pediatrics/American Heart Association (AAP/AHA), present in the delivery area and neonatal units.

10.2 Washington Adventist Hospital has the following medications immediately available to the neonatal units:

a) Antibiotics, anticonvulsants, and emergency cardiovascular drugs

b) Surfactant, prostaglandin E1

10.3 All emergency resuscitation medications to initiate and maintain resuscitation, in accordance with Advanced Cardiac Life Support (ACLS) guidelines, are present in the delivery area of Washington Adventist Hospital.

10.4 The following medications are in the delivery area of Washington Adventist Hospital:

a) Oxytocin (Pitocin)

b) Methylergonovine (Methergine)

c) 15-methyl prostaglandin F2 (Prostin)

d) Misoprostol (Cytotec)

e) Carboprost tromethamine (Hemabate)

11. Education Programs

11.1 Washington Adventist Hospital has identified minimum competencies for perinatal clinical staff, not otherwise credentialed, that are assessed prior to independent practice and on a regular basis thereafter. The competencies for clinical staff are done as part of their onboarding orientation at the hospital, nursing, and unit orientation. Following orientation, competencies are done on an annual basis based on regulatory requirements and also unit specific during skills days. If other competencies arise during the year, a plan is developed to address the specific new need. (Exhibit 46- Policy WAH.2184).

11.2 Washington Adventist Hospital provides continuing education programs for physicians, nurses, and allied health personnel on staff concerning the treatment and care of obstetrical and neonatal patients. (See Exhibit 47-examples of CME programs)

12. Performance Improvement

12.1 Washington Adventist Hospital has a multi-disciplinary continuous quality improvement program for improving maternal and neonatal health outcomes that includes initiatives to promote patient safety including safe medication practices, Universal Protocol to prevent surgical error, and educational programs to improve communication and team work.

12.2 Washington Adventist Hospital conducts internal perinatal case reviews which include all maternal, intrapartum fetal, and neonatal deaths, as well as all maternal and neonatal transports.

12.3 Washington Adventist Hospital uses multidisciplinary forums to conduct quarterly performance reviews of perinatal programs. This review includes a review of trends, all deaths, all transfers, all very low birth weight infants, problem identification and solution, issues identified from the quality management process and systems issues.

12.4 Washington Adventist Hospital participates with the Department of Health and Mental Hygiene and Montgomery County health department Fetal and Infant Mortality Review and Maternal Mortality Review programs.

12.5 Washington Adventist Hospital participates in the collaborative collection and assessment of data with the Department of Health and Mental Hygiene and the Maryland Institute for Emergency Medical Services Systems for the purpose of improving perinatal health outcomes.

13. Policies and Protocols

13.1 Washington Adventist Hospital has written policies and protocols for the initial stabilization and continuing care of all obstetrical and neonatal patients appropriate to Level IIB care rendered at the hospital. (Exhibit 48- Policies WWS 9502 and WWS 9152).

13.2 Washington Adventist Hospital has maternal and neonatal resuscitation protocols. (See Exhibit 40- Policy WAH 5736).

13.3 Washington Adventist Hospital medical staff credentialing process includes documentation of competency to perform obstetrical and neonatal invasive procedures appropriate to a Level IIB program.

13.4 Washington Adventist Hospital has written guidelines for accepting or transferring mothers or neonates as "back transports" including criteria for accepting the patient and patient information on the required care. (See Exhibit 39-Policy WWS.9170).

13.5 Washington Adventist Hospital has a licensed neonatal transport service or written agreement with a licensed neonatal transport service. (See Exhibit 39-Policy WWS.9170).

13.6 Washington Adventist Hospital has policies that allow families (including siblings) to be together in the hospital following the birth of an infant and that promote parental involvement in the care of the neonate. (Exhibit 49-Policy WWS.9454).

13.7 Washington Adventist Hospital has a policy to eliminate deliveries by induction of labor or by cesarean section prior to 39 weeks gestation without a medical indication. The hospital has a systematic internal review process that evaluates any occurrences and a plan for corrective action. Data on <39 week deliveries is attached as Exhibit 50, Policy 9518.

Section .04(3) Charity Care Policy. Each hospital shall have a written policy for the provision of charity care for uninsured and under-insured patients to promote access to obstetric services regardless of an individual's ability to pay.

(a) The policy shall include provisions for, at a minimum, the following:

(i) annual notice by a method of dissemination appropriate to the hospital's patient population (for example, radio, television, newspaper);

(ii) posted notices in the admissions office, business office and emergency areas within the hospital;

(iii) **individual notice provided to each person who seeks services in the hospital at the time of community outreach efforts, prenatal services, preadmission, or admission, and**

(iv) **within two business days following a patient's initial request for charity care services, application for medical assistance, or both, the facility must make a determination of probable eligibility.**

(b) **Public notice and information regarding a hospital's charity care policy shall be in a format understandable by the target population.**

APPLICANT RESPONSE:

Adventist HealthCare, Inc. maintains written policies in English and Spanish pertaining to the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. Policy number AHC 3.19 Charity Care Policy, and Policy 3.19.1 Charity Care Policy, Spanish Language Version (Exhibits 7 and 8) apply to all Adventist HealthCare-affiliated facilities in Maryland which include Washington Adventist Hospital. These policies are summarized and included on the website of Adventist HealthCare, Inc. and Washington Adventist Hospital (http://www.washingtonadventisthospital.com/WAH/patientsvisitors/patients/billing/charity-care/). Determination of probable eligibility is made within two business days and is stated as such in the policy.

Notices of the availability of financial assistance are prominently posted in English and Spanish in the Washington Adventist Hospital Emergency Department, Registration/Admissions Department and business offices and are provided to patients at the time of preregistration and/or registration, at prenatal visits, and at outreach events.

Public notice of nondiscrimination policy and access to care regardless of ability to pay is posted annually in The Gazette Newspapers. The most recent posting was made on July 10 and 11, 2013 and appeared in the following Montgomery County editions: Gaithersburg, Germantown, Damascus, Rockville, Bethesda, Potomac, Silver Spring and Olney; and in both the Northern and Southern Prince George's County editions. (See Exhibit 9).

Section .04(4) Medicaid Access. Each applicant shall provide a plan describing how the applicant will assure access to hospital obstetric services for Medical Assistance enrollees, including:

(a) **an estimate of the number of Medical Assistance enrollees in its primary service area, and**

(b) **the number of physicians that have or will have admitting privileges to provide obstetric or pediatric services for women and infants who participate in the Medical Assistance program.**

APPLICANT RESPONSE:

Washington Adventist Hospital has active partnerships with several community based organizations and health care clinics that provide improved access to care for low-income

residents of Montgomery and Prince George's counties. Many of these residents have limited proficiency in English and/or are from racial and ethnic minority groups. Partnerships include Mary's Center for Maternal and Child Care, Mobile Medical Care (MobileMed), the Primary Care Coalition of Montgomery County and Community Clinic, Inc. (CCI), a Federally Qualified Health Clinic. Women receive prenatal care through these programs and deliver their babies at the hospital.

Since 2006, Washington Adventist Hospital has partnered with the Montgomery County Department of Health and Human Services. Maternity Partnership Program to provide obstetric and gynecologic services to uninsured women in Montgomery County. This program will continue and the antenatal clinic portion will be part of the services at the Takoma Park campus while deliveries will be at the White Oak campus.

Over the past seven years, Maternity Partnership Program participants have been cared for at the Women's Center at Washington Adventist Hospital and serve as a testament to the hospital's continued commitment to offer quality care for the entire community served.

The Women's Center provides prenatal, postpartum and related gynecological services to the community served by Washington Adventist Hospital. The center is located on the Takoma Park campus and is fully equipped and supplied to handle different aspects of prenatal and gynecological care. The program was designed to meet the needs of women who meet the criteria for Maryland Medical Assistance as well as those who are participants in the Maternity Partnership Program. Washington Adventist Hospital anticipates the ability to accept and provide care for 500 Maternity Partnership Program patients per year.

Maternity Partnership Program participants who are referred by Montgomery County will be assured of receiving comprehensive, routine, standard clinical and laboratory services, including postpartum services, in accordance with accepted medical standards for perinatal care, as approved by the American College of Obstetricians and Gynecologists. This care will include all necessary prenatal visits, related routine laboratory services including Pap smears, screenings for sexually transmitted diseases, urine cultures and HIV screening, counseling and appropriate treatment. All clinic supplies and Rhogam supplies will be provided as a part of the routine care and at no extra cost to the patient.

Obstetric ultrasound is offered at the recommended discounted rate and no patient will be refused an ultrasound due to an inability to pay. The ultrasound will be performed by Community Radiology Associates which has multiple locations throughout Montgomery County. Most program participants are referred to the White Oak imaging location as it is the closest to their homes.

Patients who develop conditions that place them in a "high risk" category will be referred to the Maternal Fetal Medicine practice located on the Takoma Park campus. The patient will be followed by both Maternal Fetal Medicine and the obstetrician in the Women's Center for management of her pregnancy.

The advanced ultrasounds will be performed by Maternal Fetal Medicine at its offices and non-stress tests will be performed on the labor and delivery unit of the hospital. The patient experiences convenience and continuity of care with the presence of both Maternal Fetal Medicine and the hospital on one campus; the obstetric hospitalist will deliver the patient's baby in consult with Maternal Fetal Medicine. The Maternity Partnership Program participant will be pre-admitted to Washington Adventist Hospital for the delivery of her baby, unless circumstances, such as extreme prematurity, require delivery at another facility.

As part of the needs assessment, the current Washington Adventist Hospital obstetric services payor mix in the Takoma Park primary service area (PSA) and the newly defined White Oak PSA were analyzed. The assessment indicates that the overall payor mix is similar between the two service areas and in fact, there is a greater proportion of the hospital's Medicaid patients residing in the White Oak PSA. Washington Adventist Hospital expects to retain the same payor mix for OB patients due to the fact that the hospital will retain the OB clinic services at the Takoma Park campus and as noted above, serves a significant number of low-income and high risk patients.

OB Payor Mix Summary

Takoma Park OB Primary Service Area (PSA)

	WAH Discharges	% of Total		All Discharges	% of Total
Commercial	131	12.1%	Commercial	1,870	37.9%
Medicaid	905	83.9%	Medicaid	2,897	58.7%
Medicare	2	0.2%	Medicare	15	0.3%
Self-pay	41	3.8%	Self-pay	132	2.7%
Other	-	0.0%	Other	21	0.4%
Total	1,079	100%	Total	4,935	100%

White Oak OB Primary Service Area (PSA)

	WAH Discharges	% of Total		All Discharges	% of Total
Commercial	88	10.3%	Commercial	1,617	38.5%
Medicaid	735	86.2%	Medicaid	2,439	58.1%
Medicare	1	0.1%	Medicare	13	0.3%
Self-pay	29	3.4%	Self-pay	108	2.6%
Other	-	0.0%	Other	20	0.5%
Total	853	100%	Total	4,197	100%

Currently, of the 23 maternal fetal medicine or obstetrics and gynecology physicians on staff or employed by Washington Adventist Hospital, with admitting privileges to provide obstetric or pediatric services for women and infants, 19 participate in the Medical Assistance program.

Section .04(5) Staffing. Each applicant shall provide information on the proposed staffing, associated number and type of FTEs, projected expenses per FTE category and total expanses, for labor and delivery, post partum, nursery services, and other related services, including nurse staffing, non-nurse staffing and physician coverage, at year three and at maximum projected volumes; if applicable, current staffing and expenses should also be included.

APPLICANT RESPONSE:

Staffing at Washington Adventist Hospital for Obstetrics and Nursery services will grow in proportion to the projected increase in patient volume (see Table on following page). Physician coverage in the replacement hospital will be provided by private practice community physicians consistent with current arrangements.

2013 Clinical Staffing Budget

FTE Category	Clinical FTE's by Unit				Total FTE's	Average Salary Per Paid FTE	Total Expense
	Labor & Delivery	Nursery	OB	OB Clinic			
Asst. Nurse Mgr.	1.0		1.0		2.0	$ 95,368	$ 190,736
Lactation Consultant			1.0		1.0	$ 79,706	$ 79,706
Medical Assistant				1.5	1.5	$ 33,342	$ 48,739
Nurse Director	0.8	0.2	0.8	0.2	2.0	$ 97,947	$ 195,894
Patient Care Tech			7.7		7.7	$ 37,336	$ 285,643
Physician Asst II	1.3				1.3	$ 120,910	$ 159,603
Registered Nurse	20.0	8.7	19.7	1.1	49.5	$ 83,710	$ 4,161,741
Registered Nurse Float Pool	1.2		0.1		1.3	$ 94,744	$ 119,584
Registered Nurse Float Pool II			0.2		0.2	$ 96,117	$ 19,453
RN, Unit Based Per Diem	1.6	0.7	1.0		3.3	$ 96,110	$ 324,704
Scrub Tech	5.5			0.2	5.7	$ 59,124	$ 350,507
Secretary II	1.0				1.0	$ 64,750	$ 64,750
Surgical Asst.	1.0				1.0	$ 84,698	$ 84,867
Unit Support Coord.	3.2		3.2		6.4	$ 38,210	$ 244,541
Total FTE's	**36.6**	**9.6**	**34.6**	**2.9**	**83.8**		**$ 6,330,468**
Physician Coverage							**$ 1,512,000**

2019 Clinical Staffing Budget

FTE Category	Clinical FTE's by Unit				Total FTE's	Average Salary Per Paid FTE	Total Expense
	Labor & Delivery	Nursery	OB	OB Clinic			
Asst. Nurse Mgr.	1.0		1.0		2.0	$ 95,368	$ 190,736
Lactation Consultant			1.0		1.0	$ 79,706	$ 79,706
Medical Assistant				1.5	1.5	$ 33,342	$ 48,739
Nurse Director	0.8	0.2	0.8	0.2	2.0	$ 97,947	$ 195,894
Patient Care Tech			8.6		8.6	$ 37,336	$ 322,776
Physician Asst II	1.3				1.3	$ 120,910	$ 159,603
Registered Nurse	22.6	9.8	22.2	1.3	55.9	$ 83,710	$ 4,679,416
Registered Nurse Float Pool	1.3		0.3		1.6	$ 94,744	$ 152,848
Registered Nurse Float Pool II					-		$ -
RN, Unit Based Per Diem	1.8	0.8	1.1		3.8	$ 96,110	$ 360,997
Scrub Tech	6.2			0.3	6.5	$ 59,124	$ 386,717
Secretary II	1.0				1.0	$ 64,750	$ 64,750
Surgical Asst.	1.0				1.0	$ 84,698	$ 84,867
Unit Support Coord.	3.2		3.2		6.4	$ 38,210	$ 244,541
Total FTE's	**40.3**	**10.8**	**38.3**	**3.2**	**92.6**		**$ 6,971,591**
Physician Coverage							**$ 1,512,000**

2023 Clinical Staffing Budget

FTE Category	Clinical FTE's by Unit				Total FTE's	Average Salary Per Paid FTE	Total Expense
	Labor & Delivery	Nursery	OB	OB Clinic			
Asst. Nurse Mgr.	1.0		1.0		2.0	$ 95,368	$ 190,736
Lactation Consultant			1.0		1.0	$ 79,706	$ 79,706
Medical Assistant				1.5	1.5	$ 33,342	$ 48,739
Nurse Director	0.8	0.2	0.8	0.2	2.0	$ 97,947	$ 195,894
Patient Care Tech			8.8		8.8	$ 37,336	$ 329,232
Physician Asst II	1.3				1.3	$ 120,910	$ 159,603
Registered Nurse	23.0	9.8	22.7	1.3	56.8	$ 83,710	$ 4,756,547
Registered Nurse Float Pool	1.3		0.3		1.6	$ 94,744	$ 152,848
Registered Nurse Float Pool II					-		$ -
RN, Unit Based Per Diem	2.0	0.8	1.2		3.9	$ 96,110	$ 377,067
Scrub Tech	6.4			0.3	6.7	$ 59,124	$ 394,097
Secretary II	1.0				1.0	$ 64,750	$ 64,750
Surgical Asst.	1.0				1.0	$ 84,698	$ 84,867
Unit Support Coord.	3.2		3.2		6.4	$ 38,210	$ 244,541
Total FTE's	**41.0**	**10.8**	**38.9**	**3.2**	**94.0**		**$ 7,078,627**
Physician Coverage							**$ 1,512,000**

Section .04(6) <u>Physical Plant Design and New Technology.</u> All applicants must describe the features of new construction or renovation that are expected to contribute to improvements in patient safety and/or quality of care, and describe expected benefits.

APPLICANT RESPONSE:

When obstetric services relocates from Takoma Park to White Oak, the replacement facility for Washington Adventist Hospital will include all of the existing birthing and inpatient services currently provided at the Takoma Park facility. This includes labor/delivery/recovery (LDR) rooms, private inpatient post-partum/GYN patient rooms, antepartum procedure rooms, triage non-stress test, 2 C-section Rooms, and related support services and functions. The replacement facility will house a special care nursery, consistent with the requirements of the Level IIB Neonatal Program at currently at Washington Adventist Hospital. The special care nursery has been designed to provide newborns with a full range of services where the level of care is adjusted to their developmental needs. A feature of the unit design will permit control over noise and temperature, access to natural light, and lighting controls.

The construction design of the obstetrics service in the replacement facility will include the following features that are expected to contribute to improvements in patient safety and/or quality of care.

- All private patient rooms
- Electronic medical record access in all rooms and conveniently located in charting alcove between patient rooms
- Advanced physical security systems for infant protection and patient safety
- Standardized room set-up and design
- Strategically located hand washing stations to promote infection control and cross contamination control
- Ample space for family accommodation and support
- LDR's sized to include an isolette zone with appropriate support area
- Post partum rooms sized to accommodate couplet care

The expected benefits include a high degree of patient satisfaction and optimum patient outcomes.

Washington Adventist Hospital is compliant with this Standard.

Section .04(15) Outreach Program. Each applicant with an existing perinatal service shall document an outreach program for obstetrics patients in its service area who may not have adequate prenatal care, and provide hospital services to treat those patients. The program shall address adequate prenatal care, prevention of low birth weight and infant mortality, and shall target the uninsured, underinsured, and indigent patients in the hospital's primary service area, as defined in COMAR 10.24.01.B.

APPLICANT RESPONSE:

The Women's Center provides prenatal, postpartum and related gynecological services to the community served by Washington Adventist Hospital. The program was designed to meet the

needs of both women who meet the criteria for Maryland Medical Assistance as well as women who are participants in the Maternity Partnerships Program. Washington Adventist Hospital anticipates the ability to accept and provide care for 500 Maternity Partnership Program patients per year.

As indicated above, Washington Adventist Hospital has active partnerships with

- Mary's Center for Maternal and Child Care,
- Mobile Medical Care (MobileMed),
- the Primary Care Coalition of Montgomery County,
- Community Clinic, Inc. (CCI), a Federally Qualified Health Clinic, and participates in the Montgomery County Department of Health and Human Services Maternity Partnership Program

to provide obstetric and gynecologic services to uninsured women in Montgomery County. The patients receive their antenatal and postnatal care in the clinic and deliver their babies at the hospital. Participation in this program is expected to continue and expand with the new and renovated facilities.

COMAR 10.24.07- PSYCHIATRIC SERVICES

The Acute Psychiatric Section has eleven standards applicable to this review. These are addressed below.

Availability

Standard AP 1a. The projected maximum bed need for child, adolescent, and adult acute psychiatric bed is calculated using the Commission's statewide child, adolescent, and adult acute psychiatric bed need projection methodologies specified in this section of the State Health Plan. Applicants for Certificates of Need must state how many child, adolescent and adult acute psychiatric beds they are applying for in each of the following categories: net acute psychiatric bed need, and/or state hospital conversion bed need.

APPLICANT RESPONSE:

Please see 10.24.01.08G(3)(b)(Need) where the need for psychiatric beds is discussed.

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

APPLICANT RESPONSE:

Washington Adventist Hospital's Psychiatric Unit provides inpatient treatment 24 hours a day, seven days a week with no special limitation for weekdays or late night shifts. The Plan for Delivery

of Care and On-call Policies address program services and physician coverage. (Exhibit 51 at p. 24)

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

APPLICANT RESPONSE:

Licensed mental health professionals at Washington Adventist Hospital in Takoma Park perform face to face assessments 24 hours a day, seven days a week with no special time limitations. Patients believed to have a mental disorder and brought in on emergency petition will be assessed by (1) two physicians or doctors of osteopathy or (2) one physician or doctor of osteopathic medicine and a nationally licensed psychologist to determine whether the patient meets commitment criteria within no later than six hours of presenting to the emergency department. A Needs Assessment clinician performs the Initial Needs Assessment in the Emergency Department and presents medical, psychosocial, and medication information to the assigned attending or on-call physician for determination of whether the patient can be admitted onto the Washington Adventist Hospital Psychiatric Unit following EMTALA requirements. (Exhibit 52- Policy WAH ED 5026 and Policy WAH ED 5030).

Washington Adventist Hospital has been named a Designated Emergency Psychiatric Facility for 2013 by the Maryland Department of Health and Mental Hygiene. (See Exhibit 53)

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

APPLICANT RESPONSE:

The Washington Adventist Hospital Psychiatric Unit has emergency holding beds and two seclusion rooms used in emergency psychiatric situations where the patient is deemed to be an imminent danger to self or others. Staff are trained in CMS regulations and behavior management techniques to minimize the use and/or duration of said interventions through development of therapeutic milieu and rapport with patients.

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

APPLICANT RESPONSE:

Washington Adventist Hospital's psychiatric programs are tailored to each patient's needs. Chemotherapy, individual psychotherapy, group therapy, family therapy, social services and expressive therapies are available to patients in the programs. These modalities are designed to assist patients in the development of interpersonal skills within a group setting, restoration of family functioning and provision of any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family.

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

APPLICANT RESPONSE:

Washington Adventist Hospital does not provide inpatient psychiatric services for children and adolescents.

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

APPLICANT RESPONSE:

Washington Adventist Hospital provides psychiatric consultation services through full time and part time staff psychiatrists.

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

APPLICANT RESPONSE:

Washington Adventist Hospital does not wish to change the bed capacity or configuration for the Psychiatric Unit. It is currently licensed as a 40 bed acute adult psychiatric unit serving patients 18 and older.

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

APPLICANT RESPONSE:

As stated in AP4a, the patient population of the Psychiatric Unit is acute adult patients.

Accessibility

Standard AP 5. Once a patient has requested admission to an acute psychiatric inpatient facility, the following services must be made available:

(i) intake screening and admission;

(ii) arrangements for transfer to a more appropriate facility for care if medically indicated;

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

(iv) emergency treatment.

APPLICANT RESPONSE:

Washington Adventist Hospital's Behavioral Health Needs Assessment department clinical staff provides the face-to-face evaluation to determine psychiatric criteria and most appropriate level of care. The Emergency Department physician will evaluate and determine that the individual is medically stable to participate in psychiatric care. The Needs Assessment staff will arrange for an appropriate transfer only if needed services are not available.

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

APPLICANT RESPONSE:

The Washington Adventist Hospital Psychiatric Unit has a quality assurance program based upon Adventist Behavioral Health's performance improvement program. Specific metrics are identified based upon behavioral health patient population needs as well as accrediting and licensing body standards. Central to the program are the Hospital Based Inpatient Psychiatric Services core measures, readmissions, seclusion, restraint, outcomes and other CMS requirements. Protocols and programming for co-occurring disorders such as substance abuse are in place.

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

APPLICANT RESPONSE:

Although Washington Adventist Hospital is not proposing new or expanded psychiatric services no individual will be denied psychiatric services based on legal status. Washington Adventist Hospital is the only hospital in Montgomery County that has a psychiatric program accepting adult involuntary admissions.

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

APPLICANT RESPONSE:

During FY 2011, the last year for which data have been posted on the HSCRC web site, Washington Adventist Hospital provided 10.09% in uncompensated care for acute psychiatric patients. The average level of uncompensated care provided by all acute general hospitals located in Montgomery County during that period was 7.43% and the state average was 7.79%.

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

APPLICANT RESPONSE:

Washington Adventist Hospital does not serve children as inpatients. They would instead be admitted to the child and adolescent unit of Adventist Behavioral Health in Rockville, which is less than a 45-minute drive under normal road conditions.

Quality

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

APPLICANT RESPONSE:

All psychiatric care at Washington Adventist Hospital is directed by a board-certified psychiatrist who is the head of a multidisciplinary team of mental health professionals. All staff psychiatrists are evaluated by the Washington Adventist Hospital Medical Director and Chair of the Washington Adventist Hospital Psychiatric Department, and recommendations are reviewed and approved by the Medical Director of Washington Adventist Hospital.

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

APPLICANT RESPONSE:

Patients in the Psychiatric Unit at Washington Adventist Hospital receive therapeutic programming which provides active treatment in compliance with standards of practice, 7 days per week. The individual's therapist is responsible for coordinating aftercare planning to promote continuity

of care. In addition to making appointments and referrals to outpatient providers, the therapist ensures that an aftercare plan with recommendations is transmitted to the patient's next level of care provider.

Continuity

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

APPLICANT RESPONSE:

The Washington Adventist Hospital Psychiatric Unit follows the discharge planning and referral policies to ensure the patient next level of care needs are met through a variety of services including inpatient, outpatient, partial hospitalization, aftercare treatment programs and other alternative treatment programs. The policies are available for review by appropriate licensing and certifying bodies.

Care management staff are a part of the treatment team at Washington Adventist Hospital and assist with arranging the needed services at discharge to enhance the successful treatment of the individual.

Standard AP 14. Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following:

(i) the local and state mental health advisory council(s);

(ii) the local community mental health center(s);

(iii) the Department of Health and Mental Hygiene; and

(iv) the city/county mental health department(s).

Letter from other consumer organizations are encouraged.

APPLICANT RESPONSE:

Washington Adventist Hospital is not seeking to expand its Psychiatric program.

COMAR 10.24.11 - General Surgical Services

.05 Standards

A. General Standards

The following general standards encompass Commission expectations for the delivery of surgical services by all health care facilities in Maryland, as defined in

Health General §19-114 (d). Each applicant that seeks a Certificate of Need for a project or an exemption from Certificate of Need review for a project covered by this Chapter shall address and document its compliance with each of the following general standards as part of its application.

(1) Information Regarding Charges.

Information regarding charges for surgical services shall be available to the public. A hospital or an ambulatory surgical facility shall provide to the public, upon inquiry or as required by applicable regulations or law, information concerning charges for the full range of surgical services provided.

APPLICANT RESPONSE:

Policy 3.19.2 Public Disclosure of Charges (Exhibit 6) details the Adventist HealthCare policy and procedure for the provision of information regarding hospital services and policies to the public. Quarterly updates to the Representative List of Services and Charges are made and posted to the hospital internet web site (http://www.washingtonadventisthospital.com/app/files/public/467/pdf-WAH-Billing-HospitalCharges.pdf) and are available on request to the public. The Patient Access Department of Washington Adventist Hospital ensures that requests made for current charges for specific procedures are provided in a timely manner. The Patient Access Department provides staff training on this and other policies on a regular basis

(2) Charity Care Policy.

(a) Each hospital and ambulatory surgical facility shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide ambulatory surgical services on a charitable basis to qualified indigent persons consistent with this policy. The policy shall have the following provisions:

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

(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the surgical facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's arrival for surgery, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

(iii) Criteria for Eligibility. Hospitals shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. ASFs, at a minimum, must include the following eligibility criteria in charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of ASFs described in these regulations.

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

APPLICANT RESPONSE:

Adventist HealthCare, Inc. maintains written policies in English and Spanish pertaining to the General Standards on Information Regarding Charges: Policy 3.19 Charity Care Policy, and Policy 3.19.1 Charity Care Policy, Spanish Language Version (Exhibits 7-8). These policies are summarized and included on the website of Adventist HealthCare, Inc. and Washington Adventist Hospital. http://www.adventisthealthcare.com/WAH/patientsvisitors/patients/billing/charity-care/. Notices of the availability of financial assistance in English and Spanish are prominently posted in the hospital emergency department, registration/admissions department and business offices. The charity care policy is made available to patients during the preadmission and/or admission process.

Public notice of nondiscrimination policy and access to care regardless of ability to pay is posted annually in The Gazette Newspapers (Exhibit 9). The most recent posting was made on July 10 and 11, 2013 and appeared in the following editions: Gaithersburg, Germantown, Damascus, Rockville, Bethesda, Potomac, Silver Spring and Olney in Montgomery County; and both the Northern and Southern Prince George's County editions.

The percentage of total operating expenses for Washington Adventist Hospital as reported in the July 10, 2013 Maryland Hospital Community Benefit Report FY 2012 is 15.08% which ranks the hospital as 7th highest for all hospitals in Maryland, with an average for all hospitals of 10.19%.

(3) **Quality of Care.**

A facility providing surgical services shall provide high quality care.

(a) An existing hospital or ambulatory surgical facility shall document that it is licensed, in good standing, by the Maryland Department of Health and Mental Hygiene.

(b) A hospital shall document that it is accredited by the Joint Commission.

APPLICANT RESPONSE:

Washington Adventist Hospital is in possession of Maryland Department of Health and Mental Hygiene, Office of Health Care Quality License Number 15-031 issued on October 1, 2010 through January 1, 2014. (See Exhibit 10). Hospital License Number 15369 effective December 30, 2012 through December 30, 2013 was issued by the Health and Human Services Licensure and Regulatory Services of Montgomery County. (See Exhibit 11). Applications for renewal of the licenses are in process.

Washington Adventist Hospital is accredited by the Joint Commission and earned a "Gold Plus Get with the Guidelines – Stroke" quality award in 2013. The last full survey by the Joint Commission successfully concluded on August 16, 2013. (See Exhibit 12).

The hospital is in compliance with the conditions of participation of the Medicare and Medicaid programs.

(4) **Transfer Agreements.**

(a) Each ASF and hospital shall have written transfer and referral agreements with hospitals capable of managing cases that exceed the capabilities of the ASF or hospital.

(b) Written transfer agreements between hospitals shall comply with the Department of Health and Mental Hygiene regulations implementing the requirements of Health-General Article §19-308.2

APPLICANT RESPONSE:

Washington Adventist Hospital transfer policies WAH 5778 and WAH 5908 are attached as Exhibit 54.

B. Project Review Standards

The standards in this section govern reviews of Certificate of Need applications and requests for exemption from Certificate of Need review involving surgical facilities

and services. An applicant for a Certificate of Need or an exemption from Certificate of Need shall demonstrate consistency with all applicable review standards.

(1) Service Area.

An applicant proposing to establish a new hospital providing surgical services or a new ambulatory surgical facility shall identify its projected service area. An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall document its existing service area, based on the origin of patients served.

APPLICANT RESPONSE:

Washington Adventist Hospital proposes to construct 8 operating rooms (ORs) in its replacement hospital, 5 general surgery ORs and 3 specialty ORs (2 for cardiac surgery, 1 hybrid). In addition to the operating rooms, 1 dedicated cystoscopy room, 2 endoscopy rooms, and 2 C-section OR's are proposed. As of FY2012, Washington Adventist Hospital has 11 operating rooms (mixed use + specialty), 1 dedicated cystoscopy, 1 dedicated endoscopy and 2 C-section rooms.

In the existing Takoma Park facility, all 13 rooms (less C-section) are used to manage the surgical schedule. This is the case because the existing rooms are outdated and much smaller than current design standards, so that ORs are scheduled based on case types and room size requirements. Additionally, the rooms do not provide the current technology or safety features such as lack of intuitive placement of gases, IP, vacuum and electrical outlets which decreases the available square footage that is conducive to optimal patient care. When this square footage is decreased, the risk of contamination of surgical fields increases. Contamination may lead to surgical site infections, which is a national patient safety initiative. All operating rooms proposed for the replacement facility will meet current codes and standards, including storage requirements and proper sizing and placement of technology.

Service Area

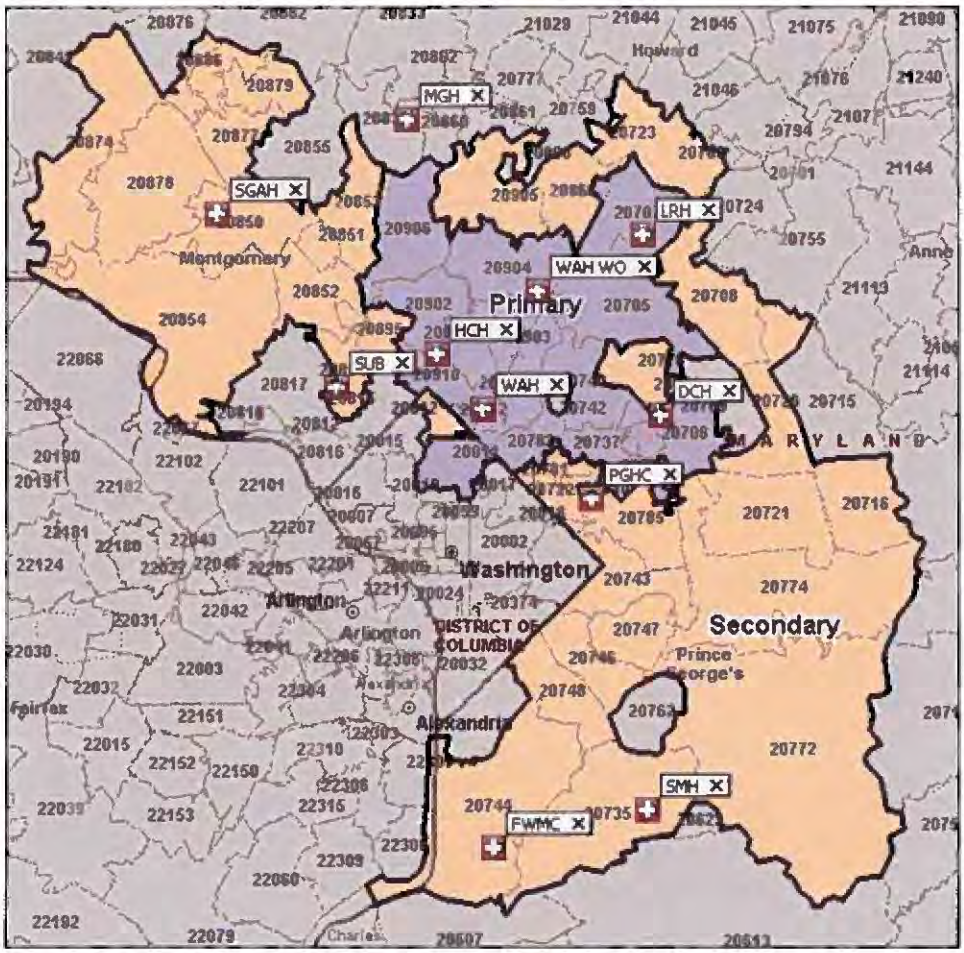
Based on FY2012 internal operating data, we have analyzed the current service area for outpatient surgeries at Washington Adventist Hospital Takoma Park.

In CY2012, the Washington Adventist Hospital PSA for surgeries consisted of 16 zip codes, 7 located in Montgomery County, 8 located in Prince George's County, and 1 located in the District of Columbia, with the primary number of discharges coming from zip code 20783 (Hyattsville). The Washington Adventist Hospital TSA for surgeries is comprised of 50 zip codes, 21 located in Montgomery County, 26 located in Prince George's County, 2 located in the District of Columbia, and 1 located in Howard County listed below.

Zip Code	City	Service Area	Surgeries
20783	Hyattsville	Primary	597
20912	Takoma Park	Primary	403
20904	Silver Spring	Primary	356
20782	Hyattsville	Primary	293
20901	Silver Spring	Primary	251
20903	Silver Spring	Primary	234
20906	Silver Spring	Primary	233

Zip Code	City	Service Area	Surgeries
20902	Silver Spring	Primary	192
20910	Silver Spring	Primary	184
20705	Beltsville	Primary	161
20740	College Park	Primary	129
20737	Riverdale	Primary	103
20784	Hyattsville	Primary	97
20011	Washington	Primary	95
20706	Lanham	Primary	92
20707	Laurel	Primary	87
20905	Silver Spring	Secondary	78
20781	Hyattsville	Secondary	77
20770	Greenbelt	Secondary	76
20785	Hyattsville	Secondary	70
20853	Rockville	Secondary	70
20774	Upper Marlboro	Secondary	68
20708	Laurel	Secondary	65
20712	Mount Rainier	Secondary	65
20743	Capitol Heights	Secondary	55
20772	Upper Marlboro	Secondary	55
20866	Burtonsville	Secondary	54
20850	Rockville	Secondary	52
20874	Germantown	Secondary	44
20012	Washington, D.C.	Secondary	41
20722	Brentwood	Secondary	41
20895	Kensington	Secondary	41
20878	Gaithersburg	Secondary	39
20723	Laurel	Secondary	38
20886	Montgomery Village	Secondary	36
20721	Bowie	Secondary	32
20852	Rockville	Secondary	32
20720	Bowie	Secondary	30
20735	Clinton	Secondary	30
20710	Bladensburg	Secondary	29
20747	District Heights	Secondary	29
20854	Potomac	Secondary	29
20879	Gaithersburg	Secondary	29
20716	Bowie	Secondary	28
20746	Suitland	Secondary	28
20748	Temple Hills	Secondary	28
20744	Fort Washington	Secondary	25
20877	Gaithersburg	Secondary	25
20814	Bethesda	Secondary	24
20851	Rockville	Secondary	24

CY2012 Washington Adventist Hospital Primary and Secondary Service Area for Surgeries



The resulting service area for surgery patients at Washington Adventist Hospital was analyzed and it was determined that it did not differ materially from inpatient MSGA services (identified in the MSGA bed need response under COMAR 10.24.01.08G(3)(b)(Need)). Therefore, we consider the new service area for surgeries to reflect what was considered for MSGA services at White Oak.

(2) **Need -Minimum Utilization for Establishment of a New or Replacement Facility.**

An applicant proposing to establish or replace a hospital or ambulatory surgical facility shall demonstrate the need for the number of operating rooms proposed for the facility. This need demonstration shall utilize the operating room capacity assumptions and other guidance included in Regulation .06 of this Chapter. This needs assessment shall demonstrate that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility.

(a) An applicant proposing the establishment or replacement of a hospital shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for inpatient and outpatient surgical procedures by the new or replacement hospital's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed new or replacement hospital by surgical specialty or operating room category; and

(iii) In the case of a replacement hospital project involving relocation to a new site, an analysis of how surgical case volume is likely to change as a result of changes in the surgical practitioners using the hospital.

APPLICANT RESPONSE:

The proposed need for 8 operating rooms in 2022 was based upon the current utilization of the Washington Adventist Hospital operating rooms for both inpatient and outpatient surgery for the most current periods, as well as forecasts of future volumes at the replacement hospital for its first five years of operation. The forecasted growth in volumes reflects both the anticipated growth in inpatient surgical volumes, as well as future outpatient surgical volumes. The actual operating room utilization statistics for the existing Hospital for CY2008 through CY2012 are shown below:

CY2008 – CY2012 OR Data

Calendar Year	Surgery Minutes - Inpatient	Surgery Minutes - Outpatient	Surgery Minutes - Total	Inpatient Cases	Outpatient Cases	MSGA Admission
2008	473,230	260,366	733,596	3,881	4,458	12,982
2009	471,456	248,379	719,835	3,948	4,522	13,079
2010	365,746	210,413	576,159	3,311	3,789	12,116
2011	338,470	201,520	539,990	3,032	3,359	10,647
2012	337,518	230,967	568,485	2,879	3,291	9,694

CY2008 – CY2012 OR Utilization Statistics

	Inpatient		Outpatient
Year	Cases/Admission	Minutes/Case	Minutes/Cases
2008	29.9%	122	58
2009	30.2%	119	55
2010	27.3%	110	56
2011	28.5%	112	60
2012	29.7%	117	70
Average	**29.1%**	**116**	**60**

Historical average utilization statistics were applied to projected inpatient and outpatient volume to estimate future surgery minutes. Specifically, inpatient surgery minutes were calculated considering projected MSGA admissions and historical cases/admission and minutes/case. Future outpatient minutes were estimated considering projected outpatient surgeries.

Washington Adventist Hospital currently operates it's ORs with 15 minutes for room prep and 15 minutes for clean-up. Therefore an estimated turnaround time of 30 minutes per case was considered. The optimal capacity of 1,900 hours per year or 114,000 minutes was applied as defined on page 14 of COMAR 10.24.11, State Health Plan for Facilities and Services: General Surgical Services . The following table summarizes the results of the analysis:

Projected Operating Room Statistics

Calendar Year	Surgery Minutes - Inpatient	Surgery Minutes - Outpatient	Surgery Minutes - Total	Total Cases	Estimated Turnaround Time	Total Minutes	ORs Needed at Optimal Capacity
2013	293,890	204,701	498,590	5,953	178,596	677,186	5.9
2014	287,431	206,748	494,179	5,932	177,954	672,133	5.9
2015	281,108	208,815	489,923	5,912	177,358	667,281	5.9
2016	274,919	210,903	485,823	5,894	176,807	662,629	5.8
2017	268,866	213,012	481,879	5,877	176,301	658,180	5.8
2018	262,949	215,142	478,091	5,861	175,841	653,932	5.7
2019	283,982	223,748	507,730	6,186	185,591	693,321	6.1
2020	309,546	237,173	546,719	6,631	198,929	745,648	6.5
2021	343,598	256,147	599,745	7,241	217,242	816,988	7.2
2022	374,506	266,393	640,898	7,679	230,365	871,264	7.6
2023	400,713	273,053	673,765	8,016	240,476	914,241	8.0

In CY2021, three years after project completion a need of 7.2 operating rooms and 8.0 operating rooms is estimated by the end of CY2023.

(3) Need -Minimum Utilization for Expansion of An Existing Facility.

An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall:

(a) Demonstrate the need for each proposed additional operating room, utilizing the operating room capacity assumptions and other guidance included at Regulation .06 of this Chapter;

(b) Demonstrate that its existing operating rooms were utilized at optimal capacity in the most recent 12-month period for which data has been reported to the Health Services Cost Review Commission or to the Maryland Health Care Commission; and

(c) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the completion of the additional operating room capacity. The needs assessment shall include the following:

(i) Historic trends in the use of surgical facilities at the existing facility;

(ii) Operating room time required for surgical cases historically provided at the facility by surgical specialty or operating room category; and

(iii) Projected cases to be performed in each proposed additional operating room.

APPLICANT RESPONSE:

Washington Adventist Hospital is not planning an expansion of operating room capacity in the replacement facility.

(4) **Design Requirements.**

Floor plans submitted by an applicant must be consistent with the current FGI Guidelines.

(a) A hospital shall meet the requirements in Section 2.2 of the FGI Guidelines.

(b) An ASF shall meet the requirements in Section 3.7 of the FGI Guidelines.

(c) Design features of a hospital or ASF that are at variance with the current FGI Guidelines shall be justified. The Commission may consider the opinion of staff at the Facility Guidelines Institute, which publishes the FGI Guidelines, to help determine whether the proposed variance is acceptable.

APPLICANT RESPONSE:

The design will be consistent with FGI guidelines.

(a) Section 2.2 of the "Guidelines for Design and Construction of Health Care Facilities" by the Facilities Guidelines Institute (FGI), formerly known as the "AIA Guidelines for Healthcare," addressed Specific Requirements for General Hospitals. The Architect has designed the project in the current state to comply with the FGI Guidelines.

(b) This standard is not applicable.

(c) The current design does include any design features that are at variance with the current FGI Guidelines.

(5) Support Services.

Each applicant shall agree to provide as needed, either directly or through contractual agreements, laboratory, radiology, and pathology services.

APPLICANT RESPONSE:

Washington Adventist Hospital provides in house services for laboratory, radiology and pathology 24 hours per day.

(6) Patient Safety.

The design of surgical facilities or changes to existing surgical facilities shall include features that enhance and improve patient safety. An applicant shall:

(a) Document the manner in which the planning of the project took patient safety into account; and

(b) Provide an analysis of patient safety features included in the design of proposed new, replacement, or renovated surgical facilities;

APPLICANT RESPONSE:

See response under section COMAR 10.24.10.04(12)(Patient Safety).

(7) Construction Costs.

The cost of constructing surgical facilities shall be reasonable and consistent with current industry cost experience.

(a) Hospital projects.

(i) The projected cost per square foot of a hospital construction or renovation project that includes surgical facilities shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate

increase proposed by the hospital related to the capital cost of the project shall not include:

1. **The amount of the projected construction cost and associated capitalized construction cost that exceeds the Marshall Valuation Service® benchmark; and**

2. **Those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.**

APPLICANT RESPONSE:

The cost of constructing the surgical facilities at the Washington Adventist Hospital White Oak campus are reasonable and consistent with current industry cost experience. The projected cost per square foot of the project has been compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

The details of this analysis are contained in Part IIB-Project Review Standards – COMAR 10.24.10.04B (7) Construction Cost of Hospital Space, including Exhibits 24-29. As described in the above, the projected cost per square foot does not exceed the Marshall Valuation Service® benchmark cost.

(8) Financial Feasibility.

A surgical facility project shall be financially feasible. Financial projections filed as part of an application that includes the establishment or expansion of surgical facilities and services shall be accompanied by a statement containing each assumption used to develop the projections.

(a) An applicant shall document that:

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the likely service area population of the facility;

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

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future

staffing levels as experienced by the applicant facility, or, if a new facility, the recent experience of similar facilities; and

(iv) The facility will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years of initiating operations.

(b) A project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project may be approved upon demonstration that overall facility financial performance will be positive and that the services will benefit the facility's primary service area population.

APPLICANT RESPONSE:

Please see financial feasibility section, COMAR 10.24.10.04B(13), for complete details.

10.24.01.08G(3)(b). Need.

For purposes of evaluating an application under this subsection, the Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

Please discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. For applications proposing to address the need of special population groups identified in this criterion, please specifically identify those populations that are underserved and describe how this Project will address their needs.

APPLICANT RESPONSE:

Both White Oak and Takoma Park are located in southeastern Montgomery County, Maryland, very close to the border between Montgomery County and Prince George's County, Maryland. The White Oak site is 6.6 miles from the Takoma Park site, and located within the primary service area of the existing hospital.

The hospital serves a broad population and service area, including Maryland residents of Montgomery and Prince George's counties, and the District of Columbia. As defined in the State Health Plan, at COMAR 10.24.10.06B.(30), the "service area" means the contiguous area comprised of the postal zip code areas from which the first 85% of a hospital's patients originated during the most recent 12-month period. (This is identified as the Total Service Area or "TSA").

Further, the first 60% represents the primary service area (PSA) and the following 25% represents the secondary service area (SSA). (While the Chapter requires use of 60% of Maryland zip codes in the definition of primary service area, there is no such reference in the definition of "service area." For consistency and since this is both logical and accurate, District of Columbia zip codes that are part of the primary service area in the 60% are included.

MSGA BED NEED ANALYSIS FOR WASHINGTON ADVENTIST HOSPITAL

Washington Adventist Hospital is currently licensed for 252 beds, of which 191 are MSGA beds. The proposed replacement hospital for Washington Adventist Hospital will have 180 MSGA beds. The following steps were applied to determine bed need for MSGA beds:

(1) Defined the new service area

(2) Estimated total discharges and patient days considering population growth, usage rates, and other relevant patient utilization factors

(3) Calculated bed need within the Washington Adventist Hospital/White Oak TSA

(1) Service Area

In CY2012, the Washington Adventist Hospital PSA for MSGA discharges consisted of 13 zip codes, 6 located in Montgomery County, 6 located in Prince George's County, and 1 located in the District of Columbia, with the primary number of discharges coming from zip code 20783 (Hyattsville). Washington Adventist Hospital realized 62.0% market share within 20783 (Hyattsville) and 62.7% of market share within its home zip code 20912 (Takoma Park). Washington Adventist Hospital's market share within its PSA for MSGA discharges was 26.0%.

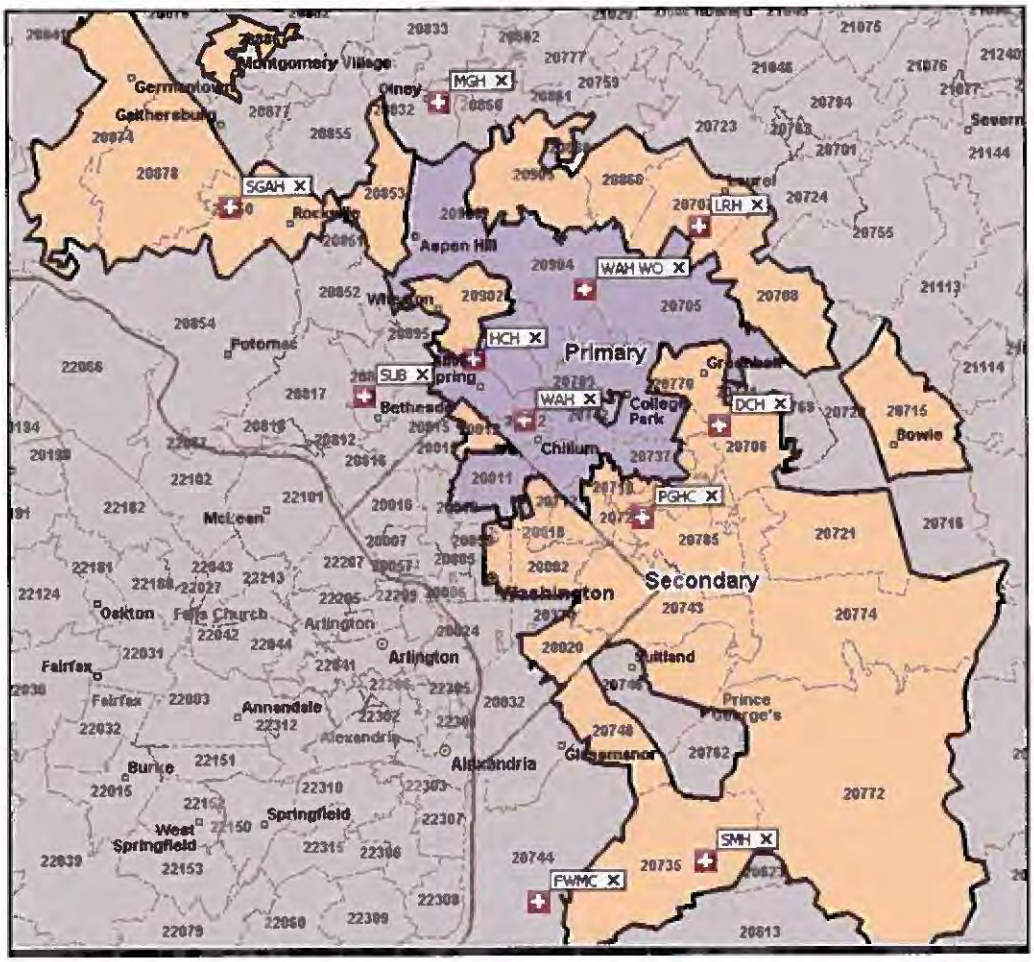
The Washington Adventist Hospital TSA is comprised of 45 zip codes, 14 located in Montgomery County, 23 located in Prince George's County, and 8 located in the District of Columbia, listed below.

CY2012 MSGA WASHINGTON ADVENTIST HOSPITAL TSA

Zip Code	City	Service Area	Discharges	% of Total	Cumulative
20783	Hyattsville	Primary	1,386	14.2%	14.2%
20912	Takoma Park	Primary	801	8.2%	22.4%
20782	Hyattsville	Primary	799	8.2%	30.7%
20903	Silver Spring	Primary	475	4.9%	35.5%
20904	Silver Spring	Primary	421	4.3%	39.8%
20901	Silver Spring	Primary	374	3.8%	43.7%
20910	Silver Spring	Primary	350	3.6%	47.3%
20740	College Park	Primary	327	3.4%	50.6%
20011	Washington, D.C.	Primary	236	2.4%	53.1%
20737	Riverdale	Primary	212	2.2%	55.2%
20705	Beltsville	Primary	202	2.1%	57.3%
20712	Mount Rainier	Primary	177	1.8%	59.1%
20906	Silver Spring	Primary	160	1.6%	60.8%

Zip Code	City	Service Area	Discharges	% of Total	Cumulative
20781	Hyattsville	Secondary	153	1.6%	62.3%
20706	Lanham	Secondary	149	1.5%	63.9%
20770	Greenbelt	Secondary	138	1.4%	65.3%
20902	Silver Spring	Secondary	137	1.4%	66.7%
20785	Hyattsville	Secondary	136	1.4%	68.1%
20784	Hyattsville	Secondary	118	1.2%	69.3%
20012	Washington, D.C.	Secondary	109	1.1%	70.4%
20707	Laurel	Secondary	101	1.0%	71.5%
20774	Upper Marlboro	Secondary	97	1.0%	72.4%
20722	Brentwood	Secondary	87	0.9%	73.3%
20743	Capitol Heights	Secondary	82	0.8%	74.2%
20708	Laurel	Secondary	78	0.8%	75.0%
20002	Washington, D.C.	Secondary	70	0.7%	75.7%
20710	Bladensburg	Secondary	65	0.7%	76.4%
20905	Silver Spring	Secondary	62	0.6%	77.0%
20017	Washington, D.C.	Secondary	60	0.6%	77.6%
20019	Washington, D.C.	Secondary	58	0.6%	78.2%
20020	Washington, D.C.	Secondary	58	0.6%	78.8%
20748	Temple Hills	Secondary	57	0.6%	79.4%
20772	Upper Marlboro	Secondary	56	0.6%	80.0%
20747	District Heights	Secondary	54	0.6%	80.5%
20715	Bowie	Secondary	52	0.5%	81.1%
20850	Rockville	Secondary	50	0.5%	81.6%
20866	Burtonsville	Secondary	46	0.5%	82.0%
20853	Rockville	Secondary	43	0.4%	82.5%
20874	Germantown	Secondary	42	0.4%	82.9%
20878	Gaithersburg	Secondary	41	0.4%	83.3%
20018	Washington, D.C.	Secondary	41	0.4%	83.8%
20721	Bowie	Secondary	39	0.4%	84.2%
20001	Washington, D.C.	Secondary	36	0.4%	84.5%
20886	Montgomery Village	Secondary	32	0.3%	84.9%
20735	Clinton	Secondary	32	0.3%	85.2%

Current WASHINGTON ADVENTIST HOSPITAL MSGA Primary and Secondary Service Area



Washington Adventist Hospital is currently located on the southern part of its PSA. Relocation to White Oak, located in zip code 20904 (Silver Spring) will allow for a more central location within its existing PSA. An analysis was performed to understand the expected differences in market share by zip code as a result of the proposed relocation to White Oak recognizing that even a short move of approximately six miles will have an impact on the current TSA.

Market dynamics that consider location of the replacement hospital, proximity to other hospitals, drive times, major streets and highways, current market share of other providers, and physician relationships were taken into consideration when evaluating market share changes as a result of the relocation to White Oak.

Specifically, the following steps were performed to estimate the market share adjustments applied to each zip code:

- Identification of proximity of zip code to all acute care hospital providers including drive time and distance
- Analysis of current market share for acute care hospital providers relative to their location to the zip code

- Approximation of the shift in market share as a result of the proposed replacement hospital recognizing both the distance and current market presence within each zip code.

The example below demonstrates the methodology showing that not any single market dynamic can be used to estimate a change in market share but that all market dynamics need to be considered to best estimate changes in market share from the proposed relocation to White Oak. For example, zip code 20705, Beltsville, is closest to Laurel Regional Hospital yet Laurel has only 22.5% market share while Holy Cross Hospital is ranked 4th in distance but has the largest market share of 26.1%. Doctors Hospital is ranked as the second closest hospital but only has 7.7% market share. Washington Adventist Hospital currently has a 16.1% market share in Beltsville and is ranked 3rd in distance. If Washington Adventist Hospital relocates to White Oak, it is estimated that it will take an additional 10% of the market as a result of its proximity to Beltsville, drive times, current market share, the proximity to other area hospitals but not ignoring the fact that Holy Cross has a strong market presence and most likely strong physician relationships in the zip code.

Zip Code 20705 – Beltsville		
	To Washington Adventist Hospital - Takoma Park	To Washington Adventist Hospital - White Oak
Distance	9.4 miles	4.7 miles
Drive time	21.2 minutes	10.7 minutes

Source: Based on Travel Time Study (Exhibit 16)

Hospital	Market Share	Ranked - Closest hospital by proximity
Laurel Regional Hospital	22.5%	1
Doctors Community Hospital	7.7%	2
Washington Adventist Hospital	16.1%	3
Holy Cross Hospital	26.1%	4
Prince Georges Hospital Center	2.7%	5
Suburban Hospital	2.3%	6
Medstar Montgomery Hospital Center	1.7%	7
Shady Grove Adventist Hospital	1.8%	8
Others	19.1%	-
Total	100.0%	

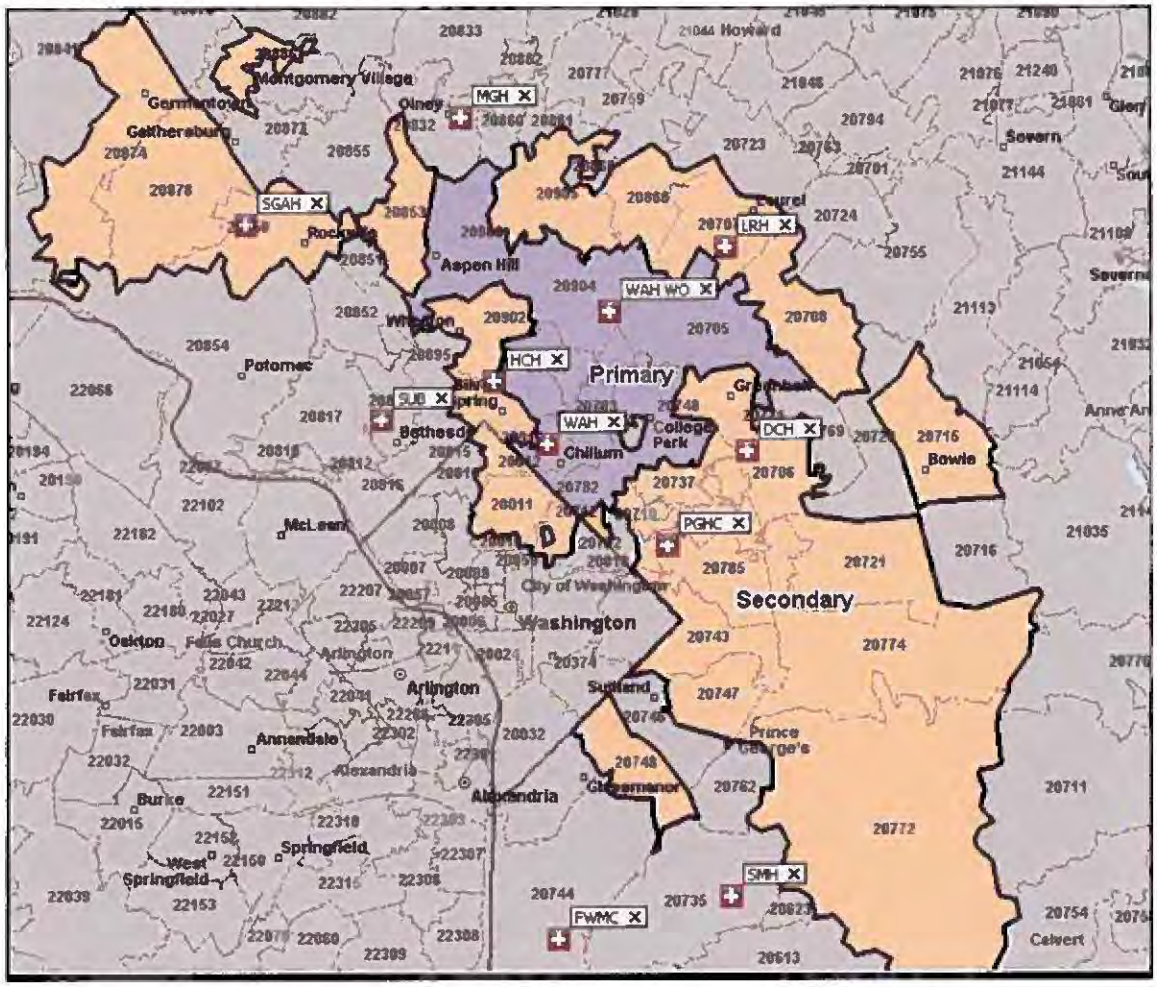
Taking into account all of the factors and methodology listed above, the following adjustments to the Washington Adventist Hospital MSGA TSA were considered:

WASHINGTON ADVENTIST HOSPITAL MSGA TSA Market Share Analysis of Proposed Location

Zip Code	City	Current Market Share at Takoma Park	Estimated Market Share Adjustment	Estimated Market Share in Proposed Location
20783	Hyattsville	62.0%	-15.0%	47.0%
20912	Takoma Park	62.7%	-15.0%	47.7%
20782	Hyattsville	59.6%	-15.0%	44.6%
20903	Silver Spring	41.7%	0.0%	41.7%
20904	Silver Spring	11.3%	45.0%	56.3%
20901	Silver Spring	21.8%	5.0%	26.8%
20910	Silver Spring	17.8%	-15.0%	2.8%
20740	College Park	29.1%	-1.0%	28.1%
20011	Washington, D.C.	33.4%	-15.0%	18.4%
20737	Riverdale	19.8%	-15.0%	4.8%
20705	Beltsville	16.1%	10.0%	26.1%
20712	Mount Rainier	54.6%	-20.0%	34.6%
20906	Silver Spring	3.2%	5.0%	8.2%
20781	Hyattsville	28.5%	-15.0%	13.5%
20706	Lanham	5.9%	-1.0%	4.9%
20770	Greenbelt	10.7%	5.0%	15.7%
20902	Silver Spring	5.3%	0.0%	5.3%
20785	Hyattsville	5.3%	-1.0%	4.3%
20784	Hyattsville	7.4%	-1.0%	6.4%
20012	Washington, D.C.	34.9%	-15.0%	19.9%
20707	Laurel	5.2%	10.0%	15.2%
20774	Upper Marlboro	4.2%	-1.0%	3.2%
20722	Brentwood	26.8%	-20.0%	6.8%
20743	Capitol Heights	2.9%	-1.0%	1.9%
20708	Laurel	5.4%	1.0%	6.4%
20002	Washington, D.C.	16.6%	-15.0%	1.6%
20710	Bladensburg	11.5%	-1.0%	10.5%
20905	Silver Spring	6.3%	15.0%	21.3%
20017	Washington, D.C.	32.3%	-15.0%	17.3%
20019	Washington, D.C.	6.6%	-5.0%	1.6%
20020	Washington, D.C.	9.7%	-8.0%	1.7%
20748	Temple Hills	2.7%	0.0%	2.7%
20772	Upper Marlboro	2.5%	0.0%	2.5%
20747	District Heights	2.4%	0.0%	2.4%
20715	Bowie	2.8%	0.0%	2.8%
20850	Rockville	1.7%	0.0%	1.7%
20866	Burtonsville	7.2%	15.0%	22.2%
20853	Rockville	2.6%	0.0%	2.6%
20874	Germantown	1.6%	0.0%	1.6%
20878	Gaithersburg	1.7%	0.0%	1.7%
20018	Washington, D.C.	16.9%	-15.0%	1.9%
20721	Bowie	3.0%	0.0%	3.0%
20001	Washington, D.C.	17.6%	-15.0%	2.6%
20886	Montgomery Village	2.0%	0.0%	2.0%
20735	Clinton	1.1%	0.0%	1.1%
Total Market Share		**11.6%**	**1.0%**	**12.6%**

As demonstrated above, individual adjustments were considered to each Zip code. Total discharges at Washington Adventist Hospital/White Oak were then calculated, considering the estimated market share by Zip code. The conclusion is that moving to the White Oak location will increase overall market share within the Takoma Park TSA approximately 1%. Finally, the primary and secondary service for Washington Adventist Hospital/White Oak was redefined based on the estimate total discharges. It was determined that moving to the White Oak location will tighten the current service area as 4 Zip codes will drop out of the primary service area and 6 will drop out of the total service area.

Washington Adventist Hospital - White Oak MSGA Primary and Secondary Service Area



The redefined Washington Adventist Hospital/White Oak TSA was considered to perform the bed need analysis.

(2) Estimated Discharges

Overall adult population within the Washington Adventist Hospital - White Oak TSA was estimated to be 1.042 million in CY2010, 1.07 million residents in CY2013, and 1.12 million residents in CY2018. This implies an overall increase in the population of approximately 2.9% between CY2010 and CY2013.

Demonstrated in the table below, MSGA discharges in the Washington Adventist Hospital/ White Oak TSA decreased 6.5% between CY2010 and CY2012. In the Washington Adventist Hospital/White Oak TSA, Medicare[5] discharges have decreased 0.8% since CY2008 and non-Medicare discharges have decreased by 4.7%, indicating a total decrease of 2.9%.

MSGA Discharges within WAH - White Oak TSA

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	9,947	10,141	9,488	8,540	7,948	-20.1%
Holy Cross	11,570	12,619	13,109	13,180	12,890	11.4%
Montgomery General	4,699	4,508	4,578	4,330	4,091	-12.9%
Shady Grove Adventist	6,923	7,317	7,547	7,446	7,547	9.0%
Suburban Hospital Center	3,650	3,555	3,529	3,592	3,771	3.3%
Laurel Regional Hospital	3,218	2,979	2,623	2,250	2,498	-22.4%
Prince Georges Hospital Ctr	6,748	7,109	6,805	5,949	5,238	-22.4%
Southern Maryland	7,407	6,986	6,926	6,914	6,417	-13.4%
Fort Washington Hospital	517	511	511	420	398	-23.0%
Doctors Community Hospital	8,945	9,535	10,407	9,857	8,736	-2.3%
Other Provider	7,511	8,026	8,295	8,880	9,520	26.7%
Total	71,135	73,286	73,818	71,358	69,054	-2.9%

The declining discharges during periods with population growth indicate historical declines in usage rates that are likely due to a number of factors, including:

- National shift from inpatient to outpatient services
- Increases in observation and decreases in one-day stays
- Loss of insurance coverage due to economic conditions
- Increased emphasis on reduction of readmissions

In fact, MSGA use rates in the White Oak TSA declined 8.2% from 2010 to 2012 or from 70.8 to 65.0 per 1,000 in population. This significant decline recognizes the weak economy, decreases in one-day stays and readmissions, and the shift to outpatient and observation stays that have already had a significant impact on volumes and use rates. With the magnitude of this decline experienced in the White Oak TSA, there are more contributing factors than just shifts from inpatient to outpatient services.

In addition to recognizing historical trends, given the potential for changes due to the Affordable Care Act, and related health care reform legislation, history-graded influences, most specifically the baby boomer cohort, were also considered. The term baby boomers is generally described as the generation of Americans born between 1946 and 1964. This population boom cohort is now aged 67-49 with 10,000 baby boomers reaching age 65 at a rate of 10,000 each day. In 2010 this demographic represented 13% of the U.S. population but is expected to grow to represent 18% of the U.S. population by 2030.

In spite of greater access to healthcare advancements than previous generations, baby boomers actually have more chronic health problems. For example, with almost 40% of baby boomers diagnosed as obese, obesity-related conditions such as hypertension, high cholesterol and heart disease are more common – which means a greater need for healthcare services as this population ages.

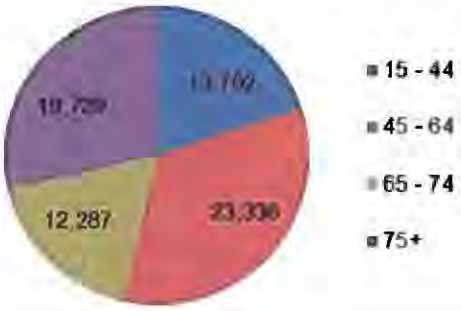
[5] For purposes of this analysis, we have grouped MSGA patients over 65 into Medicare and patients aged 15-64 into Non-Medicare.

Health insurance enrollment projections estimated the uninsured population will decline from 48.6 million in 2013 to 23.1 million in 2021 because of health exchanges or Medicaid expansion.[6] Having increased access to healthcare for the uninsured and underinsured will result in higher use rates for this population.

As a result, further declines in use rates by shifts to outpatient and observations stays would be offset by an improving economy, an aging population and those populations who would receive improved access to coverage.

Based on these factors, usage rates were maintained at 2012 levels recognizing a historical decrease in usage rates. Taking into account the estimated population growth, a baseline projection was developed using the 2012 population use rates, reflecting the changes that will occur based on population size and age composition. Using Nielsen Claritas data, population growth rates to CY2012 discharges by Zip code and age cohort (15-44, 45-64, 65-74, and 75+) were applied. The table below summarizes the growth rates considered over the 10-year period.

CY 2012 MSGA Discharges Originating in WAH - White Oak TSA



Admission Estimates by Age Cohort Originating in WAH's TSA

Ages	2012	2022	Total Change	Annual Change
15 - 44	13,702	13,224	-3.5%	-0.4%
45 - 64	23,336	25,826	10.7%	1.0%
65 - 74	12,287	21,073	71.5%	5.5%
75+	19,729	25,987	31.7%	2.8%
Total	**69,054**	**86,110**	**24.7%**	**2.2%**

Source: HSCRC data base and Nielson Claritas population projections

A total of 86,110 discharges in CY2022 was estimated for the Washington Adventist Hospital/ White Oak TSA, which indicates absolute growth of approximately 24.7% over the 10-year period, or an increase of 17,056 incremental discharges. Total Medicare discharges (patients 65 and older) are estimated to increase from 32,016 in CY2012 to 47,060 in CY2022, indicating growth of 47.0% and total non-Medicare discharges (patients 15 through 64) are estimated to increase from 37,038 in CY2012 to 39,050 in CY2022, indicating growth of 5.4%.

Washington Adventist Hospital projects further declines in volumes until the replacement hospital opens in White Oak. As a result, the improvement in volume once the new facility opens is a recapture of lost market share. In fact, market share for Washington Adventist Hospital in 2022 will be less than what it is in 2012.

(3) Estimated Bed Need

The historical average length of stay (ALOS) for patients originating in the Washington Adventist Hospital/White Oak TSA for the past five calendar years was examined. As indicated in the tables below, overall ALOS for Medicare patients has remained relatively flat within the Washington

[6] Standard & Poor's Industry Survey, Healthcare: Facilities, June 2013.

Adventist Hospital/White Oak TSA and increased 10.3% for non-Medicare patients during this time period.

MSGA ALOS within WAH - White Oak TSA (Medicare 65+)

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	5.4	5.4	5.5	5.7	5.9	8.3%
Holy Cross	5.2	4.9	4.7	4.8	4.9	-6.3%
Montgomery General	4.7	4.7	4.7	4.3	4.3	-8.9%
Shady Grove Adventist	5.1	5.4	5.3	5.5	5.4	4.0%
Suburban Hospital Center	4.4	4.4	4.5	4.5	4.7	8.1%
Laurel Regional Hospital	4.8	5.1	5.1	5.1	4.9	3.7%
Prince Georges Hospital Ctr	6.8	6.2	6.5	6.2	6.6	-2.4%
Southern Maryland	4.5	4.6	4.4	4.9	4.8	6.3%
Fort Washington Hospital	4.5	4.0	4.1	4.6	4.5	1.5%
Doctors Community Hospital	5.1	4.9	5.2	5.2	5.4	5.5%
Other Provider	6.9	6.5	6.7	6.9	6.5	-4.9%
Total	5.3	5.2	5.2	5.3	5.3	0.8%

MSGA ALOS within WAH - White Oak TSA (Non - Medicare 15 - 64)

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	4.1	4.0	4.2	4.4	4.9	19.8%
Holy Cross	4.2	4.0	3.9	4.1	4.2	-0.6%
Montgomery General	4.0	4.0	3.8	3.8	3.7	-8.0%
Shady Grove Adventist	3.8	3.8	3.8	4.0	3.8	1.1%
Suburban Hospital Center	3.5	3.9	3.8	3.7	4.2	20.3%
Laurel Regional Hospital	3.7	3.8	3.8	3.7	3.8	1.7%
Prince Georges Hospital Ctr	4.6	4.4	4.6	4.8	5.5	19.9%
Southern Maryland	3.3	3.4	3.4	3.6	4.0	19.1%
Fort Washington Hospital	3.5	3.4	3.0	3.3	3.2	-8.3%
Doctors Community Hospital	3.7	3.5	3.7	3.8	4.2	14.8%
Other Providers	6.1	5.9	6.1	5.9	6.2	2.2%
Total	4.2	4.1	4.2	4.3	4.6	10.3%

Market Share Based on Patient Days in WAH - White Oak TSA

Provider	2008	2009	2010	2011	2012	Variance
Washington Adventist	14.1%	14.0%	13.3%	12.6%	12.4%	-1.7%
Holy Cross	16.3%	16.6%	16.3%	17.2%	17.1%	0.8%
Montgomery General	6.4%	6.0%	5.9%	5.3%	4.9%	-1.4%
Shady Grove Adventist	9.1%	9.9%	9.8%	10.3%	10.0%	0.9%
Suburban Hospital Center	4.3%	4.4%	4.3%	4.3%	4.9%	0.6%
Laurel Regional Hospital	4.1%	3.9%	3.4%	2.9%	3.1%	-1.0%
Prince Georges Hospital Ctr	10.6%	10.4%	10.3%	9.3%	9.0%	-1.6%
Southern Maryland	8.6%	8.2%	7.8%	8.6%	8.2%	-0.4%
Fort Washington Hospital	0.6%	0.5%	0.5%	0.5%	0.4%	-0.2%
Doctors Community Hospital	11.5%	11.5%	12.9%	12.7%	12.1%	0.6%
Other Provider	14.4%	14.6%	15.2%	16.4%	17.6%	3.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	N/A

We applied the overall CY2012 ALOS for patients originating in the Washington Adventist Hospital/White Oak TSA by patient grouping to determine the overall estimated patient days. We assumed occupancy rates of 80% based on guidance indicated in COMAR10.24.10.05.D(4) for both Medicare and Non-Medicare patients to arrive at a total need of 1,475 beds. We recognized that historically, 17.6% of the days associated with patients originating in the Washington Adventist Hospital/White Oak TSA went to other providers outside Montgomery County and Prince George's County and therefore adjusted the total bed need to reflect only the beds needed to serve the patients who remain in those counties at the identified acute care hospitals. We calculated a total bed need of 1,215 for patients going to acute care facilities within Montgomery and Prince George's County. See calculations below:

Historically, 17.6% of the days associated with patients originating in the Washington Adventist Hospital/White Oak TSA went to other providers outside Montgomery County and Prince George's County so that the total bed need was adjusted to reflect only the beds needed to serve the patients who remain in those counties at the identified acute care hospitals. A total bed need of 1,215 for patients going to acute care facilities within Montgomery and Prince George's counties was calculated:

	Total Bed Need for Discharges Originating in WAH - White Oak TSA				
	CY2022 Admissions	**ALOS**	**Days**	**Occupancy**	**Bed Need**
Medicare	47,060	5.3	250,898	80.0%	859
Non-Medicare	39,050	4.6	179,935	80.0%	616
Total	**86,110**	**5.0**	**430,833**	**N/A**	**1,475**
CY2012 Market Share Leaving Montgomery & Prince George's County				17.6%	260
Beds Needed in Montgomery & Prince George County Hospitals					1,215

The same methodology was considered in calculating the licensed beds at the Montgomery and Prince George's hospitals currently serving this selected population.

Analysis of Beds Serving the Washington Adventist Hospital – White Oak TSA

Provider	MSGA Days Originating in WAH - WO TSA	Total MSGA Days	% MSGA Days from WAH - WO TSA	FY2013 Licensed MSGA Beds	MSGA Beds Serving WAH - WO TSA
Washington Adventist	42,423	51,796	81.9%	191	156
Holy Cross	58,448	76,245	76.7%	282	216
Montgomery General	16,893	28,007	60.3%	100	60
Shady Grove Adventist	34,304	66,234	51.8%	250	129
Suburban Hospital Center	16,781	55,074	30.5%	199	61
Laurel Regional Hospital	10,713	14,485	74.0%	53	39
Prince Georges Hospital Ctr	30,715	42,340	72.5%	152	110
Southern Maryland	28,067	50,027	56.1%	180	101
Fort Washington Hospital	1,525	7,701	19.8%	31	6
Doctors Community Hospital	41,302	51,610	80.0%	207	166
Total	**281,171**	**443,519**	**N/A**	**1,645**	**1,045**

Further analysis shows an additional net bed need of 170 for the Washington Adventist Hospital/White Oak TSA. This calculation of additional beds takes into account Washington Adventist Hospital's current licensed beds of 191 and does not consider the proposed replacement hospital will have 180 MSGA beds. While 75 MSGA beds have already been approved for Holy Cross Hospital in Germantown, those beds are not included in the analysis due to the lack of related historical data. This does not affect the bed need calculation supporting the application. Assuming 100% of those beds would support the Washington Adventist Hospital/White Oak TSA, implying direct overlap of service areas, a need is still indicated for 95 (170 – 75) MSGA beds in the Washington Adventist Hospital/White Oak TSA.

Net Bed Need for WAH - White Oak TSA	
	Bed Need
Beds Needed at Montgomery & Prince George's County Hospitals	1,215
Beds Available to Serve TSA in M & PG County	(1,045)
Net Bed Need	170

The analysis also focused on the bed need within the Washington Adventist Hospital /White Oak TSA and therefore did not consider growth in admissions from patients outside the service area. If the rest of Maryland was also expected to experience increases in its adult population, there would be further support for additional bed need.

PSYCHIATRIC BED NEED ANALYSIS FOR WASHINGTON ADVENTIST HOSPITAL

In FY2013, Washington Adventist Hospital was licensed for 252 beds, of which 40 are licensed for psychiatric services. Washington Adventist Hospital intends to continue offering psychiatric services at the Takoma Park location with no adjustment to the number of beds in service. Psychiatric services are regional and include involuntary patients.

(1) Service Area

In CY2012, the Washington Adventist Hospital PSA for psychiatric discharges consisted of 20 zip codes, 12 located in Montgomery County and 8 located in Prince George's County with the primary number of discharges coming from zip code 20910 (Silver Spring) and 20912 (Takoma Park). Washington Adventist Hospital observed 52.3% market share within 20910 and 79.9% market

share within its home zip code 20912. Washington Adventist Hospital's market share within its PSA for psychiatric discharges is 37.4%.

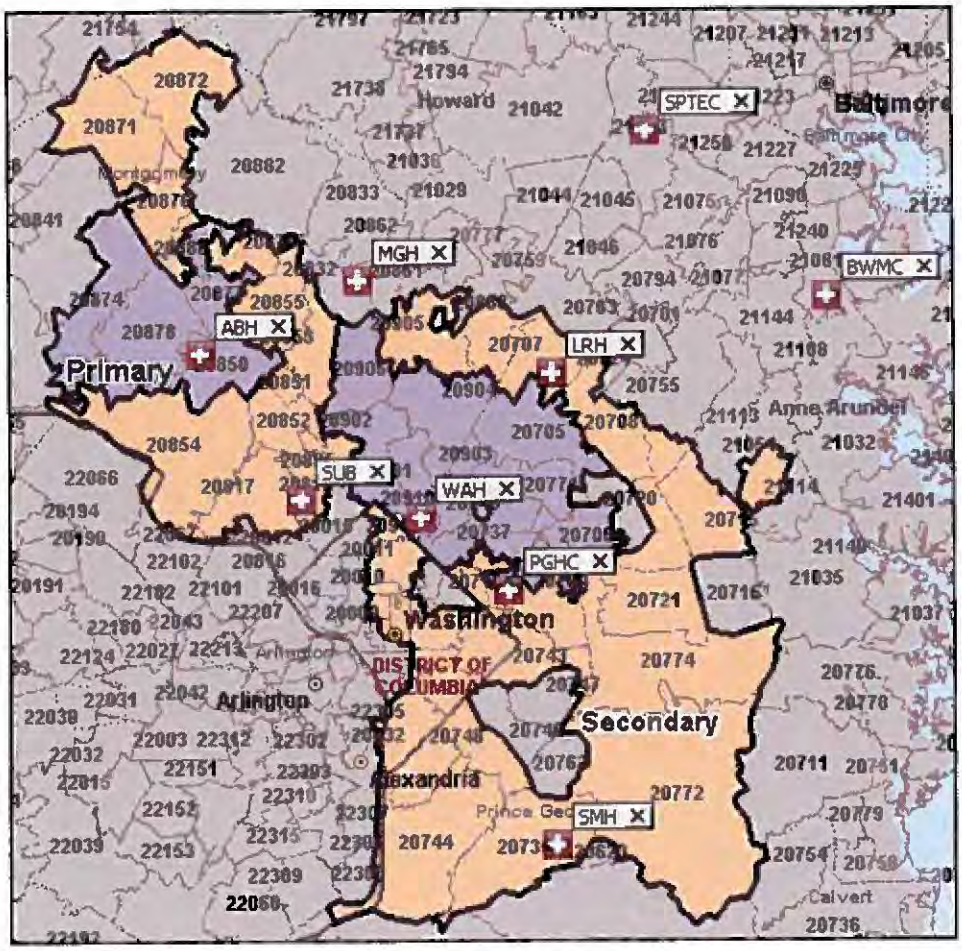
The Washington Adventist Hospital TSA is comprised of 63 zip codes, 26 located in Montgomery County, 24 located in Prince George's County, 12 located in the District of Columbia, and 1 located in Anne Arundel County, listed below.

CY2012 Psychiatric Washington Adventist Hospital TSA

Zip Code	City	Service Area	Discharges	% of Total	Cumulative %	Market Share
20910	Silver Spring	Primary	113	6.8%	6.8%	52.3%
20912	Takoma Park	Primary	107	6.4%	13.2%	79.9%
20783	Hyattsville	Primary	84	5.0%	18.2%	63.2%
20904	Silver Spring	Primary	76	4.6%	22.8%	34.5%
20901	Silver Spring	Primary	75	4.5%	27.2%	52.1%
20782	Hyattsville	Primary	69	4.1%	31.4%	67.6%
20902	Silver Spring	Primary	61	3.7%	35.0%	36.1%
20850	Rockville	Primary	58	3.5%	38.5%	34.5%
20906	Silver Spring	Primary	53	3.2%	41.7%	15.0%
20903	Silver Spring	Primary	51	3.1%	44.7%	76.1%
20737	Riverdale	Primary	30	1.8%	46.5%	33.0%
20784	Hyattsville	Primary	29	1.7%	48.3%	22.8%
20878	Gaithersburg	Primary	29	1.7%	50.0%	31.5%
20877	Gaithersburg	Primary	29	1.7%	51.7%	43.9%
20770	Greenbelt	Primary	26	1.6%	53.3%	26.5%
20740	College Park	Primary	24	1.4%	54.7%	32.9%
20874	Germantown	Primary	24	1.4%	56.2%	21.6%
20886	Montgomery Village	Primary	22	1.3%	57.5%	26.8%
20705	Beltsville	Primary	21	1.3%	58.7%	23.1%
20706	Lanham	Primary	21	1.3%	60.0%	14.9%
20002	Washington, D.C.	Secondary	21	1.3%	61.3%	46.7%
20707	Laurel	Secondary	19	1.1%	62.4%	10.9%
20011	Washington, D.C.	Secondary	18	1.1%	63.5%	38.3%
20879	Gaithersburg	Secondary	18	1.1%	64.6%	26.9%
20712	Mount Rainier	Secondary	16	1.0%	65.5%	50.0%
20781	Hyattsville	Secondary	16	1.0%	66.5%	32.7%
20876	Germantown	Secondary	16	1.0%	67.4%	27.6%
20774	Upper Marlboro	Secondary	15	0.9%	68.3%	11.5%
20814	Bethesda	Secondary	14	0.8%	69.2%	9.8%
20010	Washington, D.C.	Secondary	13	0.8%	69.9%	39.4%
20785	Hyattsville	Secondary	12	0.7%	70.7%	6.5%
20721	Bowie	Secondary	12	0.7%	71.4%	19.7%
20853	Rockville	Secondary	12	0.7%	72.1%	11.0%
20032	Washington, D.C.	Secondary	12	0.7%	72.8%	16.9%

Zip Code	City	Service Area	Discharges	% of Total	Cumulative %	Market Share
20012	Washington, D.C.	Secondary	11	0.7%	73.5%	52.4%
20743	Capitol Heights	Secondary	10	0.6%	74.1%	5.1%
20866	Burtonsville	Secondary	10	0.6%	74.7%	21.3%
20895	Kensington	Secondary	10	0.6%	75.3%	12.7%
20009	Washington, D.C.	Secondary	10	0.6%	75.9%	30.3%
20851	Rockville	Secondary	10	0.6%	76.5%	21.3%
20001	Washington, D.C.	Secondary	9	0.5%	77.0%	40.9%
20852	Rockville	Secondary	9	0.5%	77.5%	6.7%
20019	Washington, D.C.	Secondary	8	0.5%	78.0%	14.3%
20855	Derwood	Secondary	8	0.5%	78.5%	27.6%
20708	Laurel	Secondary	7	0.4%	78.9%	7.9%
20905	Silver Spring	Secondary	7	0.4%	79.3%	11.1%
20020	Washington, D.C.	Secondary	7	0.4%	79.8%	23.3%
20817	Bethesda	Secondary	7	0.4%	80.2%	7.0%
20854	Potomac	Secondary	7	0.4%	80.6%	9.7%
20003	Washington, D.C.	Secondary	7	0.4%	81.0%	28.0%
20013	Washington, D.C.	Secondary	7	0.4%	81.4%	77.8%
20772	Upper Marlboro	Secondary	6	0.4%	81.8%	4.3%
20720	Bowie	Secondary	6	0.4%	82.2%	12.2%
20744	Fort Washington	Secondary	6	0.4%	82.5%	4.0%
20872	Damascus	Secondary	6	0.4%	82.9%	16.2%
20735	Clinton	Secondary	5	0.3%	83.2%	4.1%
20871	Clarksburg	Secondary	5	0.3%	83.5%	20.8%
21114	Crofton	Secondary	5	0.3%	83.8%	9.8%
20005	Washington, D.C.	Secondary	5	0.3%	84.1%	62.5%
20722	Brentwood	Secondary	4	0.2%	84.3%	33.3%
20748	Temple Hills	Secondary	4	0.2%	84.6%	2.6%
20715	Bowie	Secondary	4	0.2%	84.8%	5.1%
20745	Oxon Hill	Secondary	4	0.2%	85.0%	3.0%

CY2012 Psychiatric Washington Adventist Hospital TSA



Because psychiatric services will remain in Takoma Park, a bed need analysis was conducted based upon the CY2012 Washington Adventist Hospital Psych TSA since there will no adjustment in the market service area.

(2) Estimated Discharges

The overall adult population within the Washington Adventist Hospital psychiatric TSA was estimated to be 1.64 million in CY2010, 1.7 million in CY2013, and 1.8 million in CY2018. This implies an overall increase in the population of approximately 3.7% between CY2010 and CY2013.

As indicated in the table below, psychiatric discharges in the Washington Adventist Hospital TSA have decreased 2.3% between CY2010 and CY2012, although they have increased 12.2% over the past 5 years. The greatest annual increase in discharges occurred between CY2008 and CY2009 with 13.5% growth. Between CY2011 and CY2012, total psychiatric discharges at Montgomery Count and Prince George's County hospitals declined 8.3% while psychiatric discharges within the Washington Adventist Hospital TSA experienced a less significant decline of 4.4%.

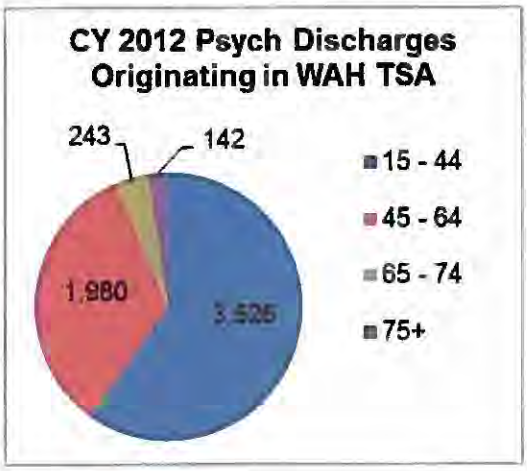
Psych Discharges in WAH TSA

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	1,491	1,671	1,444	1,397	1,420	-4.8%
Holy Cross	44	40	78	78	73	65.9%
Montgomery General	829	850	898	881	814	-1.8%
Shady Grove Adventist	47	32	38	23	36	-23.4%
Suburban Hospital Center	721	819	945	1,062	976	35.4%
Laurel Regional Hospital	311	367	337	407	384	23.5%
Prince Georges Hospital Ctr	762	1,036	1,112	1,120	1,083	42.1%
Southern Maryland	736	736	764	719	626	-14.9%
Fort Washington Hospital	4	4	3	6	3	-25.0%
Doctors Community Hospital	11	13	12	10	6	-45.5%
Other Provider	294	392	401	457	470	59.9%
Total	5,250	5,960	6,032	6,160	5,891	12.2%
Annual Change	*N/A*	*13.5%*	*1.2%*	*2.1%*	*-4.4%*	

Psych Total Discharges

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	1,798	1,972	1,757	1,703	1,670	-7.1%
Holy Cross	47	43	85	96	82	74.5%
Montgomery General	1,145	1,213	1,234	1,223	1,123	-1.9%
Shady Grove Adventist	56	38	42	29	38	-32.1%
Suburban Hospital Center	914	1,075	1,169	1,376	1,254	37.2%
Laurel Regional Hospital	646	764	800	892	719	11.3%
Prince Georges Hospital Ctr	918	1,266	1,341	1,400	1,349	46.9%
Southern Maryland	1,294	1,280	1,289	1,221	1,057	-18.3%
Fort Washington Hospital	7	7	6	8	4	-42.9%
Doctors Community Hospital	14	15	16	13	6	-57.1%
Total	6,839	7,673	7,759	7,961	7,302	6.8%
Annual Change	*N/A*	*12.2%*	*1.1%*	*2.6%*	*-8.3%*	

Based on Nielsen Claritas data, population growth rates to CY2012 discharges by zip code and age cohort (15-44, 45-64, 65-74, and 75+) were applied. The table below summarizes the growth rates considered over the 10-year period.



Discharge Estimates by Age Cohort Originating in WASHINGTON ADVENTIST HOSPITAL TSA

Ages	2012	2022	Total Change	Annual Change
15 - 44	3,526	3,475	-1.4%	-0.1%
45 - 64	1,980	2,228	12.5%	1.2%
65 - 74	243	416	71.2%	5.5%
75+	142	178	25.2%	2.3%
Total	5,891	6,297	6.9%	0.7%

Source: HSCRC data base and Nielsen Claritas population projections

Under this methodology, a baseline projection was developed that maintains population use rates and reflects the changes that will occur based on population size and age composition. A 10%

increase in non-Medicare discharges based on changes in Maryland's coverage for psychiatric services was also included.

A total of 6,297 discharges in CY2022 for the Washington Adventist Hospital TSA was estimated based on population growth and an increase of 570 discharges, or 10% growth, due to increased access and demand for psychiatric services. The adjusted CY2022 discharges, including population growth and usage adjustments, indicated absolute growth of approximately 16.6% over the 10-year period, or annual growth of 1.5%.

(3) Estimated Bed Need

The historical ALOS for patients originating in the Washington Adventist Hospital TSA for the past five calendar years was analyzed. As indicated in the tables below, overall ALOS for Medicare patients has declined 6.2% and 1.5% for non-Medicare patients during this time period.

Psych ALOS within WAH TSA (Medicare)

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	6.8	7.4	7.0	6.7	9.3	36.3%
Holy Cross	7.9	6.6	4.4	3.3	4.3	-46.0%
Montgomery General	8.9	7.3	8.1	7.8	6.7	-24.6%
Shady Grove Adventist	1.9	5.7	4.9	2.4	3.5	88.5%
Suburban Hospital Center	7.0	8.5	7.6	7.6	6.4	-7.8%
Laurel Regional Hospital	7.8	8.1	4.6	6.4	5.5	-29.8%
Prince Georges Hospital Ctr	9.7	7.1	8.1	9.7	7.8	-20.0%
Southern Maryland	6.5	8.0	6.1	7.5	7.5	15.3%
Fort Washington Hospital	2.0	3.0	-	3.7	3.0	50.0%
Doctors Community Hospital	4.3	2.3	2.0	1.3	2.5	-42.3%
Other Providers	20.8	13.1	14.8	18.1	17.6	-15.7%
Total	8.7	8.2	7.8	8.4	8.1	-6.2%

Psych ALOS within WAH TSA (Non - Medicare)

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	5.2	4.8	5.0	5.2	5.8	11.2%
Holy Cross	5.2	3.7	2.6	5.3	3.1	-39.9%
Montgomery General	5.2	5.0	4.5	4.3	4.3	-17.2%
Shady Grove Adventist	2.6	4.1	2.9	3.2	3.0	16.5%
Suburban Hospital Center	5.5	5.0	5.0	4.6	4.9	-10.4%
Laurel Regional Hospital	6.0	4.0	3.3	4.0	4.4	-26.0%
Prince Georges Hospital Ctr	5.5	5.5	5.7	5.3	5.2	-5.4%
Southern Maryland	4.9	4.9	4.3	5.0	4.5	-8.8%
Fort Washington Hospital	1.7	1.7	1.3	2.3	2.0	20.0%
Doctors Community Hospital	3.5	3.7	2.2	1.5	1.5	-57.1%
Other Providers	7.1	7.8	7.9	10.4	8.7	22.9%
Total	5.4	5.1	5.0	5.2	5.3	-1.5%

Market Share Based on Days in WAH TSA

Provider	2008	2009	2010	2011	2012	Variance
Washington Adventist	26.8%	25.9%	23.5%	21.8%	25.9%	-0.8%
Holy Cross	0.9%	0.6%	0.8%	1.1%	0.8%	-0.1%
Montgomery General	15.5%	13.9%	13.6%	12.0%	11.3%	-4.2%
Shady Grove Adventist	0.4%	0.4%	0.4%	0.2%	0.3%	0.0%
Suburban Hospital Center	13.6%	13.7%	15.7%	15.2%	15.3%	1.6%
Laurel Regional Hospital	6.4%	4.9%	3.6%	5.0%	5.3%	-1.1%
Prince Georges Hospital Ctr	14.9%	18.2%	20.7%	18.3%	18.0%	3.1%
Southern Maryland	12.6%	11.9%	10.8%	11.1%	9.0%	-3.6%
Fort Washington Hospital	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%
Doctors Community Hospital	0.1%	0.1%	0.1%	0.0%	0.0%	-0.1%
Other Provider	8.7%	10.3%	10.9%	15.1%	13.9%	5.3%
	100.0%	100.0%	100.0%	100.0%	100.0%	N/A

To determine the overall estimated patient days, the overall CY2012 ALOS from patients originating from the Washington Adventist Hospital TSA was applied by patient grouping. Occupancy rates of 70% were assumed for both Medicare and non-Medicare patients to arrive at a total need of 149 beds.

Historically, 13.9% of days originating from patients in the Washington Adventist Hospital TSA went to other providers outside Montgomery County and Prince George's County. As a result, total bed need was adjusted to reflect only the beds needed to serve the patients who remain in those counties at the identified acute care hospitals. A total bed need of 128 for patients going to acute care facilities within Montgomery and Prince George's County was calculated:

	Total Bed Need for Discharges Originating in WAH TSA						
	CY2022 Discharges	Increase in Access	Adjusted CY2022 Discharges	ALOS	Days	Occupancy	Bed Need
Medicare	594	0.0%	594	8.1	4,827	70.0%	19
Non-Medicare	5,703	10.0%	6,273	5.3	33,234	70.0%	130
Total	**6,297**	N/A	**6,867**	**6.0**	**38,061**	**N/A**	**149**
CY2012 Market Share Leaving Montgomery & Prince George's County						13.9%	21
Beds Needed In Montgomery & Prince George's County Hospitals							128

The same methodology was used to calculate the licensed beds currently serving this selected population.

Provider	Psych Days From WAH TSA	Total Psych Days	% Psych Days from WAH TSA	FY2013 Licensed Psych Beds	Psych Beds Serving TSA
Washington Adventist	8,377	9,652	86.8%	40	35
Holy Cross	259	291	89.0%	-	-
Montgomery General	3,644	4,916	74.1%	25	19
Shady Grove Adventist	112	113	99.1%	-	-
Suburban Hospital Center	4,934	6,440	76.6%	24	18
Laurel Regional Hospital	1,718	3,308	51.9%	14	7
Prince Georges Hospital Ctr	5,824	7,310	79.7%	28	22
Southern Maryland	2,906	4,833	60.1%	25	15
Fort Washington Hospital	7	11	63.6%	-	-
Doctors Community Hospital	13	13	100.0%	-	-
Total	**27,794**	**36,887**	**N/A**	**156**	**116**

Further analysis shows that there is a net psychiatric bed need of 12 for the Washington Adventist Hospital TSA.

Net Bed Need for WAH - White Oak TSA	
	Bed Need
Beds Needed at Montgomery & Prince George's County Hospitals	128
Beds Available to Serve WAH TSA in M & PG County	(116)
Net Bed Need	12

In addition, the analysis focused on the bed need within the Washington Adventist Hospital TSA and therefore did not consider growth in admissions from those patients outside the service area. If the rest of Maryland was also expected to experience increases in its adult population, there would be further support for additional bed need.

OBSTETRIC BED NEED ANALYSIS FOR WASHINGTON ADVENTIST HOSPITAL

Washington Adventist Hospital is currently licensed for 252 beds, of which 21 are licensed for obstetric ("OB") services. The proposed Washington Adventist Hospital replacement facility will include 21 OB beds, indicating no addition of OB beds.

Washington Adventist Hospital plans to continue its participation in the Maternity Partnership Program in Montgomery County and will also continue to offer prenatal services in Takoma Park. This program provides prenatal care, routine laboratory tests, prenatal classes, and dental screening for pregnant women without insurance or with low income.

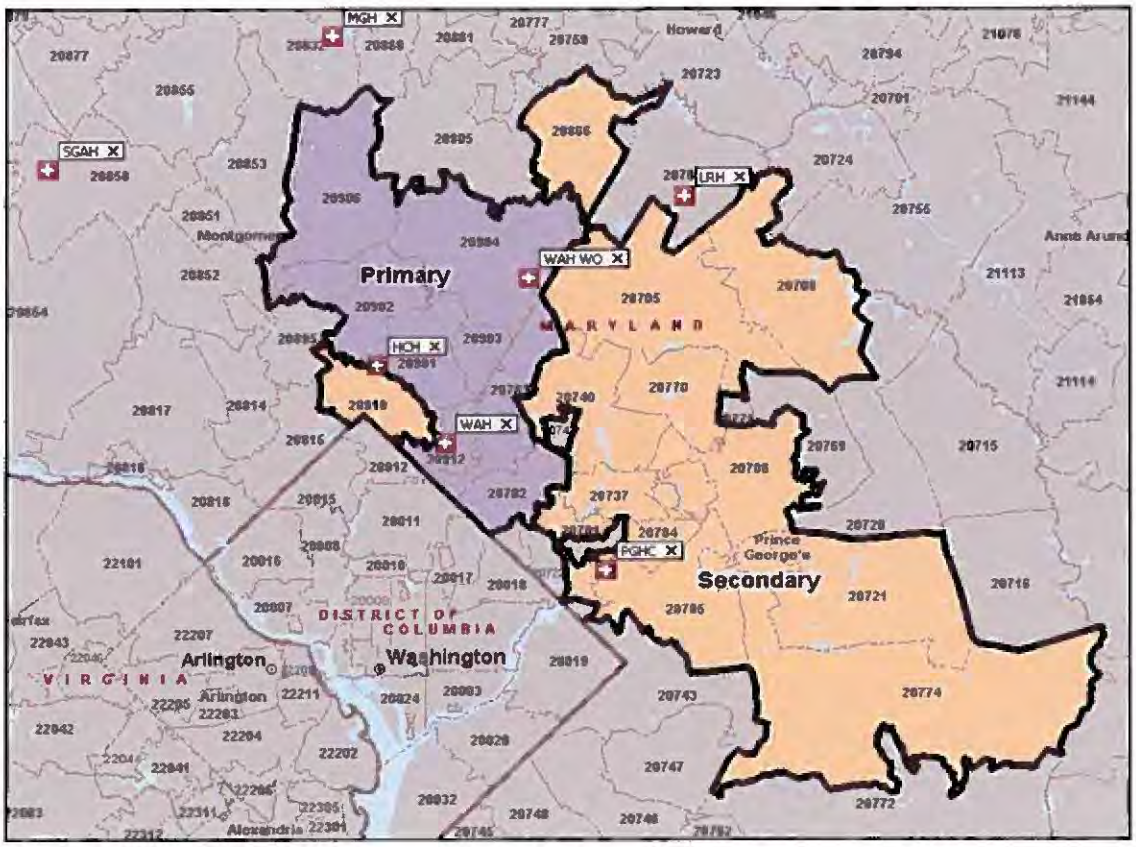
(1) Service Area

In CY2012, the Washington Adventist Hospital PSA for OB discharges consisted of 8 zip codes, 6 located in Montgomery County and 2 located in Prince George's County with the primary number of discharges coming from zip code 20783 (Hyattsville) and 20903 (Silver Spring). Washington Adventist Hospital observed 36.6% market share within 20783 and 36.5% of market share within its home zip code 20912. Washington Adventist Hospital's market share within its PSA for OB discharges is 15.5%.

The Washington Adventist Hospital TSA is comprised of 21 zip codes, 8 located in Montgomery County and 13 located in Prince George County, listed below.

Zip Code	City	Service Area	Washington Adventist Hospital	% of Total	Cumulative
20783	Hyattsville	Primary	214	12.1%	12.1%
20903	Silver Spring	Primary	184	10.4%	22.4%
20912	Takoma Park	Primary	140	7.9%	30.3%
20906	Silver Spring	Primary	131	7.4%	37.7%
20902	Silver Spring	Primary	119	6.7%	44.4%
20901	Silver Spring	Primary	114	6.4%	50.9%
20904	Silver Spring	Primary	91	5.1%	56.0%
20782	Hyattsville	Primary	86	4.9%	60.9%
20910	Silver Spring	Secondary	60	3.4%	64.2%
20706	Lanham	Secondary	57	3.2%	67.5%
20705	Beltsville	Secondary	52	2.9%	70.4%
20737	Riverdale	Secondary	45	2.5%	72.9%
20784	Hyattsville	Secondary	38	2.1%	75.1%
20770	Greenbelt	Secondary	37	2.1%	77.2%
20740	College Park	Secondary	29	1.6%	78.8%
20785	Hyattsville	Secondary	27	1.5%	80.3%
20781	Hyattsville	Secondary	20	1.1%	81.4%
20866	Burtonsville	Secondary	19	1.1%	82.5%
20708	Laurel	Secondary	17	1.0%	83.5%
20721	Bowie	Secondary	14	0.8%	84.3%
20774	Upper Marlboro	Secondary	13	0.7%	85.0%

CY2012 OB Washington Adventist Hospital TSA



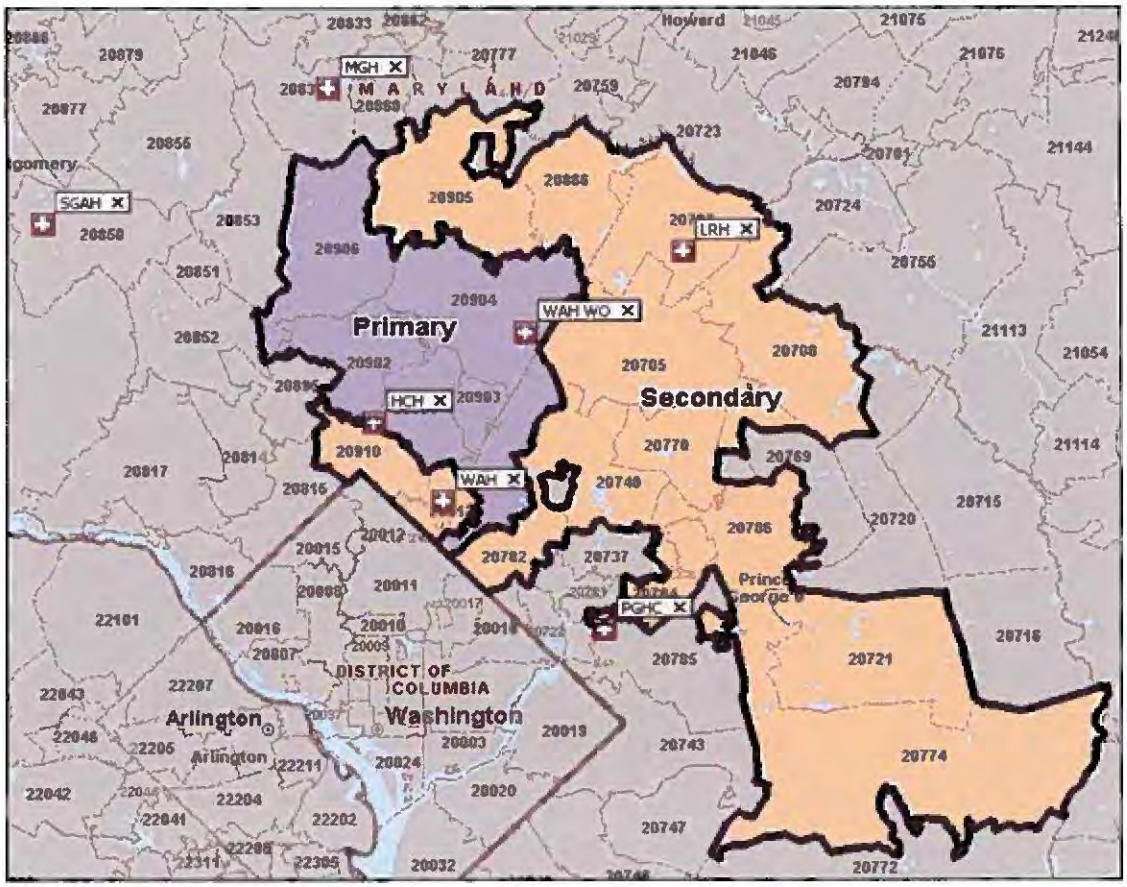
An analysis was performed to understand the expected differences in market share by zip code as a result of the proposed relocation to White Oak. Based on market dynamics that considers location of the new hospital, proximity to other hospitals, drive times, major streets and highways, current market share of other providers, and physician relationships, the following adjustments to the Washington Adventist Hospital OB TSA were considered:

Zip Code	City	Current Market Share at Takoma Park	Adjustment	Estimated Market Share in Proposed Location
20783	Hyattsville	36.6%	0.0%	36.6%
20903	Silver Spring	36.5%	0.0%	36.5%
20912	Takoma Park	37.9%	-15.0%	22.9%
20906	Silver Spring	14.4%	5.0%	19.4%
20902	Silver Spring	14.0%	5.0%	19.0%
20901	Silver Spring	19.5%	5.0%	24.5%
20904	Silver Spring	11.9%	20.0%	31.9%
20782	Hyattsville	23.3%	-15.0%	8.3%
20910	Silver Spring	12.4%	-8.0%	4.4%
20706	Lanham	10.5%	0.0%	10.5%
20705	Beltsville	13.1%	5.0%	18.1%
20737	Riverdale	13.0%	-10.0%	3.0%
20784	Hyattsville	8.8%	-6.0%	2.8%
20770	Greenbelt	10.5%	0.0%	10.5%
20740	College Park	11.8%	0.0%	11.8%
20785	Hyattsville	5.2%	-3.0%	2.2%
20781	Hyattsville	12.3%	-10.0%	2.3%
20866	Burtonsville	10.5%	5.0%	15.5%
20708	Laurel	3.8%	2.0%	5.8%
20721	Bowie	5.5%	0.0%	5.5%
20774	Upper Marlboro	3.2%	0.0%	3.2%
20707	Laurel	2.4%	5.0%	7.4%
20905	Silver Spring	5.6%	5.0%	10.6%
Total Market Share		**14.8%**	**0.9%**	**15.7%**

As demonstrated above, individual adjustments to each zip code were considered, then discharges were calculated, considering the estimated market share by zip code in White Oak to determine total discharges at Washington Adventist Hospital/White Oak. Conclusion: moving to the White Oak location will increase overall market share approximately 0.9% in the identified Zip codes.

Primary and secondary service area for Washington Adventist Hospital/White Oak was redefined as follows:

CY2012 OB Washington Adventist Hospital TSA



Bed analysis was conducted based upon the redefined Washington Adventist Hospital/White Oak TSA.

(2) Estimated Discharges

Female population between the ages of 15 through 44 ("Female – Childbearing") within the Washington Adventist Hospital/White Oak TSA was estimated to be 299,551 in CY2010, 297,117 in CY2013, and 291,850 in CY2018. This implies an overall decrease in the population of approximately 0.8% between CY2010 and CY2013.

Demonstrated in the table below, OB discharges in the Washington Adventist Hospital/White Oak TSA decreased 3.4% between CY2010 and CY2012 and 2.1% over the past five years.

OB Discharges within WAH - White Oak TSA

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	1,801	1,943	1,783	1,560	1,434	-20.4%
Holy Cross	4,852	4,756	4,765	4,750	4,816	-0.7%
Montgomery General	259	318	311	306	318	22.8%
Shady Grove Adventist	463	485	460	495	497	7.3%
Suburban Hospital Center	3	3	1	4	5	66.7%
Laurel Regional Hospital	422	472	594	555	581	37.7%
Prince Georges Hospital Ctr	932	874	900	756	759	-18.6%
Southern Maryland	59	46	66	52	62	5.1%
Doctors Community Hospital	30	30	41	24	17	-43.3%
Other Provider	658	617	679	736	789	19.9%
Total	9,479	9,544	9,600	9,238	9,278	-2.1%

Population estimates, sourced from Nielsen Claritas, for the Female – Childbearing population and newborns within the Washington Adventist Hospital TSA were examined. It was found that although the Female – Childbearing population is estimated to decline approximately 0.3% annually, newborns are expected to increase 0.4% annually.

OB Discharge Estimates within the WAH - White Oak TSA

Growth Estimate Based On:	2012 Discharges	2022 Estimated Discharges	Total Change	Annual Change
Female - Childbearing	9,278	8,959	-3.4%	-0.3%
Newborn Estimates	9,278	9,720	4.8%	0.4%

Source: HSCRC data base and Nielson Claritas population projections

Growth rates indicated by newborn projections were considered as a more appropriate measure of future OB volume.

(3) Estimated Bed Need

OB ALOS within the Washington Adventist Hospital TSA decreased 10.4% over the five year period and the ALOS of 2.6 was considered to calculate patient days in CY2022

OB ALOS within WAH - White Oak TSA

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	2.8	2.8	2.8	2.6	2.5	-11.8%
Holy Cross	3.0	2.9	2.9	2.7	2.6	-13.7%
Montgomery General	2.8	2.7	2.6	2.5	2.5	-12.2%
Shady Grove Adventist	2.8	3.2	3.4	3.3	2.8	-1.0%
Suburban Hospital Center	3.0	1.7	1.0	2.8	2.8	-6.7%
Laurel Regional Hospital	2.3	2.4	2.6	2.5	2.3	2.7%
Prince Georges Hospital Ctr	2.9	3.0	2.8	2.9	2.8	-1.8%
Southern Maryland	2.6	2.6	2.7	2.7	2.7	6.4%
Doctors Community Hospital	2.1	1.6	2.0	2.1	1.8	-13.2%
Other Provider	3.3	3.3	2.9	2.8	3.0	-9.5%
Total	2.9	2.9	2.8	2.7	2.6	-10.4%

Market Share Based on Days Within WAH - White Oak TSA

Provider	2008	2009	2010	2011	2012	Variance
Washington Adventist	18.3%	19.9%	18.2%	16.2%	14.7%	-3.6%
Holy Cross	52.4%	49.8%	50.2%	50.9%	51.1%	-1.2%
Montgomery General	2.7%	3.2%	2.9%	3.1%	3.3%	0.6%
Shady Grove Adventist	4.8%	5.7%	5.6%	6.5%	5.8%	1.0%
Suburban Hospital Center	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%
Laurel Regional Hospital	3.5%	4.1%	5.6%	5.6%	5.6%	2.1%
Prince Georges Hospital Ctr	9.7%	9.4%	9.2%	8.7%	8.9%	-0.9%
Southern Maryland	0.6%	0.4%	0.6%	0.6%	0.7%	0.2%
Doctors Community Hospital	0.2%	0.2%	0.3%	0.2%	0.1%	-0.1%
Other Provider	7.9%	7.3%	7.3%	8.3%	9.8%	1.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	N/A

An occupancy rate of 65% was assumed to arrive at a total need of 107 beds. Recognizing that historically, 9.8% of days associated with patients originating in the Washington Adventist Hospital/White Oak TSA went to other providers outside Montgomery and Prince George's counties total bed need was adjusted to reflect only the beds needed to serve the patients who remain in those counties at the identified acute care hospitals. A total bed need of 96 was calculated for patients going to hospitals within Montgomery and Prince George's counties. See calculations below:

	Total Bed Need for Discharges Originating in WAH - White Oak TSA				
	CY2022 Admissions	ALOS	Days	Occupancy	Bed Need
Population Estimates	9,720	2.6	25,362	65.0%	107
CY2012 Market Share Leaving Montgomery & Prince George's County				9.8%	10
Beds Needed in Montgomery & Prince George's County Hospitals					96

The same methodology was considered to calculate the licensed beds currently serving this selected population.

Provider	OB Days From WAH - White Oak TSA	Total OB Days	% OB Days from WAH - White Oak TSA	FY2013 Licensed OB Beds	OB Beds Serving WAH - White Oak TSA
Washington Adventist	3,558	4,437	80.2%	21	17
Holy Cross	12,379	23,404	52.9%	88	47
Montgomery General	792	1,902	41.6%	11	5
Shady Grove Adventist	1,396	14,074	9.9%	56	6
Suburban Hospital Center	14	43	32.6%	-	-
Laurel Regional Hospital	1,361	2,428	56.1%	10	6
Prince Georges Hospital Ctr	2,147	6,495	33.1%	36	12
Southern Maryland	170	5,983	2.8%	30	1
Doctors Community Hospital	31	69	44.9%	-	-
Total	**21,848**	**58,835**	**37.1%**	**252**	**92**

Further analysis shows that there is a net OB bed need of 4 for the Washington Adventist Hospital/White Oak TSA.

CY2022 Net Bed Need for WAH - White Oak TSA	
	Bed Need
Beds Needed at Montgomery & Prince George's County Hospitals	96
Beds Available to Serve WAH - White Oak TSA in M & PG County	(92)
Net Bed Need	4

[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]

TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)						
CY or FY (Circle	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
1. Admissions										
a. M/S/G/A	9,108	8,268	7,100	6,397	6,132	5,876	5,750	5,627	6,084	6,630
b. Pediatric	-	-	-	-	-	-	-	-	-	-
c. Obstetric	1,902	1,712	1,609	1,617	1,625	1,634	1,642	1,650	1,716	1,802
d. Intensive Care	1,539	1,426	1,464	1,319	1,264	1,212	1,186	1,160	1,254	1,367
e. Coronary Care	-	-	-	-	-	-	-	-	-	-
f. Psychiatric	1,779	1,706	1,791	1,850	1,911	1,974	2,039	2,106	2,176	2,187
g. Rehabilitation	-	-	-	-	-	-	-	-	-	-
h. Chronic	-	-	-	-	-	-	-	-	-	-
i. Other (Specify)	-	-	-	-	-	-	-	-	-	-
j. TOTAL	14,328	13,112	11,964	11,184	10,933	10,696	10,617	10,543	11,230	11,986
2. Patient Days										
a. M/S/G/A	45,038	44,929	40,163	35,825	35,044	34,281	33,532	32,802	35,438	38,627
b. Pediatric	-	-	-	-	-	-	-	-	-	-
c. Obstetric	4,786	4,165	3,915	3,935	3,954	3,974	3,994	4,014	4,175	4,383
d. Intensive Care	7,807	7,218	6,727	6,061	5,810	5,568	5,448	5,331	5,764	6,282
e. Coronary Care	-	-	-	-	-	-	-	-	-	-
f. Psychiatric	9,114	9,954	10,452	10,796	11,152	11,519	11,898	12,289	12,697	12,761
g. Rehabilitation	-	-	-	-	-	-	-	-	-	-
h. Chronic	-	-	-	-	-	-	-	-	-	-
i. Other (Specify)	-	-	-	-	-	-	-	-	-	-
j. TOTAL	66,745	66,266	61,257	56,617	55,959	55,342	54,873	54,436	58,074	62,053

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)						
CY or FY (Circle	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
3. Average Length of Stay										
a. M/S/G/A	4.9	5.4	5.7	5.6	5.7	5.8	5.8	5.8	5.8	5.8
b. Pediatric	-	-	-	-	-	-	-	-	-	-
c. Obstetric	2.5	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4
d. Intensive Care	5.1	5.1	4.6	4.6	4.6	4.6	4.6	4.6	4.6	4.6
e. Coronary Care	-	-	-	-	-	-	-	-	-	-
f. Psychiatric	5.1	5.8	5.8	5.8	5.8	5.8	5.8	5.8	5.8	5.8
g. Rehabilitation	-	-	-	-	-	-	-	-	-	-
h. Chronic	-	-	-	-	-	-	-	-	-	-
i. Other (Specify)	-	-	-	-	-	-	-	-	-	-
j. TOTAL	4.7	5.1	5.1	5.1	5.1	5.2	5.2	5.2	5.2	5.2
4. Occupancy										
a. M\S/G/A	66.3%	69.5%	70.1%	62.5%	61.2%	59.8%	58.5%	57.2%	66.5%	72.5%
b. Pediatric	-	-	-	-	-	-	-	-	-	-
c. Obstetric	62.4%	54.3%	51.1%	51.3%	51.6%	51.8%	52.1%	52.4%	54.5%	57.2%
d. Intensive Care	62.9%	58.2%	54.2%	48.8%	46.8%	44.9%	43.9%	43.0%	46.4%	50.6%
e. Coronary Care	-	-	-	-	-	-	-	-	-	-
f. Psychiatric	62.4%	68.2%	71.6%	73.9%	76.4%	78.9%	81.5%	84.2%	87.0%	87.4%
g. Rehabilitation	-	-	-	-	-	-	-	-	-	-
h. Chronic	-	-	-	-	-	-	-	-	-	-
i. Other (Specify)	-	-	-	-	-	-	-	-	-	-
j. TOTAL	65.1%	66.7%	66.6%	61.6%	60.8%	60.2%	59.7%	59.2%	66.0%	70.5%
5. Number of Licensed Beds										
a. M\S/G/A	186	177	157	157	157	157	157	157	146	146
b. Pediatric	-	-	-	-	-	-	-	-	-	-
c. Obstetric	21	21	21	21	21	21	21	21	21	21
d. Intensive Care	34	34	34	34	34	34	34	34	34	34
e. Coronary Care	-	-	-	-	-	-	-	-	-	-
f. Psychiatric	40	40	40	40	40	40	40	40	40	40
g. Rehabilitation	-	-	-	-	-	-	-	-	-	-
h. Chronic	-	-	-	-	-	-	-	-	-	-
i. Other (Specify)	-	-	-	-	-	-	-	-	-	-
j. TOTAL	281	272	252	252	252	252	252	252	241	241

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)						
CY or FY (Circle	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
6. Outpatient Visits										
a. Emergency	38,189	40,906	44,253	44,253	44,253	44,253	44,253	44,253	46,023	48,785
b. Outpatient Department	16,341	16,048	16,289	16,475	16,664	16,855	17,049	17,243	22,382	28,599
c. Other (OP Surgery & Interventional Radiology)	4,156	4,199	4,367	4,411	4,455	4,499	4,544	4,590	4,773	5,060
d. Other (Observation Visits)	1,226	1,300	2,278	2,942	3,082	3,214	3,193	3,174	3,524	3,829
e. TOTAL	59,912	62,453	67,187	68,081	68,454	68,821	69,039	69,260	76,702	86,273

Note 1: ICU and CCU admissions are combined in Intensive care category
Note 2: LOS for ICU only includes time spent in those beds. It does not include the time spent in step down beds as this time is included in the MSGA days.
Note 3: Increase in MSGA LOS is due to movement of short stay inpatient cases to OP Observation

* Number of beds and occupancy percentage should be reported on the basis of licensed beds.

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT

Not Applicable.

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

For purposes of evaluating an application under this subsection, the Commission shall compare the cost-effectiveness of providing the proposed service through the proposed project with the cost-effectiveness of providing the service at alternative existing facilities, or alternative facilities which have submitted a competitive application as part of a comparative review.

Please explain the characteristics of the Project which demonstrate why it is a less costly or a more effective alternative for meeting the needs identified.

For applications proposing to demonstrate superior patient care effectiveness, please describe the characteristics of the Project which will assure the quality of care to be provided. These may include, but are not limited to: meeting accreditation standards, personnel qualifications of caregivers, special relationships with public agencies for patient care services affected by the Project, the development of community-based services or other characteristics that the Commission should take into account.

APPLICANT RESPONSE:

As referenced in the response to the Cost Effectiveness standard, Adventist HealthCare considered multiple options for the future of Washington Adventist Hospital including a re-development on the existing Takoma Park campus. An effort to try and fully achieve the 19 objectives identified by the Adventist Health Care Board of Trustees (Exhibit 19) would be an immense challenge given the characteristics of the campus, the aging infrastructure, the lack of an "empty chair" during construction, and other issues. Fully re-developing the site consistent with what is achieved with the proposed White Oak facility would take 12-15 years of intense construction and demolition, would be disruptive to the residential community and would be cost prohibitive.

Instead, the organization evaluated a reasonable alternative to the White Oak project, not attempting to duplicate exactly what White Oak achieves, but a project that meets some of the 19 objectives identified by the Board.

The "on-campus alternative" to the development of a new hospital in White Oak involves a significant reinvestment in the existing hospital with a multi-phased program of demolition and construction at the campus. The resulting hospital at Takoma Park would have the equivalent number of beds to the existing hospital (252) and the project would take six and one half years to complete beginning with site preparation and demolition.

The on-campus alternative would modernize the existing hospital by demolishing buildings that are approaching the end of their useful life and provide new and renovated facilities that meet modern operational standards such as floor to ceiling heights and ADA requirements.

Program

After a careful review of the existing hospital conditions, Washington Adventist Hospital and its design team arrived at the conclusion that if the facility were to remain at Takoma Park, the entire site inventory would need to be replaced. As a result, Washington Adventist Hospital engaged the design team to produce a total Campus Master Plan, that would form the basis for any future site redevelopment. This Campus Master Plan (Exhibit 55) is a comprehensive blueprint to replace the current hospital with a new, modern, code-compliant hospital on the existing campus, albeit without correcting limitations on the campus that would have to remain.

The reason the Takoma Park site requires complete replacement of its spaces is described in the attached Campus Master Plan (Exhibit 55) in the description of "Critical Planning Issues" on page 2 of the document and is summarized below:

- Available site building area does not support retaining existing low-rise buildings

  Current site restricted areas, including stream buffer setback and legacy community related development restrictions, limits site future development potential. To provide available site building area for medical office and structured parking facilities, future site development will require higher-density building footprints.

- Limited building floor to floor heights

  10'-9" and 11'-0" floor to floor heights do not support high-acuity services, limiting future repositioning for contemporary acute care healthcare services.

- Aging facilities limit asset value of existing facilities

  The 1950s era building is over 60 years old with substantial deferred maintenance and building upgrade issues, providing diminished asset value going forward.

  The 1970s era building is approaching 50 years old with substantial deferred maintenance and building upgrade issues, providing diminished asset value going forward.

Given these constraints, the long-term vision for the hospital to remain at Takoma Park must start with the thesis that the campus must be completely re-developed. As noted previously, the Campus Master Plan, if implemented fully, would be a multi-phase effort over 12 to 15 years. This is the comprehensive planning design for the site to produce a hospital comparable to the proposed hospital at White Oak. This, however, would not be a realistic option. Instead, Washington Adventist Hospital considered an on-campus alternative that uses the comprehensive campus redevelopment master plan as a guide but seeks to achieve a reasonable alternative that while less than what is accomplished in White Oak still accomplishes some objectives and is possible. Therefore, the alternative described here defines an on-campus alternative that implements the first Phases of the Campus Master Plan. (Exhibit 56).

Washington Adventist Hospital selected this stage in the Campus Master Plan because Phase 2 provided sufficient additional program to improve the existing campus while still maintaining a reasonable project cost and schedule.

The Campus Master Plan reveals the new site layout and organization. In general, the existing parking lot directly south of the hospital will be the site in Phase 1 to build new space, upon which

the existing facilities will begin to be replaced. Phase 1 of the Master Plan (a single tower addition) provides some additional capacity, but this step is primarily used to replace programs in the oldest portion of the hospital, the 1950s building, so that it can be replaced in Step 2.

Completion of Phase 1 of this project would provide the following programs/departments:

- A new cardiac care unit
- New maternity unit, including postpartum, labor and delivery and diagnostics
- New laboratory, pharmacy, and respiratory areas.
- New heart center
- New medical same day unit
- New central utility plant
- New lobby

Completion of Phase 2 would provide the following programs/departments:

- New 36-bed medical surgical unit
- New 32 bed medical surgical unit
- New surgical suite
- New gastrointestinal endoscopy suite
- New emergency department
- New admitting and radiology areas
- New cafeteria

Upon the completion of Phase 2 construction, Washington Adventist Hospital will relocate the existing physician offices in the MOB at the north end of the site into the body of the hospital and construct a 600-car parking structure on the location of the existing MOB.

Cost

The total capital budget for the phased Takoma Park hospital renovations is $339.7 million dollars including interest and inflation. Total new construction costs are $155.6 million with the balance of costs allocated to renovations (primarily building demolition) $3.7 million; furniture, equipment and other capital costs $88.3 million; interest of $45.1 million and an inflation allowance to the mid-point of construction $15.4 million.

Washington Adventist Hospital - Option B

Phased Replacement at Takoma Park - Master Plan Phases 1, 2 & Garage

CAPITAL BUDGET

		Hospital	Garage	Total
1.	Capital Costs			
a.	New Construction			
(1)	Building & Fixed Equipment	$118,100,000	$ 20,500,000	$138,600,000
(2)	Fixed Equipment (Not Included in Construction)	2,900,000	-	2,900,000
(3)	Land Purchase	-	-	-
(4)	Site Preparation - Land Improvements	1,000,000	-	1,000,000
(5)	Architect/Engineering Fees	11,000,000	1,400,000	12,400,000
(6)	Permits, (Building, Utilities, Etc.)	600,000	100,000	700,000
	SUBTOTAL	$133,600,000	$ 22,000,000	$155,600,000

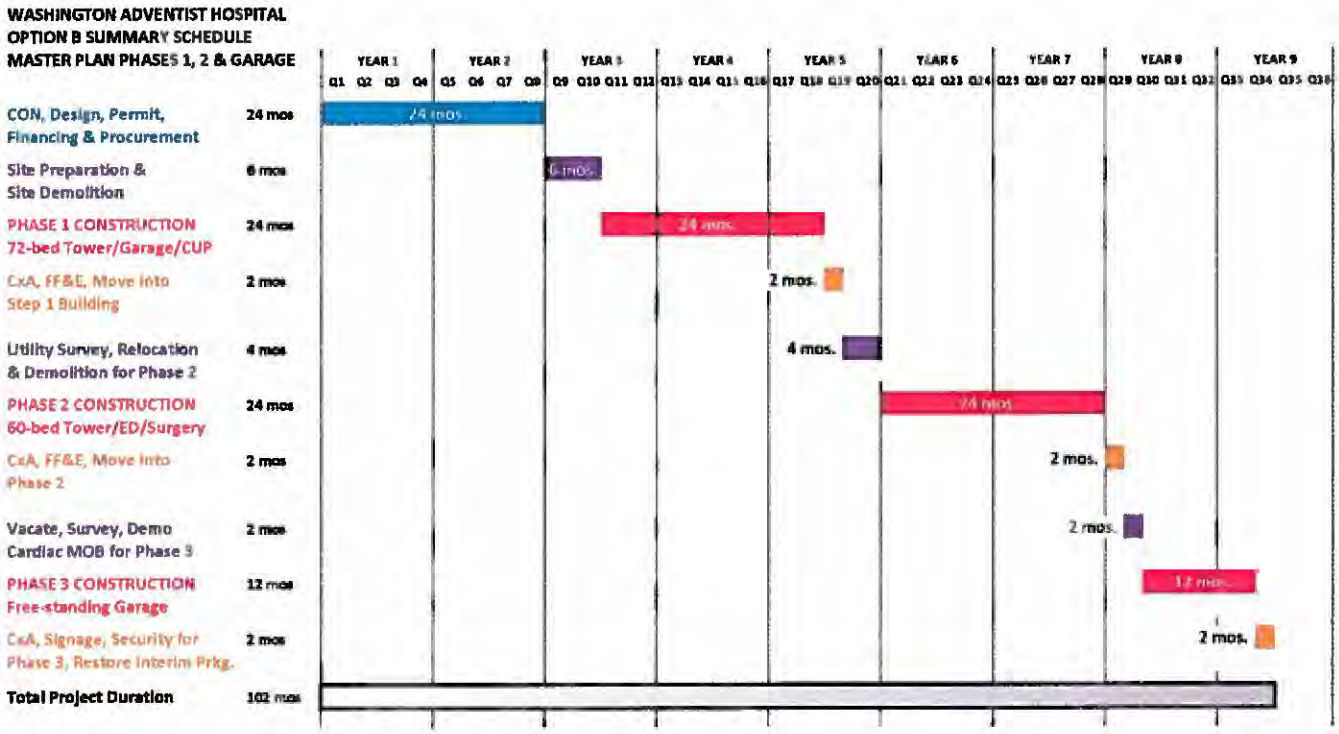
b.	Renovations			
(1)	Building demolition	$ 3,300,000	$ -	3,300,000
(2)	Renovations	-	-	-
(3)	Fixed Equipment (Not Included in Construction)	-	-	-
(4)	Architect/Engineering Fees	400,000	-	400,000
(5)	Permits, (Building, Utilities, Etc.)	-	-	-
	SUBTOTAL	$ 3,700,000	$ -	$ 3,700,000
c.	Other Capital Costs			
(1)	Major Movable Equipment	18,300,000	-	18,300,000
(2)	Minor Movable Equipment	8,800,000	-	8,800,000
(3)	Contingencies	12,000,000	1,200,000	13,200,000
(4)	Other (Specify)		-	-
	a. Furniture	10,900,000	-	10,900,000
	b. Interior & Exterior Signage	1,500,000	200,000	1,700,000
	c. IS/Comm	14,600,000	-	14,600,000
	d. Security system	2,100,000	200,000	2,300,000
	e. Relocation expense	2,900,000	-	2,900,000
	f. Certifications, inspections, etc.	1,200,000	100,000	1,300,000
	g. Takoma Park Capital Facility Upgrades	14,300,000	-	14,300,000
	TOTAL CURRENT CAPITAL COSTS (a - c)	$223,900,000	$ 23,700,000	$247,600,000
d.	Non Current Capital Cost			
(1)	Interest (Gross)	41,059,350	4,346,170	45,405,520
(2)	Inflation Allowance (2.0% per year to midpoint of each construction phase)	13,100,000	2,300,000	15,400,000
	TOTAL PROPOSED CAPITAL COSTS (a-d)	$278,059,350	$ 30,346,170	$308,405,520
2.	Financing Cost and Other Cash Requirements:			
a.	Loan Placement Fees	4,570,327	483,773	5,054,100
b.	Bond Discount			-
c.	Legal Fees (CON Related)	226,070	23,930	250,000
d.	Legal Fees (Other) (zoning)	226,070	23,930	250,000
e.	Printing			-
f.	Consultant Fees	452,140	47,860	500,000
	CON Application Assistance			-
	Other (Specify)			-
g.	Liquidation of Existing Debt			-
h.	Debt Service Reserve Fund	22,851,636	2,418,864	25,270,500
i.	Principal Amortization			-
	Reserve Fund			-
j.	Other (Specify)			-

TOTAL (a - j)	$ 28,326,243	$ 2,998,357	$ 31,324,600
3. Working Capital Startup Costs			
TOTAL USES OF FUNDS (1 - 3)	**$306,385,592**	**$ 33,344,528**	**$339,730,120**

Schedule

To achieve the intent of the on-campus alternative while operating a fully functional hospital, the modernization of the hospital is divided into two separate phases of construction and corresponding phases of demolition. The total construction duration of the multi-phased project is 6.5 years which is similar in duration to the proposed White Oak project.

The first phase of the project is the development of a new bed tower, garage and central plant on an existing parking lot to the south of the existing hospital. Phase 1 of construction will take 24 months. With the completion of the first phase of construction, existing services from the oldest portion of the existing hospital will be moved to the new tower and the vacated portion of the hospital will be demolished to make way for Phase 2 of construction. The transition period will last 6 months including survey, relocation and demolition to prepare for Phase 2.



Phase 2 will immediately follow the demolition of the existing building and will have an expected duration of 24 months. During Phase 2 an additional 60-unit bed tower, Emergency Department and Surgical Unit will be constructed. Upon completion of Phase 2, hospital services will be activated over a period of 4 months including survey, relocation and demolition of the existing cardiac MOB to prepare for construction of the new above-grade parking structure. The final activity of Phase 2 is the construction of a 600-space above-grade parking structure

on the former MOB site. The parking development will have duration of 12 months and a transition period of 2 months.

Considerations

While there are some attractive features to this on-campus alternative, it ultimately falls short of the White Oak proposal in many respects. First and foremost, this alternative does not, address the inherent challenges in accessing a small campus that is surrounded by narrow residential streets with limited public transportation options. Furthermore, Phase 1 does not substantially improve any of the long-term problems on the Takoma Park campus, including, access and circulation on the campus, the age of building stock, and it does not move the hospital to all private rooms.

In addition:

- Surgical services would be split into two different areas due to the location of the current operating rooms. This is functional but not efficient.

- There would be two central plants. The new central plant is needed for the new construction and would be sized to accommodate all future campus growth in the Campus Master Plan. The existing, outdated central plant must remain in place until the existing buildings are replaced.

- Transfer elevators would be required to move people and material from existing building levels because many of the existing buildings would remain. These are not desirable but necessary in this scheme.

- Construction and demolition will be disruptive to patients and staff. It is difficult to overstate the effect of a construction project like this on a site like Takoma Park. Noise, vibration, dust, construction vehicles, and service interruptions would all make this project challenging. It is likely that this project would adversely affect patient and staff satisfaction and inpatient visits and staff retention. It is likely many people would simply avoid the hospital for the period of the construction. The attached exhibit summarizes the risks and impacts inherent in an on-site hospital replacement of this magnitude. (See Exhibit 57).

The attached table further reviews the two options, the on-campus alternative against the proposed project. (See Exhibit 58). In each case, the proposed White Oak hospital is the superior option.

Projected income statements and Adventist Healthcare, Inc. financial ratios for each of the options evaluated can be found at Exhibit 22. While meeting the current bond covenants required for the Adventist HealthCare Obligated Group, Option B, the Washington Adventist Hospital on campus alternative, loses money and would require an ongoing subsidy, placing a tremendous strain on the resources on Adventist HealthCare. (Likewise, Option C, another alternative considered, meets the current bond covenants required for the Obligated Group but loses money, would require an ongoing subsidy and would strain the resources of Adventist HealthCare).

Conclusion

This alternative falls significantly short of meeting a "majority" of the objectives set forth by the Adventist HealthCare Board. Although the project delivers an effective modernization of most patient care spaces, it does not modernize the entire facility and significant portions of older structures remain. (See Exhibit 58). In addition, the project is implemented in the midst of current

operations presenting a series of major disruptions that endure over a significantly prolonged period of time. This in turn, presents a host of unfavorable impacts and challenges to financial viability and to the quality of care delivered during the prolonged construction and renovation periods.

The on-campus alternative is inferior to the proposal to relocate to White Oak. Although this on-campus alternative is considered Washington Adventist Hospital's best alternative to the proposed relocation, the challenge of on-campus modernization along with the disruption to operations and uncertainty of project financing render this option less cost effective than the relocation proposal.

In addition to inferior cost effectiveness, there are the effects on the neighborhood from the disruption caused by the extensive demolition, construction traffic and rebuilding. The on-campus alternative does not solve the problems of inferior access to the campus and the availability of parking. Additionally, the land use approval process in Montgomery County is complex and lengthy, requiring a special exception for this campus with an uncertain outcome. This contrasts with the White Oak campus where land use approvals have already been secured.

Further, the on-campus alternative to the proposed relocation to White Oak is inferior in terms of broader accessibility to the populations that will be served by the relocation plan. The White Oak site is more central to the service area populations, and combined with the services to remain on campus, is far superior in terms of overall accessibility. Finally, the White Oak site is located within the area defined by Montgomery County in its Master Planning Process as the White Oak Science Gateway. The five-member Montgomery County Planning Board unanimously approved a land-use blueprint on September 19, 2013 to send the White Oak Science Gateway Master Plan to the County Council and County Executive Isiah Leggett for review. The relocated Washington Adventist Hospital is an important element in the plan and references the synergy with the FDA and the planned Life Sciences Village, both on adjacent or nearby properties. This area is planned and designated as an important hub for medical and biotech development.

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

For purposes of evaluating an application under this subsection, the Commission shall consider the availability of financial and non-financial resources, including community support, necessary to implement the project within the time frame set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Please include in your response:

a. **Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. The availability of each source of funds listed in Part II, B. Sources of Funds for Project, must be documented.**

b. **Existing facilities shall provide an analysis of the probable impact of the Project on the costs and charges for services at your facility.**

c. **A discussion of the probable impact of the Project on the cost and charges for similar services at other facilities in the area.**

d. All applicants shall provide a detailed list of proposed patient charges for affected services.

APPLICANT RESPONSE:

Audited financial statements for calendar years 2011 and 2012 can be found in Exhibit 59.

Description of Project Sources:

Adventist Healthcare, Inc. intends to pursue traditional tax-exempt bond financing for this project on behalf of Washington Adventist Hospital. The financing for the proposed project in the anticipated aggregate principal amount of $278.0 million will be secured pursuant to the Amended and Restated Master Trust Indenture dated as of February 1, 2003, as supplemented and amended (the "Master Indenture") among Adventist Healthcare Inc., Adventist Rehabilitation Hospital of Maryland, Inc. ("Adventist Rehab") and Hackettstown Regional Medical Center (collectively, the "Obligated Group") and Manufacturers and Traders Trust Company (formerly Allfirst Bank), as master trustee (the "Master Trustee"). The ratios of the Obligated Group including the proposed project, presented in the table below, indicate that the Obligated Group will continue to meet the bond covenants, listed below, as required by the Master Indenture and by certain agreements between one or more members of the Obligated Group and financial institutions providing credit support (the" Bank Agreements"). Based on the proposed structure, Adventist HealthCare, Inc. does not anticipate that any bondholder consents would be required.

Debt service coverage: Not less than 1.25
Days cash on hand: Not less than 70 days
Total Liabilities to Unrestricted Net Assets: Not greater than 2.5

Adventist HealthCare Obligated Group with Option D – Key Financial Indicators (dollars in thousands)

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Operating Income	$ 26,408	$ 12,658	$ 12,552	$ 17,891	$ 22,658	$ 21,339	$ 21,147	$ 21,131	$ 3,074	$ 10,638
Excess of Revenue Over Expenses	$ 22,729	$ 15,527	$ 14,161	$ 22,241	$ 27,315	$ 26,256	$ 26,326	$ 26,605	$ 8,943	$ 16,993
Cash	$ 193,842	$ 200,140	$ 187,309	$ 194,034	$ 225,035	$ 241,231	$ 258,850	$ 278,080	$ 299,102	$ 326,338
Long Term Debt	$ 323,061	$ 308,239	$ 291,255	$ 271,603	$ 510,857	$ 487,750	$ 467,810	$ 449,223	$ 451,047	$ 442,206
Net Assets	$ 352,608	$ 372,968	$ 382,710	$ 404,954	$ 432,944	$ 461,309	$ 504,440	$ 593,290	$ 602,641	$ 619,727
Maximum Annual Debt Service	$ 28,069	$ 32,142	$ 31,678	$ 31,678	$ 43,170	$ 36,894	$ 35,882	$ 35,837	$ 36,597	$ 33,137
Debt Service Coverage	2.69	1.96	1.99	2.31	1.86	2.19	2.28	2.30	2.52	3.06
Days Cash on Hand	**100.36**	**103.84**	**98.90**	**101.61**	**116.51**	**122.65**	**129.16**	**135.87**	**138.04**	**145.01**
Debt to Capitalization	47.8%	45.2%	43.2%	40.1%	54.1%	51.4%	48.1%	43.1%	42.8%	41.6%
Total Liabilities to Unrestricted Net Assets	1.40	1.27	1.20	1.12	1.62	1.48	1.32	1.09	1.08	1.04

Note: These ratios do not assume the impending sale of Hackettstown Regional Medical Center. It is currently anticipated that a signed agreement for such sale may be executed prior to the close of the calendar year. There is no assurance that such an agreement will be executed and if so, when or what the exact terms will be. It is currently anticipated that if this transaction were to close it would likely result in significant improvement to the Obligated Group's days cash on hand.

In addition to the amount financed by tax-exempt debt for the Washington Adventist Hospital project, Adventist Healthcare Inc. will contribute $91.5 million in equity. This is comprised of $11.0 million in land, $20 million in fundraising proceeds, and $60.5 million in cash. Equity contributions will begin in 2017 after the project funds from the tax-exempt financing are depleted.

Adventist Healthcare, has conducted successful campaigns, raising over $30 million system wide over the last 10 years. The projects include the following:

Project	Amount Raised
-"Building Greater Care Together" (Tower Expansion Campaign)	$15.25M (Exceeding target goal of $12M)
-Barbara Truland Butz Healing Garden	$1.5M (Exceeding target goal of $1.25M)
-Jerome & Edna Goldberg Cardiac, Vascular and Interventional Radiology (CVIR) Suite	$5.2M (Initial target goal of $5.0M)
-Aquilino Cancer Center & Life Beyond Cancer Programs	$6.0M (Target goal of $10M) *Currently in Progress

As of October, 2013 the Washington Adventist Hospital Foundation, Next Century Health Capital Campaign in support of the relocation of Washington Adventist Hospital has raised just over $1.9M toward a total goal of $20M. The capital campaign provides the opportunity for donors to make a philanthropic commitment in support of a new state-of-the-art acute care facility for Washington Adventist Hospital. The campaign messaging is focused on inviting donors to participate in ensuring Washington Adventist Hospital's ability to continue our legacy of compassionate excellence in healthcare and our leadership in service of a healthy community today and for the next 100 years. Concurrent with the submission of the CON the hospital foundation will engage a professional fundraising firm to conduct a feasibility study. This study will allow us to gather the most up-to-date information on our donors' and potential donors' propensity to give to the campaign. In turn, this information will be used to assess and inform our goal and to fine-tune our strategy to raise $20M.

Non-Financial Resources:

In addition to the financial resources discussed above, Washington Adventist Hospital has documented support from the medical community (Exhibit 60), state and local government (Exhibit 61), and the community in (Exhibit 62).

Washington Adventist Hospital did not assume a rate increase in the financial projections in this application. However, the Hospital does reserve the right to request future rate increases based on the HSCRC rate setting system methodology and criteria. Due to the capital investment and financing related to the project, capital costs at the Hospital will increase. Project related depreciation, amortization, and interest expenses are identified in TABLE 3.

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

Current average patient charges for the top 10 APR-DRGs, Outpatient procedures, Diagnostic Imaging tests and laboratory tests can be found on the Hospital's website at: http://www.washingtonadventisthospital.com/WAH/patientsvisitors/patients/billing/ as well in Exhibit 63 in both English and Spanish.

(INSTRUCTIONS: Table 3, "Revenue and Expenses - Entire Facility (including the proposed project)" is to be completed by existing facility applicants only. Applicants for new facilities should not complete Table 3. Specify whether data are for calendar year or fiscal year. All projected revenue and expense figures should be presented in current dollars. Medicaid revenues for all years should be calculated on the basis of Medicaid rates and ceilings in effect at the time of submission of this application. Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses.) Table 4, "Revenues and Expenses - Proposed Project," is to be completed by each applicant for the proposed project only, using the same instructions outlined above for Table 3.

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)						
CY or FY (Circle)	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
1. Revenue										
a. Inpatient Services	*$196,858*	*$178,355*	*$162,345*	*$157,340*	*$155,896*	*$153,146*	*$150,322*	*$147,842*	*$156,626*	*$165,322*
b. Outpatient Services	70,377	81,403	95,518	103,698	105,336	106,917	107,225	107,418	117,690	129,652
c. Gross Patient Services Revenues	267,235	259,758	257,863	261,038	261,232	260,063	257,547	255,260	274,316	294,974
d. Allowance for Bad Debt	18,627	26,076	28,365	28,714	28,736	28,607	28,330	28,079	30,175	$ 32,447
e. Contractual Allowance	19,383	24,427	19,876	18,331	16,853	16,778	16,616	16,468	17,697	19,030
f. Charity Care	9,191	4,672	5,802	5,873	5,878	5,851	5,795	5,743	6,172	6,637
g. Net Patient Services Revenue	220,034	204,583	203,821	208,119	209,766	208,827	206,807	204,970	220,272	236,860
h. Other Operating Revenues (Specify)	4,966	5,696	4,922	5,361	4,806	4,117	4,317	4,817	7,245	7,365
i. Net Operating Revenue	$225,000	$210,279	$208,743	$213,480	$214,571	$212,944	$211,124	$209,787	$227,516	$244,225
2. Expenses										
a. Salaries, Wages, and Professional Fees (including fringe benefits)	$103,090	$101,808	$101,488	$ 98,223	$ 97,696	$ 97,408	$ 97,341	$ 97,232	$ 102,562	$ 108,759
b. Contractual Services	24,817	25,895	27,381	26,224	26,007	25,797	25,594	25,395	25,993	26,915
c. Interest on Current Debt	2,732	2,474	2,466	2,198	2,024	1,842	1,706	1,563	1,374	1,194
d. Interest on Project Debt			-	-	-	-	-	-	15,782	16,675
e. Current Depreciation	6,646	6,713	6,047	6,365	6,681	6,999	7,314	7,626	8,124	8,480
f. Project Depreciation			-	-	-	-	-	-	11,477	11,467

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)						
CY or FY (Circle)	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
g. Current Amortization	218	265	242	242	242	242	242	242	242	242
h. Project Amortization	-	-	-	-	-	175	175	175	175	185
i. Supplies	42,586	39,987	36,860	36,423	35,678	35,593	35,613	35,608	38,476	41,881
j. Other Expenses (Specify)	42,424	39,521	42,586	43,308	41,053	39,272	37,495	37,127	38,774	38,416
k. Total Operating Expenses	$222,513	$216,662	$ 217,068	$212,982	$ 209,381	$207,326	$ 205,480	$204,967	$ 242,979	$ 254,214
3. Income										
a. Income from Operation	$2,487	$(6,383)	$ (8,326)	$ 498	$ 5,191	$ 5,618	$ 5,644	$ 4,820	$(15,462)	$ (9,989)
b. Non-Operating Income	(428)	(1,012)	(1,138)	-	-	-	-	-	-	-
c. Subtotal	2,059	(7,396)	(9,464)	498	5,191	5,618	5,644	4,820	(15,462)	(9,989)
d. Income Taxes	-	-	-	-	-	-	-	-	-	-
e. Net Income (Loss)	$ 2,059	$ (7,396)	$ (9,464)	$ 498	$ 5,191	$ 5,618	$ 5,644	$ 4,820	$(15,462)	$ (9,989)
4. Patient Mix: **A. Percent of Total Revenue**										
1. Medicare	41.3%	42.5%	43.3%	44.1%	45.0%	45.8%	46.6%	47.4%	48.3%	49.1%
2. Medicaid	18.7%	19.3%	19.1%	18.8%	18.5%	18.2%	18.0%	17.7%	17.4%	17.1%
3. Blue Cross	13.2%	12.3%	12.1%	11.9%	11.7%	11.6%	11.4%	11.2%	11.0%	10.8%
4. Commercial Insurance	15.1%	14.6%	14.4%	14.2%	14.0%	13.8%	13.6%	13.4%	13.2%	13.0%
5. Self-Pay	10.9%	10.0%	9.9%	9.7%	9.6%	9.4%	9.3%	9.2%	9.0%	8.9%
6. Other (Specify)	0.8%	1.3%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.1%	1.1%
7. TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%
B. Percent of Patient Days\Visits\Procedures (as applicable)										
1. Medicare	38.8%	41.2%	42.3%	43.1%	44.0%	44.8%	45.6%	46.4%	47.3%	48.1%
2. Medicaid	25.4%	25.1%	22.4%	22.1%	21.8%	21.4%	21.1%	20.8%	20.5%	20.2%
3. Blue Cross	7.0%	6.6%	6.6%	6.5%	6.4%	6.3%	6.2%	6.1%	6.0%	5.9%
4. Commercial Insurance	12.8%	11.4%	13.0%	12.8%	12.6%	12.4%	12.2%	12.1%	11.9%	11.7%
5. Self-Pay	15.9%	15.5%	15.4%	15.2%	15.0%	14.8%	14.6%	14.3%	14.1%	13.9%
6. Other (Specify)	0.1%	0.1%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
7. TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Note: Payor mix and patient day percentages take into account the growth in the Medicare population due to the aging population. Assumes an annual increase in Medicare beneficiaries of 3.93% versus 0.52% growth in other beneficiaries.

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

Not Applicable.

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

To meet this subsection, an applicant shall demonstrate compliance with all conditions applied to previous Certificates of Need granted to the applicant.

List all prior Certificates of Need that have been issued to the project applicant by the Commission since 1990, and their status.

APPLICANT RESPONSE:

Adventist HealthCare, Inc. was issued a CON by the Commission to build a rehabilitation hospital on April 14, 1995.

Adventist Health Care, Inc. was issued a CON by the Commission on September 10, 1996 to create the Shady Grove Adventist Hospital Neonatal Intensive Care Unit (NICU).

Adventist HealthCare, Inc. was issued a CON by the Commission on November 12, 1996 to establish a 20-bed hospital-based subacute care unit. This unit operated as Care-Link at Washington Adventist Hospital.

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

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

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

Adventist HealthCare, Inc. has complied with all conditions applicable to all previously issued Certificates of Need.

10.24.01.08G(3)(f). Impact on Existing Providers.

For evaluation under this subsection, an applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers.

Indicate the positive impact on the health care system of the Project, and why the Project does not duplicate existing health care resources. Describe any special

attributes of the project that will demonstrate why the project will have a positive impact on the existing health care system.

APPLICANT RESPONSE:

Washington Adventist Hospital's relocation plans, which include building a new facility in White Oak while retaining the campus in Takoma Park for health care services, will have a positive impact on the health care system. Patients benefit from private rooms, more efficient clinical space, improved access to outpatient services, additional public transportation options and improved parking, among other enhancements. The services that will remain on the Takoma Park campus – the hospital's acute behavioral health services, an FQHC, physician offices, the maternity clinic for low income patients, ancillary services, various outpatient clinics, plus the Adventist Rehabilitation Hospital of Maryland/Takoma Park services – provide continued health care to patients in the immediate area. The hospital's proposal positively impacts the health care delivery system also through alignment with the new realities of health care including downsizing inpatient bed capacity, increasing access to outpatient services, and building the infrastructure for population based care.

There are several main points to highlight with respect to Washington Adventist Hospital's initiative and the impact to other providers.

First, data from the HSCRC and Nielsen Claritas population projections show significant aging of the population will occur in the hospital's proposed White Oak Total Service Area (WOTSA) over a 10 year period from 2012 – 2022. While the 15-44 age cohort will decline in the TSA for that period, the 65-74 age cohort will grow 71.5% (5.5% annually). Seniors use inpatient health care services at a much higher rate and even when accounting for health care reform and an increased emphasis on alternatives to hospital services, inpatient discharges will grow from 69,054 in 2012 to 86,110 in 2022 within the WOTSA.

The second major point regarding this standard is that all individual hospitals that treat patients living in zip codes within the WOTSA will experience some growth in discharges during the 10-year period from 2012 to 2022. No hospital will experience a decline in discharges from the WOTSA, even when accounting for the development of a new hospital facility in White Oak. The impact of Washington Adventist Hospital's new facility is from the growth in cases, not on baseline volume.

Third, the impact to other providers caused by Washington Adventist Hospital's relocation is not substantial and in some cases other hospitals will see an increase in discharges related to Washington Adventist's relocation. As the MSGA discharge table on page 103 of this application shows, Holy Cross Hospital had 12,890 discharges from the proposed WOTSA in 2012. If Washington Adventist Hospital was located in White Oak in CY 2012, the impact to Holy Cross would have been 1,120 cases, a market share impact of less than 2%, and the hospital will have 15,019 discharges in 2022. Likewise, Medstar Montgomery Medical Center had 4,091 discharges from the WOTSA in CY 2012. The impact of Washington Adventist's relocation is 121 cases, a market share impact of less than 1% and discharges will be 5,066 in 2022. Prince George's Hospital Center would see an increase in discharges attributable to the relocation of Washington Adventist Hospital, a market share increase of .38% from the WOTSA.

Market share in individual zip codes with the primary service area will change (see table below), however the overall net effect is that all hospitals treating patients from within the WOTSA will see an increase in discharges from 2012 through 2022, even when accounting for the relocation of Washington Adventist Hospital.

Analysis

Washington Adventist Hospital is currently licensed for 252 beds, of which 191 are MSGA beds. The proposed replacement hospital for Washington Adventist Hospital will have 180 MSGA beds.

Washington Adventist Hospital is currently located on the southern part of their PSA. Relocation to White Oak, located in zip code 20904 (Silver Spring) will allow for a more central location within its existing PSA. We performed an analysis to understand the expected differences in market share by zip code as a result of the proposed relocation to White Oak recognizing that even a short move of approximately six miles will have an impact on the current TSA. Based on market dynamics that considers location of the new hospital, proximity to other hospitals, drive times, major streets and highways, current market share of other providers, and physician relationships, we considered the following adjustments to the Washington Adventist Hospital MSGA TSA:

Washington Adventist Hospital MSGA TSA Market Share Analysis of Proposed Location

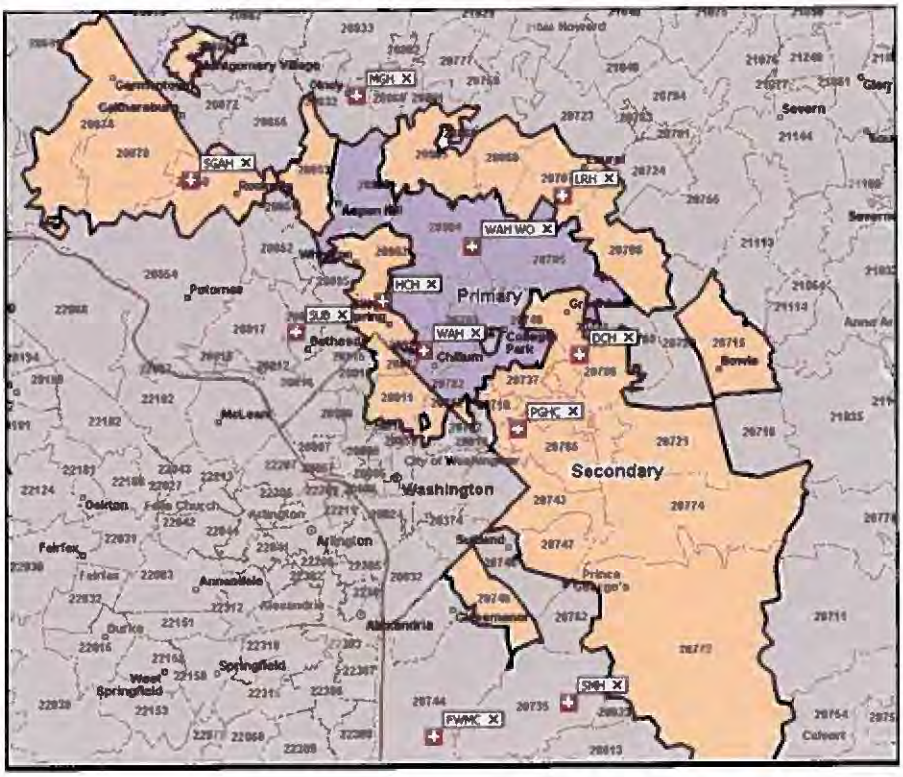
Zip Code	City	Current Market Share at Takoma Park	Estimated Market Share Adjustment	Estimated Market Share in Proposed Location
20783	Hyattsville	62.0%	-15.0%	47.0%
20912	Takoma Park	62.7%	-15.0%	47.7%
20782	Hyattsville	59.6%	-15.0%	44.6%
20903	Silver Spring	41.7%	0.0%	41.7%
20904	Silver Spring	11.3%	45.0%	56.3%
20901	Silver Spring	21.8%	5.0%	26.8%
20910	Silver Spring	17.8%	-15.0%	2.8%
20740	College Park	29.1%	-1.0%	28.1%
20011	Washington	33.4%	-15.0%	18.4%
20737	Riverdale	19.8%	-15.0%	4.8%
20705	Beltsville	16.1%	10.0%	26.1%
20712	Mount Rainier	54.6%	-20.0%	34.6%
20906	Silver Spring	3.2%	5.0%	8.2%
20781	Hyattsville	28.5%	-15.0%	13.5%
20706	Lanham	5.9%	-1.0%	4.9%
20770	Greenbelt	10.7%	5.0%	15.7%
20902	Silver Spring	5.3%	0.0%	5.3%
20785	Hyattsville	5.3%	-1.0%	4.3%
20784	Hyattsville	7.4%	-1.0%	6.4%
20012	Washington	34.9%	-15.0%	19.9%
20707	Laurel	5.2%	10.0%	15.2%
20774	Upper Marlboro	4.2%	-1.0%	3.2%
20722	Brentwood	26.8%	-20.0%	6.8%
20743	Capitol Heights	2.9%	-1.0%	1.9%
20708	Laurel	5.4%	1.0%	6.4%
20002	Washington	16.6%	-15.0%	1.6%
20710	Bladensburg	11.5%	-1.0%	10.5%
20905	Silver Spring	6.3%	15.0%	21.3%
20017	Washington	32.3%	-15.0%	17.3%
20019	Washington	6.6%	-5.0%	1.6%
20020	Washington	9.7%	-8.0%	1.7%
20748	Temple Hills	2.7%	0.0%	2.7%
20772	Upper Marlboro	2.5%	0.0%	2.5%
20747	District Heights	2.4%	0.0%	2.4%

Zip Code	City	Current Market Share at Takoma Park	Estimated Market Share Adjustment	Estimated Market Share in Proposed Location
20715	Bowie	2.8%	0.0%	2.8%
20850	Rockville	1.7%	0.0%	1.7%
20866	Burtonsville	7.2%	15.0%	22.2%
20853	Rockville	2.6%	0.0%	2.6%
20874	Germantown	1.6%	0.0%	1.6%
20878	Gaithersburg	1.7%	0.0%	1.7%
20018	Washington	16.9%	-15.0%	1.9%
20721	Bowie	3.0%	0.0%	3.0%
20001	Washington	17.6%	-15.0%	2.6%
20886	Montgomery Village	2.0%	0.0%	2.0%
20735	Clinton	1.1%	0.0%	1.1%

As demonstrated above, we first considered individual adjustments to each zip code. We then calculated total discharges at Washington Adventist Hospital/White Oak, considering the estimated market share by zip code. Finally, we redefined the primary and secondary service area for Washington Adventist Hospital/White Oak based on the estimate total discharges. We determined that moving to the location will tighten the current service area as four zip codes will shift from the primary service area to the secondary service area and six will drop out of the total service area.

Considering the same market dynamics identified above, we estimated, by zip code, the market share reduction or increase other providers in Montgomery & Prince George's counties would experience from the relocation of Washington Adventist Hospital to White Oak. The results of our analysis are summarized below.

Washington Adventist Hospital - White Oak MSGA Primary and Secondary Service Area (based on move to White Oak)



Based on the estimates for the bed need analysis a total of 86,110 discharges in CY 2022 was estimated for the Washington Adventist Hospital/White Oak TSA, which indicates absolute growth of approximately 24.7% over the 10 year period, or an increase of 17,056 incremental discharges. The table below represents the estimated discharges by age cohort for the Washington Adventist Hospital/White Oak TSA in CY2022 based on the analysis detailed in the response to bed need.

Admission Estimates by Age Cohort Originating in Washington Adventist Hospital – White Oak's TSA

Ages	2012	2022	Total Growth	Annual Growth
15 - 44	13,702	13,224	-3.5%	-0.4%
45 - 64	23,336	25,826	10.7%	1.0%
65 - 74	12,287	21,073	71.5%	5.5%
75+	19,729	25,987	31.7%	2.8%
Total	**69,054**	**86,110**	**24.7%**	**2.2%**

Source: HSCRC data base and Nielson Claritas population projections

Changes in market share by zip code and the fact that the TSA changes with a move of approximately six miles will result in some redistribution of cases among hospitals serving the TSA.

The analysis shows that between now and CY2022 there is more than enough MSGA growth to offset any lost volume. The estimate of the impact is based upon the volumes that area hospitals would gain or lose to Washington Adventist Hospital if the replacement hospital were to open in White Oak today. The analysis shows that if the replacement hospital were open today, Washington Adventist Hospital White Oak would gain MSGA cases from other area hospitals such as Holy Cross Hospital, Medstar Montgomery Medical Center, Suburban Hospital and Laurel Regional Hospital. Other area providers such as Prince George's Hospital and Doctors Community Hospital would also gain cases from the move.

Based upon the analysis, if Washington Adventist Hospital were to open a replacement hospital in White Oak today, there would be a total 1,002 cases within the redefined Washington Adventist Hospital/White Oak TSA that would move to the hospital with the majority of those cases coming from Holy Cross Hospital. See table below.

Providers	CY2012 (1)		Location Adjustment (2)		Adjusted CY2012 (3)		Incremental Growth (4)		CY2022 Discharges (5)	
	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share
Holy Cross	12,890	18.67%	(1,120)	-1.62%	11,770	17.04%	3,249	19.05%	15,019	17.44%
Montgomery General	4,091	5.92%	(121)	-0.18%	3,970	5.75%	1,096	6.43%	5,066	5.88%
Shady Grove Adventist	7,547	10.93%	0	0.00%	7,547	10.93%	2,083	12.22%	9,630	11.18%
Suburban Hospital Center	3,771	5.46%	(5)	-0.01%	3,766	5.45%	1,040	6.10%	4,806	5.58%
Laurel Regional Hospital	2,498	3.62%	(102)	-0.15%	2,397	3.47%	662	3.88%	3,058	3.55%
Prince Georges Hospital Ctr	5,238	7.59%	259	0.38%	5,497	7.96%	1,518	8.90%	7,015	8.15%
Southern Maryland	6,417	9.29%	0	0.00%	6,417	9.29%	1,771	10.39%	8,188	9.51%
Fort Washington Hospital	398	0.58%	0	0.00%	398	0.58%	110	0.64%	508	0.59%
Doctors Community Hospital	8,736	12.65%	244	0.35%	8,980	13.00%	2,479	14.53%	11,459	13.31%
Other Providers	9,520	13.79%	(157)	-0.23%	9,363	13.56%	2,585	15.15%	11,948	13.88%
Washington Adventist	**7,948**	**11.51%**	**1,002**	**1.45%**	**8,950**	**12.96%**	**464**	**2.72%**	**9,414**	**10.93%**
Total	69,054	100.00%	-	0.00%	69,054	100.00%	17,056	100.00%	86,110	100.00%

Notes:
(1) Actual CY2012 discharges and market share within the WAH - White Oak TSA
(2) Adjustment to market share assuming a relocation to White Oak
(3) Adjusted CY2012 market share, applied to the incremental growth calculated in the bed need section of the CON.
(4) Incremental growth by provider indicates slight increases over Adjusted CY2012 market share for all providers due to actual projected discharges for WAH.
(5) CY2022 discharges = adjusted CY2012 discharges + calculated incremental growth.

The location adjustment represents what would happen today if Washington Adventist Hospital would relocate to White Oak. The incremental growth takes into account the estimated additional cases that will come from population growth over the next 10 years. This growth will more than offset any lost cases resulting from the move. For example, in CY2012, Holy Cross Hospital market share is estimated to decrease approximately 1.23% although it will observe an increase of approximately 2,129 more MSGA cases due to volume growth. Washington Adventist Hospital is estimated to lose market share of approximately 0.58% as a result of losing approximately 19.8% MSGA discharges from CY2012 to CY2018 until the new hospital opens. When the new hospital would open in late CY2018, Washington Adventist Hospital will expect to maintain its market share going forward. The table above shows that every hospital will experience increased MSGA cases with only slight changes in overall market share from where they are today.

In addition, an analysis of the current payor mix in the Takoma Park TSA and the newly defined White Oak TSA indicates that the overall payor mix is not significantly different between the two service areas.

Payor Summary for Both Service Areas

	Takoma Park TSA			
	WAH Discharges	% of Total	All Discharges	% of Total
Commercial	1,818	21.9%	22,270	30.4%
Medicaid	1,148	13.8%	9,044	12.3%
Medicare	4,164	50.1%	34,790	47.5%
Self-Pay	1,140	13.7%	5,654	7.7%
Other	36	0.4%	1,279	1.7%
Total	8,306	100.0%	73,313	100.0%

	White Oak TSA			
	WAH Discharges	% of Total	All Discharges	% of Total
Commercial	1,758	22.1%	21,506	30.5%
Medicaid	1,102	13.9%	8,409	11.9%
Medicare	3,936	49.5%	33,638	47.6%
Self-Pay	1,124	14.1%	5,525	7.8%
Other	36	0.5%	1,259	1.8%
Total	7,956	100.0%	70,613	100.0%

Impact to Other Area Hospitals – Obstetrics

Washington Adventist Hospital is currently licensed for 252 beds, of which 21 are licensed for obstetric ("OB") services. The proposed replacement hospital for Washington Adventist Hospital will include 21 OB beds, indicating no addition of OB beds.

An analysis was performed to understand the expected differences in market share by zip code as a result of the proposed relocation to White Oak. Based on market dynamics that considers location of the new hospital, proximity to other hospitals, drive times, major streets and highways, current market share of other providers, and physician relationships, the following adjustments to the Washington Adventist Hospital OB TSA were considered:

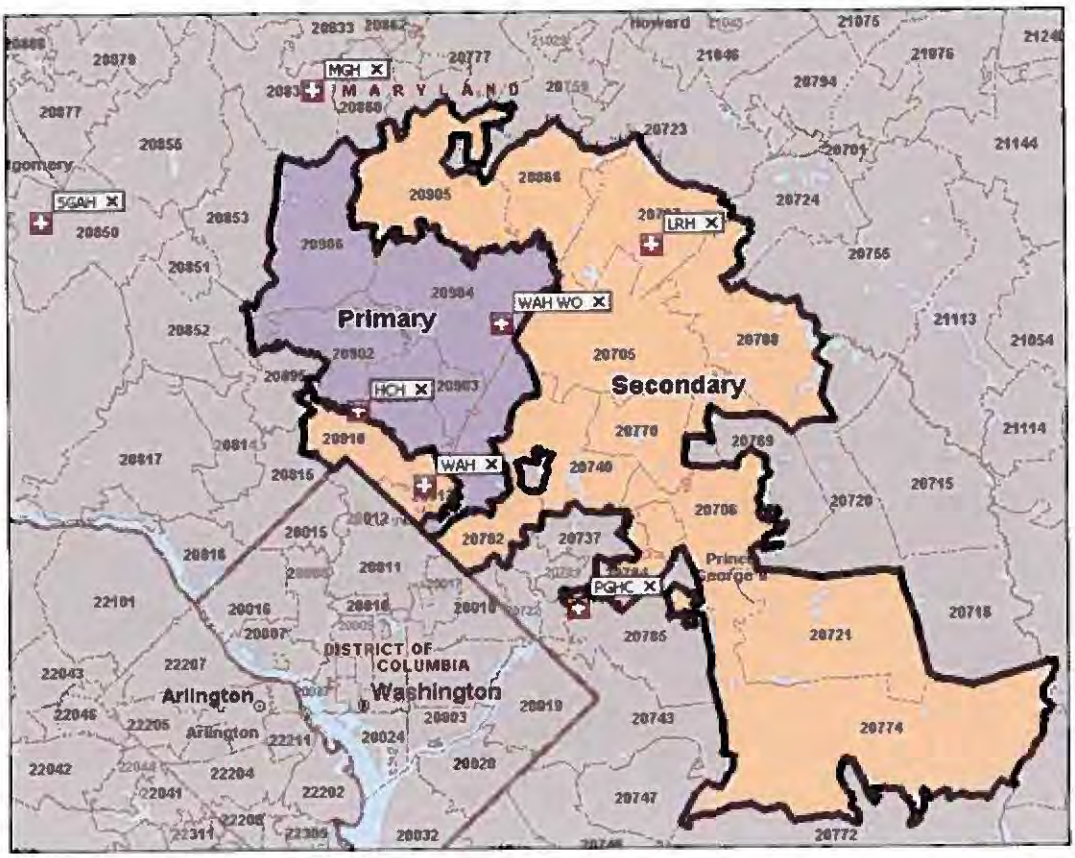
Zip Code	City	Current Market Share at Takoma Park	Adjustment	Estimated Market Share in Proposed Location
20783	Hyattsville	36.6%	0.0%	36.6%
20903	Silver Spring	36.5%	0.0%	36.5%
20912	Takoma Park	37.9%	-15.0%	22.9%
20906	Silver Spring	14.4%	5.0%	19.4%
20902	Silver Spring	14.0%	5.0%	19.0%
20901	Silver Spring	19.5%	5.0%	24.5%
20904	Silver Spring	11.9%	20.0%	31.9%
20782	Hyattsville	23.3%	-15.0%	8.3%
20910	Silver Spring	12.4%	-8.0%	4.4%
20706	Lanham	10.5%	0.0%	10.5%
20705	Beltsville	13.1%	5.0%	18.1%
20737	Riverdale	13.0%	-10.0%	3.0%
20784	Hyattsville	8.8%	-6.0%	2.8%
20770	Greenbelt	10.5%	0.0%	10.5%
20740	College Park	11.8%	0.0%	11.8%
20785	Hyattsville	5.2%	-3.0%	2.2%
20781	Hyattsville	12.3%	-10.0%	2.3%
20866	Burtonsville	10.5%	5.0%	15.5%
20708	Laurel	3.8%	2.0%	5.8%
20721	Bowie	5.5%	0.0%	5.5%
20774	Upper Marlboro	3.2%	0.0%	3.2%
20707	Laurel	2.4%	5.0%	7.4%
20905	Silver Spring	5.6%	5.0%	10.6%

As demonstrated above, individual adjustments to each Zip code were first considered. Discharges were then calculated, considering the estimated market share by Zip code in White Oak to determine total discharges at Washington Adventist Hospital/White Oak.

Finally, primary and secondary service area was redefined for Washington Adventist Hospital/White Oak.

Considering the same market dynamics identified above, we estimated, by zip code, the market share reduction or increase other providers in Montgomery & Prince George's County would experience from the relocation of Washington Adventist Hospital to White Oak today. The results of our analysis are summarized below.

CY2012 OB Washington Adventist Hospital TSA



Population estimates, sourced from Nielsen Claritas, for the Female – Childbearing population and newborns within the Washington Adventist Hospital TSA were estimated with the finding that although the Female – Childbearing population is estimated to decline approximately 0.3% annually, newborns are expected to increase 0.4% annually.

OB Discharge Estimates within the WAH - White Oak TSA

Growth Estimate Based On:	2012 Discharges	2022 Estimated Discharges	Total Change	Annual Change
Female - Childbearing	9,278	8,959	-3.4%	-0.3%
Newborn Estimates	9,278	9,720	4.8%	0.4%

Source: HSCRC data base and Nielson Claritas population projections

Growth rates are indicated by newborn projections, which measure future OB volume more appropriately.

Again, changes in market share by zip code and the fact that the TSA changes with a move of approximately six miles will result in some redistribution of cases among hospitals serving the TSA. The analysis shows that between now and CY2022 there is OB growth that will offset most, if not all, lost volume. The estimate of the impact is based on the volumes that area hospitals would gain or lose to Washington Adventist Hospital if the replacement hospital were to open today. The

analysis shows that if the new replacement hospital were open today, Washington Adventist Hospital White Oak would gain OB cases from other area hospitals such as Holy Cross, Medstar Montgomery Medical Center, Shady Grove Adventist Hospital and Laurel Regional Hospital. Prince George's Hospital would gain cases from the move.

Based on the analysis if Washington Adventist Hospital was to open its new replacement hospital in White Oak today there would be a total 163 OB cases that would move to Washington Adventist Hospital. See table below.

Providers	CY2012 (1)		Location Adjustment (2)		Adjusted CY2012 (3)		Incremental Growth (4)		CY2022 Discharges (5)	
	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share
Holy Cross	4,816	51.91%	(151)	-1.63%	4,665	50.28%	203	46.03%	4,868	50.09%
Montgomery General	318	3.43%	(26)	-0.28%	292	3.15%	13	2.88%	305	3.14%
Shady Grove Adventist	497	5.36%	(31)	-0.34%	466	5.02%	20	4.60%	486	5.00%
Suburban Hospital Center	5	0.05%	0	0.00%	5	0.05%	0	0.05%	5	0.05%
Laurel Regional Hospital	581	6.26%	(4)	-0.04%	577	6.22%	25	5.69%	602	6.20%
Prince Georges Hospital Ctr	759	8.18%	51	0.55%	810	8.73%	35	7.99%	845	8.70%
Southern Maryland	62	0.67%	0	0.00%	62	0.67%	3	0.61%	65	0.67%
Doctors Community Hospital	17	0.18%	0	0.00%	17	0.18%	1	0.17%	18	0.18%
Other Providers	789	8.50%	(2)	-0.02%	787	8.49%	34	7.77%	822	8.45%
Washington Adventist	1,434	**15.46%**	**163**	**1.76%**	**1,597**	**17.21%**	**107**	**24.20%**	**1,704**	**17.53%**
Total	9,278	100.00%	-	0.00%	9,278	100.00%	442	100.00%	9,720	100.00%

Notes:
(1) Actual CY2012 discharges and market share within the WAH - White Oak TSA
(2) Adjustment to market share assuming a relocation to White Oak
(3) Adjusted CY2012 market share, applied to the incremental growth calculated in the bed need section of the CON.
(4) Incremental growth by provider indicates slight increases over Adjusted CY2012 market share for all providers due to actual projected discharges for WAH.
(5) CY2022 discharges = adjusted CY2012 discharges + calculated incremental growth.

The location adjustment represents what would happen today if Washington Adventist Hospital would relocate to White Oak and the incremental growth takes into account the estimated additional cases that will come from population growth over the next 10 years. Volume growth in total will offset the total lost cases resulting from the move. For example, in CY2012, it is estimated that Holy Cross market share will decrease approximately 1.82% although it will observe an increase of approximately 52 OB cases due to volume growth. It should be noted that Holy Cross is scheduled to open a new hospital in Germantown in 2014. This new hospital is in a growing area and further offsets any impact to its Silver Spring campus.

In the case of Medstar Montgomery General Hospital, by CY2022 estimates indicate a loss of approximately 13 OB cases in the Washington Adventist Hospital/White Oak TSA compared to CY2012 levels with a market share decrease of approximately 0.29%. While a loss of cases is identified within the Washington Adventist Hospital/White Oak service area, only 42.1% of total discharges going to Medstar Montgomery Medical Center originate in the Washington Adventist Hospital/White Oak TSA. Therefore, it is expected that Medstar Montgomery Medical Center will gain more than 13 OB cases from zip codes within its service area that are not included in the Washington Adventist Hospital/White Oak TSA. Washington Adventist Hospital is estimated to increase its market share by approximately 2.07%. The table above shows that every hospital will experience limited effects on its OB cases with only slight changes in overall market share from where they are today.

In addition, an analysis of the current payor mix in the Takoma Park TSA and the newly defined White Oak TSA which indicates the overall payor mix is not significantly different between the two service areas.

Payor Mix Summary

	Takoma Park TSA			
	WAH Discharges	% of Total	All Discharges	% of Total
Commercial	238	15.8%	4,048	41.7%
Medicaid	1,209	80.2%	5,305	54.7%
Medicare	6	0.4%	39	0.4%
Self-Pay	54	3.6%	251	2.6%
Other	-	0.0%	56	0.6%
Total	1,507	100.0%	9,699	100.0%

	White Oak TSA			
	WAH Discharges	% of Total	All Discharges	% of Total
Commercial	229	16.0%	4,131	44.5%
Medicaid	1,150	80.2%	4,811	51.9%
Medicare	3	0.2%	29	0.3%
Self-Pay	52	3.6%	250	2.7%
Other	-	0.0%	57	0.6%
Total	1,434	100.0%	9,278	100.0%

Washington Adventist Hospital has attempted to quantify the gross revenue impacts to surrounding hospitals. In this analysis, the Hospital attempts to quantify the net change in gross MSGA and OB revenues (at 2013 charge levels) by 2022 due to the relocation of Washington Adventist Hospital and projected population growth. A detailed step by step analysis can be found in Exhibit 64. In summary, the analysis shows that while there is an impact to other hospitals due to market share shifts, there is no unwarranted impact and further the impact is more than fully offset by the projected population growth in the White Oak TSA market.

Recruitment and Retention

1. an assessment of the sources available for recruiting additional personnel;

APPLICANT RESPONSE:

To recruit additional personnel, the Human Resources Department utilizes the expertise of a recruitment media and advertising agency to guide a national recruitment strategy. The department advertises employment opportunities through a wide variety of electronic and print resources including digital media, job postings, banners, email blasts, search engines and job aggregators to target a widespread audience. Candidates for all areas -- nursing, allied health and non-clinical care positions -- are recruited through various web sites such as WashingtonPost.com, AdvanceWeb.com. DCJobs.com, Indeed.com, LinkUp.com, Nurse.com and ZipRecruiter.com. In addition, DCJobs.com automatically delivers hospital job postings to the appropriate state workforce agencies through cross-posting or email.

Washington Adventist Hospital is an Equal Employment Opportunity employer.

2. **recruitment and retention plans for those personnel believed to be in short supply;**

APPLICANT RESPONSE:

Washington Adventist Hospital has developed a number of initiatives under its "People Strategy to Maintain Competitive Advantage" toward recruitment and retention of those personnel believed to be in short supply. From the very start, the hospital applies an enhanced recruiting and onboarding strategy toward its candidate selection screening process.

Learning opportunities and career ladders available to help employees maintain and enhance their skill level include:

- Enhanced courses through a learning management system that delivers convenient e-learning education courses
- Emphasized training, certifications and performance enhancement strategies
- Development of career ladders
- Identification of key talent for succession planning

The hospital has implemented an enhanced leadership development strategy to:

- Train managers on providing meaningful performance feedback and coaching to direct reports
- Increase leadership presence throughout the hospital
- Incorporate regular employee engagement surveys and follow-up action plans in response to feedback

The hospital also continuously monitors regional career changes in the health care arena to ensure that its employees continue to receive a competitive employment compensation package. These efforts include:

- Developing a "total rewards" approach that encompasses pay, benefits, learning and development, in addition to a wide variety of employee health and wellness programs.
- Tracking competitor sign-on and retention bonuses to adopt if needed
- Continuously examining market pay and behavior to quickly respond with market adjustments and other retention initiatives

3. **for existing facilities, a report on average vacancy rate and turnover rates for affected positions,**

APPLICANT RESPONSE:

The Vacancy rate for Washington Adventist Hospital presently is 6%. The overall turnover rate at Washington Adventist Hospital is 20.6%

Complete Table 5

(INSTRUCTION: FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours.

TABLE 5. MANPOWER INFORMATION

(INSTRUCTION: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project.)

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration	54.6	0.0	$116,838	Employee	$ -
Direct Care Staff	864.3	54.0	$71,179	Employee	$3,843,665
Support Staff	234.3	-15.0	$40,693	Employee	$(610,402)
				Benefits	$ 678,985
Total staffing changes required by this project			39.0	TOTAL	$3,912,248

***(INSTRUCTION: Indicate method of calculating benefits percentage)*:_**
Benefits are calculated using a historical 21% of salary expenses

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

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

APPLICANT RESPONSE:

William G. "Bill" Robertson
President & Chief Executive Officer
Adventist Healthcare, Inc.
820 W. Diamond Avenue, 6th Floor
Gaithersburg, MD 20878

2. **Are the applicant, owners, or the responsible persons listed above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.**

APPLICANT RESPONSE:

Yes, current involvement comprises:

Shady Grove Adventist Hospital
9901 Medical Center Drive
Rockville, MD 20850
Years: 2000-Present

Shady Grove Adventist Emergency Center at Germantown
19731 Germantown Road
Germantown, MD 20874
Years: 2000-Present

Adventist Behavioral Health
14901 Broschart Road
Rockville, MD 20850
Years: 2000-Present

Adventist Rehabilitation Hospital of Maryland
9909 Medical Center Drive
Rockville, MD 20850
Years: 2001-Present

Washington Adventist Hospital
7600 Carroll Avenue
Takoma Park, MD 20912
Years: 2000-Present

Hackettstown Regional Medical Center
651 Willow Grove Street
Hackettstown, NJ 07840
Years: 2000-Present

Reginald S. Lourie Center for Infants and Young Children
12301 Academy Way
Rockville, MD 20852
Years: 2006-Present

Capital Choice Pathology
12041 Bournefield Drive
Silver Spring, MD 20904
Years: 2000-Present

Previous involvement:

Adventist Senior Living Services, Inc.
Rockville, MD 20850
Years: 2000- 2010

Bradford Oaks Nursing and Rehabilitation Center
Clinton, MD
Years: 2000-2010

Glade Valley Nursing and Rehabilitation Center
Walkersville, MD
Years: 2000-2010

Sligo Creek Nursing and Rehabilitation Center
Takoma Park, MD
Years: 2000-2010

Shady Grove Nursing and Rehabilitation Center
Rockville, MD
Years: 2000-2010

Fairland Nursing and Rehabilitation Center
Silver Spring, MD
Years: 2000-2010

Kingshire Manor Assisted Living
Rockville, MD
Years: 2000-2010

Springbrook Nursing and Rehabilitation Center
Silver Spring, MD
Years: 2000-2010

Shawnee Mission Medical Center
Shawnee Mission, KS
Years: 1996-2000

St. Luke's Shawnee Mission Health System
Shawnee Mission, KS
Years: 1997-2000

Adventist Health Systems
Southwest Cluster
Years: 1988-1996

Rollins Brook Community Hospital
Lampasas, TX
Years: 1992-1996

Willow Creek Psychiatric Hospital
Arlington, TX
Years: 1992-1996

St. Luke's South
Overland Park, KS
Years: 1999-2000

Huguley Health System
Fort Worth, TX
Years: 1988-1996

Metroplex Hospital
Killeen, TX
Years: 1988-1996

Central Texas Medical Center
San Marcos, TX
Years: 1988-1996

East Pasco Medical Center
Zephyrhills, FL
Years: 1986-1988

3. **Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to number 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owners or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.**

APPLICANT RESPONSE:

No

4. **Are any facilities with which the applicant is involved, or have any facilities with which the applicant has in the past been involved (listed in response to Question 2, above) ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to actions to suspend the licensure or certification at the applicant's facility or facilities listed in response to Question 2? If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable governmental authority.**

APPLICANT RESPONSE:

No

5. **Have the applicant, owners or responsible individuals listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).**

APPLICANT RESPONSE:

No

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

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

10-3-2013
Date

Signature of Owner or Board-designated Official

AFFIRMATION

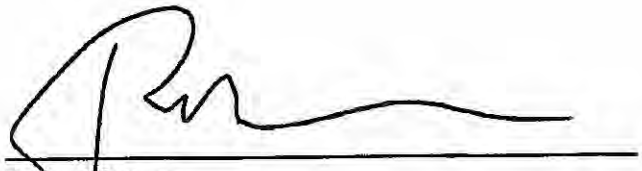
I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Linda Berman
Grants Manager
Adventist Healthcare

10/1/13
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.



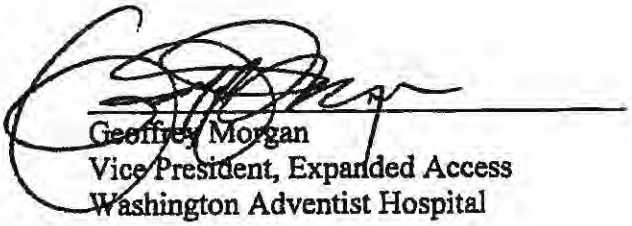
10/1/13

Robert Jepson
Vice President of Business Development
Adventist Healthcare

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.

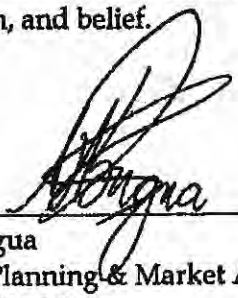


Geoffrey Morgan
Vice President, Expanded Access
Washington Adventist Hospital

10/2/13
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.



10/2/2013

Peter Mbugua
Manager, Planning & Market Analysis
Adventist Healthcare

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.

10/2/13

Kristen Pulio
Associate Vice President Reimbursement
Adventist Healthcare

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.

Maureen Dymond
Vice President, Financial Operations
Adventist HealthCare

10/2/13
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.

Joyce Newmyer
President
Washington Adventist Hospital

October 2, 2013
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.

Pippa Laundy

Pippa Laundy
Deloitte Financial Advisory Services LLP

10/2/2013

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.

R. Lee Piekarz
Deloitte Financial Advisory Services

10/2/13
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.

Scott Martin, Heery

OCT. 3, 2013
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.

Ray Brower, RTKL

10/2/2013
Date

AFFIRMATION

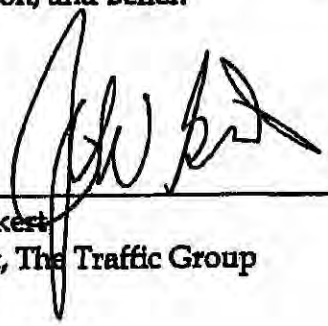
I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Gregg Stackel, RTKL

10/2/2013
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.



Wes Guckert
President, The Traffic Group

10/3/2013
Date

five CBD zones in section 59-C-6.2, the requirement for each moderately priced dwelling unit, as defined in chapter 25A of this Code, shall be one half the number of spaces indicated above.

Dwelling, one-family. Two parking spaces for each dwelling unit; except, that when the slope between the standard street sidewalk elevation at the front lot line and side lot line adjacent to a street, established in accordance with the county Road Construction Code, and the finally graded lot elevation at the nearest building line exceeds, at every point along the front lot line, a grade of three inches per foot, such space shall not be required. The second space required need not be constructed at the time of initial construction of the dwelling other than grading.

Dwelling, semi-detached or two-family. Same as one-family dwelling.

Educational institution, private. One parking space for each employee, including teachers and administrators, plus sufficient off-street parking space for the safe and convenient loading and unloading of students, plus additional facilities for all student parking.

Eleemosynary and philanthropic institution. One parking space for each employee, plus one parking space for each four hundred square feet of total floor area for residents and visitors.

Fourplex. A lot or parcel used for the development of dwellings in this zone shall provide at least one off-street parking space per dwelling unit.

Fraternity, sorority and dormitory. One parking space for each two students residing on the premises in a fraternity, three students in a sorority and four students in a dormitory, plus one additional space for each housemother or manager and each employee.

Furniture store. One parking space for each five hundred square feet of total floor area plus one space for each employee.

Heliport. If at ground level, adequate space for off-street parking of at least fifteen vehicles. If elevated, reasonable parking space shall be provided or be available for use, either at ground level or on or in an elevated structure, as the discretion of the board of appeals may require for the convenience of persons using or working at the facility.

Helistop, permitted use. If at ground level, adequate space for off-street parking of at least five vehicles for commercial helistops and two vehicles for noncommercial helistops. If elevated,

reasonable parking space shall be provided or be available for use, either at ground level or on or in an elevated structure for the convenience of persons using the facility.

Helistop, special exception. If at ground level, adequate space for off-street parking of at least five vehicles for commercial helistops and two vehicles for noncommercial helistops. If elevated, reasonable parking space shall be provided or be available for use, either at ground level or on or in an elevated structure, as the discretion of the board of appeals may require for the convenience of persons using the facility.

Hospital. One parking space for each one thousand square feet of total floor area, plus one space for each resident doctor, plus adequate reserved space for visiting staff doctors, plus one space for each three employees on the major shift.

Hotel, motel or inn. One space for each two guest rooms, plus one parking space for each two employees on the major shift; plus one parking space for each four hundred square feet of area used for ball rooms, private meeting rooms, dining rooms and similar places of assembly.

Hotel, resort, rural. One parking space for each guest room, sleeping room or suite, one parking space for each five employees, plus one parking space for each four hundred square feet of area used for ballrooms, private meeting rooms, private dining rooms and other similar places of assembly.

Housing for the elderly or handicapped. One parking space for each four residential units of housing for the elderly or handicapped as defined in section 59-A-2.1.

Industrial or manufacturing establishment or warehouse. One parking space for each one and one-half employees on the major shift, plus one space for every vehicle used in connection with the business, and sufficient additional parking to provide waiting area for loading and unloading. (Follow subsection 59-C-5.434 for I-3 requirements.)

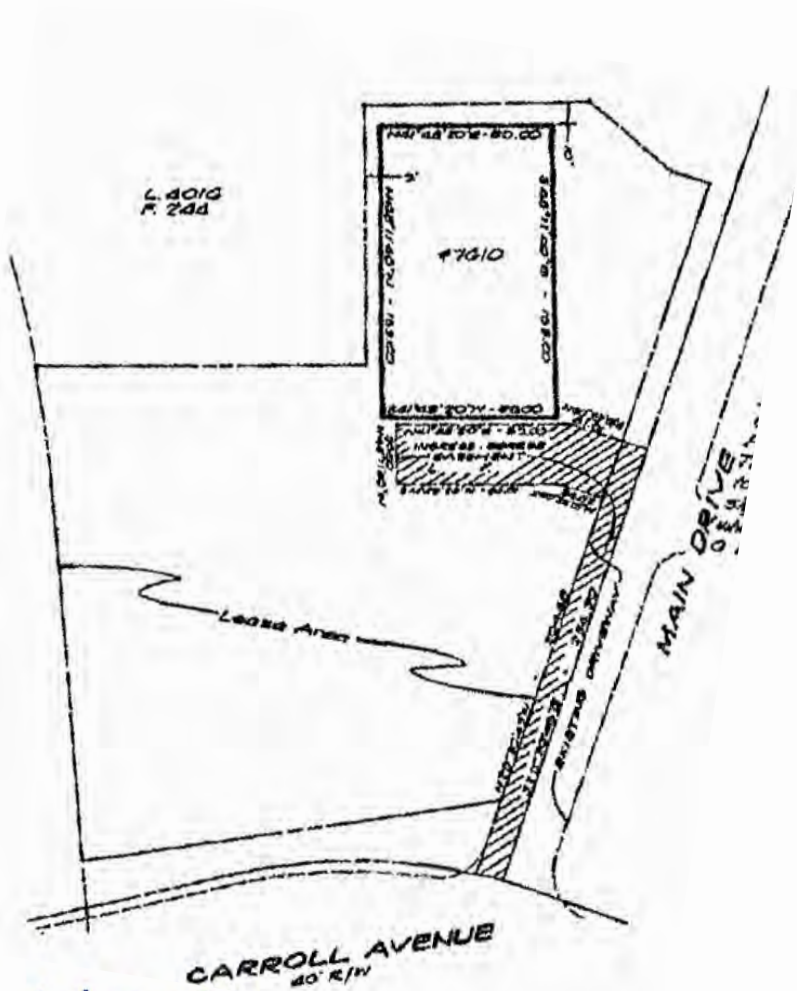
Medical or dental clinic. One parking space for each two hundred square feet of the total floor area of the building.

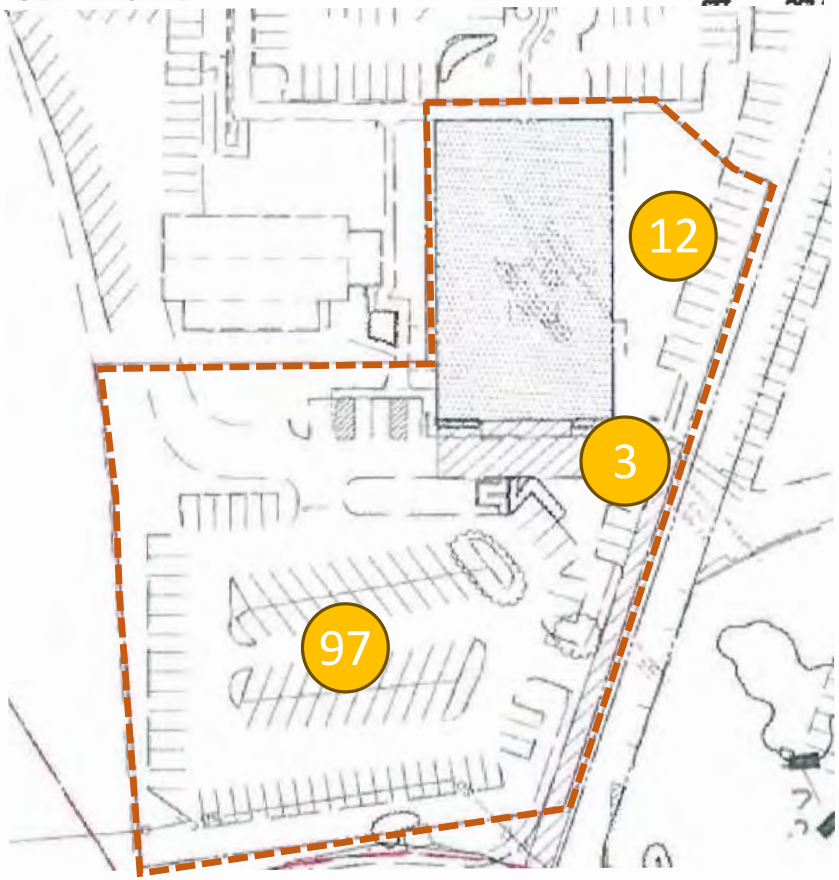
Mobile home development. Two parking spaces for each mobile home in the development.

Mortuary or funeral parlor. One parking space for each twelve square feet in the main chapel or parlor, plus one parking space for each employee on the major shift, and one parking space for each vehicle used in connection with the business.

Parking Lease

WITNESSETH, that the Lessor, for and in consideration of the covenants, conditions, and agreements herein contained, and on the part of the Lessee to be paid, kept and performed, does hereby lease to the Lessee, and the Lessee does hereby lease from the Lessor, certain premises as outlined in red on the plat attached hereto as Exhibit A, consisting of 69,618 square feet of parking area as further described in Exhibit B (the "Property").





Total: 112

EXHIBIT L

Adventist HealthCare

EXHIBIT M

Adventist HealthCare

820 West Diamond Avenue
Gaithersburg, MD 20878
AdventistHealthCare.com

October 7, 2025

Lavanya Sithanandam, MD
Park Pediatrics / Park Travel Medicine
Units 400, 440

RE: Notice of Special Meeting Scheduled for October 8, 2025

Dear Dr. Sithanandam:

This letter is in follow-up to the September 23, 2025 Notice of Special Assessment (the "**Notice**") issued by the President of the Board of Directors (the "**Board**") of the Adventist ACC Condominium Association, Inc. (the "**Condominium**"). As we describe below, the Notice does not accurately or fairly describe the situation and the facts that the Board is using to justify the proposed special assessment. The Notice is misleading and requires additional context. Washington Adventist Hospital (the "**Hospital**"), as a fellow Condominium unit owner, respectfully asks that you vote against the proposed special assessment, as it intends to do on behalf of the Condominium units that it owns.

As you know, the Hospital intends to demolish the vacant hospital buildings and parking areas on its unused campus, and recently obtained a permit to install a fence to secure the demolition area. The area of the fence is outlined in green on the attached plan (the "**Plan**"). Despite the Board's claims to the contrary in the Notice, the fence **does not** impact (a) the 112 parking spaces leased by the Condominium, as outlined in blue on the Plan (the "**Parking Area**"), or (b) the 45 parking spaces located along Campus Drive adjacent to the Condominium building.[1] This results in a total of 157 available parking spaces outside of the fence area, and far fewer than that number of spaces are actually utilized by the Condominium's physicians, staff, and patients on a daily basis.

As you are aware, the Parking Area is owned by the Hospital and is the subject of a lease to the Condominium (the "**Lease**"), the 40 year term of which has expired and it continues on a month to month basis. Under the Lease, the Condominium is a "holdover tenant" with additional parking rent required. The Hospital has sought, in good faith, to negotiate a new lease with the Board for the Parking Area without success (so far). It is disappointing to see this effort to negotiate a commercially reasonable lease be rebuffed and cast in such a negative light by the Board in the Notice.

The Board proposes to raise an enormous sum from Condominium unit owners--$160,000. There is little explanation for this sum other than the cost of a parking study (which usually costs $7,000—$10,000). If the Board intends to raise a huge sum with which to pay legal fees to litigate with the Hospital, the Hospital respectfully suggests that these proposed contributions from Condominium unit owners would be better spent on a new parking arrangement rather than litigation.

[1] The Notice undercounts parking spaces within the Parking Area. Per the Plan, there are 112 parking spaces within the Parking Area, not 92. Current commercial zoning only requires approximately 48 parking spaces.

Exhibit 7(m)

We believe that the special assessment as proposed violates the Condominium's Bylaws and lacks necessary details. Article VIII, Section 3 of the Bylaws, entitled "Special Assessment," provides that ***the Council Unit Owners may levy in any assessment year a special assessment or assessments, applicable to that year only…"*** The Notice, however, indicates that most of the proposed special assessment would be used to cover ongoing legal expenses that are expected to continue beyond the current year. In addition, the Notice does not specify the payment terms or the due date for the proposed special assessment.

We hope that the Board will revisit its approach. The Hospital remains ready, willing, and able to negotiate a commercially reasonable new lease for the Parking Area, which already contains more than adequate parking facilities for the Condominium.

Thank you for your consideration. We are happy to discuss this communication in substance with you, as well as any other questions you may have regarding the Plan or Lease. Please call: Geoff Morgan, Vice President, at 301-315-3374, or via Email at gmorgan@adventisthealthcare.com.

Sincerely,

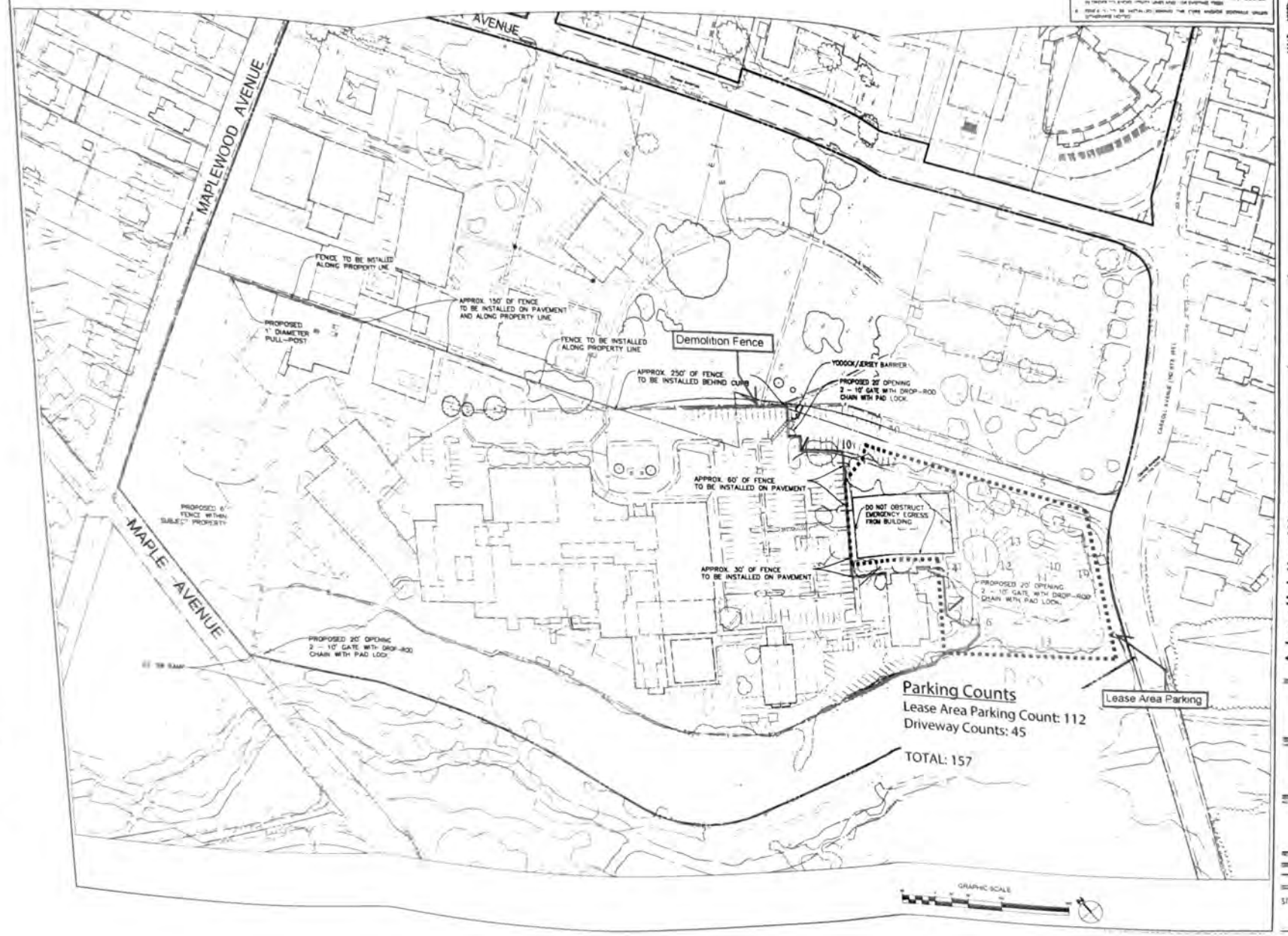
Geoff Morgan
Vice President, Chief Facilities & Real Estate Officer
Adventist HealthCare

Enclosure

APPROVED
Department of Permitting Services
Permit # COMBUILD-1116230
Date 8/11/2025

CONSTRUCTION TAKE-OFFS

SHEET NOTES



RODGERS CONSULTING

312

Adventist HealthCare
SITE SECURITY FENCING

Takoma, Montgomery County, Maryland - 4th Election District

SITE PLAN-OVERALL

CS-103

OBER KALER
Attorneys at Law

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Offices In
Maryland
Washington, D.C.
Virginia

February 14, 2014

Via Hand Delivery and Email
Rebecca Goldman, Health Policy Analyst
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Washington Adventist Hospital, Inc.
Matter No.: 13-15-2349
Response to Additional Completeness Questions

Dear Ms. Goldman:

On behalf of Washington Adventist Hospital, Inc. (WAH), we are hereby submitting the required ten (10) copies of our response to the additional Completeness Questions in your December 10, 2013 letter regarding the above-referenced project. We will also provide an electronic copy of our response and exhibits.

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

Sincerely,

Howard L. Sollins

HLS:tjr
Enclosures
cc: Kevin McDonald, Chief
Paul Parker, Director
Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
Joel Riklin, Program Manager
Certificate of Need Division
Maryland Health Care Commission
Suellen Wideman, Assistant Attorney General
Maryland Health Care Commission
Ms. Ruby Potter, Health Facilities Coordination Office
Donna Kinzer, Executive Director
Health Services Cost Review Commission

cc: Ulder Tillman MD, MPH, Health Officer
Montgomery County
William G. Robertson, President & Chief Executive Officer
Adventist HealthCare
Robert E. Jepson, Vice President
Adventist HealthCare
Joyce Newmyer, President
Washington Adventist Hospital

PART I – PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. **Staff previously requested the applicant to specify the outpatient and clinic services that will be provided at the White Oak campus. WAH responded to this request. Please also specify the outpatient and clinic services that will be provided at the Takoma Park campus after completion of the project and whether these services will be rate regulated.**

APPLICANT RESPONSE:

The following are outpatient services currently planned for the Takoma Park campus after the opening of the new facility on the White Oak campus:

- Outpatient behavioral health services
- Federally Qualified Health Center
- Women's Center (providing prenatal care, postpartum and related gynecological services)
- Physician offices
- Walk-in primary care services
- Diagnostics (lab, imaging, etc.) in support of the Takoma Park campus services

The Women's Center, behavioral health services and the Federally Qualified Health Center are already operational. Other outpatient services or clinics such as wound care, may be considered. We do not plan for any outpatient services to be rate regulated, with the possible exception of outpatient behavioral health as part of Adventist Behavioral Health.

2. **Regarding the response to question 6, please provide additional information about the freestanding comprehensive cancer center planned in a nearby facility for oncology and patients, which is referenced at Exhibit 68.**

    a. **What is the planned location and timeframe for the freestanding comprehensive cancer center?**

APPLICANT RESPONSE:

Adventist HealthCare plans to open a freestanding, non-rate regulated cancer center in the White Oak section of Montgomery County later this year at a site close to, but not located on, the new hospital campus. Elements will include physician offices; clinic services; and the Women's Imaging and Breast Center. Either before or at the same time the new hospital opens in White Oak, these services will move to the new hospital campus as part of the development of a larger, comprehensive cancer center.

    b. **Will this center be a program of Washington Adventist Hospital?**

APPLICANT RESPONSE:

Some services of the cancer center will be programmatic elements of Washington Adventist Hospital which may or may not be considered 'at the hospital.' Other services will include space sub-leased to other parties.

c. Will this center be rate-regulated?

APPLICANT RESPONSE:

Adventist HealthCare is currently evaluating whether or not some services of the cancer center will be rate regulated.. A final determination has not yet been made, and much of this decision is based upon discussions with the HSCRC about the global budget agreement for Washington Adventist Hospital.

d. What is the rationale for not including outpatient cancer services in the replacement hospital program as part of the Certificate of Need application?

APPLICANT RESPONSE:

This was not included in the CON application because a final determination has not yet been made whether the cancer center will be a freestanding, non-rate regulated outpatient service or rate regulated as a part of Washington Adventist Hospital. This decision is pending the final global budget discussions with the HSCRC. Once rate negotiations with the HSCRC are complete, an analysis will be done to determine whether the cancer center will have rate regulated services or be completely non-rate regulated.

e. Was an analysis done comparing the cost-effectiveness of operating a free-standing, comprehensive cancer center to one that would be part of the relocation project? If so, please provide it.

APPLICANT RESPONSE:

An analysis will be developed once all aspects of the global budget rate negotiations for Washington Adventist Hospital are complete.

f. Will the hospital's charity care policy apply to this center? If not, please describe the availability of charity care at this center.

APPLICANT RESPONSE:

The hospital's charity care policy will apply if the center is a rate regulated part of Washington Adventist Hospital. If the center is non-rate regulated, a charity care policy consistent with the organization's mission and values will be developed to ensure appropriate access to care for patients in need of financial assistance.

g. How will patients be impacted by separating the location from the main hospital?

APPLICANT RESPONSE:

Patients will benefit significantly from development of this comprehensive cancer center. More than 80% of all cancer care is delivered in the outpatient setting[1], and a freestanding, comprehensive, community-based cancer center allows patients to have easy access to sites of care and individualized treatment plans that maximize convenience and enhance care coordination. The length of time from initial diagnosis to treatment is decreased when a patient is able to have tests completed, see their physician and undergo therapy all in one day in the same location.

PART II – PROJECT BUDGET

3. Regarding the response to question 12, please explain why the bond proceeds deposit at Exhibit 69 ($51,980,476) does not match the bond financing amount in the project budget ($278,010,000).

APPLICANT RESPONSE:

Exhibit 69 relates to the Capitalized Interest Fund, which is money set aside to pay for the interest payments during the construction period. The $278,010,000 represents bond proceeds, which covers a portion of the project cost, cost of issuance, capitalized interest and debt service reserve funds. The two amounts are not comparable and should not agree.

PART III—CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3)
Response to State Health Plan for Facilities and Services: Acute Hospital Services, COMAR 10.24.10

[1]Kuznar W. Community oncology clinics under increasing financial pressure. Association for Value-Based Cancer. http://www.valuebasedcancer.com/article/community-oncology-clinics-under-increasing-financial-pressure.

4. **Regarding COMAR 10.24.10.04A(1), Information Regarding Charges, Staff would like to stress the need to update the list of representative charges at least quarterly. The current posting is dated for a period ending June 30, 2013.**

APPLICANT RESPONSE:

Adventist HealthCare is committed to updating the representative charges timely with respect to COMAR 10.24.10.04A(1). The organization uses the quarterly discharge abstract data tapes as the source for this information, as it is consistent with HSCRC reporting and audited and reconciled annually. The final discharge abstract data tape is due to the HSCRC 90 days after the close of the quarter. This allows for the all of the coding to be complete in order to get accurate patient information. As such, there is a lag in each quarter. AHC's process is to update the representative list of charges on a quarterly basis for a rolling 12 months worth of data. Because the data is not complete immediately, there is approximately a one quarter lag in that data. At the time of the initial filing, the 12 months ending June 30 was the most recent period of final HSCRC discharge abstract data tapes. Since the initial filing, the quarter ending September 2013 data has been finalized and has been uploaded to the website.

5. **Please send an electronic version of Exhibit 75 to rebecca.goldman@maryland.gov, if available, so that staff can more easily read this information. Alternatively, WAH may provide a more legible version.**

APPLICANT RESPONSE:

A large-scale copy is being sent as an attachment in this submission and will be resubmitted by email today.

6. **Utilization projections presented in the response to Question 20a address growth rates. Please demonstrate what population-based use rates (discharges per 1,000 population) were assumed in the projections and how those compare to the use rates in the past five years.**

APPLICANT RESPONSE:

The growth rates identified in the response to question 20a represented population growth estimates by age and zip code[2]. By applying population growth rates to historical discharges, we inherently held the base year, or CY2012, use rates by zip code and age cohort constant. We individually projected discharges by zip code and age cohort and summed the totals to determine the overall estimate included in the application.

For example, in Beltsville (zip code 20705), we noted the following use rates by age cohort for CY2012.

[2] Population growth rates from Nielsen Claritas database

Zip Code 20705 – Actual CY2012 Use Rates by Age Cohort

	Population	Discharges	Use Rate
15-44	11,533	256	22.2
45-64	6,922	522	75.4
65-74	1,583	225	142.1
75+	1,327	254	191.4
Total	**21,365**	**1,257**	**58.8**

We then considered population growth estimates by age cohort and applied the same use rate to determine total discharges within that zip code. We have provided an example for CY2013 and CY2014 below but the same methodology was considered throughout the projection period and for every zip code within the White Oak TSA.

Zip Code 20705 - CY2013 Projection Estimate

	% Growth Rate	Projected Population	Use Rate	Projected Discharges
15-44	-0.3%	11,501	22.2	255
45-64	1.3%	7,014	75.4	529
65-74	6.1%	1,680	142.1	239
75+	1.4%	1,345	191.4	257
Total	0.8%	**21,540**	**59.4**	**1,280**

Zip Code 20705 - CY2014 Projection Estimate

	% Growth Rate	Projected Population	Use Rate	Projected Discharges
15-44	-0.4%	11,458	22.2	254
45-64	0.9%	7,076	75.4	534
65-74	5.9%	1,779	142.1	253
75+	2.3%	1,376	191.4	263
Total	0.7%	**21,689**	**60.1**	**1,304**

As demonstrated above; the use rates by age cohort are consistent with CY2012 levels, but the overall use rate within each zip code has slightly increased due to growth in the older, higher-use populations. The following tables provide detail on population estimates, use rates, and discharges for the zip code 20705 for the entire projection period.

Zip Code 20705 – Population Estimates (CY2013 – CY2022)

	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018	CY2019	CY2020	CY2021	CY2022
15-44	11,501	11,458	11,415	11,372	11,329	11,287	11,245	11,203	11,161	11,119
45-64	7,014	7,076	7,138	7,201	7,265	7,329	7,394	7,459	7,525	7,591
65-74	1,680	1,779	1,884	1,994	2,112	2,236	2,368	2,507	2,654	2,811
75+	1,345	1,376	1,408	1,441	1,475	1,509	1,544	1,580	1,617	1,654
Total	**21,540**	**21,689**	**21,845**	**22,009**	**22,181**	**22,361**	**22,550**	**22,748**	**22,957**	**23,175**
Growth	0.8%	0.7%	0.7%	0.7%	0.8%	0.8%	0.8%	0.9%	0.9%	1.0%

Zip Code 20705 – Use Rates (CY2013 – CY2022)

	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018	CY2019	CY2020	CY2021	CY2022
15-44	22.2	22.2	22.2	22.2	22.2	22.2	22.2	22.2	22.2	22.2
45-64	75.4	75.4	75.4	75.4	75.4	75.4	75.4	75.4	75.4	75.4
65-74	142.1	142.1	142.1	142.1	142.1	142.1	142.1	142.1	142.1	142.1
75+	191.4	191.4	191.4	191.4	191.4	191.4	191.4	191.4	191.4	191.4
Total	**59.4**	**60.1**	**60.8**	**61.6**	**62.3**	**63.1**	**63.8**	**64.6**	**65.4**	**66.3**
Growth	1.0%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.3%	1.3%

Zip Code 20705 – Discharge Estimates (CY2013 – CY2022)

	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018	CY2019	CY2020	CY2021	CY2022
15-44	255	254	253	252	251	251	250	249	248	247
45-64	529	534	538	543	548	553	558	562	567	572
65-74	239	253	268	283	300	318	336	356	377	399
75+	257	263	270	276	282	289	296	302	310	317
Total	**1,280**	**1,304**	**1,329**	**1,355**	**1,382**	**1,410**	**1,439**	**1,470**	**1,502**	**1,535**
Growth	1.9%	1.9%	1.9%	1.9%	2.0%	2.0%	2.1%	2.1%	2.2%	2.2%

The same process was performed for each zip code within the White Oak TSA and totaled to determine overall discharge projections used in the bed need analysis. The table below summarizes the CY2012 use rate by zip code that was applied in determining the overall projections.

CY2012 Use Rates within the White Oak TSA

Zip Code	15-44	45-64	65-74	75+	Total
20705 - Beltsville	22.2	75.4	142.1	191.4	58.8
20740 - College Park	12.3	74.9	148.0	345.2	46.4
20782 - Hyattsville	19.8	63.2	129.4	305.9	54.0
20783 - Hyattsville	26.6	84.9	152.9	336.3	60.9
20901 - Silver Spring	17.5	55.9	136.0	350.1	59.0
20903 - Silver Spring	28.8	66.8	174.7	432.0	66.6
20904 - Silver Spring	24.3	66.5	161.1	330.4	82.5
20906 - Silver Spring	24.0	66.2	145.9	318.8	91.5
20912 - Takoma Park	24.0	70.9	155.6	392.2	64.6
20011 - Washington	5.0	14.0	29.1	41.9	13.4
20012 - Washington	9.7	21.0	43.5	96.8	26.4
20017 - Washington	7.0	14.6	16.6	20.4	12.0
20706 - Lanham	33.3	91.1	183.7	391.5	83.8
20707 - Laurel	27.5	78.7	212.7	330.4	73.2
20708 - Laurel	33.2	90.9	195.8	362.6	72.6
20710 - Bladensburg	24.7	120.6	184.6	342.3	76.7
20712 - Mount Rainier	14.0	64.9	154.4	223.7	44.7
20715 - Bowie	28.9	71.8	171.1	389.7	90.1
20721 - Bowie	22.2	45.5	124.7	360.4	57.5
20735 - Clinton	29.6	84.5	222.5	492.3	96.3
20737 - Riverdale	33.2	96.2	174.9	316.5	67.5
20743 - Capitol Heights	37.8	111.6	180.7	324.8	92.5
20747 - District Heights	30.8	86.8	176.3	330.0	72.1
20748 - Temple Hills	24.7	79.3	132.5	276.7	69.6
20770 - Greenbelt	29.4	78.3	132.0	337.7	64.0
20772 - Upper Marlboro	23.0	65.4	167.0	366.2	63.9
20774 - Upper Marlboro	25.8	67.3	135.4	257.0	63.7
20781 - Hyattsville	23.9	74.0	133.1	337.7	56.7
20784 - Hyattsville	33.3	89.8	192.4	348.4	73.7
20785 - Hyattsville	46.9	107.8	196.9	373.5	91.9
20850 - Rockville	21.9	55.5	113.6	397.4	72.4
20853 - Rockville	20.0	56.7	119.1	306.2	69.2
20866 - Burtonsville	25.5	62.0	139.8	326.6	58.2
20874 - Germantown	26.7	62.5	171.4	394.9	55.2
20878 - Gaithersburg	19.1	46.8	116.2	350.5	49.9
20886 - Montgomery Village	27.1	66.8	141.1	318.9	61.4
20902 - Silver Spring	23.7	66.2	134.5	319.9	64.7
20905 - Silver Spring	22.3	48.2	125.0	339.1	64.7
20910 - Silver Spring	18.2	58.3	136.5	400.2	58.5
Total	**24.4**	**67.0**	**142.6**	**304.3**	**65.0**

* Use rates for Washington DC Zip Codes only reflect the utilization for patients who went to a hospital located in Maryland.

Use rates over the past five years have declined from 69.8 in CY2008 to 65.0 in CY2012. The table below demonstrates population based MSGA use rates for the past five years for adults (older than 15) within the White Oak TSA.

Historical Use Rates within White Oak TSA

	Population	Discharges	Use Rate	YoY Change
CY2008	1,018,421	71,135	69.8	N/A
CY2009	1,030,268	73,286	71.1	1.8%
CY2010	1,042,345	73,818	70.8	-0.4%
CY2011	1,051,950	71,358	67.8	-4.2%
CY2012	1,062,013	69,054	65.0	-4.1%

We discussed in the application that we believe the declining use rates were due to a number of factors, including:

- National shift from inpatient to outpatient services
- Increases in observation and one-day stays
- Loss of insurance coverage due to economic conditions
- Increased emphasis on reduction of readmissions

While we believe it is important to recognize historical trends, given the potential for changes due to the Affordable Care Act legislation and related healthcare reform, we did not only rely on historical trends for estimating future patient needs.

We maintained usage rates at 2012 levels recognizing a decrease in usage rates but also recognizing the Baby Boomer generation is now turning 65 at a rate of 10,000 each day.[3] In 2010 this demographic represented 13% of the U.S. population, but is expected to grow to represent 18% of the U.S. population by 2030. In spite of greater access to health-care advancements than previous generations, Baby Boomers actually have more chronic health problems. With almost 40% of Baby Boomers diagnosed as obese, for example, obesity-related conditions such as hypertension, high cholesterol and heart disease are more common – which means a greater need for health-care services as this population ages.[4]

The table below provides a summary of the total projected population, use rates, and discharges within the White Oak TSA. As discussed, we held CY2012 use rates constant by zip code and age cohort. The slight differences between the calculated use rate by age cohort within the White Oak TSA, in total, are due to different population growth rates within each zip code. Within the overall White Oak TSA, the use rate for individuals aged 15 to 74 has declined with the only increase in the 75+ age cohort. The overall use rate for adults within the White Oak TSA has increased solely due to the aging population.

[3] Pew Research Center. "Baby Boomers Retire." December 29, 2010.
[4] King DE, Matheson E, Chirina S, et al. The status of Baby Boomers' health in the United States: The healthiest generation? JAMA Intern Med. 2013;173(5):385-386. doi:10.1001/jamainternmed.2013.2006

	CY2012			CY2022		
Age Cohort	Population	Use Rate	Discharges	Population	Use Rate	Discharges
15-44	562,476	24.4	13,702	547,793	24.1	13,224
45-64	348,524	67.0	23,336	388,839	66.4	25,826
65-74	86,182	142.6	12,287	148,252	142.1	21,073
75+	64,831	304.3	19,729	84,450	307.7	25,987
Total	1,062,013	65.0	69,054	1,169,333	73.6	86,110

Response to State Health Plan for Facilities and Services: Psychiatric Services, COMAR 10.24.07

7. **Responding to COMAR 10.24.07 AP6, you have stated that, "The Washington Adventist Hospital Psychiatric Unit has a quality assurance program based upon Adventist Behavioral health's performance improvement program." Please clarify whether this program includes "separate written quality assurance programs, program evaluations, and treatment protocols" for the special populations listed that are served are the hospital (patients with a secondary diagnosis of substance abuse and geriatric patients) as specified in the standard. Also please provide a sample of the program's quality assurance reports.**

APPLICANT RESPONSE:
Treatment protocols for the geriatric patients and the substance abuse patients along with the quality assurance program and program evaluation formats, are included as ATTACHMENT 94.

Response to Other Criteria

8. **Regarding the response to question 30c, please provide the following clarifications:**
   a. **Explain why case-mix is not held constant for each projection in Exhibit 80, and explain the assumptions that led the specific mix factor in each projections.**

APPLICANT RESPONSE:

In the original projections case-mix was held constant within each major service (MSGA, OB/NUR, and Psych). Because OB and Psych have a significantly lower CMI than MSGA on average, as different rates of growth for MSGA, OB and NUR were applied, the overall CMI of the entire population fluctuates. Under a global arrangement, which is being currently being finalized with the HSCRC, CMI will no longer cause fluctuations in revenue in the short term and therefore the projections will be modified to take this change in assumption into consideration once a finalized agreement is reached.

   b. **What is the source of the estimates for market basket referred to on page 38?**

APPLICANT RESPONSE:

Source: IHS Global Insight, 2013Q2, Historical Data through 2013Q1; Released by: CMS, OACT, National Health Statistics Group, DNHS@cms.hhs.gov

Found at (also attached):

http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html

9. **Your response to question 32 on page 40 states that "...if the HSCRC were to adopt the 50 per cent variable cost factor, adjustments to other rate setting methodologies and assumptions would likely also be made ....", please respond to the following:**
   a. **Please identify what rate increase would be required to support the project if indeed HSCRC uses the 50% variable cost factor. Also, for the sake of gaining insight into how the assumption on variable cost reimbursement affects rates, what rate increase would be required if HSCRC used a 100% variable cost factor?**
   b. **You are encouraged to present alternative projections of revenues and expenses that include other changes beyond the variable cost factor. If you submit such an alternative, please provide it with inflation and, if possible without inflation. Submit a clear statement of assumptions such as HSCRC update factors, and projected inflationary increases in expenses. Show how key changes in revenues and expenses are calculated.**

APPLICANT RESPONSE:

Adventist HealthCare is nearing completion of a negotiated global reimbursement agreement with the HSCRC. We are currently updating the financial pro formas for the Washington Adventist Hospital CON consistent with this revenue agreement and will submit the new information as part of a CON modification that is currently underway.

10. **Regarding the response to question 33f, what are the expense deductions projected to begin in 2015 and increase through 2017?**

APPLICANT RESPONSE:

These are savings that Washington Adventist Hospital intends to identify and implement in order to be financially viable. They will include any and all of the following:

1. Contracting improvements in medical and surgical supplies
2. Contracting improvements in pharmaceuticals
3. Contracting improvements in purchased services, to include Information Technology, Laboratory testing, Maintenance of Clinical Equipment
4. Utilization improvements: reduced length of stay and related reduction in staffing hours and pharmaceuticals and other variable supplies expenses

5. Utilization improvements: continued reduction of readmissions and MHAC's, and reduction of potentially avoidable utilization, including emergency department visits
6. Sustained improvements in labor productivity

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.

2-12-14

William G. Robertson Date
President and CEO
Adventist Healthcare

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.

Terry Forde

February 12, 2014

Terry Forde
Executive Vice President, and Chief Operating Officer
Adventist HealthCare, Inc.

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.

Geoffrey Morgan
Vice President, Expanded Access
Washington Adventist Hospital

2/13/14
Date

AFFIRMATION

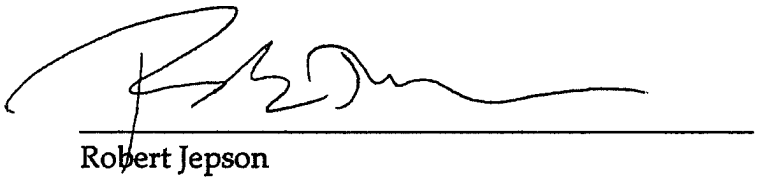
I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Joyce Newmyer
President
Washington Adventist Hospital

2.12.14
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.



Robert Jepson
Vice President of Business Development
Adventist Healthcare

2/12/14
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.

Maureen Dymond
Vice President, Financial Operations
Adventist Healthcare

2/12/14
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.

Kristen Pulio
Associate Vice President, Reimbursement
Adventist Healthcare

2/12/14
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.

Linda Beth Berman
Grant Manager
Adventist Healthcare

2/12/14
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.

R. Lee Piekarz
Deloitte Financial Advisory Services, LLP

2/12/14
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.

Pippa Laundy
Deloitte Financial Advisory Services, LLP

2/12/14
Date

Exhibit 75

This Exhibit is also being provided in a hard copy, oversized version

ZIP CODE	Population	4 HCH Holy Cross Hospital 1500 Forest Glen Road Silver Spring, MD 20910			Average Time Travel within zip code		Drive Time in Minutes for Population Exceeding 30 min.	7 DCH Doctors Community 8118 Good Luck Road Lanham, MD 20706			Average Time Travel within zip code		Drive Time in Minutes for Population Exceeding 30 min.	6 LRH Laurel Regional Hospital 7300 Van dusen Road Laurel, MD 20707			Average Time Travel within zip code		Drive Time in Minutes for Population Exceeding 30 min.	8 PGHC Prince George's 3001 Hospital Drive Cheverly, MD 20785			Average Time Travel within zip code		Drive Time in Minutes for Population Exceeding 30 min.	8a Proposed PGHC Prince George's 900 Capital Beltway Largo, MD 20774			Average Time Travel within zip code		Drive Time in Minutes for Population Exceeding 30 min.	Travel Time to ANY hosp
		Miles to	Time to					Miles to	Time to					Miles to	Time to						Miles to	Time to						Miles to	Time to				
20783	37,201	6.4 mi.	11 min.	11	13			7.1 mi.	16 min.	16	17			12.2 mi.	19 min.	19	22				10.1 mi.	20 min.	20	18				15.0 mi.	21 min.	21	23			10
		6.1 mi.	14 min.	14				7.0 mi.	15 min.	15				10.7	23 min.	23					6.3 mi.	17 min.	17					13.0 mi.	21 min.	21				10
		6.8 mi.	14 min.	14				8.3 mi.	21 min.	21				14.4 mi.	24 min.	24					6.3 mi.	17 min.	17					17.2 mi.	26 min.	26				6
20782	25,569	7.5 mi.	15 min.	15	18			6.3 mi.	15 min.	15	17			14.8 mi.	25 min.	25	26				5.2 mi	14 min.	14	14				10.1 mi.	23 min.	23	24			7
		7.2 mi.	16 min.	16				8.0 mi.	19 min.	19				14.4 mi.	26 min.	26					5.7 mi.	16 min.	16					10.5 mi.	26 min.	26				8
		8.2 mi.	17 min.	17				6.2 mi.	15 min.	15				11.8 mi.	26 min.	26					5.0 mi.	14 min.	14					10.0 mi.	21 min.	21				9
		7.9 mi.	22 min.	22				6.2 mi.	15 min.	15				11.8 mi.	26 min.	26					4.5 mi.	12 min.	12					10.1 mi.	23 min.	23				11
		6.6 mi.	17 min.	17				7.3 mi.	17 min.	17				13.8 mi.	25 min.	25					5.8 mi.	16 min.	16					11.2 mi.	24 min.	24				6
		8.2 mi.	22 min.	22				7.8 mi.	18 min.	18				13.4 mi.	29 min.	29					4.7 mi.	14 min.	14					9.8 mi.	24 min.	24				11
20903	17,998	5.6 mi.	16 min.	16	11			10.1 mi.	21 min.	21	20			12.2 mi.	19 min.	19	18				12.5 mi.	25 min.	25	24				14.8 mi.	20 min.	20	20			10
		4.0 mi.	9 min.	9				10.3 mi.	24 min.	24				10.8 mi.	20 min.	20					12.7 mi.	25 min.	25					14.6 mi.	19 min.	19				8
		5.0 mi.	9 min.	9				9.5 mi.	18 min.	18				9.8 mi.	18 min.	18					11.9 mi.	29 min.	29					14.6 mi.	20 min.	20				9
		5.5 mi.	8 min.	8				9.2 mi.	16 min.	16				11.3 mi.	16 min.	16					11.6 mi.	17 min.	17					13.8 mi.	19 min.	19				7
20910	35,967	3.3 mi.	9 min.	9	7			13.1 mi.	22 min	22	22			15.2 mi.	22 min.	22	23				8.4 mi.	23 min.	23	24				17.8 mi.	25 min.	25	23			7
		1.8 mi.	5 min.	5				11.7 mi.	18 min.	18				13.8 mi.	19 min.	19					14.0 mi.	20 min.	20					16.5 mi.	20 min.	20				5
		1.5 mi.	4 min.	4				11.9 mi.	20 min	20				14.0 mi.	21 min.	21					14.3 mi.	22 min.	22					16.7 mi.	22 min.	22				4
		3.1 mi.	10 min.	10				14.4 mi.	26 min.	26				16.5 mi.	27 min.	27					16.8 mi.	28 min.	28					18.2 mi.	26 min.	26				10
		1.6 mi	7 min.	7				13.3 mi.	23 min	23				15.4 mi.	24 min.	24					15.6 mi.	25 min.	25					17.8 mi.	24 min.	24				7
20904	48,587	5.2 mi.	10 min.	10	12			11.0 mi.	21 min.	21	23			10.0 mi.	18 min.	18	19				13.4 mi.	23 min.	23	25				16.1 mi.	23 min.	23	24			7
		8.5 mi.	13 min.	13				10.3 mi.	18 min.	18				5.8 mi.	15 min.	15					12.7 mi.	20 min.	20					15.3 mi.	22 min.	22				3
		9.0 mi.	14 min.	14				12.5 mi.	23 min	23				5.5 mi.	13 min.	13					14.9 mi.	24 min.	24					18.2 mi.	22 min.	22				9
		6.1 mi.	11 min.	11				12.2 mi.	24 min.	24				9.5 mi.	21 min.	21					14.6 min.	25 min.	25					17.5 mi.	25 min.	25				9
		8.3 mi.	14 min.	14				13.7 mi.	26 min.	26				8.7 mi.	18 min.	18					16.1 mi.	28 min.	28					20.4 mi.	26 min.	26				9
		7.5 mi.	13 min.	13				13.7 mi.	25 min.	25				10.5 mi.	23 min.	23					16.1 mi.	27 min.	27					18.6 mi.	27 min.	27				11
		7.5 mi.	12 min.	12				13.9 mi.	25 min.	25				10.5 mi.	23 min.	23					16.1 mi.	26 min.	26					22.1 mi.	26 min.	26				11
20705	22,361	8.3 mi.	13 min.	13	16			6.9 mi.	16 min.	16	17			4.8 mi.	12 min.	12	10				9.6 mi.	17 min.	17	19				12.1 mi.	17 min.	17	19			10
		14.0 mi.	18 min.	18				5.8 mi.	12 min.	12				7.0 mi.	15 min.	15					9.1 mi.	14 min.	14					11.7 mi.	15 min.	15				12
		11.5 mi.	20 min.	20				7.8 mi.	17 min.	17				3.6 mi.	8 min.	8					11.1 mi.	19 min.	19					13.9 mi.	21 min.	21				8
		8.9 mi.	15 min.	15				10.5 mi.	19 min.	19				4.9 mi.	12 min.	12					12.7 mi.	21 min.	21					15.3 mi.	22 min.	22				5
		8.8 mi.	12 min.	12				10.2 mi.	16 min.	16				4.1 mi.	9 min.	9					12.4 mi.	18 min.	18					15.0 mi.	18 min.	18				7
		11.9 mi.	18 min.	18				10.8 mi.	21 min.	21				0.6 mi.	1 min.	1					14.1 mi.	23 min.	23					18.8 mi.	22 min.	22				1
20902	42,000	1.5 mi.	5 min.	5	9			13.6 mi.	22 min	22	25			15.5 mi.	22 min.	22	25				15.8 mi.	23 min.	23	27				18.3 mi.	24 min.	24	27			5
		2.7 mi.	7 min.	7				12.6 mi.	22 min	22				14.5 mi.	23 min.	23					14.8 mi.	24 min.	24					17.6 mi.	25 min.	25				7
		5.1 mi.	12 min.	12				15.1 mi.	27 min	27				11.9 mi.	25 min.	25					17.3 mi.	28 min.	28					19.7 mi.	28 min.	28				12
		4.1 mi.	11 min.	11				14.7 mi.	27 min	27				16.7 mi.	27 min.	27					16.9 mi.	28 min.	28					19.6 mi.	29 min.	29				11
		4.7 mi.	11 min.	11				15.2 mi.	28 min	28				12.2 mi.	26 min.	26					17.4 mi.	29 min.	29					20.6 mi.	30 min.	30				11
		4.1 mi.	10 min.	10				14.1 mi.	25 min.	25				16.0 mi.	25 min.	25					16.3 mi.	27 min.	27					19.0 mi.	28 min.	28				10
20737	16,357	12.6 mi.	18 min.	18	20			3.7 mi.	8 min.	8	10			10.4 mi.	22 min.	22	23				3.4 mi.	8 min.	8	9				8.2 mi.	18 min.	18	17			8
		13.1 mi.	19 min.	19				4.1 mi.	10 min.	10				10.8 mi.	23 min.	23					3.0 mi.	8 min.	8					11.1 mi.	16 min.	16				8
		11.8 mi.	21 min.	21				4.7 mi.	12 min.	12				10.5 mi.	24 min.	24					3.4 mi.	9 min.	9					8.6 mi.	18 min.	18				9
		13.3 mi.	20 min.	20				3.1 mi.	10 min.	10				12.2 mi.	23 min.	23					3.3 mi.	10 min.	10					7.4 mi.	15 min.	15				10
20011	57,701	5.3 mi.	14 min.	14	15			10.0 mi.	26 min.	26	26			17.2 mi.	27 min.	27	28				7.7 mi.	20 min.	20	20				14.5 mi.	30 min.	30	28			9
		4.3 mi.	11 min.	11				14.7 mi.	26 min.	26				16.6 mi.	26 min.	26					8.3 mi.	22 min.	22					19.7 mi.	28 min.	28				9
		6.5 mi.	17 min.	17				8.8 mi.	21 min.	21				15.1 mi.	27 min.	27					6.4 mi.	16 min.	16					13.2 mi.	26 min.	26				9
		5.9 mi.	16 min.	16				16.4 mi.	30 min	30				18.3 mi.	30 min.	30					9.7 mi.	25 min.	25					21.1 mi.	30 min.	30				14
		7.0 mi.	17 min.	17				10.3 mi.	25 min.	25				18.9 mi.	30 min.	30					6.8 mi.	16 min.	16					15.2 mi.	26 min.	26				13
20770	21,083	11.1 mi.	16 min.	16	17			1.2 mi.	4 min.	4	9			9.0 mi.	18 min.	18	17				6.2 mi.	12 min.	12	13				7.7 mi.	14 min.	14	16			4
		10.4 mi.	14 min.	14				2.1 mi.	7 min.	7				8.5 mi.	19 min.	19					5.5 mi.	10 min.	10					8.8 mi.	14 min.	14				7
		15.9 mi.	23 min.	23				4.6 mi.	10 min.	10				7.9 mi.	17 min.	17					11.0 mi.	18 min.	18					9.5 mi.	19 min.	19				10
		10.1 mi.	14 min.	14				4.5 mi.	10 min.	10				7.0 mi.	16 min.	16					7.3 mi.	12 min.	12					12.3 mi.	17 min.	17				10
		10.6 mi.	17 min.	17				3.9 mi.	12 min.	12				7.4 mi.	17 min.	17					7.0 mi.	15 min.	15					10.6 mi.	17 min.	17				12
20906	57,059	5.9 mi.	16 min.	16	17			16.8 mi	33 min.	33	33			12.7 mi.	28 min.	28	29				18.8 mi.	33 min.	33	33				26.1 mi.	31 min.	31	32			16
		4.9 mi.	13 min.	13				17.1 mi.	30 min.	30				18.9 mi.	30 min.	30					19.0 mi.	31 min.	31					21.7 mi.	32 min.	32				13
		5.6 mi.	14 min.	14				16.4 mi.	31 min.	31		38039		13.5 mi.	31 min.	31		1,854,418			18.4 mi.	32 min.	32		47549	1,892,457		21.2 mi.	33 min.	33		38039	1,797,359	14
		7.8 mi.	20 min.	30				20.0 mi.	37 min.	37				14.3 mi.	32 min.	32					21.9 mi.	38 min.	38					28.0 mi.	33 min.	33				20
		8.4 mi.	19 min.	19				18.3 mi.	35 min.	35				11.5 mi.	26 min.	26					20.3 mi.	35 min.	35					25.5 mi.	30 min.	30				19
		4.5 mi.	12 min.	12				16.7 mi.	29 min.	29				18.5 mi.	29 min.	29					18.6 mi.	30 min.	30					20.8 mi.	30 min.	30				12
20912	20,094	3.9 mi.	11 min.	11	10			9.2 mi.	22 min.	22	22			13.5 mi.	22 min.	22	21				7.8 mi.	20 min.	20	21				16.4 mi.	24 min.	24	22			1
		4.4 mi.	9 min.	9				9.3 mi.	22 min.	22				13.5 mi.	21 min.	21					13.7 mi.	21 min.	21					15.5 mi.	22 min.	22				1
		2.8 mi.	9 min.	9				11.9 mi.	21 min.	21				13.7 mi.	21 min.	21					13.8 mi.	22 min.	22					16.2 mi.	21 min.	21				4
20740	24,683	9.4 mi.	12 min.	12	14			3.9 mi.	9 min.	9	11			8.4 mi.	18 min.	18	18				6.5 mi.	11 min.	11	13				10.2 mi.	16 min.	16	18			9
		11.1 mi.	17 min.	17				4.3 mi.	12 min.	12				8.9 mi.	21 min.	21					5.5 mi.	14 min.	14					9.7 mi.	15 min.	15				12
		7.5 mi.	12 min.	12				6.7 mi.	15 min.	15				6.2 mi.	13 min.	13					8.7 mi.	15 min.	15					11.2 mi.	16 min.	16				11
		8.4 mi.	12 min.	12				6.6 mi.	12 min.	12				7.7 mi.	16 min.	16					8.6 mi.	13 min.	13					12.5 mi.	23 min.	23				9
		7.3 mi.	15 min.	15				5.4 mi.	12 min.	12				8.6 mi.	19 min.	19					8.0 mi.	14 min.	14					11.7 mi.	19 min.	19				10
		10.7 mi.	17 min.	17				6.1 mi.	14 min.	14				9.9 mi.	21 min.	21					4.4 mi.	13 min.	13					13.3 mi.	22 min.	22				13
		10.9 mi.	15 min.	15				1.7 mi.	5 min.	5				8.9 mi.	17 min.	17					5.9 mi.	11 min.	11					8.9 mi.	13 min.	13				5
20706	31,128	14.3 mi.	20 min.	20	21			2.7 mi.	8 min.	8	7			17.1 mi.	25 min.	25	24				7.0 mi.	14 min.	14	13				7.1 mi.	13 min.	13	13			8
		12.4 mi.	19 min.	19				1.4 mi.	4 min.	4				10.4 mi.	21 min.	21					7.4 mi.	15 min.	15					7.4 mi.	13 min.	13				4
		13.9 mi.	21 min.	21				1.7 mi.	5 min.	5				11.6 mi.	24 min.	24					4.5 mi.	11 min.	11					7.8 mi.	15 min.	15				5
		13.8 mi.	19 min.	19				3.3 mi.	8 min.	8				16.6 mi.	24 min.	24					3.6 mi.	9 min.	9					4.8 mi.	8 min.	8				8
		14.5 mi.	19 min.	19				4.2 mi.	9 min.	9				17.3 mi.	23 min.	23					5.1 mi.	9 min.	9					5.4 mi.	10 min.	10				9
		17.5 mi.	26 min.	26				4.9 mi.	13 min.	13				13.8 mi.	28 min.	28					8.7 mi.	17 min.	17					7.8 mi.	13 min.	13				13
		13.5 mi.	20 min.	20				2.6 mi.	7 min.	7				11.5 mi.	22 min.	22					8.5 mi.	15 min.	15					8.6 mi.	16 min.	16				7
		14.2 mi.	20 min.	20				0.2 mi.	1 min.	1				10.5 mi.	21 min.	21					5.5 mi.	13 min.	13					6.8 mi.	13 min.	13				1
20901	30,446	2.6 mi.	6 min.	6	6			11.0 mi.	18 min.	18	21			12.8 mi.	17 min.	17	20				13.0 mi.	18 min.	18	21				15.8 mi.	22 min.	22	22			6
		4.7 mi.	8 min.	8				11.2 mi.	21 min.	21				10.3 mi.	18 min.	18					13.2 mi.	22 min.	22					16.5 mi.	24 min.	24				7
		0.5 mi.	2 min.	2				12.6 mi.	22 min.	22				14.4 mi.	22 min.	22					14.6 mi.	23 min.	23					16.7 mi.	23 min.	23				2
		3.8 mi.	8 min.	8				11.1 mi.	20 min.	20				13.0 mi.	19 min.	19					13.1 mi.	20 min.	20					15.6 mi.	21 min.	21				6
		1.4 mi.	5 min.	5				12.3 mi.	22 min.	22				14.2 mi.	22 min.	22					14.3 mi.	23 min.	23					16.5 mi.	21 min.	21				5
20905	16,400	11.7 mi.	21 min.	21	18			18.3 mi.	35 min.	35	32	9371	520,114	9.6 mi.	23 min.	23	22				20.2 mi.	35 min.	35	32	11714	527,143		25.8 mi.	34 min.	34	31	9371	515,429	20
		12.2 mi.	22 min.	22				18.7 mi.	35 min.	35				10.0 mi.	23 min.	23					20.7 mi.	36 min.	36					25.9 mi.	34 min.	34				21
		10.9 mi.	20 min.	20				17.5 mi.	34 min.	32				10.8 mi.	24 min.	24					19.4 mi.	34 min.	34					24.9 mi.	33 min.	33				19
		10.1 mi.	17 min.	17				16.6 mi.	30 min.	30				7.9 mi.	18 min.	18					18.6 mi.	31 min.	31					23.9 mi.	29 min.	29				15
		8.9 mi.	16 min.	16				15.4 mi.	29 min.	29				10.3 mi.	24 min.	24					17.3 mi.	30 min.	30					23.6 mi.	30 min.	30				15
		8.3 mi.	15 min.	15				14.8 mi.	28 min.	28				8.8 mi.	21 min.	21					16.8 mi.	28 min.	28					22.4 mi.	29 min.	29				14
		10.8 mi.	18 min.	18				15.9 mi.	31 min.	31				7.4 mi.	19 min.	19					17.9 mi.	31 min.	31					23.7 mi.	31 min.	31				14
20866	27,712	12.1 mi.	19 min.	19	17			17.8 mi.	31 min.	31	26			6.4 mi.	16 min.	16	13				19.8 mi.	31 min.	31	27				23.6 mi.	30 min.	30	27			14
		11.1 mi.	17 min.	17				16.8 mi.	28 min.	28				5.5 mi.	14 min.	14					18.8 mi.	29 min.	29					23.4 mi.	28 min.	28				12
		13.2 mi.	18 min.	18				14.8 mi.	23 min.	23				3.4 mi.	9 min.	9					16.8 mi.	23 min.	23					19.6 mi.	24 min.	24				13
		9.4 mi.	14 min.	14				13.2 mi.	23 min.	23				4.7 mi.	11 min.	11					15.4 mi.	24 min.	24					20.4 mi.	26 min.	26				9
20707	28,129	14.8 mi.	21 min.	21	20			16.1 mi.	24 min.	24	23			3.6 mi.	10 min.	10	8				18.4 mi.	25 min.	25	23				20.6 mi.	26 min.	26	25			10
		13.8 mi.	18 min.	18				15.2 mi.	22 min.	22				3.9 mi.	10 min.	10					17.4 mi.	22 min.	22					19.6 mi.	24 min.	24				10
		11.2 mi.	18 min.	18				12.6 mi.	22 min.	22				3.6 mi.	9 min.	9					14.8 mi.	22 min.	22					17.0 mi.	24 min.	24				7
		13.1 mi.	21 min.	21				10.5 mi.	21 min.	21				2.1 mi.	6 min.	6					13.8 mi.	22 min.	22					16.3 mi.	24 min.	24				6
		14.7 mi.	21 min.	21				10.5 mi.	22 min.	22				1.2 mi.	4 min.	4					14.1 mi.	22 min.	22					16.5 mi.	24 min.	24				4
		14.6 mi.	21 min.	21				11.5 mi.	25 min.	25				2.4 mi.	8 min.	8					14.8 mi.	25 min.	25					20.4 mi.	26 min.	26				8
20708	19,921	15.2 mi.	23 min.	23	22			12.7 mi.	21 min.	21	16			3.1 mi.	10 min.	10	12				16.0 mi.	22 min.	22	19				18.4 mi.	24 min.	24	20			10
		18.0 mi.	25 min.	25				9.7 mi.	19 min.	19				4.6 mi.	12 min.	12					13.0 mi.	20 min.	20					15.4 mi.	22 min.	22				12
		16.2 mi.	21 min.	21				8.0 mi.	16 min.	16				3.5 mi.	9 min.	9					11.3 mi.	16 min.	16					13.7 mi.	18 min.	18				9
		16.5 mi.	22 min.	22				8.3 mi.	15 min.	15				6.0 mi.	13 min.	13					11.6 mi.	18 min.	18					14.0 mi.	19 min.	19				13
		15.7 mi.	21 min.	21				5.1 mi.	11 min.	11				7.9 mi.	16 min.	16					10.8 mi.	17 min.	17					13.2 mi.	19 min.	19				11
20715	21,283	18.9 mi.	30 min.	30	28			7.7 mi.	16 min.	16	17			11.3 mi.	22 min.	22	25				15.5 mi.	24 min.	24	20				13.0 mi.	24 min.	24	20			16
		17.7 mi.	29 min.	29				6.5 mi.	15 min.	15				11.6 mi.	24 min.	24					11.9 mi.	22 min.	22					11.8 mi.	22 min.	22				15
		25.8 mi.	32 min.	32				9.6 mi.	19 min.	19				13.1 mi.	25 min.	25					16.2 mi.	23 min.	23					16.1 mi.	22 min.	22				19
		23.0 mi.	30 min.	30				9.3 mi.	19 min.	19				12.9 mi.	25 min.	25					13.3 mi.	21 min.	21					10.0 mi.	22 min.	22				19

		23.5 mi.	25 min.	25				12.9 mi.	16 min.	16				15.7 mi.	27 min.	27				13.9 mi.	16 min.	16				13.8 mi.	16 min.	16				16
		21.3 mi.	26 min.	26				10.7 mi.	16 min.	16				13.7 mi.	26 min.	26				11.6 mi.	17 min.	17				11.5 mi.	16 min.	16				16
		22.9 mi.	27 min.	27				12.3 mi.	17 min.	17				25.1 mi.	29 min.	29				13.2 mi.	18 min.	18				13.2 mi.	17 min.	17				17
20721	24,416	16.7 mi.	23 min.	23	27			5.9 mi.	13 min.	13	17			18.9 mi.	24 min.	24	29			7.2 mi.	14 min.	14	19			3.7 mi.	9 min.	9	11			9
		19.3 mi.	26 min.	26				9.1 mi.	18 min.	18				21.5 mi.	28 min.	28				7.9 mi.	19 min.	19				3.9 mi.	10 min.	10				10
		22.2 mi.	32 min.	32				9.1 mi.	19 min.	19				17.0 mi.	34 min.	34				10.8 mi.	25 min.	25				6.8 mi.	16 min.	16				16
		18.0 mi.	24 min.	24				7.4 mi.	14 min.	14				20.2 mi.	25 min.	25				6.6 mi.	16 min.	16				1.7 mi.	6 min.	6				6
		20.4 mi.	28 min.	28				10.2 mi.	20 min.	20				22.5 mi.	30 min.	30				9.0 mi.	21 min.	21				5.0 mi.	12 min.	12				12
		22.7 mi.	29 min.	29				12.1 mi.	19 min.	19				24.9 mi.	31 min.	31				13.3 mi.	21 min.	21				5.7 mi.	12 min.	12				12
20774	39,156	20.5 mi.	26 min.	26	31	22375	1,202,649	9.9 mi.	17 min.	17	21			22.6 mi.	28 min.	28	32	27969	1,269,773	8.2 mi.	19 min.	19	23			3.3 mi.	9 min.	9	14			9
		21.3 mi.	27 min.	27				10.7 mi.	17 min.	17				23.5 mi.	29 min.	29				11.9 mi.	19 min.	19				2.6 mi.	8 min.	8				8
		24.2 mi.	32 min.	32				13.6 mi.	23 min.	23				26.3 mi.	34 min.	34				14.7 mi.	24 min.	24				7.1 mi.	16 min.	16				16
		28.9 mi.	35 min.	35				18.3 mi.	25 min.	25				31.1 mi.	36 min.	36				19.3 mi.	26 min.	26				11.0 mi.	21 min.	21				21
		28.7 mi.	34 min.	34				18.1 mi.	24 min.	24				30.8 mi.	35 min.	35				19.0 mi.	25 min.	25				10.7 mi.	19 min.	19				19
		23.8 mi.	34 min.	34				13.2 mi.	24 min.	24				26.0 mi.	36 min.	36				12.4 mi.	27 min.	27				7.5 mi.	16 min.	16				16
		21.7 mi.	27 min.	27				11.1 mi.	17 min.	17				23.9 mi.	29 min.	29				12.3 mi.	19 min.	19				6.0 mi.	10 min.	10				10
20772	38,410	24.2 mi.	30 min.	30	39	34569	1,486,467	13.7 mi.	20 min.	20	29			26.4 mi.	31 min.	31	41	38410	1,555,605	14.8 mi.	21 min.	21	30			8.5 mi.	13 min.	13	22			13
		24.4 mi.	31 min.	31				13.8 mi.	22 min.	22				26.5 mi.	33 min.	33				14.9 mi.	23 min.	23				8.6 mi.	15 min.	15				15
		31.2 mi.	37 min.	37				20.6 mi.	27 min.	27				33.4 mi.	38 min.	38				21.8 mi.	28 min.	28				10.7 mi.	20 min.	20				20
		22.4 mi.	34 min.	34				16.8 mi.	25 min.	25				29.6 mi.	36 min.	36				18.0 mi.	26 min.	26				11.7 mi.	18 min.	18				18
		29.6 mi.	37 min.	37				19.0 mi.	28 min.	28				31.8 mi.	39 min.	39				20.2 mi.	28 min.	28				13.9 mi.	21 min.	21				21
		31.7 mi.	37 min.	37				21.1 mi.	27 min.	27				33.9 mi.	39 min.	39				22.3 mi.	29 min.	29				16.0 mi.	20 min.	20				20
		30.1 mi.	40 min.	40				19.5 mi.	30 min.	30				32.3 mi.	42 min.	42				20.7 mi.	31 min.	31				14.4 mi.	23 min.	23				23
		33.7 mi.	45 min.	45				23.1 mi.	36 min.	36				35.9 mi.	47 min.	47				24.3 mi.	37 min.	37				18.0 mi.	29 min.	29				29
		34.6 mi.	46 min.	46				24.0 mi.	37 min.	37				36.8 mi.	48 min.	48				25.2 mi.	38 min.	38				18.9 mi.	30 min.	30				30
		37.5 mi.	50 min.	50				26.9 mi.	41 min.	41				39.7 mi.	52 min.	52				28.0 mi.	42 min.	42				20.2 mi.	34 min.	34				20
20748	30,353	29.3 mi.	35 min.	35	33	30353	1,011,767	18.7 mi.	26 min.	26	24			31.4 mi.	37 min.	37	35	30353	1,062,355	19.8 mi.	27 min.	27	23			13.5 mi.	19 min.	19	17			19
		26.9 mi.	32 min.	32				16.3 mi.	23 min.	23				29.1 mi.	34 min.	34				17.5 mi.	24 min.	24				11.2 mi.	16 min.	16				16
		29.5 mi.	34 min.	34				18.9 mi.	24 min.	24				31.7 mi.	35 min.	35				16.8 mi.	25 min.	25				13.8 mi.	17 min.	17				17
		27.1 mi.	31 min.	31				16.5 mi.	21 min.	21				29.3 mi.	33 min.	33				17.6 mi.	22 min.	22				11.4 mi.	14 min.	14				14
		29.8 mi.	34 min.	34				19.2 mi.	24 min.	24				32.0 mi.	35 min.	35				10.5 mi.	21 min.	21				14.1 mi.	17 min.	17				17
		28.4 mi.	34 min.	34				17.8 mi.	25 min.	25				30.6 mi.	36 min.	36				10.5 mi.	21 min.	21				12.7 mi.	18 min.	18				18
20747	32,341	24.2 mi.	30 min.	30	29			13.6 mi.	20 min.	20	19			26.4 mi.	31 min.	31	30			14.7 mi.	21 min.	21	20			8.5 mi.	13 min.	13	12			13
		22.8 mi.	26 min.	26				12.2 mi.	17 min.	17				25.0 mi.	28 min.	28				13.4 mi.	18 min.	18				7.1 mi.	10 min.	10				10
		23.4 mi.	29 min.	29				12.8 mi.	20 min.	20				25.5 mi.	31 min.	31				13.9 mi.	21 min.	21				7.6 mi.	13 min.	13				13
		21.2 mi.	28 min.	28				10.6 mi.	18 min.	18				23.4 mi.	30 min.	30				7.6 mi.	20 min.	20				5.5 mi.	11 min.	11				11
		22.4 mi.	30 min.	30				11.8 mi.	21 min.	21				24.6 mi.	32 min.	32				7.6 mi.	21 min.	21				6.7 mi.	14 min.	14				14
20743	31,698	22.7 mi.	31 min.	31	27			15.6 mi.	23 min.	23	19			24.9 mi.	33 min.	33	29			8.0 mi.	17 min.	17	14			10.5 mi.	16 min.	16	13			16
		22.6 mi.	31 min.	31				12.0 mi.	22 min.	22				24.7 mi.	33 min.	33				6.7 mi.	19 min.	19				6.8 mi.	15 min.	15				15
		21.7 mi.	30 min.	30				11.1 mi.	20 min.	20				23.9 mi.	31 min.	31				6.1 mi.	18 min.	18				6.0 mi.	13 min.	13				13
		19.1 mi.	24 min.	24				8.5 mi.	14 min.	14				21.5 mi.	25 min.	25				9.7 mi.	15 min.	15				3.4 mi.	7 min.	7				7
		19.8 mi.	26 min.	26				7.7 mi.	18 min.	18				22.0 mi.	28 min.	28				2.8 mi.	9 min.	9				4.9 mi.	13 min.	13				9
		17.0 mi.	21 min.	21				7.0 mi.	14 min.	14				19.2 mi.	23 min.	23				2.2 mi.	7 min.	7				8.9 mi.	13 min.	13				7
20785	28,535	18.7 mi.	26 min.	26	23			8.1 mi.	17 min.	17	14			20.9 mi.	28 min.	28	25			6.0 mi.	16 min.	16	9			3.0 mi.	9 min.	9	10			9
		19.1 mi.	25 min.	25				7.3 mi.	16 min.	16				21.3 mi.	27 min.	27				3.5 mi.	10 min.	10				5.0 mi.	10 min.	10				10
		17.4 mi.	22 min.	22				6.8 mi.	13 min.	13				19.6 mi.	24 min.	24				4.1 mi.	12 min.	12				2.9 mi.	7 min.	7				7
		18.5 mi.	22 min.	22				7.9 mi.	12 min.	12				20.7 mi.	24 min.	24				1.5 mi.	5 min.	5				5.0 mi.	11 min.	11				5
		16.0 mi.	23 min.	23				6.0 mi.	16 min.	16				18.2 mi.	25 min.	25				0.6 mi.	3 min.	3				6.1 mi.	14 min.	14				3
		15.6 mi.	20 min.	20				5.0 mi.	10 min.	10				17.8 mi.	22 min.	22				3.0 mi.	8 min.	8				5.1 mi.	9 min.	9				8
20712	7,253	9.0 mi.	25 min.	25	25			7.8 mi.	20 min.	20	20			16.3 mi.	28 min.	28	28			4.0 mi.	12 min.	12	12			8.7 mi.	20 min.	20	20			12
20710	7,639	16.1 mi.	22 min.	22	22			6.0 mi.	14 min.	14	14			18.2 mi.	23 min.	23	23			1.6 mi.	6 min.	6	6			6.3 mi.	14 min.	14	14			6
20781	9,505	14.0 mi.	21 min.	21	22			4.9 mi.	12 min.	12	14			16.1 mi.	23 min.	23	24			2.5 mi.	8 min.	8	10			7.2 mi.	16 min.	16	19			8
		12.4 mi.	22 min.	22				6.1 mi.	16 min.	16				14.6 mi.	24 min.	24				3.8 mi.	12 min.	12				8.5 mi.	21 min.	21				12
20784	21,958	13.8 mi.	20 min.	20	21			2.4 mi.	8 min.	8	6			16.0 mi.	21 min.	21	22			4.7 mi.	12 min.	12	13			5.8 mi.	12 min.	12	13			8
		14.0 mi.	21 min.	21				1.4 mi.	4 min.	4				16.2 mi.	22 min.	22				4.7 mi.	13 min.	13				7.6 mi.	14 min.	14				4
20017	17,026	8.7 mi.	26 min.	26	25			10.5 mi.	23 min.	23	23			18.0 mi.	34 min.	34	32		544832.0	5.6 mi.	17 min.	17	16			12.6 mi.	22 min.	22	22			17
		7.1 mi.	23 min.	23				8.5 mi.	23 min.	23				15.9 mi.	30 min.	30				5.2 mi.	15 min.	15				12.2 mi.	22 min.	22				15
20012	12,974	4.3 mi.	15 min.	15	13			9.7 mi.	27 min.	27	25			15.8 mi.	25 min.	25	23			8.0 mi.	25 min.	25	24			18.8 mi.	28 min.	28	26			10
		2.9 mi.	11 min.	11				13.3 mi.	22 min.	22				14.7 mi.	21 min.	21				15.5 mi.	23 min.	23				17.7 mi.	24 min.	24				10
20853	25,635	6.5 mi.	17 min.	17	22			18.9 mi.	33 min.	33	32	20508	830,574	18.2 mi.	25 min.	25	23			21.2 mi.	34 min.	34	33	25635	845,955	25.4 mi.	35 min.	35	34	25635	876,717	17
		7.8 mi.	20 min.	20				24.2 mi.	32 min.	32				16.9 mi.	23 min.	23				26.5 mi.	32 min.	32				28.7 mi.	34 min.	34				20
		9.0 mi.	23 min.	23				23.5 mi.	32 min.	32				16.2 mi.	23 min.	23				25.8 mi.	33 min.	33				28.0 mi.	34 min.	34				18
		9.6 mi.	23 min.	23				23.4 mi.	30 min.	30				16.0 mi.	21 min.	21				25.6 mi.	31 min.	31				27.8 mi.	32 min.	32				17
		11.6 mi.	27 min.	27				25.4 mi.	35 min.	35				18.0 mi.	25 min.	25				27.6 mi.	35 min.	35				29.8 mi.	36 min.	36				20
20850	44,896	9.5 mi.	22 min.	22	21			25.7 mi.	35 min.	35	34	37413	1,518,981.3	18.4 mi.	25 min.	25	29			28.0 mi.	35 min.	35	34	37413	1,533,946.7	30.2 mi.	36 min.	36	34	37413	1,511,498.7	22
		11.2 mi.	16 min.	16				22.5 mi.	29 min.	29				23.9 mi.	28 min.	28				24.8 mi.	30 min.	30				27.0 mi.	31 min.	31				16
		12.8 mi.	21 min.	21				24.0 mi.	34 min.	34				25.5 mi.	33 min.	33				26.3 mi.	34 min.	34				28.5 mi.	26 min.	26				21
		15.3 mi.	22 min.	22				26.6 mi.	36 min.	36				26.2 mi.	33 min.	33				28.9 mi.	36 min.	36				31.1 mi.	37 min.	37				22
		15.0 mi.	20 min.	20				26.3 mi.	34 min.	34				22.1 mi.	27 min.	27				28.5 mi.	34 min.	34				30.7 mi.	35 min.	35				20
		14.3 mi.	22 min.	22				25.6 mi.	35 min.	35				24.3 mi.	29 min.	29				27.9 mi.	36 min.	36				30.1 mi.	37 min.	37				22
20878	53,931	18.2 mi.	29 min.	29	26			29.5 mi.	42 min.	42	39	53931	2,087,900	28.3 mi.	37 min.	37	33	53931	1,772,019	31.7 mi.	43 min.	43	39	53931	2,118,718	33.9 mi.	44 min.	44	40	53931	2,172,649	29
		18.8 mi.	30 min.	30				30.1 mi.	43 min.	43				28.9 mi.	38 min.	38				32.4 mi.	44 min.	44				34.6 mi.	45 min.	45				30
		16.0 mi.	24 min.	24				27.2 mi.	37 min.	37				25.3 mi.	31 min.	31				29.5 mi.	37 min.	37				31.7 mi.	39 min.	39				24
		18.2 mi.	24 min.	24				29.4 mi.	37 min.	37				25.8 mi.	30 min.	30				31.7 mi.	37 min.	37				33.9 mi.	39 min.	39				24
		18.2 mi.	28 min.	28				29.5 mi.	41 min.	41				22.6 mi.	35 min.	35				31.8 mi.	42 min.	42				34.0 mi.	40 min.	40				28
		16.5 mi.	20 min.	20				27.7 mi.	33 min.	33				24.5 mi.	27 min.	27				30.0 mi.	34 min.	34				32.2 mi.	35 min.	35				20
		19.1 mi.	25 min.	25				30.3 mi.	38 min.	38				27.1 mi.	32 min.	32				22.6 mi.	38 min.	38				34.8 mi.	40 min.	40				25
20866	11,773	19.6 mi.	28 min.	28	29			30.9 mi.	41 min.	41	42	11773	488,580	26.0 mi.	35 min.	35	34	11773	403,225	33.1 mi.	41 min.	41	41	11773	485,636	35.3 mi.	43 min.	43	43	11773	509,182	28
		19.7 mi.	27 min.	27				31.0 mi.	40 min.	40				26.1 mi.	34 min.	34				33.3 mi.	41 min.	41				35.5 mi.	42 min.	42				27
		20.9 mi.	29 min.	29				32.2 mi.	43 min.	43				26.4 mi.	35 min.	35				34.5 mi.	43 min.	43				36.7 mi.	44 min.	44				29
		22.8 mi.	32 min.	32				32.9 mi.	42 min.	42				25.5 mi.	33 min.	33				35.2 mi.	40 min.	40				37.4 mi.	44 min.	44				28
	Total Population		Total Fastest Time Runs		Average Drive all data points	Population exceeding 30 minute Drive Time	Total Drive Time in Minutes for Population Exceeding 30 Min.		Total Fastest Time Runs		Average Drive all data points	Population exceeding 30 minute Drive Time	Total Drive Time in Minutes for Population Exceeding 30 Min.		Total Fastest Time Runs		Average Drive all data points	Population exceeding 30 minute Drive Time	Total Drive Time in Minutes for Population Exceeding 30 Min.		Total Fastest Time Runs		Average Drive all data points	Population exceeding 30 minute Drive Time	Total Drive Time in Minutes for Population Exceeding 30 Min.		Total Fastest Time Runs		Average Drive all data points	Population exceeding 30 minute Drive Time	Total Drive Time in Minutes for Population Exceeding 30 Min.	Avg. TT to any Hospital
	1,039,178		37		20	87,297	3,700,882		22		21	171,036	7,300,567		11		24	162,436	6,607,809		13		21	188,016	7,403,855		40		22	176,163	7,382,834	12
			Total Equal Time Runs			8.40%			Total Equal Time Runs			16.46%			Total Equal Time Runs			15.63%			Total Equal Time Runs			18.09%			Total Equal Time Runs			16.95%		
			1						7						0						6						5					

LEGEND	20 min.	Data point with fastest travel time to location.	20 min.	Data point w/ fastet TT to more than one Hospital	33 min.	Data points or zip code location where TT exceeds 30 minutes.

Exhibit 94

Adventist Behavioral Health
Treatment Protocol for Geriatric Psychiatric Inpatient Populations

Overview

Older adults with psychiatric illness present unique challenges for treatment as compared to younger adults with psychiatric illness (Bartels & Drake, 2005). Further, shortcomings in the mental health service system result in older adults being less likely to optimally engage in primary care and other outpatient mental health services. As a result, older adults are increasingly represented in psychiatric inpatient settings. Elderly or *geriatric* populations are a diverse group for which the U.S. Census Bureau defines Older adults as individuals 55 through 64; Elderly as 65 through 74; Aged as 75 through 84 and the Very Old, 85 and older (Townsend, 2003). Advanced research reveals geriatric psychiatric inpatients most often present with a range of disturbance in mood; thoughts and cognitions; behavior; and physical ailments. Of the 31 million Americans over age 65, 5 million are clinically significant for depressive symptoms. That number increases to 13% in aged adults 80 and older (Blazer, 2009). When anxiety and depression first appear in late life they are frequently associated with other conditions such as physical illness, traumatic event, dementia, medication toxicity or withdrawal (Videbeck, 2011a). Despite the complexities, the presence of these symptoms can be understood and are most often responsive to treatment. Treatment outcomes are enhanced when evidence-based practice guidelines are used to help return older adults to their optimal level of functioning.

Best Practice

Clinical focus in this population is indicated for depression, anxiety, agitation, alcohol use, psychosis, cognitive impairment, Alzheimer's dementia, bipolar and schizophrenia. Medical co-morbidities and increased risk of drug-drug interactions are considered and factored into treatment interventions. Patients receive comprehensive assessments to determine medical, psychiatric, behavioral and psychosocial needs. These assessments inform an individualized treatment plan for inpatient implementation as well as to inform outpatient providers for continuity in care. The treatment plan is further specified with goals chosen by the patient after being informed by the physician of individual risks and benefits of treatment options relative to their medical conditions. The decision-making is further shared with the treatment team and strengthened by family or guardian input and participation.

Treatment interventions are diverse and include psychopharmacology, psychoeducation, group therapy, individual and supportive therapies, expressive therapies, and pastoral counseling. The environment of care provides adequate space for ambulation challenges, individualized care that includes a single room, aid for activities of daily living (ADLs), and a therapeutic milieu.

Adventist Behavioral Health System Services

Professional Staff

A multidisciplinary team of psychiatrists, social workers, nurses, nurse practitioners, expressive therapist, and chaplains is involved with delivering patient care. Team members have

experience in diagnosing and treating disorders commonly experienced by older individuals. In addition, other medical or rehabilitation consultations are obtained as necessary.

Phase One A: Comprehensive Assessment

1. Psychiatric Assessments (Psychiatrist)
2. Nursing assessments (Nurse)
3. History & Physical (Nurse Practitioner/Medical Doctor)
4. Dietary & Nutritional, as indicated (Dietitian)
5. Psychosocial Assessment (Social Worker/Therapist)

Psychological Assessments & Outcome Measures

- Psychosocial: Multiple sociocultural factors comprise the late-life experience. The Psychosocial Intake and GAIN-Short Screen are used to gather history, including a screen for alcohol use.
- Cognitive Impairment: Geriatric populations present with varies levels of functional and cognitive abilities. The Mini-Cognitive (Mini-Cog^{TM}) is used to assess for cognitive impairment.
- Psychosis: While schizophrenia is not initially diagnosed in elderly patients (Videbeck, 2011b), psychotic symptoms that appear later in life are usually associated with other mental conditions. Further, similar to longer life spans in the general population; older chronically mentally ill patients are increasingly served on inpatient units. The Folstein Mental Mini Status Exam is used to assess for psychosis, mood disturbance and agitation.
- Depression: While depression is common in late life, it is not a natural part of aging. The Geriatric Depression Scale-Short Form (GDS-SF) is used to measure depression.
- Anxiety: Phobias and generalized are the most common late-life anxiety disorders. The Geriatric Anxiety Inventory (GAI) is used to measure anxiety.

Phase One B: Most Common Psychiatric Diagnosis

- Psychosis
- Depression
- Agitation
- Anxiety

Phase Two: Medical and Psychiatric Stabilization

- Medication management psychopharmacology for psychiatry conditions.
- Management of medical conditions, as necessary for treatment.
- Nursing staff follows practice guidelines in Lippincott (2010) for medical aspects of patient care.
- Nutrition management, as necessary for treatment.

Phase Three: Patient Management

Treatment Interventions

TRACK 1: Treatment interventions for patients, with no indicated cognitive impairment include: Anti-depressant and anti-anxiety medications, Cognitive-behavioral group therapy (CBT). Problem-solving group therapy (PST), individual behavior therapy, supportive group therapy (ST), expressive therapy (ET), and pastoral counseling (PC). These modalities focus on thoughts and emotional distress associated with depressive and other symptoms related to a range of anxiety disorders.

TRACK 2: Treatment interventions for older patients with mild to moderate cognitive impairment and daily functioning challenges include: Mood stabilizing and antipsychotic medications, PST, ST, ET, PC, reminiscence (RT), and skill building (SB) therapies. These modalities focus on behaviors associated with mood disturbance, thought disorder, and schizophrenia spectrum disorders. *See Figure 1.*

Older psychiatric patients frequently present with chronic medical co-morbidities; for example, diabetes, hypertension, Grade 1 and 2 wounds. These conditions are assessed, monitored, and managed by medical and nursing staff using Lippincott nursing guidelines. Treatment interventions for these patients focus on psychoeducation for medication side effects, the effects of interacting medications, and practical problem-solving in the home environment.

Special Populations: Some geriatric patients may present with impairment in daily functioning; for example, intellectual disability or other developmental disorders. Treatment interventions for these individuals include a multidisciplinary team and individualized treatment plan that focuses on assistance with activities of daily living (ADLs), behavioral approaches, and social skill training.

Treatment Monitoring

Treatment Plan

Patients meet with their attending psychiatrist daily. Treatment plan options take into consideration the patient's needs, preferences, and values. Changes are made to the individualized treatment plan as necessary.

Treatment Team

Patients participate in multidisciplinary treatment team meeting twice weekly and as needed to review progress toward successful discharge.

Phase Four: Preparation for Discharge

- The treatment team reviews disposition options and transition plans.
- Patient's participate in family or interagency meetings, when applicable, to determine conditions for discharge.
- Follow-up appointments are secured with primary care and next-level providers.

- Referrals to special services; for example, Electroconvulsive Therapy (ECT) and physical therapy, are made as necessary.
- Discharge care plans are transmitted to next-level providers for continuity in care.

References & Resources

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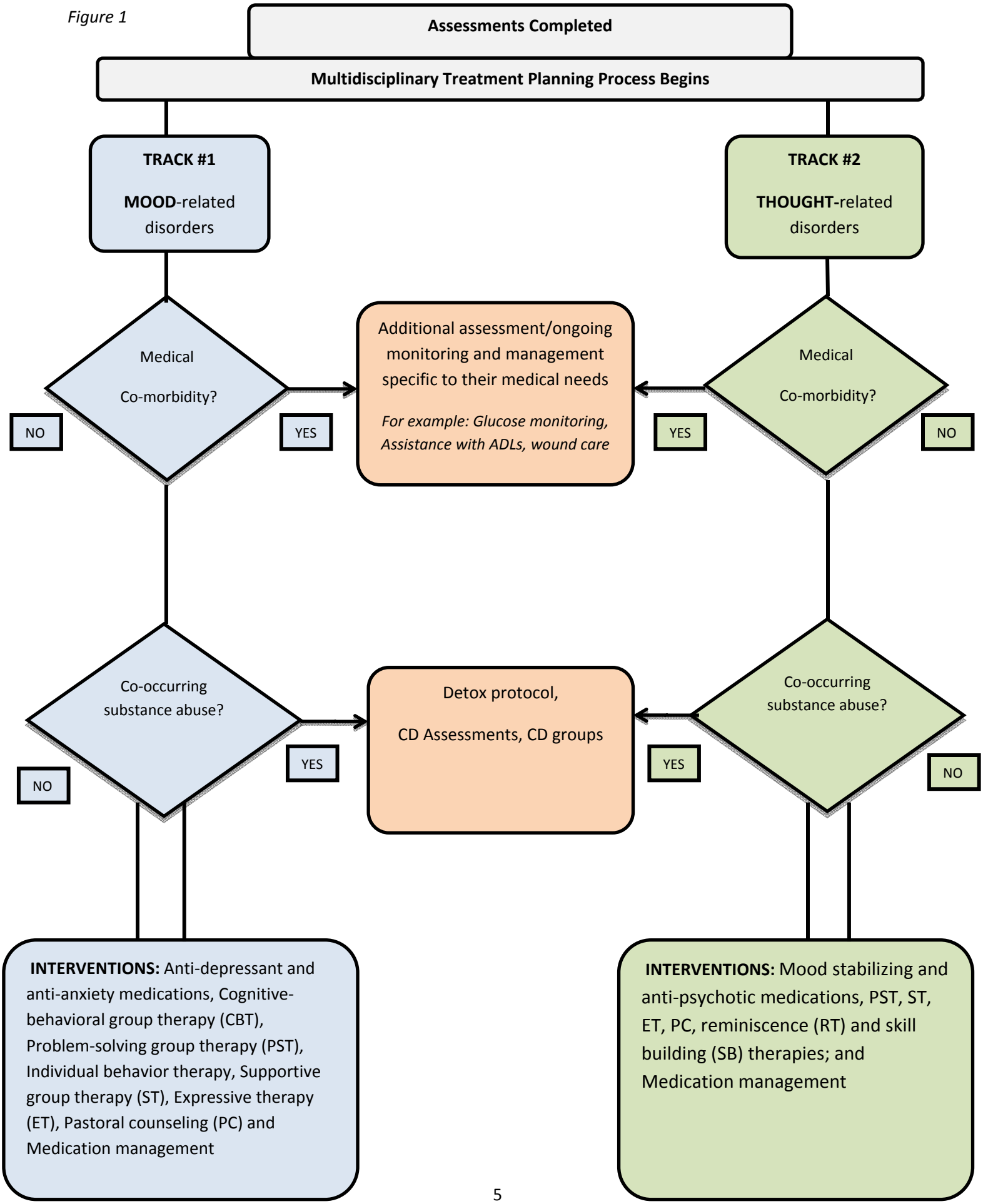
Videbeck, S. L. (2011a). Anxiety, Anxiety Disorders, and Stress-Related illness. In *Psychiatric Mental Health Nursing* (pp. 235). Philadelphia, PA; Wolters Kluwer, Lippincott Williams & Wilkins.

Videbeck, S. L. (2011b). Schizophrenia. In *Psychiatric Mental Health Nursing* (pp. 274). Philadelphia, PA; Wolters Kluwer, Lippincott Williams & Wilkins.

Figure 1


Assessments Completed
Multidisciplinary Treatment Planning Process Begins
TRACK #1
MOOD-related disorders
TRACK #2
THOUGHT-related disorders
Medical Co-morbidity?
NO
YES
Additional assessment/ongoing monitoring and management specific to their medical needs
For example: Glucose monitoring, Assistance with ADLs, wound care
YES
Medical Co-morbidity?
NO
Co-occurring substance abuse?
NO
YES
Detox protocol,
CD Assessments, CD groups
YES
Co-occurring substance abuse?
NO
INTERVENTIONS: Anti-depressant and anti-anxiety medications, Cognitive-behavioral group therapy (CBT), Problem-solving group therapy (PST), Individual behavior therapy, Supportive group therapy (ST), Expressive therapy (ET), Pastoral counseling (PC) and Medication management
INTERVENTIONS: Mood stabilizing and anti-psychotic medications, PST, ST, ET, PC, reminiscence (RT) and skill building (SB) therapies; and Medication management

Adventist Behavioral Health
Quality Assurance Program for the Treatment Protocol for Geriatric Psychiatric Inpatient Populations

Scope

Adventist Behavioral Health (ABH) provides inpatient treatment for geriatric adults whose acute mental illnesses require immediate stabilization. The goal of the treatment program is to stabilize the patient through medication management, psychoeducation, individual and supportive therapies, group therapy, family meetings, expressive therapy (art, movement, music and dance) and pastoral care. This quality assurance program is specific to the practice, process and outcomes related to the ABH Geriatric Program.

Purpose

The purpose of the Quality Assurance Program for Geriatric Program is to ensure there is a systematic process in place to measure, assess, evaluate and improve our organizational performance for the geriatric program. This Quality Assurance Program provides for measurements regarding the stability of systems and processes. There is also further evaluation of outcomes to help determine priorities for quality improvement.

Methodology

The Geriatric Program will be reviewed through a random sample of closed medical records, examining the four phases of the Geriatric Program: comprehensive assessment, medical and psychiatric stabilization, patient management and preparation for discharge as well as monitoring the status of outcomes. The two indicators in this program include

A) *Compliance* as defined by patient completing all four stages the Geriatric Program. The Program is comprised of four phases: 1) comprehensive assessments, 2) medical and psychiatric stabilization, 3) patient management, and 4) preparation of discharge. For this measure each phase will be evaluated for a yes or no response.

B) *Improved Outcomes* will be defined as positive movement in psychosocial functioning as measured through the assessments completed at admission and then again at discharge.

<u>Psychological Assessments & Outcome Measures</u>

- Psychosocial: Multiple sociocultural factors comprise the late-life experience. The Psychosocial Intake and GAIN-Short Screen are used to gather history, including a screen for alcohol use.
- Cognitive Impairment: Geriatric populations present with varies levels of functional and cognitive abilities. The Mini-Cognitive (Mini-Cog™) is used to assess for cognitive impairment.

- Psychosis: While schizophrenia is not initially diagnosed in elderly patients (Videbeck, 2011b), psychotic symptoms that appear later in life are usually associated with other mental conditions. Further, similar to longer life spans in the general population; older chronically mentally ill patients are increasingly served on inpatient units. The Folstein Mental Mini Status Exam is used to assess for psychosis, mood disturbance and agitation.
- Depression: While depression is common in late life, it is not a natural part of aging. The Geriatric Depression Scale-Short Form (GDS-SF) is used to measure depression.
- Anxiety: Phobias and generalized are the most common late-life anxiety disorders. The Geriatric Anxiety Inventory (GAI) is used to measure anxiety

Data will be analyzed and presented to the ABH Performance Improvement Committee and other stakeholders for review, feedback and action.

Model (PDCA)

The Quality Assurance Program will follow the continuous improvement model Plan, Do, Check, Act. All collected data will be reviewed at the ABH Performance Improvement Committee. Variance in data or benchmarks will be reviewed by the committee; action plans created and monitored using the PDCA model.

Evaluation

The Quality Assurance Program for the Geriatric Programs will be reviewed during the Program Evaluation for the Geriatric Programs.

Adventist Behavioral Health
Program Evaluation Treatment Protocol for Geriatric Psychiatric Inpatient Populations

I. Executive Summary

To evaluate an inpatient psychiatric program that addresses the specific needs of the geriatric population. The program provides comprehensive assessments to determine medical, psychiatric, behavioral and psychosocial needs of the older adult patient. Treatment interventions are diverse and include psychopharmacology, psycho-education, group therapy, individual and supportive therapies, expressive therapies, and pastoral counseling. The setting and environment of care provides adequate space for ambulation challenges and individualized. This evaluation focuses on structure, process and clinical outcomes for this geriatric psychiatric program.

II. Introduction to the report

A. Purpose of the evaluation

Applying the standards of the geriatric psychiatric program to determine value, quality, utility, effectiveness and significance; which can lead to recommendations intended to inform clinicians about best practice for the older adult psychiatric patient. The evaluation will be completed annually or as needed. In addition; the evaluation can help stakeholders determine the effectiveness of the geriatric psychiatric program and the continuation and/or expansion.

B. Audiences for the evaluation report

Centers for Medicare and Medicaid Services (CMS), Joint Commission (JC), Maryland Office of Health Care Quality (OHCQ), payors, family, patient, community mental health providers, mental health advocacy groups, long term care facility, assisted living, primary care providers, Adventist Healthcare (AHC) and Adventist Behavioral Health (ABH) administrators, ABH employees, and others as identified.

C. Limitations of the evaluation and explanation of disclaimers (if any)

D. Overview of report contents

III. Focus of the evaluation

A. Description of the evaluation object

The geriatric program is comprised of four phases: 1) comprehensive assessments, 2) medical and psychiatric stabilization, 3) patient management, and 4) preparation of discharge.

B. Evaluative questions or objectives used to focus the study

Program goals and objectives focus on medical and psychiatric stabilization; to include comprehensive assessments, medication management, individualized treatment plan, assistance with activities of daily living, behavioral approaches and social skill training.

C. Information needed to complete the evaluation:
   - Geriatric program
   - Data collection instruments (surveys, observation data, interviews, chart reviews)
   - Methods and techniques used to analyze and interpret the data
   - Policy and procedures
   - Evidence based/clinical guidelines for caring for geriatric psychiatric population

IV. Brief overview of the geriatric program evaluation plan and procedures

V. Presentation of evaluation results

A. Summary of evaluation findings

B. Interpretation of evaluation findings

VI. Conclusions and recommendations

A. Criteria and standards used to judge evaluation object

B. Judgments about evaluation object (strengths and weaknesses)

C. Recommendations

VII. Minority reports or rejoinders (if any)

VIII. Appendices

A. Description of evaluation plan/design, instruments, and data analysis and interpretation

Instruments - Psychological Assessments & Outcome Measures:
Psychosocial: Multiple sociocultural factors comprise the late-life experience. The Psychosocial Intake and GAIN-Short Screen are used to gather history, including a screen for alcohol use.

Cognitive Impairment: Geriatric populations present with varies levels of functional and cognitive abilities (Gundeman, et. al., 2004). The Mini-Cognitive (Mini-Cog™) is used to assess for cognitive impairment.

Psychosis: While schizophrenia is not initially diagnosed in elderly patients (Videbeck, 2011), psychotic symptoms that appear later in life are usually associated with other mental conditions. Further, similar to longer life spans in the general population; older chronically mentally ill patients are increasingly served on inpatient units. The Folstein Mental Mini Status Exam is used to assess for psychosis, mood disturbance and agitation.

Depression: While depression is common in late life, it is not a natural part of aging. The Geriatric Depression Scale-Short Form (GDS-SF) is used to measure depression.

Anxiety: Phobias and generalized are the most common late-life anxiety disorders. The Geriatric Anxiety Inventory (GAI) is used to measure anxiety.

B. Detailed tabulations or analyses of quantitative data, and transcripts or summaries of qualitative data

C. Other information, as necessary

References

Chen, H. (2005). Practical Program Evaluation: Assessing and Improving Planning, Implementation and Effectiveness. Sage Publications. Thousand Oaks, CA.

Fitzpatrick, J., Sanders, J., & Worthen, B. (2004). Program Evaluation: Alternative Approaches and Practical Guidelines. 3rd Edition. Pearson Education, Inc. Boston, MA.

Isaac, S. & Michael, W. (1995). Handbook in Research and Evaluation: For Education and Behavioral Sciences. 3rd Edition. Educational and Industrial Testing Services. San Diego, CA.

Adventist Behavioral Health
Treatment Protocol for Substance Abuse Psychiatric Inpatient Populations

Overview

Treating substance abuse/dependence in the context of co-occurring mental health conditions is an important aspect of treatment in the acute psychiatric inpatient setting. The Substance Abuse & Mental Health Service Administration (SAMHSA) and the Centers for Disease Control (CDC) have complete and comprehensive data available on the incidence of alcohol misuse, illicit drug use, and tobacco use and the relationship of the use of these substances to mental and physical health problems among adults and adolescents (Tusaie & Fitzpatrick, 2013). There are two concepts that have been used to define aspects of dependence to include: behavioral and physical. Some individuals who develop substance related problems do recover without treatment whereas others would require brief or long term interventions. Selecting the best treatment(s) would depend on the nature of the drugs abused and the individuals' stage of readiness for change as precontemplation, contemplation, preparation, action and maintenance (Sadock & Sadock, 2008). There are several valid and reliable psychometric tools available for Providers to use for screening, treatment and management of individuals with substance abuse or dependence.

Best Practices

Clinical focus in the substance use disorder population should be focused on abuse and dependence of alcohol, opioids, inhalants, nicotine, stimulants, and PCP/hallucinogens. Three severity areas of focus on inpatient include abuse, dependence, and withdrawal. Tools used to screen, as well as to evaluate treatment outcome, are crucial aspects of clinical care. Standard operating procedures are used to evaluate and to document intoxication, detoxification, as well as withdrawal prevention.

Adventist Behavioral Health System Services

Professional Staff

A multidisciplinary team comprised of psychiatrists, social workers, nurses, psychiatric nurse practitioners, and expressive therapists is involved with delivering patient care. Team members have experience in diagnosing and treating disorders commonly experienced by patients with psychiatric diagnoses, including substance use disorders. In addition, other medical or rehabilitation consultations are obtained as necessary.

Phase One: Initial Evaluation/Screening

All patients are to be screened for substances of abuse. Several methods that help accomplish this goal are employed and include (but are not necessarily limited to) urine toxicology assessment, standardized screening assessments, as well as the completion of a comprehensive psychiatric/substance abuse history. The following are examples of

these tools and are listed here to provide a concrete demonstration of methods employed, with respect to the substance of abuse:

1. Alcohol: Blood Alcohol Level (BAL) is obtained on admission to the unit, or before admission in the Emergency Department (ED). As part of the history gathered on admission, screening tools such as AUDIT, or other evidenced based tools, are used with the patient. If/when there is a concern that the patient is experiencing Delirium Tremens (DT), a medical consult is obtained for evaluation of a transfer to a medical floor.
2. Opioids: Urine toxicology to assess the presence of opioids is obtained either on admission to the unit, or prior to it in the ED. Screening tools such as the DAST-20, or other evidence based methods, are employed.
3. Cannabis: Urine toxicology to assess the presence of cannabis is obtained either on admission, or prior to it in the ED. Screening tools such as the DAST-20 (or other evidence based tool) are used.
4. Stimulants/Cocaine: Urine toxicology to assess the presence of stimulants such as cocaine is obtained either in the ED, or upon admission to the inpatient unit.
5. Nicotine/tobacco: Patients are screened for tobacco use by means of the collection of a history, as well as by use of other evidenced based screening tools such as the CAGE Questionnaire for tobacco.
6. PCP/Hallucinogens: Urine toxicology is used to identify the presence of these substances either upon admission, or before admission in the ED setting.

Phase Two: Detoxification/Replacement Therapies

All patients identified as being in need of detoxification and treatment for withdrawal prevention will be detoxified according to standardized guidelines and best practice methods. These will be guided by the substance of use and the treatment to which it is most appropriate.

1. Alcohol: Clinical scales to monitor withdrawal symptoms, as well as signs, are employed to ensure that detoxification occurs and to minimize the potential for withdrawal. Examples of such scales include the Clinical Institute Withdrawal Assessment (CIWA) protocol method. These involve the use of benzodiazepines as a treatment for withdrawal.
2. Opioids: Scales used to monitor signs and symptoms of withdrawal from substances such as heroin and prescription narcotic analgesics are used to assist in the detoxification process. Such scales include the Clinical Opiate Withdrawal Scale (COWS) protocol.
3. Cannabis: Detoxification from cannabis involves several supportive and clinical methods that are tailored to each patient according to his/her needs and symptoms. Examples include appropriate pain control or other as needed medications for any associated withdrawal symptom that may be present. Finally, both methadone and suboxone may be used as detoxification and/or

replacement therapies in patients deemed as appropriate candidates for these medications.

4. Stimulants/Cocaine: Similar to cannabis, treatment of cocaine withdrawal utilizes mostly supportive care and observation. In addition, an EKG is obtained to mitigate the potential cardiac sequelae of use/intoxication.
5. Nicotine/Tobacco: Detoxification/treatments for nicotine cravings involve nicotine patches and gums and serve as forms of replacement therapies. They are also used to help to prevent withdrawal symptoms.
6. PCP/Hallucinogens: All patients who screen positively for PCP and/or hallucinogens are provided with supportive measures for detoxification of these substances. This includes close monitoring of their mood, as well as any physical (e.g., vital sign) monitoring that may be helpful to these patients.

Phase Three: Peer/Staff Support as well as Rehabilitation Referral Upon Discharge

1. Alcohol:
    a. During the admission, all patients with alcohol abuse or dependence diagnoses are encouraged to attend AA/NA evening groups on the unit. These are offered once weekly during the week and once on the weekend and serve as adjunctive treatment components of the patient's plan of care.
    b. Upon discharge, all patients with alcohol abuse or dependence who are deemed in need (by the treatment team along with the patient) of inpatient (28 day) rehab are referred there. Those who are deemed appropriate for less intensive programs, or who require less intensive programs based on his/her (work) schedule are referred to community based outpatient programs. These are referred to as Intensive Outpatient Programs or IOP.
2. Opioids:
    a. During the admission, all patients with opioid abuse or dependence are assessed for:
        i. Replacement therapy. Those who are already on methadone or buprenorphone are kept on it at the dose confirmed by their outpatient prescribing clinic/psychiatrist. Neither methadone detox, nor methadone maintenance therapies are initiated from the inpatient unit. Buprenorphine maintenance therapy is offered to patients who are deemed appropriate candidates.
        ii. All patients with opioid abuse or dependence diagnoses are encouraged to attend AA/NA evening groups on the unit. These are offered once weekly during the week and once on the weekend.
    b. Upon discharge, all patients with opioid abuse or dependence who are deemed in need (by the treatment team along with the patient) of inpatient (28 day) rehab are referred there. Those who are deemed

appropriate for less intensive programs, or who require less intensive programs based on his/her (work) schedule are referred to community based outpatient programs. These are referred to as Intensive Outpatient Programs or IOP. Those patients who came from a clinic/psychiatrist who provided methadone or buprenorphine therapies are referred back to those clinics/providers.

3. Cannabis:
    a. During the admission, all patients with cannabis abuse or dependence diagnoses are encouraged to attend AA/NA evening groups on the unit. These are offered once weekly during the week and once on the weekend and serve as adjunctive treatment components of the patient's plan of care.
    b. Upon discharge, all patients with cannabis abuse or dependence who are deemed in need (by the treatment team along with the patient) of inpatient (28 day) rehab are referred there. Those who are deemed appropriate for less intensive programs, or who require less intensive programs based on his/her (work) schedule are referred to community based outpatient programs. These are referred to as Intensive Outpatient Programs or IOP.
4. Stimulants/cocaine:
    a. During the admission, all patients with stimulant/cocaine abuse or dependence diagnoses are encouraged to attend AA/NA evening groups on the unit. These are offered once weekly during the week and once on the weekend and serve as adjunctive treatment components of the patient's plan of care.
    b. Upon discharge, all patients with stimulant/cocaine abuse or dependence who are deemed in need (by the treatment team along with the patient) of inpatient (28 day) rehab are referred there. Those who are deemed appropriate for less intensive programs, or who require less intensive programs based on his/her (work) schedule are referred to community based outpatient programs. These are referred to as Intensive Outpatient Programs or IOP.
5. Nicotine/Tobacco:
    a. During the admission, all patients with nicotine/tobacco abuse or dependence diagnoses are encouraged to attend AA/NA evening groups on the unit. These are offered once weekly during the week and once on the weekend and serve as adjunctive treatment components of the patient's plan of care.
        i. Replacement therapy with the nicotine patch or gum is offered to patients.
        ii. Medication treatment therapies are offered to the patient. Buproprion therapy is offered to those who are both deemed appropriate, and who desire this form of medication treatment.

b. Upon discharge, all patients with nicotine/tobacco use are given information on the health implications of smoking.

6. PCP/hallucinogens:
    a. During the admission, all patients with PCP/hallucinogen abuse or dependence diagnoses are encouraged to attend AA/NA evening groups on the unit. These are offered once weekly during the week and once on the weekend and serve as adjunctive treatment components of the patient's plan of care.
    b. Upon discharge, all patients with PCP/hallucinogen abuse or dependence who are deemed in need (by the treatment team along with the patient) of inpatient (28 day) rehab are referred there. Those who are deemed appropriate for less intensive programs, or who require less intensive programs based on his/her (work) schedule are referred to community based outpatient programs. These are referred to as Intensive Outpatient Programs or IOP.

All substance abuse/dependence rehab referrals are based on the American Society of Addiction Medicine (ASAM) placement criteria.

Outcome Measures

1. Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES 8A): Given to all patients with substance abuse/dependence once on admission and once upon discharge.
2. 30 Day Readmission Rate: Data monitored on all patients as an outcome measure of overall level of treatment success.

References

Tusaie, K. R. & Fitzpatrick, J. J. (2013). Advanced practice psychiatric nursing: Integrating psychotherapy, psychopharmacology, and complementary and alternative approaches.

Sadock, B. J. & Sadock, V. A. (2008). Concise textbook of Clinical Psychiatry.

Hall, B. (2013). Chapter 5: Depression In College of Psychiatric and Neurologic Pharmacists (Eds.), BCPP examination review and recertification course Lincoln, Nebraska: College of Psychiatric and Neurologic Pharmacists.

Miller, W.R. & Tonigan, J.S. (1996). Assessing drinkers' motivation for change: The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES), Psychology of Addictive Behaviors, 10(2), 81-89.

Adventist Behavioral Health
Quality Assurance Program for the Treatment Protocol for Substance Abuse Psychiatric Inpatient Populations

Scope
Adventist Behavioral Health (ABH) provides inpatient treatment for those patients with mental illness or substance abuse problems or both. The goal of the treatment program is standardized screening assessments; comprehensive psychiatric/substance abuse history; identification of patients in need of detoxification; treatment for withdrawal prevention and peer/staff support as well as rehab referral upon discharge. This quality assurance program is specific to the practice, process and outcomes related to the Treatment Protocol for Geriatric Psychiatric Inpatient Populations.

Purpose
The purpose of the Quality Assurance Program for the Treatment Protocol for Geriatric Psychiatric Inpatient Populations is to ensure there is a systematic process in place to measure, assess, evaluate and improve our organizational performance in this population. This Quality Assurance Program provides for measurements regarding the stability of systems and processes. There is also further evaluation of outcomes to help determine priorities for quality improvement.

Methodology
The Treatment Protocol for Geriatric Psychiatric Inpatient Populations will be reviewed through a random sample of closed medical records, examining the three phases of the protocol: 1) initial evaluation/screening; 2) detoxification/replacement therapies; and 3) peer/staff support as well as rehab referral upon discharge.

The two indicators in this program include:

A) *Compliance* as defined by patient completing all three stages Treatment Protocol for Geriatric Psychiatric Inpatient Populations program. The Program is comprised of three stages: 1) initial evaluation/screening; 2) detoxification/replacement therapies; and 3) peer/staff support as well as rehab referral upon discharge. For this measure each phase will be evaluated for a yes or no response.

B) *Improved Outcomes* will be defined as positive movement in outcomes as measured through the assessments completed at admission and then again at discharge and readmission rates.

<u>Outcomes Measures</u>

- Stages of Readiness and Treatment Eagerness Scale (SOCRATES 8A). The SOCRATES will be given to all patients with substance abuse/dependence once on admission and once upon discharge.

- 30 Day Readmission Rate: Data monitored on all patients as an outcome measure of overall level of treatment success

Data will be analyzed and presented to the ABH Performance Improvement Committee and other stakeholders for review, feedback and action.

Model (PDCA)

The Quality Assurance Program will follow the continuous improvement model Plan, Do, Check, Act. All collected data will be reviewed at the ABH Performance Improvement Committee. Variance in data or benchmarks will be reviewed by the committee; action plans created and monitored using the PDCA model.

Evaluation

The Quality Assurance Program for Substance Abuse Disorders in Psychiatric Inpatient Populations will be reviewed during the Program Evaluation for Substance Abuse Disorders in Psychiatric Inpatient Populations.

Adventist Behavioral Health
Program Evaluation for the Treatment Protocol for Substance Abuse Psychiatric Inpatient Populations

I. Executive Summary

To evaluate an inpatient psychiatric program that addresses the specific needs of those patients with substance abuse disorders. The program provides comprehensive assessments to determine medical, psychiatric, behavioral and psychosocial needs of those patients with substance abuse disorders. Treatment interventions are diverse and include initial evaluation/screening for drugs and alcohol, detoxification/replacement therapies, peer/staff support, and rehab referral upon discharge. This evaluation focuses on structure, process and clinical outcomes for those inpatient psychiatric patients with substance abuse disorders.

II. Introduction to the report

A. Purpose of the evaluation

The purpose of this evaluation is to apply the standards of the Program for substance abuse disorders in psychiatric inpatients to determine value, quality, utility, effectiveness and significance; which can lead to recommendations intended to inform clinicians about best practice for the patient with a co-occurring psychiatric diagnoses and a substance use disorders. The evaluation will be completed annually or as needed. In addition; the evaluation can help stakeholders determine the effectiveness of the program for substance abuse disorders in psychiatric inpatients and the continuation and/or expansion.

B. Audiences for the evaluation report

Centers for Medicare and Medicaid Services (CMS), Joint Commission (JC), Maryland Office of Health Care Quality (OHCQ), payors, family, patient, community mental health providers, mental health advocacy groups, State or Federal agencies such as Substance Abuse and Mental Health Services Administration (SAMHSA), primary care providers, Adventist Healthcare (AHC) and Adventist Behavioral Health (ABH) administrators, ABH employees, and others as identified.

C. Limitations of the evaluation and explanation of disclaimers (if any)

D. Overview of report contents

III. Focus of the evaluation

A. Description of the evaluation object

The Clinical Guidelines for Substance Use Disorders In Psychiatric Inpatient Populations, is comprised of three stages: 1) Initial Evaluation/Screening 2)

Detoxification/Replacement Therapies and 3) Peer/Staff Support as well as Rehabilitation Referral upon Discharge.

B. Evaluative questions or objectives used to focus the study

Program goals and objectives focus on abuse and dependence of alcohol, opiods, inhalants, nicotine, stimulants, and PCP/hallucinogens. Standard operating procedures are used to evaluate and to document intoxication, detoxification, as well as withdrawal prevention.

C. Information needed to complete the evaluation
   - Clinical guidelines for substance use disorders on psychiatric inpatient populations
   - Data collection instruments (surveys, observation data, interviews, chart reviews)
   - Methods and techniques used to analyze and interpret the data
   - Policy and procedures
   - Evidence based/clinical guidelines for caring for inpatient psychiatric patients with substance abuse disorders

IV. Brief overview of evaluation plan and procedures

V. Presentation of evaluation results

A. Summary of evaluation findings

B. Interpretation of evaluation findings

VI. Conclusions and recommendations

A. Criteria and standards used to judge evaluation object

B. Judgments about evaluation object (strengths and weaknesses)

C. Recommendations

VII. Minority reports or rejoinders (if any)

VIII. Appendices

A. Description of evaluation plan/design, instruments, and data analysis and interpretation

1. Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES 8A): Given to all patients with substance abuse/dependence once on admission and once upon discharge.

2. 30 Day Readmission Rate: Data monitored on all patients as an outcome measure of overall level of treatment success.

B. Detailed tabulations or analyses of quantitative data, and transcripts or summaries of qualitative data

C. Other information, as necessary

References

Chen, H. (2005). Practical Program Evaluation: Assessing and Improving Planning, Implementation and Effectiveness. Sage Publications. Thousand Oaks, CA.

Fitzpatrick, J., Sanders, J., & Worthen, B. (2004). Program Evaluation: Alternative Approaches and Practical Guidelines. 3rd Edition. Pearson Education, Inc. Boston, MA.

Isaac, S. & Michael, W. (1995). Handbook in Research and Evaluation: For Education and Behavioral Sciences. 3rd Edition. Educational and Industrial Testing Services. San Diego, CA.

Measures
Wadhington Adventist Hospital Acute Care-HBIPS
HB-1 Admission screening for violence risk, substance abuse, psychological trauma and patient strengths completed
HBIPS-1a Admission Screening- Overall Rate
HBIPS-1d Admission Screening- Adult (18 through 64 years)
HBIPS-1e Admission Screening- Older Adult (≥65 years)
HB-2 Hours of physical restraint use
HBIPS-2a Physical Restraint- Overall Rate
HBIPS-2d Physical Restraint- Adult (18 through 64 years)
HBIPS-2e Physical Restraint- Older Adult (≥ 65 years)
HB-3 Hours of seclusion
HBIPS-3a Seclusion- Overall Rate
HBIPS-3d Seclusion- Adult (18 through 64 years)
HBIPS-3e Seclusion- Older Adult (≥ 65 years)
HB-4 Patients discharged on multiple antipsychotic meds
HBIPS-4a Multiple Antipsychotic Medications at Discharge- Overall Rate
HBIPS-4d Multiple Antipsychotic Medications at Discharge- Adult (18 through 64 years)
HBIPS-4e Multiple Antipsychotic Medications at Discharge- Older Adult (≥ 65 years)
HB-5 Patients d/c on multiple antipsychotic meds with appropriate justification
HBIPS-5a Multiple Antipsychotic Medications at Discharge with Appropriate Justification-Overall Rate
HBIPS-5d Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Adult (18 through 64 years)
HBIPS-5e Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Older Adult (≥ 65 years)
HB-7 Post discharge continuing care plan transmitted to next level of care
HBIPS-7a Post Discharge Continuing Care Plan Transmitted- Overall Rate
HBIPS-7d Post Discharge Continuing Care Plan Transmitted - Adult (18 through 64 years)
HBIPS-7e Post Discharge Continuing Care Plan Transmitted - Older Adult (≥65 years)

Takoma Park Campus Overview

After the completion of the White Oak hospital, the Takoma Park campus will be re-developed, changing its focus to lower-intensive services more suited to campus conditions. In this respect, the proposed project makes the best use of an aging campus by changing some functions from clinical to non-clinical uses. Replacing high-intensity clinical services with low-intensity occupancies will reduce the strain on the infrastructure and utilities so that areas such as behavioral health can remain at Takoma Park with only moderate upgrades and expansions.

The re-development of the Takoma Park campus includes the following:

- Behavioral health services will remain in place in Takoma Park and will be licensed as part of Adventist Behavioral Health. As part of the modernization of this area, a portion of the existing 1990s building will be renovated to accommodate the conversion of semi-private rooms to private. This will connect to the existing unit via the existing corridor, making one larger behavioral health area. The existing patient rooms will then be converted from semi-private rooms to private rooms.

- The existing Emergency Department will be converted into space for a walk-in clinic, providing a community service and most logical re-use of the existing space. In response to the Takoma Park community, the walk-in clinic will initially operate 24/7 and future hours of operation will depend upon how much the service is utilized by the community. The layout of the clinic space is similar to an emergency department except that the required infrastructure (including utilities such as air flow) is not as demanding. The ingress and egress of the Emergency Department along with the close proximity of the existing parking make this program change from Emergency Department to clinic space straightforward and logical. The Federally Qualified Healthcare Center operated by Community Clinics, Inc., and the Women's Center clinic will be located in space in and near the current Emergency Department.

- Existing hospital support functions such as Laboratory, Pharmacy and Radiology will remain in their current configuration. They will continue to support the new programs at Takoma Park and the most cost-effective utilization of these spaces is to retain them as is.

The balance of the Takoma Park campus will be re-purposed for occupancies and services that make the most sense given the building condition and constraints. Building space will be renovated to house offices for physicians, and Washington Adventist Hospital will lease space to the adjacent Washington Adventist University. Adventist Rehabilitation Hospital of Maryland/Takoma Park will remain in its current space. The reasons for this are as follows:

- These occupancies have less stringent mechanical and plumbing requirements and have lower Energy Use Intensity so they will result in a net reduction of energy use and heating/cooling for the campus. This will in turn free up capacity in the existing utilities to upgrade services to the existing inpatient services which will remain.

- The ceiling heights in the existing Takoma Park buildings are low by current health care standards. Developing new inpatient units in these buildings would be challenging. It is more logical to change the occupancies in these areas to uses that will not be as challenging for the building. As a result, the ceiling height issues are mitigated.

The services in Takoma Park will meet the needs of the community while at the same time making the best use of the existing buildings. The combination of a new facility in White Oak, complete with inpatient and outpatient services within the hospital's primary service area, along with the services in Takoma Park, provide additional points of access to care for the community.

Takoma Park Services Project Construction Characteristics and Costs		
Base Building Characteristics	Complete if Applicable	
	New Construction	Renovation
Class of Construction		
Class A	n/a	n/a
Class B	n/a	B
Class C	n/a	n/a
Class D	n/a	n/a
Type of Construction/Renovation	n/a	n/a
Low	n/a	n/a
Average	n/a	Average
Good	n/a	n/a
Excellent	n/a	n/a
Number of Stories	n/a	4[1]
Total Square Footage	n/a	126,910[2]
Basement		42,240
First Floor		67,770
Second Floor		15,900
Third Floor		1,000
Fourth Floor		n/a
Fifth Floor		n/a
Sixth Floor		n/a
Seventh Floor		n/a
Eighth Floor		n/a
Penthouse Floor		n/a
Perimeter in Linear Feet		n/a, Interior Renovation
Basement		n/a
First Floor		n/a
Second Floor		n/a
Third Floor		n/a
Fourth Floor		n/a
Fifth Floor		n/a
Sixth Floor		n/a
Seventh Floor		n/a
Eighth Floor		n/a
Penthouse Floor		n/a
Wall Height (floor to eaves)		Varies by bldg.[3]
Basement		11 (Typical)
First Floor		11 (Typical)
Second Floor		11 (Typical)
Third Floor		11 (Typical)
Fourth Floor		n/a
Fifth Floor		n/a
Sixth Floor		n/a
Seventh Floor		n/a
Eighth Floor		n/a
Elevators		
Type *Passenger Freight*		
Number	n/a	n/a, Existing to Remain
Sprinklers (Wet or Dry System)	n/a	Wet
Type of HVAC System	n/a	Mechanically Ventilated
Type of Exterior Walls	n/a	n/a, Existing to Remain

NOTES: Values for renovation work include only renovated floors and areas of existing building. Floors and areas designated as existing to remain are excluded

1 Number of stories for renovation work at Takoma Park includes only floors on which renovations are taking place. Floors designated as existing to remain are excluded.

2 Total square footage values for renovation work at Takoma Park includes only renovated areas of the existing building. Areas designated as existing to remain are excluded

3 Wall heights at the existing Takoma Park campus vary. Wall height for renovation indicates the typical condition.

Chart 1. Project Construction Characteristics and Costs (cont.)		
	Costs	Costs
Site Preparation Costs		$0
Normal Site Preparation		n/a
Demolition		n/a
Storm Drains		n/a
Rough Grading		n/a
Hillside Foundation		n/a
Terracing		n/a
Pilings		n/a
Offsite Costs		$0
Roads		n/a
Utilities		n/a
Jurisdictional Hook-up Fees		n/a
Signs		$0
Landscaping		$0

Washington Adventist Hospital - Takoma Park
Behavioral Health & Walk-in Physician Clinic @ Takoma Park
CAPITAL BUDGET

A.	Uses of Funds		
1.	Capital Costs		Takoma Park
	a. New Construction		
	(1) Building & Fixed Equipment		-
	(2) Fixed Equipment (Included above)		-
	(3) Land Purchase		-
	(4) Site Preparation - Land Improvements		-
	(5) Architect/Engineering Fees		-
	(6) Permits, (Building, Utilities, Etc.)		-
	SUBTOTAL	$	-
	b. Renovations		
	(1) Building demolition		1,200,000
	(2) Renovations		10,100,000
	(3) Fixed Equipment		-
	(4) Architect/Engineering Fees		1,100,000
	(5) Permits, (Building, Utilities, Etc.)		100,000
	SUBTOTAL	$	12,500,000
	c. Other Capital Costs		
	(1) Major Movable Equipment		400,000
	(2) Minor Movable Equipment		200,000
	(3) Contingencies		700,000
	(4) Other (Specify)		
	a. Furniture		200,000
	b. Interior & Exterior Signage		-
	c. IS/Comm		300,000
	d. Security system		-
	e. Relocation expense		100,000
	f. Certifications, inspections, etc.		100,000
	g. Takoma Park Capital Facility Upgrades		2,300,000
			-
	TOTAL CURRENT CAPITAL COSTS (a - c)	$	16,800,000
	d. Non Current Capital Cost		
	(1) Interest (Gross)		-
	(2) Inflation Allowance (2.0% per year to midpoint of each construction phase)		1,300,000
	TOTAL PROPOSED CAPITAL COSTS (a-d)	$	18,100,000

Washington Adventist Hospital - Takoma Park
Behavioral Health & Walk-in Physician Clinic @ Takoma Park
CAPITAL BUDGET

2. Financing Cost and Other Cash Requirements:

a.	Loan Placement Fees	369,278
b.	Bond Discount	
c.	Legal Fees (CON Related)	
d.	Legal Fees (Other)	
e.	Printing	
f.	Consultant Fees	
	CON Application Assistance	
	Other (Specify)	
g.	Liquidation of Existing Debt	
h.	Debt Service Reserve Fund	
i.	Principal Amortization	
	Reserve Fund	
j.	Other (Specify)	
	TOTAL (a - j)	$ 369,278

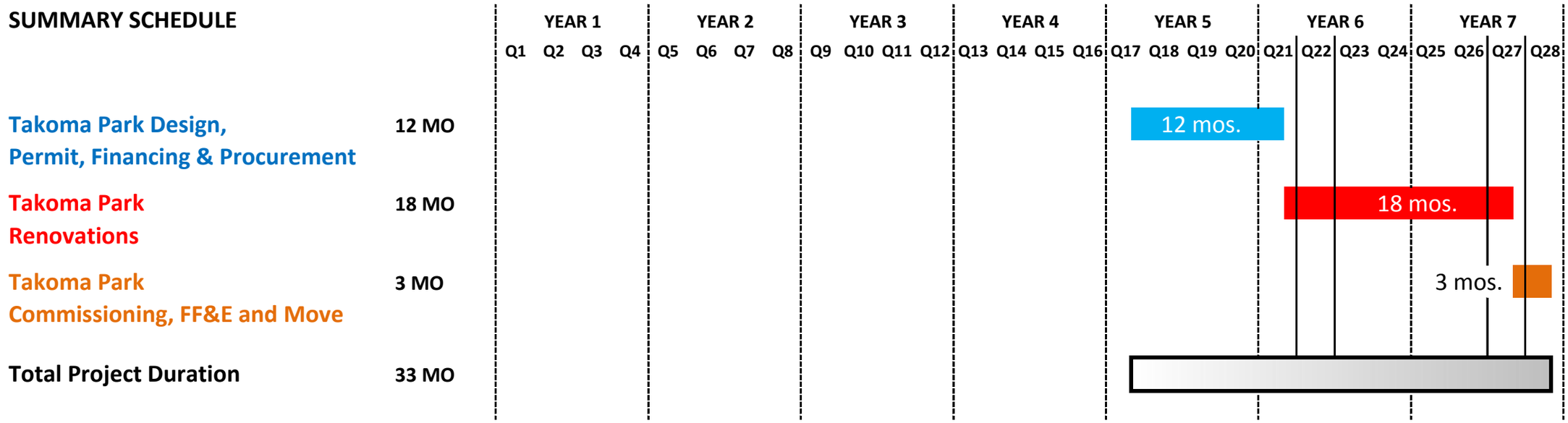
3. Working Capital Startup Costs

TOTAL USES OF FUNDS (1 - 3)	**$ 18,469,278**

B. Sources of Funds for Project:

		Phase 3 Takoma Park
1	Cash	-
2	Pledges: Gross _____, less allowance for uncollectables_____=Net	
3	Gifts, bequests	
4	Interest income (gross)	89,278
5	Authorized Bonds	18,380,000
6	Mortgage	
7	Working capital loans	
8	Grants or Appropriation	
	(a) Federal	
	(b) State	
	(c) Local	
9	Other (Specify) (Land)	
	TOTAL SOURCES OF FUNDS (1-9)	**$ 18,469,278**

WASHINGTON ADVENTIST HOSPITAL - TAKOMA PARK
BEHAVIORAL HEALTH & WALK-IN PHYSICIAN CLINIC
SUMMARY SCHEDULE



City of Takoma Park, Maryland

Office of the City Manager
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email: SuzanneL@takomaparkmd.gov

7500 Maple Avenue
Takoma Park, MD 20912
www.takomaparkmd.gov

Suzanne R. Ludlow, City Manager

April 10, 2018

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

Re: Request for Project Change After Certification – Adventist HealthCare – Washington Adventist Hospital – Docket No. 13-15-2349

Dear Mr. Steffen:

As the Maryland Health Care Commission considers the recent Adventist HealthCare (AHC) Request for Project Change After Certification and its closely related request for an exemption from a Certificate of Need, the City of Takoma Park asks for the opportunity to present testimony to the Commission before it makes a determination about AHC's proposed changes. The Request for Project Change and the exemption request filed by AHC would, if approved, completely undermine the commitments made in the approved 2015 Certificate of Need (CON). Rather than continue to provide Takoma Park with access to a spectrum of health care services when Washington Adventist Hospital's main hospital is moved to White Oak, the City could be left with virtually nothing. These filings have left our community with no confidence that AHC plans to provide any desirable health care services in Takoma Park. Our duty to our residents requires us to continue our work to mitigate the lasting health care and economic impacts the hospital's move will have on our community.

Adventist HealthCare is now seeking to eliminate a 24 bed rehabilitation hospital and a 40 bed inpatient psychiatric hospital that it represented to the Commission would remain on the Takoma Park Washington Adventist Hospital (WAH) campus and be upgraded to "anchor" other health care services to be provided there. AHC seeks to move the rehabilitation hospital to White Oak, and to move the critically important psychiatric facility 18 miles away to Rockville.

AHC made extensive promises regarding the provision of health care services on the Takoma Park Campus, which it cited, and the Commission relied upon, in the CON filings. The health services to remain on the Takoma Park campus were to help retain some of the White Oak hospital's market share in Takoma Park and surrounding areas and to mitigate the adverse effects of the relocation to White Oak. Those services were to include inpatient rehabilitation and psychiatric care, primary care, outpatient radiology and laboratory services, 24-hour urgent care, and even the ability to use shuttle services to the White Oak hospital. Now, as AHC seeks to renege on its promises to the Commission, it is also asking the Commission to bend its regulations past the breaking point and allow it to eliminate the

services slated to remain in Takoma Park and significantly revise its plans for White Oak – without regulatory scrutiny.

Allowing AHC to proceed with the changes without proper scrutiny would set a terrible precedent, encouraging future CON applicants to engage in similar bait-and-switch Application/Change Request practices and leaving the Commission powerless to stop them.

Takoma Park agrees with many of the legal and procedural concerns detailed in the March 29, 2018, letter from Gallagher Evelius & Jones LLP on behalf of Holy Cross Hospital of Silver Spring.

AHC officials have advised the City that the loss of the rehabilitation center and behavioral health unit means that the other health services planned for the Takoma Park campus likely will also depart. An urgent care facility will remain, AHC has said, because it is a specific condition of the CON approval, but it will not have the support services or location described in the CON. For example, the radiology and laboratory services, major components of what was promised to be left, will no longer be available for the center. And, the center would not be located in the space currently used by the Emergency Department, as described in the CON, so residents may not even know of its existence. The possibility of a large boarded vacant hospital building on the relatively small site will mean that few would want to even venture onto the campus to look for the urgent care center. This, of course, seems to be the intent so that AHC may again approach the Health Care Commission via an administrative process to request elimination of the Takoma Park urgent care CON condition with the argument that the urgent care is not being heavily used.

The City of Takoma Park asks that the Maryland Health Care Commission require that the 24-hour urgent care clinic be located on an attractive, visible site, and that the clinic have the on-site radiology and laboratory services that excellent urgent care facilities are expected to have.

While the City is concerned about the quality and viability of the urgent care clinic, it is the moving of the behavioral health services from the Takoma Park campus to Rockville that is the greatest health care concern of the City and of many in the surrounding region in Montgomery and Prince George's Counties. How will this move affect the quality of mental health services available to our community? How will emergency petition patients be handled, particularly if they present themselves or are brought by family members to the Takoma Park urgent care clinic? How will the emergency departments of other hospitals accommodate the increase in emergency petition patients coming to their facilities? Without hearing from the impacted jurisdictions and health care facilities, how will the State Health Care Commission know that the changed service level for behavior health care is acceptable?

Moving the inpatient behavioral health unit from Takoma Park to Rockville also constitutes a significant change to the 2015 CON and is not the proper subject of a CON exemption. The Commission deemed the psychiatric beds, which currently are part of WAH, to be a subject of the CON and imposed an express condition that WAH report on the operation of the Takoma Park psychiatric hospital in the fourth year of the operation of the new hospital. WAH is asking the Commission to allow the relocation of the psychiatric beds to Rockville, 18 miles away, as if the 2015 CON and the promises WAH made to obtain that CON do not exist.

Besides the changes proposed for the urgent care clinic and the behavioral health services, moving the rehabilitation beds from Takoma Park to White Oak is also troubling. It clearly is not a permissible project change. Under section 10.24.01.17C(2) of the Commission's regulations, "[c]hanges in the

fundamental nature of a facility *or the services to be provided in the facility* from those that were approved by the Commission" require a new Certificate of Need. AHC is seeking to add two stories to its planned general hospital to house inpatient rehabilitation beds, a service that was not part of the approved plan for White Oak. Accordingly, AHC's proposal is not the proper subject of a change request and mandates a new CON application. AHC's attempt to move the rehabilitation beds without a CON is particularly outrageous because maintaining a rehabilitation hospital in Takoma Park was an integral part of AHC's plan under the 2015 CON that supposedly reduced the cost of the White Oak project and would contribute to the financial viability of the Takoma Park campus.

Significant investments (of over $18 million) were to be made to the facilities on the Takoma Park campus, and the financial information about those investments was part of the CON filing. The Takoma Park campus buildings are aging, the parking facilities are in poor condition and the property has almost no stormwater infrastructure. Improvements to the interior and exterior of the facilities were planned to help ensure the success of the inpatient specialty hospitals. Now, it is not clear what AHC intends to do with the bulk of those funds. In the exemption request to the Commission, AHC notes it plans on using the $5.3 million that had been designated for enlarging and renovating the behavioral health unit in Takoma Park to pay for adding the psychiatric beds to the Shady Grove facility. In the Request for a Project Change to the Commission, AHC says it plans to use the same $5.3 million to help pay for the two additional floors on the White Oak hospital for the rehabilitation hospital. In that Request for a Project Change, AHC notes that the costs for the moving of the rehabilitation hospital and behavioral health unit can be "easily absorbed by AHC given its strong financial position." (p. 4)

Besides not living up to its commitments in the CON, it is clear that AHC intends to walk away from Takoma Park, leaving the vacant remains of its buildings for others to deal with. This is unacceptable. This is not a situation of a bankrupt hospital closing and unable to clean up its site. AHC is a hospital system that is building a new facility and that had budgeted to reinvest $18 million in its Takoma Park campus, and now simply wishes to leave as quickly and as cheaply as possible.

We request that the Maryland Health Care Commission hear from the City of Takoma Park on the effects of the WAH abandonment of Takoma Park and the mitigation measures that are needed if the AHC requests are approved.

We have been advised that there is no official requirement for Takoma Park to be included as a stakeholder in deliberations around these types of filings. We also understand that there is no public comment period or other means of participation for Takoma Park, Montgomery County and Prince George's County residents. Takoma Park invested significant taxpayer dollars on legal and healthcare expert fees and dedicated valuable manpower and City Council Meeting agenda time during the six-year CON process to protect its residents from the loss of vital health care services and to ensure that the 13-acre campus remained vibrant despite the loss of the main hospital. We request that the Commission solicit input from the affected parties and the public before acting on AHC's requests.

Since the Commission issued the CON in 2015, hospital representatives have met regularly with City officials regarding WAH's transition to White Oak and led the City to believe they intended to reuse the Takoma Park campus in accordance with the plans approved in the CON. Simultaneously, however, AHC planned for the abandonment of the Takoma Park campus in direct contradiction of the promises it made in the CON process. During the monthly meetings with the City, WAH officials gave no indication that it was planning to relocate the psychiatric and rehabilitation facilities to Rockville and White Oak, planning to eliminate the radiology and laboratory services that were to be available to the public and

used by the urgent care center, and planning to relocate the urgent care center from the current hospital's emergency department to an as-yet unidentified location on or near the Takoma Park campus.

We believe AHC withheld this information from us so that it could pursue a series of administrative efforts to get approvals from the Maryland Health Care Commission without having to file for a new Certificate of Need and without having to consider the impacts of the changes on the entities most affected.

The Maryland Health Care Commission is the regulatory agency responsible for planning for health system needs. The Commission spent six years carefully analyzing AHC's proposal to ensure that it would not have an adverse impact on the health care system in the region. We appreciate that the Commission took seriously the City of Takoma Park's concerns throughout that process. We ask the Commission to continue to uphold its responsibility and carefully analyze the impact of the AHC's proposed changes. If the Commission acts to approve the requests by Adventist HealthCare, we ask you to impose conditions to mitigate the adverse impacts on our community. The City of Takoma Park would like to discuss possible mitigation measures with the Commission, but at a minimum, such conditions should include:

- Ensuring that the 24-hour urgent care center has radiology and laboratory services appropriate for an excellent urgent care facility, and that the facility is located in a visible, attractive and easily accessible location.
- Razing the vacated hospital buildings on the Takoma Park campus, and restoration of the site with sod and appropriate erosion, environmental and public safety measures, within four months of the hospital's move to the White Oak facility.
- Addressing the issues raised by moving the behavioral health unit to Rockville, including identifying community mental health programs near Takoma Park and ensuring that nearby health facilities are able to accept and appropriately care for the number of emergency petition patients that will need services.

Despite the questionable outline of savings presented in AHC's filing, we assure you that the costs and impacts to Takoma Park, Montgomery County and Prince George's County will be significant. Washington Adventist Hospital has been the City's largest employer for many decades. We had expected to see health services and jobs remain at the Takoma Park campus. At this point, WAH's complete and total departure from Takoma Park represents a stunning loss to our community.

We are deeply disappointed in the direction this process has taken and urge you to consider the issues outlined above. We are committed to working with you as the review process for AHC's filing moves forward and would be happy to provide additional information to support our case.

Regards,

Suzanne R. Ludlow

Suzanne R. Ludlow
City Manager

CC: Robert R. Neall, *Secretary of Health*
Kevin R. McDonald, *Chief, Certificate of Need Division*

Isiah Leggett, *Montgomery County Executive*
Rushern Baker, *Prince George's County Executive*
Dr. Travis A. Gayles, M.D., PhD., *Health Officer, Montgomery County*
Pamela B. Creekmur, R.N., *Health Officer, Prince George's County*
Takoma Park City Council
Montgomery County Council
Prince George's County Council

Takoma Park City Council Meeting – May 25, 2022
Agenda Item 3

Voting Session
Resolution to Approve a Letter to the Maryland Healthcare Commission Expressing Support for Adventist HealthCare's Request for Modification of the White Oak Medical Center Certificate of Need & Proposed Healthcare Services in Takoma Park

Recommended Council Action
Approve Resolution

Context with Key Issues
In collaboration with a Council subcommittee including Mayor Stewart, Councilmembers Kovar and Dyballa, and City management, Adventist HealthCare has developed an updated proposal for future healthcare services in Takoma Park after the eventual closure of the urgent care. At the center of the Adventist Healthcare proposal is a new primary care office in the medical office building located on the former Washington Adventist Hospital Campus. The medical office building is the first building on the left as you enter the campus from Carroll Avenue. It has its own parking lot, offering convenient access for patients. Importantly, this property is not owned by Adventist HealthCare and, therefore, is not included in the pending sale of the former hospital campus to Washington Adventist University. In addition, the Adventist Healthcare proposal includes a commitment to provide behavioral health counseling embedded in the primary care office as well as to donate space for a behavioral health crisis response center in Takoma Park.

On April 20, Andrew R. Nicklas, Deputy General Counsel & Director of Government Relations for Adventist HealthCare, presented the updated proposal to the City Council. The Adventist Healthcare Request for Modification of the White Oak Medical Center Certificate is scheduled to be an agenda item on the Maryland Healthcare Commission (MHCC) June 16 meeting. The Request for Modification submission to MHCC includes the updated proposal for healthcare services in Takoma Park. If this resolution is approved, the City Council Letter of Support will be appended to Adventist Healthcare's Request for Modification submission to show that the City of Takoma Park is supportive of the proposed healthcare services.

Council Priority
Livable Community for All

Environmental Considerations
The proposal involves pre-existing buildings within City limits.

Fiscal Considerations
Adventist Healthcare is not asking for a financial commitment from the City in their updated proposal.

Racial Equity Considerations
Healthcare in Takoma Park is a top priority to meet the health care needs of disadvantaged, underserved, and chronic need populations.

Attachments and Links
- Draft Resolution

- AHC Request to Modify Certificate of Need Condition
- Takoma Park City Council Letter of Support for AHC's Request to Modify

Introduced by:

CITY OF TAKOMA PARK, MARYLAND

RESOLUTION 2022-

RESOLUTION APPROVING A LETTER TO THE MARYLAND HEALTHCARE COMMISSION EXPRESSING SUPPORT FOR ADVENTIST HEALTHCARE'S REQUEST FOR MODIFICATION OF THE CERTIFICATE OF NEED FOR THE WHITE OAK MEDICAL CENTER

WHEREAS, Adventist Healthcare (AHC) has filed a request with the Maryland Healthcare Commission for Modification of the Certificate of Need for the White Oak Medical Center (Docket No. 13-15-2349); and

WHEREAS, the request is to close the Urgent Care Center currently located on the former Washington Adventist Hospital campus and replace it with a primary care office with embedded behavioral health counseling; and

WHEREAS, the offices are proposed to be located in the medical office building on the former hospital campus; and

WHEREAS, AHC has also committed to the City to donate a physical space in that building for a behavioral health crises response center that will be established through a partnership with the Montgomery County Department of Health and Human Services.

NOW, THEREFORE, BE IT RESOLVED THAT the City Manager and Mayor are authorized to sign the attached letter to the Maryland Healthcare Commission supporting the proposal from Adventist Healthcare and the Request for Modification of the Certificate of Need.

Adopted this ____ day of May, 2022.

May 25, 2022

Paul E. Parker
Director, Center for Healthcare Facilities Planning & Development
Maryland Healthcare Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Parker,

The Takoma Park City Council and City Manager would like to express our support for the Request for Modification of the Certificate of Need for the White Oak Medical Center from Adventist Healthcare (Docket No. 13-15-2349). The Request for Modification is based on the Adventist Healthcare Proposal for Healthcare Services in Takoma Park. This proposal is endorsed by the City following several months of robust discussion between Adventist Healthcare and City leadership.

The services offered by Adventist Healthcare (AHC) to replace the urgent care center have evolved significantly since the AHC July 2021 modification request. The expanded scope of the new AHC services resulted from direct feedback from both Councilmembers and City staff as to what types of services our City residents would need to compensate for the loss of the urgent care center. We believe the updated proposal is much improved and will make a valuable contribution to the work of meeting the health care needs of the Takoma Park community. We thank the AHC executive team for their regular involvement in workgroup discussions since January 2021.

The AHC augmented proposal includes the establishment of a primary care office with embedded behavioral health counseling. AHC has also committed to donating a physical space for a behavioral health crisis response center that will be established through a partnership with the Montgomery County Department of Health and Human Services. Primary healthcare that is sustainable and preventative will benefit all of our residents.

Behavioral healthcare for residents in crisis is another pressing need in our community. We look forward to supporting the enhanced proposal to be presented by the AHC team at the June 16th Maryland Healthcare Commission meeting.

The City of Takoma Park will continue to engage with Adventist Healthcare in partnership in the coming months to monitor the impact of these services on healthcare in our community and to facilitate the crisis response center. In particular, we look forward to updates from Adventist Healthcare on the volume of patients, the patients' demographic profiles and diagnoses, and the status of proposal implementation among other measurable outcomes.

We greatly appreciate the Maryland Healthcare Commission's ongoing efforts to work with the City and its healthcare stakeholders to ensure that the healthcare needs of our residents are met. Please let us know if there is any additional information we can provide.

Sincerely,

Mayor Kate Stewart for the Takoma Park City Council

Jamal Fox, City Manager of Takoma Park

IN THE MATTER OF **WASHINGTON ADVENTIST HOSPITAL (NOW ADVENTIST HEALTHCARE WHITE OAK MEDICAL CENTER)** **DOCKET NO. 13-15-2349**	**BEFORE THE MARYLAND** **HEALTH CARE** **COMMISSION**

REQUEST FOR APPROVAL TO MODIFY
A CERTIFICATE OF NEED CONDITION

Adventist HealthCare, Inc. (AHC) d/b/a Adventist HealthCare White Oak Medical Center (WOMC), requests the Maryland Health Care Commission (the Commission) to modify a condition of the certificate of need (CON) issued to WOMC (the Condition) in the above-captioned CON review which permitted the hospital, formerly named Washington Adventist Hospital, to relocate to its current cite.

The Condition states:

> Adventist HealthCare, Inc. must open an urgent care center on its Takoma Park campus coinciding with its closure of general hospital operations on that campus. The urgent care center must be open every day of the year, and be open 24 hours a day. Adventist HealthCare, Inc. may not eliminate this urgent care center or reduce its hours of operation without the approval of the Maryland Health Care Commission.

This filing seeks modification of the Condition to enable AHC to operate a primary care office in Takoma Park with embedded behavioral health counseling

services in lieu of the urgent care. AHC proposes the modified condition read as follows:

> With its closure of the urgent care center on the former Washington Adventist Hospital campus, Adventist HealthCare, Inc. shall open a primary care office with embedded behavioral health counseling in Takoma Park as outlined in Exhibit A. Adventist HealthCare, Inc. may not eliminate these~~is~~ services without the approval of the Maryland Health Care Commission.

Furthermore, working with representatives of the City of Takoma Park and Montgomery County, AHC will donate a physical location for the establishment of a behavioral health crisis response center in Takoma Park. In developing this petition, AHC engaged extensively with representatives of the City of Takoma Park as evidenced by the letter of support from the City endorsing this filing. AHC will update the City of Takoma Park on the status of implementation of these new services.

A. BACKGROUND

AHC previously appeared before the Commission in July of 2021, requesting approval to reduce the hours of the urgent care in Takoma Park from 24 hours per day to 12 hours per day. As part of the modification request, AHC offered to develop a plan to provide needed, sustainable primary healthcare services in Takoma Park. The Commission denied that proposal, preferring that AHC develop a plan to provide services in Takoma Park before approving a modification to the Condition. The Commission requested that AHC engage with representatives from the City of

Takoma Park in developing this plan. Since that time, AHC engaged extensively with City of Takoma Park representatives.

In November 2021, AHC presented a proposal to the Takoma Park City Council to replace the urgent care with a primary care office and behavioral health counseling services and to support establishing a local behavioral health crisis response center. Councilmembers had several questions and recommended forming a workgroup to examine the proposal in detail. From January through April of 2022, AHC participated in regular workgroup meetings. To demonstrate our commitment to the process and to facilitate a robust and in-depth discussion, AHC brought several executive leaders and subject matter experts to these meetings. The members of the workgroup for both AHC and the City of Takoma Park included:

- Kate Stewart, Mayor of Takoma Park
- Peter Kovar, Ward 1 Councilmember
- Cindy Dyballa, Ward 2 Councilmember
- Jessica Clarke, Deputy City Manager
- Dr. Marissa Leslie, AHC Medical Director of Behavioral Health Services
- Mary McNamara Ward, AHC Vice President, Physician Network Operations
- Kandy McFarland, AHC Interim Vice President of Behavioral Health
- Kim Emerson, AHC Director of Behavioral Health Integration, and
- Andrew Nicklas, AHC Deputy General Counsel.

These meetings helped AHC better understanding the needs of Takoma Park residents and helped City representatives better understand the scope of the proposed services. Ultimately, the workgroup's efforts resulted in the augmented proposal attached hereto as Exhibit A. This proposal was presented, in-person, to the Takoma Park City Council in April of 2022 and has been endorsed by the City via their letter of support.

B. THE URGENT CARE IN TAKOMA PARK IS NOT SUSTAINABLE

AHC has operated the urgent care in Takoma Park since August 26, 2019. Both AHC and Commission staff made reasonable, good faith projections that the urgent care would be well utilized. AHC invested nearly $450,000 in startup expenses including renovations and medical equipment. AHC promoted the urgent care through multiple forms of media and in multiple languages, including

- Direct mail sent to local residents
- Social media promotions (See: https://www.facebook.com/AdventistUCTakomaPark/);
- An article in the Takoma Park newsletter
- Website updates on all AHC related sites
- Inclusion of the UCC on material announcing the WOMC
- Additional flyers and handouts distributed at public events, and
- Inclusion of Takoma Park on AHC Urgent Care outdoor advertising.

Information on the hours of operation and public transportation options to reach the urgent care are readily available on the website.

Despite these efforts, AHC continues to experience low patient volumes. Since opening in August 2019 through October 2021, the Takoma Park urgent care

has seen approximately half the patients as the three other former AHC urgent cares – despite being the only center open 24 hours. In 2021, the Takoma Park urgent care saw an average of 25 patients per day compared to approximately 44 to 50 patients per day in the three other centers – again despite being the only one open 24/7. (See Exhibits B & C)

Takoma Park is served by five urgent care centers in addition to the one operated by AHC. (See Exhibit D) Takoma Park will continue to have access to urgent cares without the AHC urgent care.

These low volumes make the Takoma Park urgent care unsustainable. From opening in August of 2019 through September of 2021, the urgent care lost over $2.2 million. From January through September of 2021, the Takoma Park urgent care lost $740,874 while the other three AHC urgent care centers each earned a profit ranging from nearly $150,000 to over $230,000. This is not to say that earning profits is the primary goal of health care, however, AHC cannot sustain this operation with annual losses of nearly $1 million. (See Exhibit E & F)

Significant staffing challenges add to the operational struggles of the urgent care and contribute to the financial losses. Recruiting staff has become so difficult that it is nearly untenable. AHC is forced to hire contract staff at a significantly greater cost and is still struggling to find people. These higher costs exacerbate the financial distress caused by the low patient volumes.

Continuing urgent care operations is simply not viable for AHC. Furthermore, AHC has chosen to step away from urgent care operations as a whole.

CFG Health Care, an established urgent care operator, has been brought on to take over operations of the other three AHC urgent care locations under the name Patriot Urgent Care. AHC has chosen to focus on building an extensive clinically integrated network of community providers. This strategy more directly supports AHC's goal of keeping people healthy, managing chronic conditions, reducing acute issues, and improving the overall health of the communities we serve. For these reasons, we believe the services proposed in this filing will better serve the City of Takoma Park.

C. PROPOSED SERVICES FOR TAKOMA PARK

AHC met extensively with City representatives to understand the healthcare needs of City residents. As part of a discussion about access to primary care, the most pressing needs we heard were related to behavioral health. AHC has assessed this information and, in response, proposes a suite of targeted healthcare services that we believe will best meet these needs.

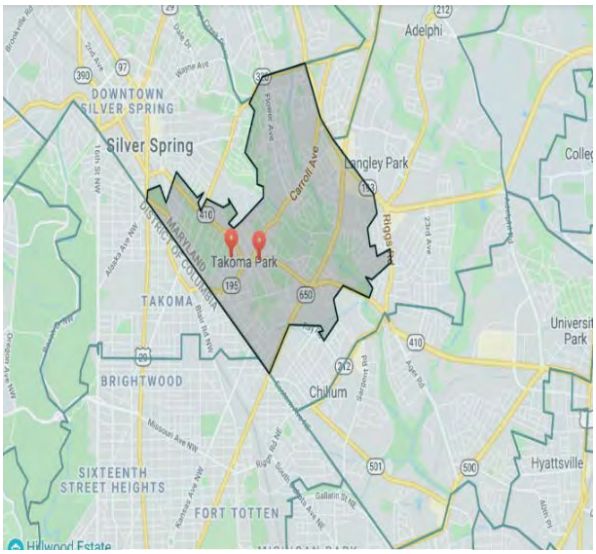
i. Primary Care with Embedded Behavioral Health Counseling

AHC has built the largest clinically integrated network of community providers in Maryland. Expanding access to community-based care improves health outcomes by reducing acute issues through routine preventative care and proper management of chronic conditions. Therefore, AHC proposes to establish a new primary care office with additional embedded behavioral health counseling services in the medical office building on the former hospital campus. The office

has been newly renovated and can be opened within a matter of weeks after approval of this petition.

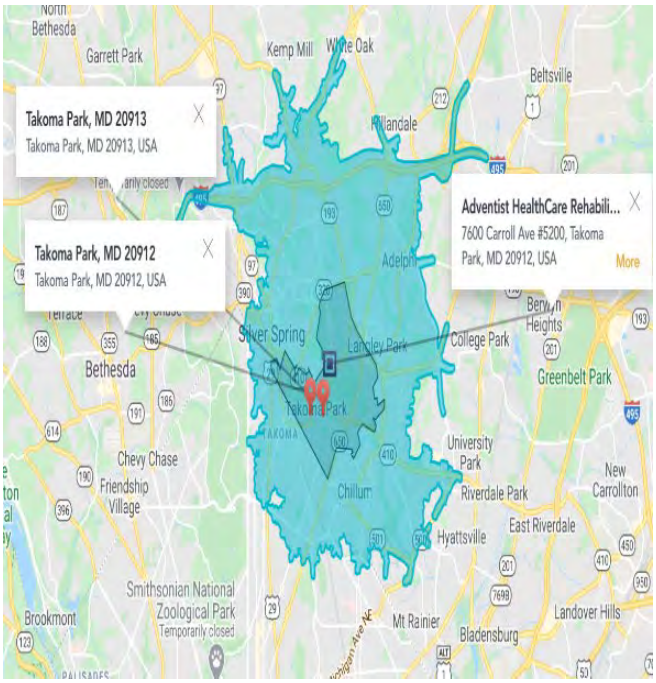
a. Primary Care

AHC conducted a market analyses to assess the ambulatory care needs of the Takoma Park community. The primary service area is comprised principally of two zip codes – 20912 and 20913, as depicted below:

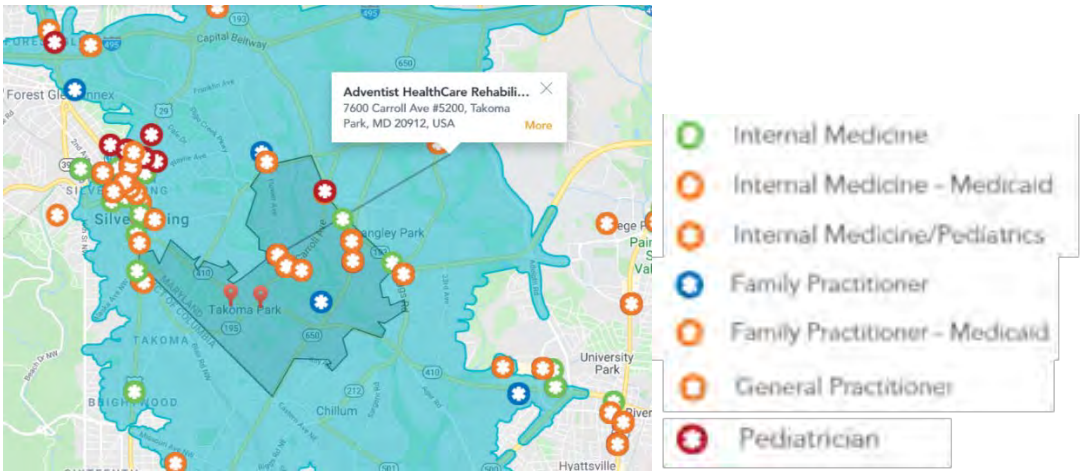


According to the 2020 Census, the total population for this area is about 26,000 persons with approximately 10,000 households and the median age is only 34 years old. The population is expected to grow slowly, with only 0.34% growth predicted by 2024. (Source: Buxton).

For the purposes of reviewing ambulatory needs data, AHC analyzed the zip codes map plus an area within a 20-minute drive time from the AHC urgent care in Takoma Park as displayed below.



The graphic below depicts primary care outpatient locations in Takoma Park and surrounding zip codes. AHC found that, compared to Montgomery County as a whole, there is a lack of primary care providers in Takoma Park despite a high demand for care. There are approximately 15 primary care locations within Takoma Park including private and community clinics with approximately 27 full time providers giving an overall ratio of 962 patients to every one primary care provider. As a comparison, Montgomery County, as a whole, has a ratio of approximately 732 patients to one primary care physician. Despite this deficiency in providers, there is a high demand for primary care as there were approximately 150,000 primary care visits in Takoma Park in 2018 – a care usage frequency of about 130% of the national average.

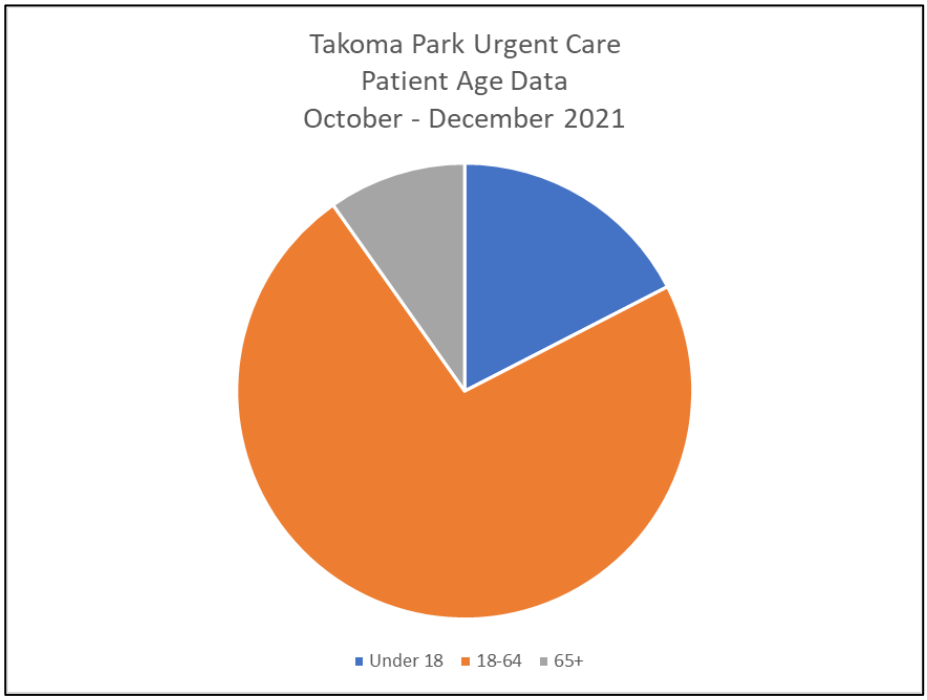


There are a number of primacy care providers in neighboring Silver Spring, including an existing AHC primary care office on Colesville Road. However, southern Takoma Park has far fewer primary care locations and could benefit from a primary care center focusing on family care which would be ideal given the young age range of the population.

The office would employ a family care practitioner and a medical assistant as well as support staff. It would offer a full range of primary care for patients, including preventative care and treatment of chronic conditions. The office would operate Monday – Friday from 8am to 5pm but patients would have 24/7 access to the on-call line with live answering. The office will be able to accommodate approximately 18-20 patients per day. AHC will consider expanded hours of operation as the office expands. This was the case in the AHC primary care office in Silver Spring, which has grown to sustain three providers. This is in comparison

to the urgent care which saw an average of 25 patients per day in 2021 – despite being open 24/7. [1]

AHC primary care offices serve patients from 16/17 years old through geriatric patients. It is industry standard to separate pediatric practices from general adult services as internists do not treat patients under 16. As you can see below, this potentially covers over 80% of the age range of patients seen at the urgent care. For families with younger children, AHC will meet with the current pediatric office down the hall from our proposed location, or other local practices, to build relationships for referrals.



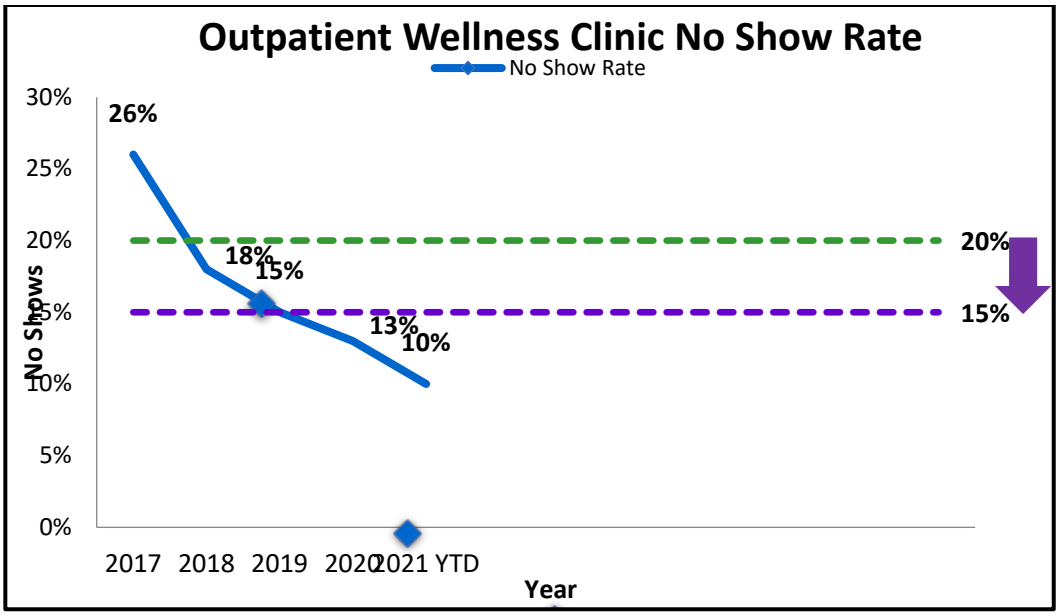
	Under 18	18-64	65+	Total
Total Visits	475	1983	267	2725
Percent of Total	17%	73%	10%	100%

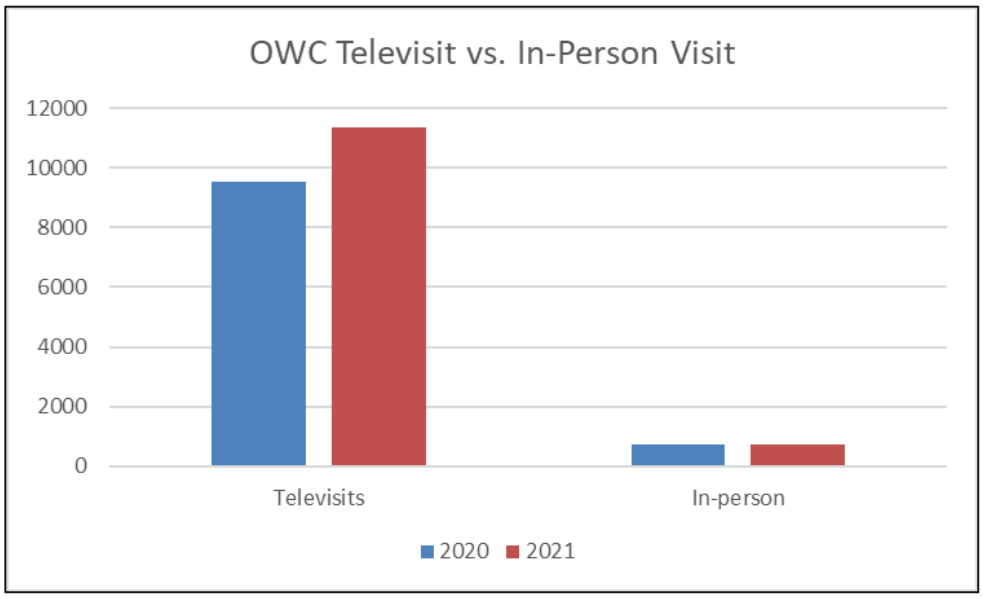
[1] See Exhibit C.

b. Behavioral Health Counseling

The new primary care office will also provide behavioral health counseling delivered both in-person and through telehealth. Counseling (provided by professional counselors and licensed social workers) and medication management (provided by psychiatrists and psychiatric nurse practitioners) will be available in-person one day a week and five days a week via telehealth. A private space with a computer will be made available at the office for patients without the technology or a private space for telehealth. A therapist can see approximately six patients per day in-person and exponentially more can be seen via telehealth depending on demand. As demand increases, the availability of in-person services can increase as well. Counseling services, unlike the physical care, will be available for children, adolescents, adults, and older adults. Services will be available in English and Spanish.

Telehealth has been transformational for behavioral healthcare. Patients are more easily able to access and comply with medication management and psychotherapy. Issues around transportation, busy work schedules, childcare, stigma, privacy, and difficulty leaving the house due to symptoms of their psychiatric diagnosis can all be eased with telehealth services. With the expansion of telehealth services, the "no-show" rate for behavioral health visits at AHC's outpatient wellness clinic has dropped to 10%.





	2020		2021	
	Count	% of Total	Count	% of Total
Televisits	9517	93%	11363	94%
In-person	736	7%	730	6%
Total	10253		12093	

Embedding counseling services within a primary care office facilitates access to behavioral health care. Primary care providers are the largest referral source to

behavioral counseling as patients often first report mental health concerns to their primary care provider. Additionally, AHC primary care and behavioral health services are clinically integrated and share an electronic medical record, allowing for enhanced collaboration on mutual patients and a streamlined referral process. Both behavioral and physical health services can be augmented to meet community demand.

c. Operations and Care Coordination

The physical and behavioral health services offered at the proposed primary care office offer patients an opportunity to develop a long-term relationship with a provider. Primary care focuses on preventative and chronic care management. Comparatively, urgent care visits are more transactional and focus on the issue being presented at the time. Establishing a long-term relationship with a provider leads to better health outcomes. Patients are more likely to complete regular wellness checks and screenings when they have a consistent primary care provider. This leads to early detection of potential health issues and provides an opportunity to take corrective actions to avoid future complications and crisis situations. Primary care practitioners have a more complete understanding of their patients' health. They can get to know patients on a personal level and gain a sense of all the things that may be affecting someone's health. This relationship enables primary care physicians to oversee a patient's care more effectively, coordinate among specialists as needed, and help patients reach their long-term health goals.

Community members seeking either physical or behavioral health care will not need any pre-existing relationship with AHC to access these services. Likewise, people seeking behavioral health services will not need to be patients of the primary care office. Anyone can contact the office and schedule a visit. If someone arrives without an appointment, staff will engage with them and work to get a visit scheduled.

The primary care office will accept the exact same insurance as the urgent care, including Medicaid, Medicare, and commercial insurance. The primary care office also has a charity care policy for those who are underinsured or uninsured that offers discounted rates for care. Interestingly, the payor mix at the AHC primary care office in Silver Spring is very similar to the payor mix seen at the urgent care in Takoma Park. The primary care office, however, unlike the urgent care, will assist individuals without insurance with enrolling in Medicaid.

Additionally, AHC primary care offices participate in the Project Access program. Project Access is a countywide program administered by the Primary Care Coalition and funded by Nexus Montgomery and Montgomery County to provide access to care for low-income, uninsured community members. AHC's clinically integrated network of providers participate in the program. From July through December of 2021, approximately 200 appointments were made for Project Access members to AHC physicians' offices within five miles of Takoma Park. Project Access members in Takoma Park will be able to seek care in their community and be referred to AHC's many local specialists and other specialists

who also participate in the program. Opening a primary care office in Takoma Park will expand access to care for vulnerable individuals who may be limited in their health care options.

The primary care model is rooted in the principles of integration and coordination between clinical care practitioners, patients, and community service providers. The vision of AHC is to build capabilities in primary care practices that will allow them to improve outcomes, reduce costs, and optimize patient experience. Using a powerful analytics tool, we can aggregate clinical data to identify patterns of healthcare issues impacting a community and develop strategic interventions to address these issues on a communal scale. These capabilities include coordination of evidence-based clinical, psychological, and social services interventions.

AHC has an associated community health and wellness division which provides targeted community-based health education programs and wellness screenings. AHC also offers free, targeted community behavioral health workshops. These clinics are offered in-person and, leveraging the telehealth platform, can now be offered virtually as well. Topics have included Coping with Stress, Anxiety and Depression, Mindful Eating, Mindfulness, Coping with Loneliness, and Grief & Loss (see Exhibit G). These approachable and accessible workshops have had strong attendance and have led several participants to pursue medication and/or psychotherapy services. AHC hosted 48 workshops in 2021 and 13 in the first quarter of 2022. Workshops are offered in English and Spanish but can be targeted to meet the needs of other ethnic communities. AHC will work with

community leaders to identify and reach out to communities in need and offer culturally appropriate services such as for the Ethiopian, French African, and Hispanic communities in Takoma Park.

AHC is committed to promoting the new primary care office to help ensure its success. We have developed a comprehensive marketing plan that includes traditional marketing via television, the internet, and print publications as well as direct community engagement with local businesses and community support organizations. See page 13 of Exhibit A for a detailed description of this plan.

Additional information on the operations of the primary care center and how these services compare to the services of the urgent care can be found in the proposal submitted to the City of Takoma Park attached here as Exhibit A. The AHC primary care model results in high quality, patient centered care and supports overall community health.

ii. Behavioral Health Crisis Response

AHC supports the City of Takoma Park's desire to establish a behavioral health crisis response center to serve individuals experiencing acute behavioral health episodes. City representatives clearly expressed a desire for local behavioral health crisis services, and while AHC does not provide this service directly, we will support the City's effort to establish this service. The crisis response center is being pursued through a partnership between the City of Takoma Park and Montgomery County representatives. Both have agreed that this service is needed and have identified public funds that can be used to establish an interim crisis center in the

City. One of the primary hurdles to moving this forward has been identifying an appropriate place to house the center. To that end, AHC will donate the physical space required. AHC has two units available in the medical office building on the former hospital campus[2] and AHC behavioral health clinical leaders have determined that they are both suitable for this purpose. AHC will also assist in recruiting the medical personnel to staff the center. Crisis center staff will not be employed by AHC, but we will leverage our access to the pipeline of behavioral health workers to help recruit the appropriate medical personnel. AHC will continue to work with City and County officials on this effort.

Additionally, AHC has connected Takoma Park representatives to the Nexus Montgomery Behavioral Health Workgroup that is examining behavioral health access across the County. This is a coalition of the Montgomery County Health Department and the County's four hospital systems. AHC supports ensuring that Takoma Park has a role as strategies are developed to address behavioral health access countywide.

D. CONTINUED COMMITMENT TO TAKOMA PARK

AHC has served the healthcare needs in Takoma Park since 1907 and remains committed to doing so. Throughout the COVID-19 pandemic, AHC has provided services to the community including free COVID testing, inpatient care, an

[2] These two units are in addition to the space currently set aside for the primary care office.

outpatient COVID-19 infusion center, and a robust Community Vaccination Clinic that administered over 20,000 doses to the community.

AHC has also continued to operate the Manor House in the City. The Manor House is an assisted living facility for adults with chronic and severe mental illness who are unable to live independently in a safe and supportive residential environment as an alternative to long-term psychiatric hospitalization.

Additionally, AHC provided free space on the former hospital campus to four different community organizations and the City of Takoma Park to support food distribution efforts in the community. We also recently contributed approximately $12,000 in staff and supplies to support flu vaccinations in the area.

E. CONCLUSION

AHC is proud if its history of service to the residents of Takoma Park. Through collaboration and partnership with City leadership, we have developed a plan to provide valuable, needed services in Takoma Park for years to come. AHC respectfully requests the Commission approve this petition.

Andrew R. Nicklas, Esq.
Deputy General Counsel
Adventist HealthCare
820 W. Diamond Avenue
Suite 600
Gaithersburg, MD 20878

Certificate of Service

I hereby certify on this 6th day of May 2022 a copy of the Request For Approval To Modify A Certificate Of Need Condition was emailed to

Wynee Hawk, Chief
Certificate of Need Section
Maryland Health Care Commission
wynee.hawk1@maryland.gov

_____
Andrew R. Nicklas

CASE NO. A-6938

APPEAL OF WASHINGTON ADVENTIST ACC, BOARD OF COUNCIL OF UNIT OWNERS by LAVANYA SITHANANDAM, MD, PRESIDENT

EXHIBIT LIST

1. Application

2. List of adjoining/confronting property owners

3. DPS Building Permit Number 1116230

4. Motion to Intervene from Patrick O'Neil, Esquire, attorney for subject property owner

5. (a) Envelope showing date notice mailed
   (b) Notice of hearing scheduled for December 17, 2025

6. Motion to Dismiss or for Summary Disposition from Elana Robison, Assistant County Attorney

7. Opposition to Motion to Dismiss or for Summary Disposition from Soo Lee-Cho, Esquire, with attachments
   (a) Special Exception Case No. S-807 (1982)
   (b) Plat No. 3600
   (c) Lease
   (d) Gorove Slade Memorandum
   (e) Oct. 10, 2025 Email from G. Morgan to Dr. Sithanandam
   (f) Aug. 22, 2019 Washington Post article
   (g) Deed
   (h) Declaration
   (i) Washington Adventist Hospital Demolition Update
   (j) CON Application
   (k) Montgomery County Code § 59-E-7.6 (1977)
   (l) Adventist HealthCare Parking Exhibit
   (m)Oct. 7, 2025 Letter from G. Morgan to Dr. Sithanandam
   (n) Resp. to Additional Completeness Questions (Feb. 14, 2014)
   (o) Takoma Park Campus Overview
   (p) Apr. 10, 2018 letter from S.R. Ludlow to B. Steffen
   (q) Proposed Letter from Takoma Park City Council to P.E. Parker, MHC (5-25-22)

CASE NO. A-6938
APPEAL OF WASHINGTON ADVENTIST ACC, BOARD OF COUNCIL OF UNIT OWNERS by LAVANYA SITHANANDAM, MD, PRESIDENT
EXHIBIT LIST
Page 2

8. Pre-Hearing Submission of Montgomery County from Elana Robison, Associate County Attorney
   (a) Commercial Building Permit Application No. 1116230
   (b) Building Permit No. 1116230
   (c) Site Plan - Overall
   (d) Opinion of the Board; Case No. S-807
   (e) Resolution to Revoke Special Exception, Case No. S-238
   (f) Montgomery County Zoning Ordinance Sec. 6.4.3
   (g) Condominium Plat No. 3300
   (h) MCATLAS Photo
   (i) Aerial Photos (Google Map)
   (j) Street View Photos (Google Map)

9. Pre-Hearing Submission of Appellant from Soo Lee-Cho, Esquire
   (a) Commercial Building Permit Application
   (b) Building Permit No. 116230
   (c) Opinion of the Board: Case No. S-807
   (d) Condominium Plat No. 3600
   (e)(i)-(iii) Fence Permit Site Plan Markups
   (f) October 30, 2025 Gorove Slade Parking Study
   (g) October 17, 2025 Gorove Slade Memorandum
   (h) October 10, 2025 Email from Geoffrey Morgan
   (i) October 7, 2025 Letter from Geoffrey Morgan
   (j) April 28, 2025 Washington Adventist Hospital Demolition Update
   (k) (i) Deed
   (ii) Lease
   (l) June 21, 1984 Washington Adventist ACC Condominium Declarations
   (m) Montgomery County Zoning Ordinance Section 59-E-7.6(1977)
   (n) Application for Certificate of Necessity
   (o) Hospital Response to Additional Completeness Questions
   (p) Takoma Park Campus Overview
   (q) Takoma Park City Council Letter, Re: Modification of Certificate of Need
   (r) Resume of Katie Wagner

10. Pre-Hearing Submission of Intervenor from Patrick O'Neil, Esquire
   (a) Deed – 7600 Carroll Avenue, Takoma Park, MD 20912.
   (b) Maryland Real Property Article, Sec. 14-108, 14-602, 14-606, 14-607 and 14-608.
   (c) Leased Parking Area Exhibit Continued to Page 3

(d) Site Plan – with parking availability outside security fence
(e) 9/16/25 and 9/29/25 AHC Parking Count PowerPoint
(f) Additional AHC Parking Counts.
(g) Resume of Anne (Nancy) Randall
(h) Resume of William Zeid, PE

11. Supplemental Pre-Hearing Submission from Soo Lee-Cho, Esquire
(a) S-807 Exhibit 16 Site Plan

12. _____

13. _____

14. _____

15. _____

16. _____

17. _____