COMMUNITY BENEFIT NARRATIVE
Effective for FY2011 Community Benefit Reporting

Washington Adventist Hospital

1. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

Table I

BED DESIGNATION	INPATIENT ADMISSIONS	PRIMARY SERVICE AREA ZIP CODES	ALL OTHER MARYLAND HOSPITALS SHARING PRIMARY SERVICE AREA	PERCENTAGE OF UNINSURED PATIENTS BY COUNTY		PERCENTAGE OF MEDICAID PATIENTS BY COUNTY	
271	17,409	20783	Holy Cross	Montgomery Co.	45.07%	Montgomery Co.	53.72%
		20912	Montgomery General	Prince Georges Co.	43.91%	Prince Georges Co.	38.76%
		20782	Doctors Community Hospital	Anne Arundel Co.	1.21%	Howard Co.	0.57%
		20903	Suburban Hospital Center	Howard Co.	1.16%	Anne Arundel Co.	0.55%
		20904	Prince Georges Hospital Ctr	Frederick Co.	0.79%	Frederick Co.	0.30%
		20901	Shady Grove Adventist	Calvert Co.	0.42%	Charles Co.	0.27%
		20910	Laurel Regional Hospital	Charles Co.	0.42%	Baltimore City	0.23%
		20902	University of Maryland	Baltimore Co Co.	0.37%	Calvert Co.	0.19%
		20740		Baltimore City	0.28%	Baltimore Co.	0.19%
		20906		Carroll Co.	0.14%	St. Marys Co.	0.11%
		20737		St. Marys Co.	0.09%	Washington Co.	0.08%
		20705		Queen Annes Co.	0.05%	Somerset Co.	0.04%
		20706		Washington Co.	0.05%	Wicomico Co.	0.04%
				Allegany Co.	0.05%	Caroline Co.	0.04%
				Other	5.99%	Other	4.90%

Washington Adventist Hospital

Table II

Community Benefit Service Area(CBSA)		
Target Population		523,880
Sex	Male	253,706
Sex	Female	270,174
Race	White	191,001
	Black/African American	192,164
	Native American	2,092
	Asian	44,403
	Native HI/PI	488
	Other	67,480
	2 + Race	26,252
Average Age		18-44
Median Household Income within CBSA		$84,503
Percentage of households with incomes below the federal poverty guidelines within the CBSA		
Montgomery County		4.70%
Prince George's County		8.10%
Percentage of uninsured people by County within the CBSA		
Montgomery County		7.50%
Prince George's County		9.40%
Percentage of Medicaid recipients by County within the CBSA		
Montgomery Co.		53.72%
Prince Georges Co.		38.76%
Howard Co.		0.57%
Anne Arundel Co.		0.55%
Frederick Co.		0.30%
Charles Co.		0.27%
Baltimore City		0.23%
Calvert Co.		0.19%
Baltimore Co.		0.19%
St. Marys Co.		0.11%
Washington Co.		0.08%
Somerset Co.		0.04%
Wicomico Co.		0.04%
Caroline Co.		0.04%
Kent Co.		0.04%
Allegany Co.		0.02%
Carroll Co.		0.02%
Worcester Co.		0.02%
Other		4.79%
Life Expectancy by County within the CBSA		
Montgomery Co.		83.1
Prince George's Co.		77.5
Mortality Rates by County within the CBSA		
Montgomery Co.		545.1/100,000
Prince George's Co.		809.4/100,000

II. COMMUNITY HEALTH NEEDS ASSESSMENT

In November 2011, Adventist HealthCare Center on Health Disparities released its 2011 Annual Progress Report, Health Disparities in the Era of Reform Implementation. The first chapter of the report details demographic trends and assesses disparities across a range of issues within three broad health topics affecting our community: maternal and infant health, heart disease and stroke, and cancer. The report also provides an overview of the Affordable Care Act (ACA) provisions that will improve health equity, and highlights accomplishments of the Center on Health Disparities over the past five years. Adventist HealthCare partnered with Montgomery County Department of Health and Human Services to support the development of the Healthy Montgomery website http://www.healthymontgomery.org/ . This website outlines thirty-three community indicators. As an organization we have worked on many of them, however for the purpose of this report we will focus on heart disease and stroke, maternal/child health and cancer.

1. Identification of Community Health Needs:
Describe in detail the process(es) your hospital used for identifying the health needs in your community and the resource(s) used.

The report incorporates descriptive findings from national, state and county-level databases on the racial and ethnic makeup of the population, the prevalence of disease across these groups, and the rates of receiving appropriate treatment.

Nationally, we analyzed the U.S. Census Bureau's American Community Survey and Profiles of General Population and Housing Characteristics to produce a broad demographic overview by county, race, and ethnicity.

In Maryland, we produced descriptive tabulations based on data from the Maryland Behavioral Risk Factor Surveillance System, the Maryland Cancer Registry, the Maryland Vital Statistics Administration, the Maryland Health Care Commission, and the Maryland Department of Health and Mental Hygiene's (MDHMH) Office on Minority Health & Health Disparities. Locally, we worked with Montgomery County Health and Human Services and reviewed the Healthy Montgomery website indicators.

In addition to these data sources, we have also summarized findings from various national and state-level reports on insurance coverage, disease condition, and healthy behaviors released by the Agency for Healthcare Research and Quality, the Kaiser Family Foundation, and the MDHMH's Family Health Administration, Office of Chronic Disease Prevention.

2. In seeking information about community health needs, what organizations or individuals outside the hospital were consulted?

Adventist HealthCare and the Center on Health Disparities have ongoing partnerships with several community based organizations and health care clinics. For example, Adventist HealthCare and the Center work with CHEER (Community Health and Empowerment through Education and Research). CHEER, serving the residents of the Takoma Park and Long Branch neighborhoods, is a community-driven process for identifying community goals, and for gathering the information and resources needed to measure and fulfill them. We also partner with clinics that serve the low-income residents of Montgomery County, many of whom are limited English proficient and/or racial and ethnic minorities. These clinics include Mary's Center for Maternal and Child Care and Mercy Clinic. Another partner, Mobile Medical Care (MobileMed), operates three mobile healthcare vehicles and provides primary and preventative healthcare to the uninsured, low income, working poor and homeless in Montgomery County. We also partner with Mercy Health Clinic by providing free diagnostic services to their uninsured patients.

Adventist HealthCare expanded its prenatal services in 2006 by partnering with the Montgomery County Department of Health and Human Services in its Maternal Partnerships Program, a referral program that collaborates with hospitals to provide obstetric and gynecologic services for uninsured women in Montgomery County.

Adventist HealthCare also provides health services for women in the community with breast cancer through a partnership with the Komen Foundation. In addition, Adventist HealthCare and the Center have ongoing collaborations with Sinai Hospital of Baltimore, the University of Maryland School of Public Health, and the Primary Care Coalition of Montgomery County.

The Center on Health Disparities at Adventist HealthCare has convened an Advisory Board to help guide its efforts. The Advisory Board is comprised of both internal and external (community members) experts. Members include clinicians, researchers, administrators and others from our hospitals, community-based organizations, local and state health departments, University of Maryland, the National Institutes of Health, and other public health stakeholder organizations.

Furthermore, the Advisory Board houses three subcommittees, which correspond to the three focus areas of the Center: provision of health services, education and training for providers, and research. These three subcommittees help us to develop and monitor our overall strategic plan to continue to meet the needs of our diverse communities.

3. When was the most recent needs identification process or community health needs assessment completed?

Provide date here: 11/02/11 (mm/dd/yy)

4. Although not required by federal law until 2013, has your hospital conducted a community health needs assessment that conforms to the definition on the previous page within the past three fiscal years?

_X_ Yes
___ No

If you answered yes to this question, please provide a link to the document or attach a PDF of the document with your electronic submission.

http://www.adventisthealthcare.com/pdf/AHC-CHD-ProgressReport-2001.pdf
See below for a summary of highlights from the 2011 Progress Report.

A description of the community served

The Progress Report provides an in-depth look at the community served by our hospitals. The tri-county area of Maryland that Adventist HealthCare serves—Frederick, Montgomery, and Prince George's Counties—has experienced a significant increase in the proportion of residents who belong to a racial or ethnic minority group. The proportion of Maryland residents of Hispanic ethnicity grew by nearly 50% from 2000 to 2010. Approximately 85% of Prince George's County residents belong to a minority group, the highest percentage in the tri-county area. Throughout the tri-county area, whites have the highest median household income. Across the state, blacks are the most likely to live in poverty. Hispanic residents are most likely to be uninsured, while black residents tend to rely on Medicaid or other public insurance programs more than other racial groups.

The following figure shows the share of the population in the tri-county area and Maryland as a whole, by race and ethnicity, for 2000 and 2010.

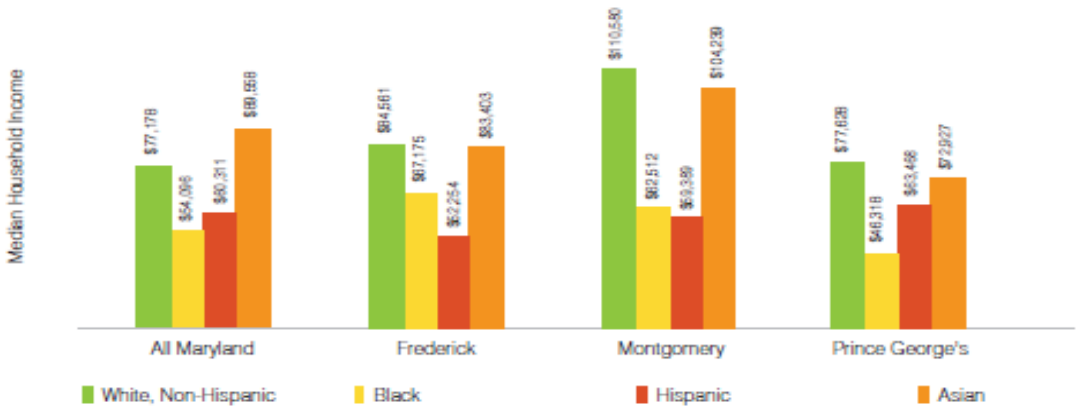
Share of Population, Tri-County, Maryland, by Race/Ethnicity, 2000 & 2010

	Frederick		Montgomery		Prince George's		All Maryland	
	2000	2010	2000	2010	2000	2010	2000	2010
White	88.1%	77.8%	59.5%	49.3%	24.3%	14.9%	63.4%	54.7%
Black	6.3%	8.4%	14.8%	16.6%	62.2%	63.5%	29.5%	29.0%
Asian	1.7%	3.8%	11.3%	13.9%	3.8%	4.0%	4.0%	5.5%
Hispanic or Latino	2.4%	7.3%	11.5%	17.0%	7.1%	14.9%	6.0%	8.2%

Source: U.S. Census Bureau (2011). Profile of General Population and Housing Characteristics. http://planning.maryland.gov/msdc/

The following figure shows the median household incomes in the tri-county area and the state by race and ethnicity in Maryland in 2009.

FIGURE 3: Median Household Income, Tri-County, Maryland, by Race, 2009



Source: U.S. Census Bureau. (2011). American Community Survey 1-Year Estimates. http://www.census.gov/acs/www/09

A description of the health needs identified through the assessment process.

The 2011 Progress Report also provides a look at health outcomes in the tri-county area for a range of conditions in three broad areas: maternal and infant health, heart disease and stroke, and cancer. While some improvement has been observed in certain conditions, overall, minorities generally experience a higher prevalence of these diseases, and also have poorer health outcomes and higher mortality rates.

Maternal and Infant Health

In recent years, the birth rate for Hispanic mothers was the highest across the state, growing by over 40% between 2005 and 2009. During the same time period, the birth rate among white mothers decreased by 11% and remained the same for black mothers. Black women in the tri-county area are most likely to receive late or no pre-natal care. In Prince George's County, more than 11% of expectant black mothers did not get prenatal care in 2009. By comparison, less than 3% of pregnant white women in Frederick County receive late or no pre-natal care. Also, black mothers delivered low birth rate babies almost twice as often as white mothers in 2009.

Heart Disease and Stroke

Similar to data in national statistics, heart disease and stroke affect Maryland's white population more than its black population. Although incidence rates have declined among all racial and ethnic groups in the state over recent years, blacks experience the highest death rates for diseases of the heart. For example, in 2008, the death rate from coronary heart disease in Prince George's County (with a higher proportion of minority residents) was higher than it was in Montgomery and Frederick Counties. Similarly, minority populations experience more of the negative effects of stroke; differences in stroke incidence rates are nominal between racial and ethnic groups, yet blacks have a significantly higher cerebrovascular death rate than whites.

Cancer

Overall, cancer incidence rates are declining in Maryland. Within the tri-county area, incidence rates of cancer are similar, but the mortality rates are not. Prince George's County has the highest morality rate for three out of four cancers analyzed (colorectal, breast, and prostate; not lung). The incidence of lung cancer is highest among whites in the tri-county area, except in Montgomery County, where blacks are most likely to have the disease than other racial groups.

Incidence and mortality rates for colorectal cancer have been declining in the state; however, the mortality rate is still higher for blacks than whites. Similarly, prostate cancer incidence and mortality rates have been declining among both white and black men, but black men still are diagnosed with and die from prostate cancer more often than whites.

Improvement has also been seen in breast cancer, with rates declining over the past several years, closing the gap somewhat. However, black women in the tri-county area die from breast cancer at much higher rates than white women. For example, in 2007, the breast cancer mortality rate among black women in Montgomery County was 28.8, compared to 19.9 for white women. Likewise, in Prince George's County, the mortality rate for black women was 33.6 compared to 25.3 for white women.

These statistics indicate that there is still a great need for improved health care in the tri-county area, particularly in regards to the health of the minority population. Our assessment supports that these three areas are community health priorities, where opportunities for improvement abound. Adventist HealthCare and the Center on Health Disparities remain committed to providing high-quality care for all residents in the communities we serve, as we strive to achieve our goal to eliminate health disparities and promote health equity. The comprehensive results of our assessment can be found in our 2011 Progress Report.

To download a PDF of the complete 2011 Progress Report, please visit our website at: http://www.adventisthealthcare.com/health-disparities/.

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

a. Does your hospital have a CB strategic plan?

_X__Yes
___No

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and provide additional information if necessary):

i. Senior Leadership

1. _X__CEO
2. _X _CFO
3. _X__Other (Vice President for Mission Integration & Spiritual Care)

ii. Clinical Leadership

1. _X__Physician
2. ___Nurse
3. __X_Social Worker
4. ___Other (please specify)

iii. Community Benefit Department/Team

1. ___Individual (please specify FTE)
2. _X Committee(Ismael Gama, Raquel Samuels, Sarah Toth, Judy Lichty, Marcos Pesquera, Cindy Glass, Sue Heitmuller, Parv Chotoo and Maria Chervonak)
3. ___Other (please describe)

c. Is there an internal audit (i.e., an internal review conducted at the hospital) of the Community Benefit report?

Spreadsheet	__X__yes	_____no
Narrative	__X__yes	_____no

d. Does the hospital's Board review and approve the completed FY Community Benefit report that is submitted to the HSCRC?

Spreadsheet __X__yes _____no
Narrative _____yes _____no

Washington Adventist Hospital

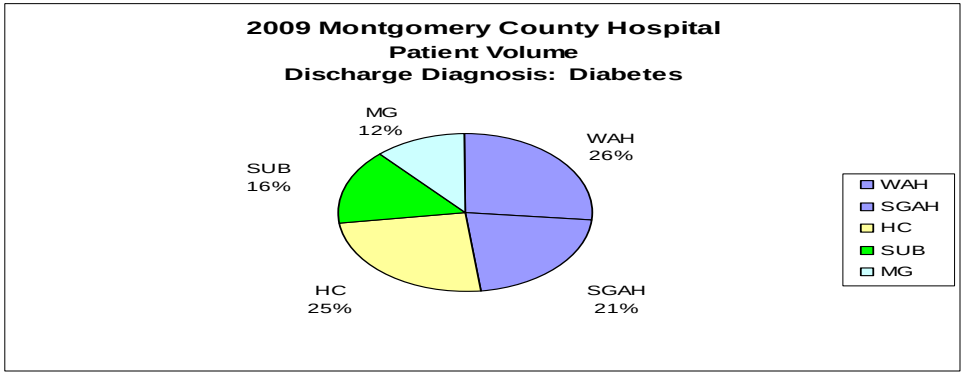
IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

Table III

Initiative 1.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Breast Cancer Screening for Low-Income Women – According to the Montgomery County Healthy Communities needs assessment Montgomery County is in the yellow almost red zone compared to other communities. For Prince George's County needs assessment, Priority 1: Ensure That Prince George's County Residents Receive the Health Care They Need, Particularly Low Income, Uninsured/Underinsured Adults and Children	Navigate to Health: Rapid Referral Program – Shady Grove Adventist Hospital and Washington Adventist Hospital.	The goal of Adventist HealthCare's Navigate to Health: Rapid Referral Program is to provide comprehensive breast care services to bridge the gap to medically under-served, low-income, minority women in Montgomery and Prince George's Counties in Maryland. The focus is to expand and enhance breast care services while providing a rapid and continuous process between referral and screening and the diagnosis and treatment for all patients served.	Multi-year/ongoing	Primary Care Coalition, Mary's Center - Safety Net Clinic, Mercy Clinic - SafetyNet Clinic, Mobile Medical - SafetyNet Clinic, Spanish Catholic - SafetyNEt Clinic, Muslim Clinic - SafetyNet Clinic, Montgomery County Women's Cancer Control, Shady Grove Radiology.	Adventist HealthCare (AHC) and the Primary Care Coalition (PCC) conduct process evaluation to determine the effectiveness of this program. Currently AHC and the PCC convene monthly Quality Improvement meetings that include AHC, PCC and each of the participating clinics to openly communicate about successes and challenges, and discussion regarding what is working with the collaboration and continued identification of program gaps.	Yearly Adventist HealthCare provides over 1,800 mammograms to low-income women. Wait time from referral to screening for those patients coming for the SafetyNet Clinics is down to 1 – 2 weeks.	This program has continued to grow and expand with the needs of the community since 1993. It has all intentions of continuing.

Initiative II



Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Diabetes is an important risk factor in Heart Disease and Stroke. Currently, 47% of diabetic discharges for Montgomery County come from Shady Grove and Washington Adventist Hospitals combined. In the Prince George's County Needs Assessment Priority 2: Prevent and Control Chronic Disease In Prince George's County	Diabetes Outpatient Program	The Adventist Healthcare Diabetes Self-Management Education (DSME) Program provides a quality comprehensive program, to empower the person with diabetes to better manage his or her disease, prevent the complications of diabetes, and achieve optimum health status. Secondly, to improve the overall health of the community served by providing chronic disease management related to diabetes. Also to: • To improve the lives of those living with diabetes by enabling them to better understand the disease-- leading to improved health and wellness, • decreasing the incidence of life-altering complications • To decrease healthcare costs • To make our program accessible to all people with diabetes in the communities within the Adventist HealthCare area • Create a seamless continuum of care • Adhere to best practice standards • Maintain a fully accredited program through the AADE • Tools gained will empower our clients to make decisions that are based upon the principles and standards of DSME.	Multi-year/ongoing	Ad Astra for language interpretation, Montgomery County HHS - African American Health Diabetes Outpatient Program, - Animas Corporation, - Partner with professionals with additional expertise in other departments such as the cardiac rehabilitation department and the behavioral health department as the need arises.	The evaluation process is on-going in several ways: via the participants, the team and the Advisory Board. Following the completion of the 9 hour outpatient DSME class, on going support will be offered to program participants through information and referrals to the following: o MTN Program (for those who meet the eligibility requirements) o Local support groups o Local classes o Internet Websites o Bibliography of Reference Books. Program participants will be notified that they are eligible to receive an annual evaluation, which includes two hours of diabetes education, follow up, assessment, and review. Participants will be contacted and appointments made close to the time that their annual review is due.	Measurable outcome objectives will be measured Pre and Post program. Outcomes will be tabulated and tracked specifically on the program objectives.	This program will be ongoing.

V. PHYSICIANS

Washington Adventist Hospital has noted an increase in the numbers of specialties where there are not enough physicians willing to treat uninsured and underserved patients in our service area.

Categories as defined by Community Benefit report:

Hospital-based physicians with whom the hospital has an exclusive contract;

- Anesthesia
- Emergency Physicians
- Radiologists

Non-Resident house staff and hospitalists;

- OB-Gyn
- Internal Medicine
- Psychiatry

Coverage of Emergency Department Call

- Gastrointestinal surgery
- ENT
- General Surgery
- Orthopedic Surgery
- Plastic Surgery
- Urology
- Thoracic and Vascular Surgery
- Psychiatry
- Neurology

Physician recruitment to meet community need.

Cardiac, Vascular and Thoracic
Ophthalmology
Pediatrics
Oncology
Family Medicine
Neurosurgery
General Endocrinology

Physician Category	**Amount**
Emergency Department On-Call	$1,150,898
Non-Resident House Staff and Hospitalist	$7,384,921
Recruitment of Physicians to meet community need	$3,588,977

VI. APPENDICES

Appendix 1

Charity Care Policy

Washington Adventist Hospital informs patients of their eligibility for financial assistance under its charity care policy at several intervals. The Hospital's charity policy is clearly posted in the emergency room and inpatient admitting areas so that patients are aware that they can request financial assistance if they do not have the resources necessary for the total payment of their bill. If a patient requests a copy of the Hospital's charity policy at either the time of admission or discharge a copy of the charity policy will be provided to them.

If the Hospital determines at the time a patient is admitted that they do not have the financial means to pay for their services the patient is told that they can apply for financial assistance from the Hospital. If a patient is admitted without resolving how their bill will be paid a financial counselor will visit their room to discuss possible payment arrangements. If the financial counselor determines that the patient may be eligible for Medicaid an outside contractor experienced in qualifying patients for Medicaid will speak to the patient to determine if the patient qualifies for Medicaid or some other governmental program.

As self pay and other accounts are researched by representatives from the billing department after no payments or only partial payments have been received, the billing department will explain to the patients that financial assistance may be available if they do not have the financial means to pay their bill. If patients request financial assistance a copy of the Hospital's charity application will be sent to them.

The Hospital has started an initiative with the outside contractor experienced in qualifying patients for Medicaid to review potential emergency room patients who may qualify for Medicaid.

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Charity Care Policy

Effective Date	01/08 (previously "Financial Assistance Policy")	Policy No:	AHC 3.19
Cross Referenced:	AHC 3.19.1 Public Disclosure	Origin:	PFS
Reviewed:	02/09, 06/15/10	Authority:	EC
Revised:	05/09, 06/09, 10/09, 06/15/10, 3/11/11	Page:	1 of 15

SCOPE

This policy applies to all AHC-affiliated facilities, except for Hackettstown Regional Medical Center, which has its own Charity Care policy that is compliant with New Jersey regulations.

PURPOSE:

To provide a systematic and equitable way to ensure that patients who are uninsured or underinsured and lack adequate resources to pay for services have access to medically needed care at our institutions consistent with our mission and values while also complying with Maryland State regulations.

BENEFITS:

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

OUR VALUES:
Respect: we recognize the infinite worth of each individual and care for the whole person.

POLICY:

All patients, regardless of race, creed, gender, age, national origin or financial status, may apply for Charity Care. Printed public notification regarding the program will be made annually.

Each application for Charity Care will be reviewed, and a determination made based upon an assessment of the patient's circumstances. Circumstances could include, but not limited to; the needs of the patient and/or family, available income and/or other financial resources. It is part of Adventist Healthcare's mission to provide necessary medical care to those who are unable to pay for that care. However, this policy encourages a patient or their representative to cooperate with, and avail themselves of all available programs (including Medicaid, workers compensation, and other state and local programs) which might provide coverage for the services related to the request for Charity Care.

SCOPE:

A. The Charity Care policy applies to charges for medically necessary patient services that are rendered at one of the following facilities: Shady Grove Adventist Hospital, Washington Adventist Hospital, Adventist Behavioral Health, and Adventist Rehabilitation Hospital of Maryland. A patient may apply for Charity Care at anytime during or after medical care. Pre-approved charity for scheduled medical services is approved by the appropriate staff based on criteria established in this policy and on based on individual patient circumstances. Services not covered by the Charity Care policy include, but not limited to:

1. Services not charged and billed by the hospital are not covered by this policy; i.e., private physician services.
2. Cosmetic, other elective procedures, convenience and/or other hospital services, which are not medically necessary, are excluded from consideration as a free or discounted service.
3. Patients who are eligible for County, State, Federal or other assistance programs are excluded from the Adventist HealthCare Charity Care Program to the extent that services would be covered under those programs.
4. Patients where it has been proven by the electronic income estimator that the patient/household has the means to cover their medical services.

B. The patient would be required to fully complete an application for Charity Care and/or completion of the "Income" and "Family Size" portions of the State Medicaid Application could be considered as "an application for Charity Care." A final decision will be determined by using; an electronic income estimator, the state of Maryland poverty guidelines and the review of requested documents. An approved application for assistance will be valid for twelve (**12**) months from the date of service and may[1] be applied to any qualified services (see "A" above), rendered within the twelve (**12**) month period. The patient or Family Representative may reapply for Charity Care if their situation continues to merit assistance.

1. Once a patient qualifies for Charity Care under this policy the patient or any immediate family member of the patient living in the same household shall be eligible for Charity Care at the same level for medically necessary care when seeking subsequent care at the same hospital during the 12 month period from the initial date of service.

[1] Patient may be subjected to provide current financial documents within the twelve month approval period to support any new visits under Charity Care.

2. When the patient is a minor, an immediate family member is defined as; mother, father, unmarried minor natural or adopted siblings, natural or adopted children residing in the same household.
3. When the patient is not a minor, an immediate family member is defined as: spouse, minor natural or adopted siblings, natural or adopted children residing in the same household.

This program provides for care to be, either free or rendered at a reduced charge to those most in need, based on limited income and family size, (i.e., individuals who have income that is less than or equal to 500% of the federal poverty level), and the absence of other available financial resources. See attached Sliding Scale Chart.

C. Where a patient is deceased with no designated Executor, or no estate on file within the appropriate jurisdiction(s), the cost of any services rendered can be charged to Charity Care without having completed a formal application. This would occur after a determination that other family members have no legal obligation to provide Charity Care. After receiving a death certificate and appropriate authorization, the account balance will be adjusted via the appropriate adjustment codes 23001 – Account in active AR, 33001 – Account in Bad Debt.

D. Where a patient is from out of State with no means to pay, follow instructions for "B" above.

E. A Maryland Resident who has no assets or means to pay, follow instructions for "B" above.

F. A Patient who files for bankruptcy, and has no identifiable means to pay the claim, upon receipt of the discharge summary to include debt owed to AHC, charity will be processed without a completed application and current balances adjusted as instructed in "C" above.

G. Where a patient has no address or social security number on file and we have no means of verifying assets or, patient is deemed homeless, charity will be processed without a completed application and current balances adjusted as instructed in "C" above.

H. A Patient is denied Medicaid but is not determined to be "over resource" follow instructions for "B" above.

I. A Patient who qualifies for federal, state or local governmental programs whose income qualifications fall within AHC Charity Care Guidelines, automatically qualify for AHC Charity Care without the requirement to complete a charity application.

J. Patients with a Payment Predictability Score (PPS) of 500 or less, and more than 2 prior obligations in a Collection Status on their Credit Report and Income and Family Size are within the Policy Guidelines, charity will be processed without a completed application and current balances adjusted as instructed in "C" above.

K. If a patient experiences a material change in financial status, it is the responsibility of the patient to notify the hospital within ten days of the financial change.

PROCEDURE:

A. Financial Counselor(s), Registration, Collection and Patient Communication staff should be thoroughly familiar with the criteria and process for Charity Care.

B. An 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 at the Hospital.

C. Patients being admitted should be prescreened for potential Charity Care qualification, using the questions found in the Registration- Charity Care Pathway and the electronic income estimator.

D. All inpatients without documented Insurance Coverage and no means to pay for Hospital services as Self Pay will be referred to the Government Services Vendor by the Admitting Office Staff to complete a Medicaid application.

E. All applications for Charity Care should be sent to the Patient Financial Services Office. The Application should include at minimum, information regarding the patient's family size and income level. **Manager of Collections and Customer Service (or designee) will take the following actions:**

1. Review application to ensure that all required information is complete and if necessary, contact patient/guarantor via mail or phone specifying what information is still needed.

2. Determine probable eligibility within two business days following the patient's request accompanied by a completed application.

3. If the patient/guarantor is deemed over scale according to the federal poverty guideline, then a denial letter will be sent to the patient/guarantor specifying that they are over scaled per the Federal Poverty Guidelines.

4. If the patient/guarantor qualifies according to their income, the Customer Service Manager (or designee) will query the patient accounting system to identify all of the patient or guarantor's accounts, looking for patient responsibility balances.

5. Accounts still outstanding with the patient/guarantor's insurance carrier or the Government Services Vendor for payment or Medicaid Eligibility will be held until the insurance either makes or denies payment, it will then be processed according to policy for Charity Care.

6. The Manager (or designee) will then complete an adjustment form, using the Charity Care adjustment code, 23001 or 33001 and note all accounts where a charity application has been received with the activity codes listed below.

Charity Care decisions are noted on a patient account with the following activity codes:

a. CHRP - Charity Care Appl. Rec'd/Processing
b. CHDN - Charity Care Appl. Denied - Final
c. CHIN - Charity Care Appl. Incomp/Need Info
d. CHLT - Charity Care Appl. approval sent to patient
e. CHWO - Charity Care write-off - Approved

7. The Manager (or designee) will notify any agencies that hold accounts for the patient/guarantor that they have been approved/denied Charity Care, providing details if there is any patient/guarantor responsibility.

8. The application will then be forwarded to imaging to be scanned into the patient folder.

AUTOMATED CHARITY PROCESS - Accounts sent to outsourced agencies:

Outsourced agencies are using software to determine a patient or guarantor's Payment Predictability Score (PPS). Where the PPS meets criteria for Charity Care, an adjustment will be made to the Patient's Account without a completed application by the patient, See "C" above. Adjustments will be processed electronically via an electronic report sent to the PFS Regional Director or designee for review and final approval. The approved accounts are automatically written off by PFS per the amount of Charity Care applied to each account. Supporting Documents for the write-offs are kept in Electronic Files on the PFS – "N" Drive, by Vendor.

NOTICE TO BE POSTED IN THE ADMISSIONS OFFICE, BUSINESS OFFICE AND THE EMERGENCY DEPARTMENT

ADVENTIST HEALTHCARE
NOTICE OF AVAILIBILITY OF CHARITY CARE

Shady Grove Adventist, Adventist Behavioral Health, Washington Adventist Hospital and Adventist Rehab Hospital of Maryland will make available a reasonable amount of health care without charge to persons eligible under Community Services Administration guidelines. Charity Care is available to patients whose family income does not exceed the limits designated by the Income Poverty Guidelines established by the Community Services Administration. The current income requirements are the following. If your income is not more than five time these amounts, you may qualify for Charity Care.

Size of Family Unit	Guideline
1	$10,890
2	$14,710
3	$18,530
4	$22,350
5	$26,170
6	$29,990
7	$33,810
8	$37,630

Note: The guidelines increase **$3,820** for each additional family member.

If you feel you may be eligible for Charity Care and wish to apply, please obtain an application for Community Charity Care from the Admissions Office or by calling (301) 315-3660. A written determination of your eligibility will be made two business days of the receipt of your completed application.

Revised March 2011

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Charity Care Policy

Effective Date	01/08 (previously "Financial Assistance Policy")	Policy No:	AHC 3.19
Cross Referenced:	AHC 3.19.1 Public Disclosure	Origin:	PFS
Reviewed:	02/09, 06/15/10	Authority:	EC
Revised:	05/09, 06/09, 10/09, 06/15/10, 3/11/11	Page:	7 of 15

ADVENTIST HEALTHCARE

Patient Financial Services, 1801 Research Blvd, Suite 300, Rockville, MD 20850

□ Washington Adventist Hospital □ Adventist Behavioral Hospital
□ Shady Grove Adventist Hospital □ Adventist Rehabilitation Hospital of Maryland

CHARITY CARE APPLICATION- DEMOGRAPHICS

Date: _____Account Number(s)_____

Patient Name: _____ Birth Date: _____

Address: _____ Sex: _____

Home Telephone: _____ Work Telephone: _____ Cell Phone: _____

Social Security #: _____ US Citizen: _____ No Residence: _____

Marital Status: ___ Married ___ Single ___ Divorced

Name of Person Completing Application_____

Dependents Listed on Tax Form:

Name: _____ Age: ____Relationship:_____

Name: _____ Age: ____Relationship: _____

Name: _____ Age: ____Relationship: _____

Name: _____ Age: ____Relationship: _____

Employment: Patient employer **Spouse employer**

Name: _____ Name:_____

Address: _____ Address: _____

Telephone #: _____ Telephone #:_____

Social Security #: _____ Social Security #: _____

How long employed: _____ How long employed: _____

TOTAL FAMILY INCOME $_____

Note: All Financial applications must be accompanied by income verification for each working family member. Be sure you have attached income verification for all amounts listed above. This verification may be in the following forms: minimum of 3 months worth of pay-stubs, an official income verification letter from your employer and/or your current taxes or W-2s. If you are not working and are not receiving state or county assistance, please include a "Letter of Support" from the individual or organization that is covering your living expenses. Any missing documents will result in a delay in processing your application or could cause your application to be denied.

CHARITY CARE APPLICATION- LIVING EXPENSES

EXPENSES :

Rent / Mortgage _____

Food _____

Transportation _____

Utilities _____

Health Insurance premiums _____

Medical expenses not covered by insurance _____

Doctor: _____

_____

_____

Hospital: _____

_____

TOTAL: _____

Has the applicant ever applied or is currently applying for Medical Assistance?

Please Circle the appropriate answer: **YES or NO**

If yes, please provide the status of your application below (caseworker name, DSS office location, etc.)

I hereby certify that to the best of my knowledge and belief, the information listed on this statement is true and represents a complete statement of my family size and income for the time period indicated.

Applicant Signature: _____ Date: _____

Return Application To: Adventist HealthCare

Patient Financial Services

Attn: Customer Service Manager

1801 Research Blvd, Suite 300

Rockville, MD 20850

COMMUNITY CHARITY CARE APPLICATION- OFFICIAL DETERMINATION ONLY

This application was: **Denied /Approved /Need more information**

The reason for Denial:

What additional information is needed?:

Approval Details:

Patient approved for _____%
$_____ will be a Charity Care Adjustment
$_____ will be the patient's responsibility

Approval Letter was sent on _____

AUTHORIZED SIGNATURES:

_____
CS/COLLECTION MANAGER
UP TO $1500.00

_____
Sr. ASSISTANT DIRECTOR
UP TO $2500.00

_____
REGIONAL DIRECTOR
UP TO $25,000.00

_____
VP of Revenue Cycle or HOSPITAL CFO
OVER $25,000.00

Revised October 2008

2011 POVERTY GUIDELINES

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	100%	$10,890	100%	0%
2	100%	$14,710	100%	0%
3	100%	$18,530	100%	0%
4	100%	$22,350	100%	0%
5	100%	$26,170	100%	0%
6	100%	$29,990	100%	0%
7	100%	$33,810	100%	0%
8	100%	$37,630	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	125%	$13,613	90%	10%
2	125%	$18,388	90%	10%
3	125%	$23,163	90%	10%
4	125%	$27,938	90%	10%
5	125%	$32,713	90%	10%
6	125%	$37,488	90%	10%
7	125%	$42,263	90%	10%
8	125%	$47,038	90%	10%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	150%	$16,335	80%	20%
2	150%	$22,065	80%	20%
3	150%	$27,795	80%	20%
4	150%	$33,525	80%	20%
5	150%	$39,255	80%	20%
6	150%	$44,985	80%	20%
7	150%	$50,715	80%	20%
8	150%	$56,445	80%	20%

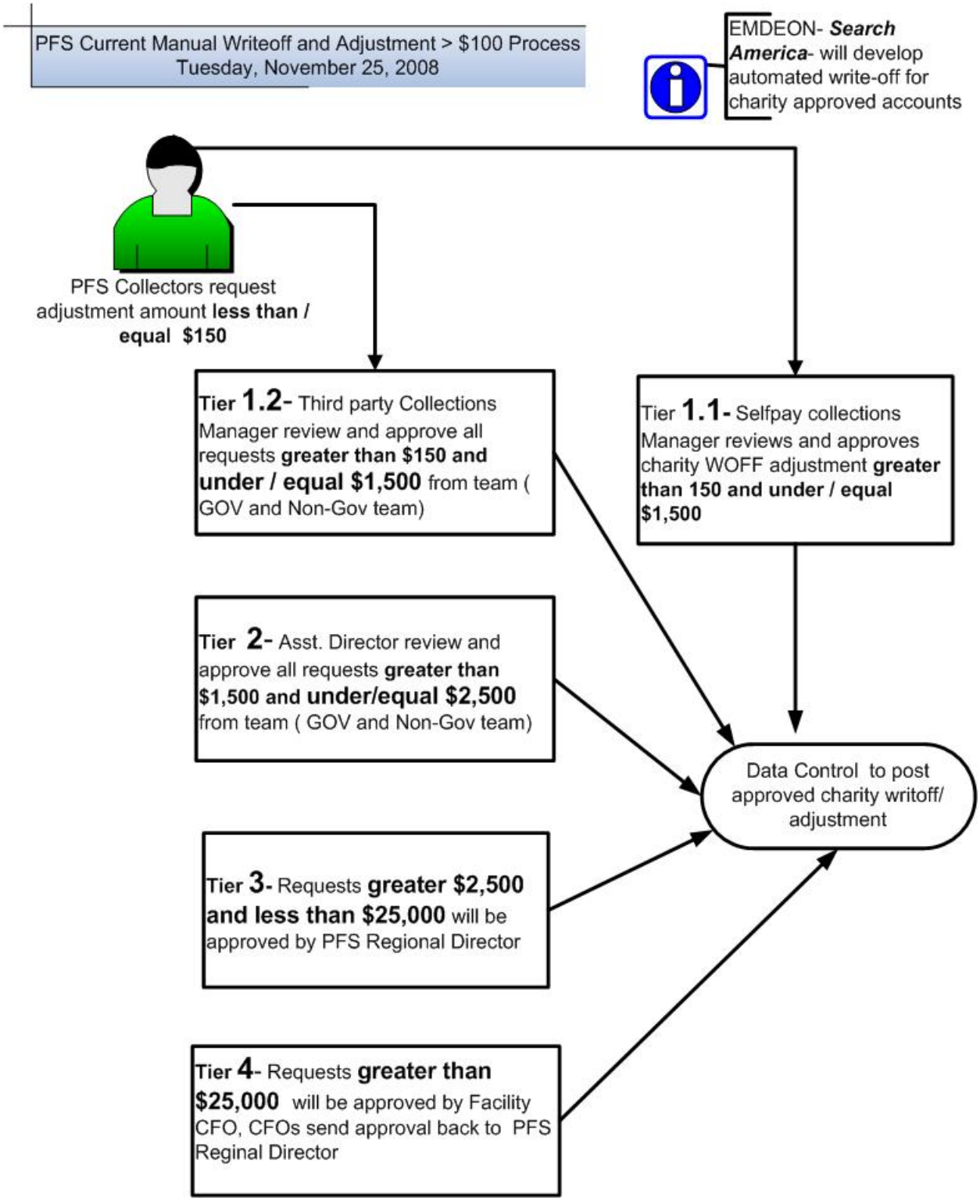
FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	175%	$19,058	70%	30%
2	175%	$25,743	70%	30%
3	175%	$32,428	70%	30%
4	175%	$39,113	70%	30%
5	175%	$45,798	70%	30%
6	175%	$52,483	70%	30%
7	175%	$59,168	70%	30%
8	175%	$65,853	70%	30%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	200%	$21,780	60%	40%
2	200%	$29,420	60%	40%
3	200%	$37,060	60%	40%
4	200%	$44,700	60%	40%
5	200%	$52,340	60%	40%
6	200%	$59,980	60%	40%
7	200%	$67,620	60%	40%
8	200%	$75,260	60%	40%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	225%	$24,503	50%	50%
2	225%	$33,098	50%	50%
3	225%	$41,693	50%	50%
4	225%	$50,288	50%	50%
5	225%	$58,883	50%	50%
6	225%	$67,478	50%	50%
7	225%	$76,073	50%	50%
8	225%	$84,668	50%	50%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	250%	$27,225	40%	60%
2	250%	$36,775	40%	60%
3	250%	$46,325	40%	60%
4	250%	$55,875	40%	60%
5	250%	$65,425	40%	60%
6	250%	$74,975	40%	60%
7	250%	$84,525	40%	60%
8	250%	$94,075	40%	60%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	275%	$29,948	30%	70%
2	275%	$40,453	30%	70%
3	275%	$50,958	30%	70%
4	275%	$61,463	30%	70%
5	275%	$71,968	30%	70%
6	275%	$82,473	30%	70%
7	275%	$92,978	30%	70%
8	275%	$103,483	30%	70%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	300%	$32,670	20%	80%
2	300%	$44,130	20%	80%
3	300%	$55,590	20%	80%
4	300%	$67,050	20%	80%
5	300%	$78,510	20%	80%
6	300%	$89,970	20%	80%
7	300%	$101,430	20%	80%
8	300%	$112,890	20%	80%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	350%	$38,115	15%	85%
2	350%	$51,485	15%	85%
3	350%	$64,855	15%	85%
4	350%	$78,225	15%	85%
5	350%	$91,595	15%	85%
6	350%	$104,965	15%	85%
7	350%	$118,335	15%	85%
8	350%	$131,705	15%	85%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	400%	$43,560	10%	90%
2	400%	$58,840	10%	90%
3	400%	$74,120	10%	90%
4	400%	$89,400	10%	90%
5	400%	$104,680	10%	90%
6	400%	$119,960	10%	90%
7	400%	$135,240	10%	90%
8	400%	$150,520	10%	90%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	450%	$49,005	5%	95%
2	450%	$66,195	5%	95%
3	450%	$83,385	5%	95%
4	450%	$100,575	5%	95%
5	450%	$117,765	5%	95%
6	450%	$134,955	5%	95%
7	450%	$152,145	5%	95%
8	450%	$169,335	5%	95%

Effective Date	01/08	Policy No:	AHC 3.19
Cross Referenced:	Previously: Financial Assistance Policy	Origin:	PFS
Reviewed:	02/09	Authority:	EC
Revised:	03/11	Page:	14 of 16

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	500%	$54,450	0%	100%
2	500%	$73,550	0%	100%
3	500%	$92,650	0%	100%
4	500%	$111,750	0%	100%
5	500%	$130,850	0%	100%
6	500%	$149,950	0%	100%
7	500%	$169,050	0%	100%
8	500%	$188,150	0%	100%


PFS Current Manual Writeoff and Adjustment > $100 Process
Tuesday, November 25, 2008
EMDEON- Search America- will develop automated write-off for charity approved accounts
PFS Collectors request adjustment amount less than / equal $150
Tier 1.2- Third party Collections Manager review and approve all requests greater than $150 and under / equal $1,500 from team (GOV and Non-Gov team)
Tier 1.1- Selfpay collections Manager reviews and approves charity WOFF adjustment greater than 150 and under / equal $1,500
Tier 2- Asst. Director review and approve all requests greater than $1,500 and under/equal $2,500 from team (GOV and Non-Gov team)
Data Control to post approved charity writoff/ adjustment
Tier 3- Requests greater $2,500 and less than $25,000 will be approved by PFS Regional Director
Tier 4- Requests greater than $25,000 will be approved by Facility CFO, CFOs send approval back to PFS Reginal Director

Appendix 3

Our mission is to demonstrate God's care by improving the health of people and communities through a ministry of physical, mental and spiritual healing.

Our vision: Adventist HealthCare will be a high performance integrator of wellness, disease management and health care services, delivering superior health outcomes, extraordinary patient experience and exceptional value to those we serve.

Washington Adventist Hospital's Mission, Vision, and Value statement was developed based on the following five concepts:

1. Respect: Recognize the infinite worth of each individual and care for each individual as a whole person.
2. Integrity: Be above reproach in all that we do.
3. Service: Provide compassionate and attentive care in a manner that inspires confidence.
4. Excellence: Provide world class clinical outcomes in an environment that is safe for both our patients and our caregivers.
5. Stewardship: Take personal responsibility for the efficient and effective accomplishment of our mission.

The overriding goal of our organization is to manage our staff and operations applying these concepts on a daily basis with no exceptions.