TO: Camille Bash, Vice President Finance

FROM: Stella Reed, Director Patient Financial Services

DATE: October 20, 2014

SUBJECT: HSCRC Annual Filing 2014

Attached, please find the following data:

PDF File	Letter dated May 30, 2014, stating Policies and Procedures have been reviewed by the Hospital Board of Directors.
PDF File	Credit and Collection Policy
PDF File	Financial Assistance Policy with Exhibits A- D
PDF File	Accounts Receivable Clearing House Agreement dated 7/13/2010
PDF File	Accounts Receivable Clearing House W-9 Form
PDF File	Accounts Receivable Outsourcing Agreement dated 1/31/2016
PDF File	Debt Collection Financial Assistance Report FYE 2014
PDF File	English and Spanish Brochure page for Financial Assistance

DOCTORS COMMUNITY HOSPITAL
8118 Good Luck Road
Lanham, Maryland 20706-3596
301-552-8118

DATE: May 30, 2014

TO: Camille Bash, Vice President, Finance
Stella Reed, Director, Patient Financial Services

FROM: Heidi Riedlbauer, Secretary, Board of Directors

SUBJECT: Policies and Procedures for Patient Financial Services

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This memorandum certifies that the Annual Collections Policy was reviewed and approved by the Hospital's Board of Directors at the May 29, 2014 Board of Directors Meeting.

Heidi L. Riedlbauer
Secretary, Board of Directors

Doctors Community Hospital
Hospital Policy

Subject: Credit and Collection Policy | Policy Number: 030

Date: October 1, 1995
Last Revised Date: November 2010 | Page 1 of 4

Philip B. Down, President
Approved by:

PURPOSE:
The purpose of this policy is to establish an organization that consolidates the financial management activities of the hospital so that controls meet accounting standards, ensures optimal cash flow, meets all compliance standards and minimizes bad debt. It is the goal of the hospital to enhance relations among the hospital, the patient, the physicians and the community by performing all activities in a professional, courteous and timely manner.

GENERAL POLICY: The Director of Patient Financial Services is responsible to ensure that subordinate staff seeks collection of hospital debt at the earliest possible opportunity, unless patients have applied for financial assistance. (See Financial Assistance Policy Number 050)

Patient's Request for Estimate of Charges:
The patient may make a request for an estimate of charges for all services excluding emergency services, to the Hospital's Business Office during normal working hours of Monday through Friday from 8:00 a.m. to 4:30 p.m. The hospital's business office will provide the patient an estimate of charges in writing by one of the following written methods, US mail, e-mail, or fax.

Insurance
Insurance benefits are verified and authorizations are sought at time of patient scheduling for elective procedures or within 24 hours of an unplanned admission. Hospital staff bill insurance accounts on an electronic billing system and perform billing follow-up of accounts. Insurance follow-up is consistently completed until the claim is paid or acknowledged by the insurance. Denied claims are analyzed to determine if appeal should be initiated. Claims are appealed when there is evidence that technical denials or medical necessity denials should be challenged.

Self-Pay Collection
Collection efforts are made during the registration process seeking payment for self-pay accounts and or co-payments. The hospital sends an initial summary bill to all patients, which lists major service categories. Attached to summary bills is a Patient Financial Services Brochure, which provides information on billing and how to apply for Patient Financial Assistance (See Financial Assistance Policy 050).

Self-pay and residual self-pay balances are outsourced to a contracted agent who sends statements and letters seeking collection of hospital debt. The billing agent is directed to seek full payment at the earliest possible date and can accept monthly payment arrangements until the account is paid in full. The

billing/collection agent's collection activity to include statements and letters has been reviewed and approved by the hospital's Director of Patient Financial Services.

Sale of Debts: Neither the hospital nor its billing/collection agent will sell patient debts to businesses for the purpose of hospital profit for patient debt collection.

Credit Bureau Reporting
Credit bureau reporting is done in the name of the hospital's collection agent who analyses the account to ensure the balance due is the patient's liability and not due from an insurance company. All accounts placed with the Credit Bureau are sent to the Director of Patient Financial Services of the Hospital prior to placement reporting to review the data and respond to the hospital's collection agent, with approval or denial to report. Accounts are not reported until collection efforts were made with the patient by sending letters or making collection calls through the call center process for debt collection, which normally takes 6 months from placement date. The collection agent does not report accounts to the credit bureau when legal placement is made in order to ensure that the same debt is not reported twice to the credit bureau.

When patient debts are paid in full, the hospital's collection agent will notify the credit bureau, within 60 days that the debt has been satisfied and paid.
If a patient was reported to a credit bureau and it is determined that the patient qualified under a presumptive mean-test or qualifies for financial assistance, the hospital would report the debt as closed.

Bad Debt
The hospital classifies accounts as bad debt beyond 120 days from discharge date regardless of patient/guarantor payment activity since collection action is completed through the hospital billing/collection agent. The billing/collector agent, based upon payment history of the patient, may not have classified the debt as a bad debt in their system at the same time as the hospital. However, classification of the debt as a bad debt will not occur until the contracted billing/collection agent has exhausted collection efforts and the account is older than 120 days from discharge date, There could be circumstances when the debt would be placed earlier if return mail has been received and skip tracing is not successful. (See Bad Debt policy number 090).

Court Action
When collection efforts are not successful or the patient fails to meet payment commitments, legal action may be filed with the court. Prior to court filing, accounts are reviewed by the hospital's Patient Services Team Leader who oversees credit and collection duties.

Judgments and Liens:
The hospital will not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill. If a hospital holds a lien on a patient's primary residence, the hospital will maintain its position as a secured creditor with respect to other creditors to whom the patient may owe a debt.

Vacate Judgment
If it is determined that the patient qualifies for Financial Assistance for the period of time for the debt, the hospital will refund to the patient any payment amounts exceeding $25.00 within a 2 year period from the date of service was found to be eligible for Financial Assistance. (See Financial Assistance Policy 050). An exception will be if the patient did not cooperate in providing the data for the financial assistance application and in such cases the refund period will be limited to 30 days from the patient's request for Financial Assistance.

Interest
Neither the hospital nor its billing/collection agent charges pre-judgment interest to patients.

Patient Complaints:

All patient complaints received by hospital staff or the hospital's billing/collection agent are referred to the Director of Patient Financial Services. The Director of Patient Financial Services will refer any clinical complaints to the hospital's Risk Manager and place a bill hold on the account until resolution is determined. Other billing complaints are reviewed and response is sent to the patient as instructed by the Director of Patient Financial Services.

Discounts

Patients who pay the full amount at time of service are given a 2% discount, which is applied against total charges. The hospital does not provide any special discounts to payers, or contractual allowances outside the designated allowance as determined by the Health Services Cost Review Commission.

Doctors Community Hospital

Financial Assistance Policy

SUBJECT: Financial Assistance Policy **Policy Number 050**

Prepared by: Patient Financial Services **Date: May 5, 2003**

Revised: December 17, 2007
January 2008, May 2009,
Oct 2009, Feb 2010,
April 2010, May 2010, Aug 2010,
Nov 2010, June 2013, Mar 2014

Philip B. Down, President
Page 1 of 3

Approved by

PURPOSE

To provide general information and guidelines to identify indigent persons who have no means of paying for medical services or treatments.

POLICY

General Statement:

The Patient Financial Services Department of the hospital is responsible for determining the eligibility for Financial Assistance patients. Referral for Financial Assistance is made by Registration, Billing, and Financial Counseling Staff within the department or by other departments such as, Nursing, Quality Assurance, Social Services, Physician Offices or the patient or a patient's family member with legal authority to act on behalf of the patient. Referral for Financial Assistance is also made by Medicaid Advocates and Collection Agents. The hospital will consider all medical debts for services provided within the hospital excluding purely cosmetic services.

1. Patient Education

Doctors Community Hospital recognizes its charitable mission to provide reasonable care to those patients who cannot afford Healthcare and has provided the following methods to communicate the Financial Assistance Program.

a. **Published notices of available Financial Assistance are printed in local newspapers annually,**
b. **Signs are posted at emergency registration, outpatient registration and the hospital's business office in patient waiting areas,**

c. Financial policy brochures written in English and Spanish, specifying who to call for Financial Assistance, medical assistance and billing questions, is available in patient lobby waiting areas of the hospital,
d. Financial policy brochures are provided to every inpatient at time of admission. The information is a hand-out as part of the Hospital's admission package,
e. Financial policy is provided to every patient with their initial summary bill,
f. Financial policy is provided to every patient upon patient request by the business office,
g. An overview of Financial Assistance is provided to all hospital employees as part of the annual employee orientation in order to provide direction or assistance to patients.

2. Eligibility Criteria

Patients will be considered for Financial Assistance regardless of race, sex, national origin or creed. To qualify for Financial Assistance, the following areas of eligibility must apply:

a. Free Care will be given to patients whose gross income is at or below 200 percent of the Federal Poverty Guidelines when considering number of family members in the household.

b. Reduced Cost Program is available with a 25% balance bill reduction when the family unit income is between 200 to 300 percent of the Federal Poverty Guidelines. Reduced cost program includes patient liability after third party payment such as deductible, coinsurance and co-payment amounts.

c. Medical Hardship is available for patients whose gross family income is between 200 and 500 percent of the Federal Poverty Guidelines, when hospital debt exceeds 25% of the family gross income for the family unit. and such eligibility will remain active during a 12 month period beginning on the date which the reduced cost medically necessary care was initiated. All immediate family members within the family household who have medical debts at Doctors Community Hospital will be considered. However, debts for other providers or account balances for patient deductible, coinsurance or co-payments will be excluded under the Medical Hardship Program.

3. Other Eligibility Consideration:

a. Self-pay patients enrolled in certain means-tested programs will qualify as presumptive Financial Assistance eligibility for free care by submitting proof of enrollment in a social service program within 30 days of request for free care. If the patient fails to summit the means-tested documentation within 30 days, upon patient request an additional 30 days will be granted for documentation. Programs that should be considered for presumptive assistance are as follows:

   i. Household with children in the free or reduced lunch program,
   ii. Supplemental Nutritional Assistance Program (SNAP),
   iii. Low income household energy assistance program,
   iv. Primary Adult Care Program,
   v. Women's, Infants and Children program (WIC),

b. In addition to programs listed in means-test for presumptive charity, the hospital will consider all accounts as free care without patient application or further proof when such patients' insurance eligibility through the hospital eligibility verification system indicate that the patient qualifies for a program such as pharmacy only or physician only coverage. Other state programs not mentioned where the patient is eligibility for assistance programs where there is no medical insurance coverage will also be considered.

c. Patients who qualify against credit bureau Propensity to Pay scoring when considering income estimates, household size and up to 200 % of federal poverty levels will have patient liability written off in full to presumptive charity.

d. The hospital may apply discretion and approve patients beyond the 12 month medical bill period when the patient's health status is severe or other financial circumstances prevent payment from the patient.

4. Ineligible Patients

The following is a list of situations where patients will not qualify for Financial Assistance.

a. Patients who have health insurance and services are payable by other third-party insurance,
b. Patients who refuse to complete the hospital's Financial Screening Application, when presumptive free care is not warranted,
c. A non U S citizen who traveled to the US primarily for the purpose of receiving medical services at no cost,
d. Patients whose credit bureau report validates the patient's application was false or misleading,
e. Patients who fail to provide supporting information to validate information contained on the Financial Assistance Application,
f. Patients whose monetary assets exceed $10,000 excluding up to $150,000 in a primary residence and retirement benefits where the IRS has granted preferential treatment.

5. Application Requests

Self pay patients, who do not meet the presumption means-test, are requested to complete an application when they apply for Financial Assistance. A Financial Screening Application (see Exhibit A) is given to the patient when one of the following situations occurs:

a. Patient requests Financial Assistance,
b. Patients or family member expresses inability to pay for medical debts,
c. Other hospital departments staff request Financial Assistance for the patient,
d. Medicaid Advocates or Collection Agents request Financial Assistance Application.

6. Application Process

Applicants are requested to complete the Financial Screening form and a cover letter listing documents to support program eligibility will be attached (see Exhibit B). Listed below is the required information, which must be received and verified prior to consideration for Financial Assistance, when presumptive meant test programs do not apply

a. All gross income for all family members of the household unit,
b. Other income such as, Alimony, Child support and stipends,
c. Assets as listed in Section Item 4, "Ineligible Patients" under section F of this document,
d. Monthly expenses for immediate family members of the household,
e. List of outstanding debtors,
f. List of medical debts owed or paid for the past 12 months for services at Doctors Community Hospital.

7. Approval Process

Excluding presumption programs, prior to approving patient applications, information is reviewed and additional verification of eligibility may be made by obtaining a credit bureau application. The patient generally is notified by letter, (see Exhibit C) unless the patient calls the office or makes a visit to the business office to determine eligibility. Patients are advised of the amount of eligibility and if there is any patient liability and who to call to make payment arrangements. Approval for write-off for Financial Services is made by the Director of Patient Financial Services with additional approval of the Vice President of Finance for account balances greater than $5,000.

8. Denial Process

Upon final review of the application and patient income and expense documents, patient's who do not qualify for the program are notified by letter indicating the reason for denial and how to request reconsideration if the patient disagrees with the hospital decision (see Exhibit D).

Exhibit A (1)

DOCTORS COMMUNITY HOSPITAL
"Slow for caring."

DOCTOR'S COMMUNITY HOSPITAL
8118 Good Luck Road
Lanham, Maryland 20706-3596

Financial Screening Form

Please Print Legibly

Patient Name _____ SS # ___-___-___

Patient Address _____

City _____ State _____ Zip Code _____

Birth Date ___/___/___ Home Phone No. ( ) ___-___ Work Phone No. ( ) ___-___

Spouse Name *(if applicable)* _____ SS # ___-___-___

Spouse Address *(if different from Patient)* _____

City _____ State _____ Zip Code _____

Birth Date ___/___/___ Home Phone No. ( ) ___-___ Work Phone No. ( ) ___-___

LIST ALL CHILDREN UNDER 21 YEARS OF AGE

Child's Name _____ Birth Date ___/___/___

Child's Name _____ Birth Date ___/___/___

Child's Name _____ Birth Date ___/___/___

Child's Name _____ Birth Date ___/___/___

Child's Name _____ Birth Date ___/___/___

RESPONSIBLE PARTY INFORMATION *(Do NOT Complete if Patient is Responsible Party)*

Responsible Party Name _____ SS # ___-___-___

Address _____

City _____ State _____ Zip Code _____

Birth Date ___/___/___ Home Phone No. ( ) ___-___ Work Phone No. ( ) ___-___

EMPLOYMENT INFORMATION

Place of Employment _____

Address _____

City _____ State _____ Zip Code _____

Telephone No. ( ) ___-___ Extension _____ Supervisor Name _____

INSURANCE INFORMATION

Do you have health insurance? ..... ☐ Yes ☐ No

If YES, Name of Company _____ Policy # _____

Have you ever applied to a State Medical Assistance Program? ..... ☐ Yes ☐ No

If YES, Name of State _____ Birth Date ___/___/___

Do you receive assistance from the state? ..... ☐ Yes ☐ No

Exhibit A (2)

Please provide proof of income and expenses with this application:

Such as: Last 2 pay stubs, W-2 Forms, Bank Statements, Utility Bills, Mortgage Statements

MONTHLY INCOME

	GROSS	NET
Patient Salary		
Spouse / Other		
Soc. Sec. Income		
Disab. Income		
Pension Income		
Interest Income		
Unemployment		
TOTAL		

OTHER MONEY RECEIVED

Alimony		
Child Support		
Other		
TOTAL		

OTHER ASSETS

Name of Bank (Checking) _____

Account # _____

Name of Bank (Savings) _____

Account # _____

Name of Bank (Checking) _____

Account # _____

Name of Credit Union _____

Account # _____

Other Bank Account(s) _____

_____

Do you own stocks? ..... ☐ Yes ☐ No

Do you own bonds? ..... ☐ Yes ☐ No

Do you own property? ..... ☐ Yes ☐ No

I have answered the questions in this application correctly to the best of my recollection and based on my records. I understand that the Account Review Committee of Doctors Community Hospital may request additional information from credit reporting agencies, employers and other third parties.

Applicant Signature _____

Date of Application _____

MONTHLY EXPENSES

Rent / Mortgage _____

To Whom Paid _____

Telephone No. ( ) ____ - _____ Ext. _____

Auto Payment _____

Year _____ Make _____ Model _____

Financed By _____

Phone No. ( ) ____ - _____ Ext. _____

Electricity _____

Gas Utility _____

Telephone _____

Alimony _____

Child Support _____

Credit Cards *(See Below)* _____

Medical / Dental *(See Below)* _____

TOTAL _____

DOCUMENT CREDIT CARDS & MEDICAL / DENTAL

List Credit Cards

Account # _____

Account # _____

Account # _____

List Medical / Dental

_____ _____

_____ _____

_____ _____

Other Expenses

_____

_____

_____

_____

_____

_____

_____

_____

Exhibit B

Dear Patient:

It is believed that you may qualify for the hospital's Financial Assistance Program. Hospital Financial Assistance is only considered when there are no other financial assistance programs, which pay medical debts or insurance coverage.

Financial Assistance help is limited to medical expenses for services at Doctors Community Hospital. The program does not cover services elsewhere or physician bills. If you qualify for the program, all or part of your medical expenses may be considered.

If you quality for one of the following programs, please complete the attached application form and only provide with your application proof of eligibility in any one of the social service programs such as;

Children with reduced or free lunch program,
Supplemental Nutritional Assistance Program (SNAP),
Low-income household energy assistance program,
Primary Adult Care Program (PAC),
Women, Infants and Children (WIC).

If you do not qualify for one of the social service programs as listed above, you must complete the attached application screening form and provide with your application sufficient documents to prove your total income and expenses. In addition, the hospital may perform a credit check at the hospital's expense, validating your eligibility for the program. Documents required to be considered for Financial Assistance are as follows:

Wage statements for all household members such as pay stubs,
Other income such as, alimony, child support and stipends,
Your W-2 forms for current and prior year,
Bank statements, which show income and expenses,
Statement of any other income received in your household,
Copies of monthly statements and expenses paid to creditors,
List of outstanding medical expenses, owed or paid to Doctors Community Hospital for the past 12 months.

Please provide documents supporting assets excluding retirement programs where benefits are listed as exclusions under the IRS.

If you are unemployed and receive help or other support for daily living, you may provide a letter from another source indicating what kind of help you are receiving such as free room and board, utilities payments etc.

Failure to provide information to support your need for Financial Assistance may disqualify your eligibility. Please send all information within 30 days of this letter to:

Leslie Meade, Lead Patient Accounts Coordinator
Doctors Community Hospital
8118 Good Luck Road
Lanham, MD 20706-3596
(301) 552-8186

MNEMONIC: CHARITY1 ACTIVE: Y NAME: FINANCIAL APPLICATION APPROVED
PAGE SIZE: 66 LINE LENGTH: 75 LEFT MARGIN: 20
AUTO SPOOL: AUTO SORT:

Exhibit C

DOCTORS COMMUNITY HOSPITAL
8118 GOODLUCK ROAD
LANHAM, MARYLAND 20706

[DATE]

[GUARANTOR NAME]
[GUARANTOR ADDRESS LINE]
[GUARANTOR CITY,STATE ZIP]

RE: [ACCOUNT #]
[PATIENT NAME]

Dear [GUARANTOR NAME]:

Your application has been approved for financial assistance for the following account(s):

ACCOUNT #	AMOUNT APPROVED	REMAINING BALANCE PAYABLE BY PATIENT

If there is a remaining balance on your account(s), please call the hospital's Business Office at 301-552-8092 to establish a payment plan.

Yours truly,

Leslie Meade
Collections Team Leader

Exhibit D

Dear Patient:

We regret to inform you that your application for financial assistance has been denied for the following reason (s).

_____ Your application was missing sufficient documentation to prove income and expenses,

_____ Your income exceeds eligibility criteria under the Federal Poverty Guidelines. Please contact our office at (301) 552-8092 to establish a payment plan,

_____ There is a conflict in the Credit Report and data reported with your application,

_____ Our records indicate that you have third-party insurance or you may qualify for a state program for Medical Assistance.

_____ Other reason (s) _____

_____

_____

_____

If you disagree with this decision, please provide missing information or contact me to provide reasons why your debts should be reconsidered for Financial Assistance by calling (301) 552-8186 within the next fifteen day (15) from the date of this letter to reopen your case.

Thank you,

Leslie Meade, Team Leader
Patient Accounts Coordinator

ARCH
ACCOUNTS RECEIVABLE CLEARING HOUSE

ADDENDUM TO MANAGEMENT SERVICES AGREEMENT

July 13, 2010

Ms. Stella Reed
Director, Patient Financial Services
Doctors Community Hospital
8118 Good Luck Road
Lanham, Maryland 20706

Dear Stella,

This shall serve as an Addendum to the Accounts Receivable Outsourcing Agreement dated January 31, 2006, by and between Doctors Community Hospital (DCH) and Accounts Clearing House, LLC (ACH).

- All Early-Out Services will be proved by Accounts Receivable Clearing House, LLC and all bad debt collections services will be under the auspices of Accounts Clearing House, LLC.

All other terms and conditions as set forth in the Accounts Receivable Outsourcing Agreement shall remain in force and are not affected by this Addendum.

If you are in agreement with these changes and clarifications, please sign where indicated below.

Doctors Community Hospital

By: Stella Reed
Stella Reed
Director, Patient Financial Services

Date: 7-14-2010

Accounts Clearing House, LLC/Accounts

By: RWatkins
Ronald Watkins
President

Date: 7-13-10

DOCTORS COMMUNITY HOSPITAL BUSINESS ASSOCIATES AGREEMENT

Specific definitions:

a. Business Associate. "Business Associate" shall mean Accounts Recievable Clearing House, LLC.
b. Covered Entity. "Covered Entity" shall mean Doctors Community Hospital.
c. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
d. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.
e. Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
f. Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501.
g. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

Obligations and Activities of Business Associate

a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law.
b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement. [This provision may be included if it is appropriate for the Covered Entity to pass on its duty to mitigate damages to a Business Associate.]
d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.
e. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

f. Business Associate agrees to provide access, at the request of Covered Entity, and in the time (in less than 45 days after receiving written request) and manner, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524. [Not necessary if business associate does not have protected health information in a designated record set.]

g. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner [Insert negotiated terms]. [Not necessary if business associate does not have protected health information in a designated record set.]

h. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available [to the Covered Entity, or] to the Secretary, in a time and manner [Insert negotiated terms] or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

i. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

j. Business Associate agrees to provide to Covered Entity or an Individual, in time and manner [Insert negotiated terms], information collected in accordance with Section [Insert Section Number in Contract Where Provision (i) Appears] of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

k. The Covered Entity and Business Associate agree to negotiate to amend the Agreement as necessary to comply with any amendment to any provision of HIPAA or its implementing regulations set forth at 45 C.F.R. parts 160 and 164, including but not limited to, the Privacy Regulation, which materially alters either Party or both Parties' obligations under the Agreement. Both Parties agree to negotiate in good faith mutually acceptable and appropriate amendment(s) to the Agreement to give effect to such revised obligations. If the Parties are unable to agree to mutually acceptable amendment(s) within 30 days of the relevant change in law or regulations, either Party may terminate the Agreement consistent with its terms.

l. In the event that any provision of this Agreement violates any applicable statute, ordinance or rule of law in any jurisdiction that governs this Agreement, such provision shall be ineffective to the extent of such violation without invalidating any other provision of this Agreement.

m. Business Associate agrees to indemnify, defend and hold harmless the Covered Entity, its directors, officers, agents, shareholders, and employees against all claims, demands, or causes of action that may arise from Business Associate's employees, agents, or independent contractors improper disclosure of the protected health information and from any intentional or negligent acts or omissions.

n. The Agreement shall be governed by the laws of the State of Maryland and shall be construed in accordance therewith.

Permitted Uses and Disclosures by Business Associate

a. Specify purposes:

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information on behalf of, or to provide services to, Covered Entity for the following purposes, if such use or disclosure of Protected Health Information would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity: Purposes: CAP SURVEY

Specific Use and Disclosure Provisions [only necessary if parties wish to allow Business Associate to engage in such activities]

a. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

b. Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

c. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

d. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions [provisions dependent on business arrangement]

a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.
b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.
c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity. [Include an exception if the Business Associate will use or disclose protected health information for, and the contract includes provisions for, data aggregation or management and administrative activities of Business Associate].

Term and Termination

a. Term. The Term of this Agreement shall be effective as of November 13, 2008, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section. [Term may differ.]
b. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:
    1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement.
    2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
    3. If neither termination nor cure are feasible, Covered Entity shall report the violation to the Secretary.

c. Effect of Termination.

1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy (in a manner that protects the confidentiality and privacy of the material) all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
2. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon [Insert negotiated terms] that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.
c. Survival. The respective rights and obligations of Business Associate under Section [Insert Section Number Related to "Effect of Termination"] of this Agreement shall survive the termination of this Agreement.
d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

Steven R Reed 7-14-2010 7-13-10

Hospital Representative Date Business Associate Date

BUSNASSOC3/05/03

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2

Name (as shown on your income tax return)
ACCOUNTS RECEIVABLE CLEARING HOUSE, LLC

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☑ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ .....
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)
PO BOX 2373

Requester's name and address (optional)

City, state, and ZIP code
GLEN BURNIE, MD 21060-2373

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number
26 2238344

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here | Signature of U.S. person ▶ [signature] | Date ▶ 7-13-10

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

ACCOUNTS RECEIVABLE OUTSOURCING AGREEMENT

THIS AGREEMENT is made by and between Doctor's Community Hospital, with its principal offices at 8118 Good Luck Road, Lanham, Maryland 20706 ("Client") and Accounts Clearing House, LLC, a Maryland corporation with its principle offices at 300 Hospital Drive, Suite 30, Glen Burnie, Maryland, 21061 (ACH) as of the date of execution by a duly authorized representative of ACH. The effective date of this Agreement shall be _____.

In consideration of the mutual promises, covenants and agreements contained in this Agreement, the parties agree as follows:

1. SERVICES.

1.1 Accounts Receivable Outsourcing. ACH will seek to obtain reimbursement for Client's charges for *"Accounts"* (see Exhibit 1) placed with ACH through the follow-up, rebilling and collection activities relating to such Accounts (the "Accounts Receivable Outsourcing"). All activities undertaken on behalf of Client shall be done in the name of the Client. During the term of this Agreement, ACH will be the sole provider of Accounts Receivable Outsourcing services to the Client for the *Accounts*. As part of ACH's Accounts Receivable Outsourcing Services, ACH will:

(a) provide follow-up, tracking, re-billing and collection efforts and related activities for the *Accounts*;
(b) staff and manage an off-site receivables management center to handle the re-billing, follow-up, tracking and collection activities for the *Accounts* to include providing an off-site manager for the supervision of the management of the *Accounts* and other personnel as deemed necessary by ACH to perform the Accounts Receivable Outsourcing Services required by this Agreement;
(c) if necessary, provide on-site staff support at no additional cost to Client;
(d) prepare and send to Client, ACH's standard monthly management reports;
(e) develop work flows and follow-up letters for collection of the *Accounts*, with said work flows and letters to be mutually agreed upon as to process, content and format;
(f) direct all payments on the *Accounts* to Client. Any payments received by ACH will be logged and forwarded to Client within two (2) business days;
(g) establish a mutually agreed upon procedure for handling unpaid *Accounts* and for the request, use, maintenance and return of Client's patient files. ACH will prepare monthly and send to Client a hard copy of all returned *Accounts*.

All *Accounts* placed with ACH must be placed for a minimum of 120 days. ACH reserves the right to establish and amend its follow-up and collection efforts and activities as ACH, in its opinion, subject to Client approval, deems to be appropriate for the management of the *Accounts*. All follow-up and collection efforts and activities shall be in accordance with patient relation's policies and procedures consistent with those employed by Client. ACH and Client will establish a mutually agreed upon procedure for handling unreimbursed Accounts and for the request, use, maintenance, and return of Client's patient files.

1.2 Third-Party Agreements. Client acknowledges that in order for ACH to perform the Accounts Receivable Outsourcing Services, ACH will be required to enter into agreements with third-party payers and fiscal intermediaries regarding the provision of electronic claims submission, eligibility verification, claims statusing and other similar services (the "Third-Party Agreements"). Client agrees to indemnify and hold ACH harmless from and against any and all claims, actions, suits, proceedings, costs, expenses, damages, and liabilities incurred by ACH, including court costs and attorney's fees, related to any claim by any other party to a Third-Party Agreement, arising out of or relating to Client's provision of inaccurate or incomplete information to ACH or Client's negligence or willful misconduct.

2. CLIENT RESPONSIBLITIES AND OBLIGATIONS.

2.1 General. Client will cooperate and cause its employees to cooperate with ACH in every reasonable respect as mutually agreed by Client and ACH to allow ACH to perform its duties under the Agreement.

2.2 Provision of Account Information. Client will furnish ACH with all appropriate information necessary to enable ACH to perform the Accounts Receivable Outsourcing Services under this Agreement. As part of said responsibility Client will provide ACH:

(a) All patient and billing information mutually deemed appropriate and necessary by ACH and Client regarding the *Accounts*;

(b) Access to requested patient files, UB92 and /or HCFA 1500 forms, face sheets, itemized bills and other relevant *Account* documentation; and

(c) Cash receipt and application information.

Client is responsible for providing the information identified above relating to the accounts to ACH in the required format as agreed upon by Client and ACH. ACH will have no responsibility for the accuracy of the information received or problems arising out of erroneous or incomplete information received from Client. Further Client warrants that all *Accounts* are valid and legally recoverable debts.

2.3 Installation of Telephone Lines. At ACH' request and cost, Client will make available within 10 days following the Effective Date, a private dedicated "voice grade" telephone line to be used for the transmission of Account information to ACH. In the event that this Agreement is terminated within twelve (12) months from its inception, all installation and monthly charges for this telephone line shall be the sole responsibility of Client.

2.4 Special Instructions. Client will notify ACH in advance of any special instructions to be used by ACH in providing Accounts Receivable Outsourcing Services (such as listing of specific patients who are to be excluded from follow-up and collection activities due to their "VIP" status or for any other reasons).

3. FEES

3.1 Monthly Fee. The fees payable to ACH for providing Accounts Receivable Outsourcing Services to Client will be based on terms as specified in Exhibit I.

3.2 Payment Terms. Client will pay to ACH, within forty-five (45) days from the date an invoice is delivered to Client, all payments due under this Agreement. Any amount payable under this Agreement and not paid within forty-five (45) days will be delinquent and shall bear interest at the lesser of one and one-half percent (1 ½%) per month or the maximum monthly rate allowed by the applicable state.

3.3 Fee Change. ACH shall have the right to adjust the monthly fee in the event that Client fails to disclose to ACH at or prior to this Agreement is executed, accurate and complete information relating to Client's accounts receivable profile, which information, if disclosed, would have led ACH to propose a higher or lower Monthly Fee. In the event that ACH increases or decreases the Monthly Fee, ACH will provide Client with ninety- (90) day's prior written notice of this change. If any proposed fee increase is unacceptable to Client, Client may terminate this Agreement upon ninety (90) day's prior written notice to ACH.

3.4 Statement. ACH each month will render to Client a written statement setting forth all payments on the *Accounts* made to ACH directly and all deductions.

3.5 Taxes. All taxes and other levies in the nature of sales, use or excise taxes as they apply to the State of Maryland resulting from the services provided to the Client by ACH hereunder shall be the responsibility of the Client and shall be paid by the Client directly.

4. INITIAL TERM, RENEWALS AND TERMINATION.

The initial term of this Agreement will be two (2) years commencing as of the executed date of the Agreement. This Agreement shall be self-renewing for additional one (1) year terms unless wither party delivers to the other, written notice of termination at least thirty (30) days prior to the expiration of the then current term. This Agreement may be terminated by either party, for any reason, upon thirty (30) days prior written notice to the other without penalty from the date of inception of signed Agreement unless otherwise specified in the Agreement. Upon any termination of this Agreement, (a) ACH will continue its efforts with respect to the Accounts assigned prior to and existing as of the date of termination for a period of ninety (90) days; (b) ACH will continue its efforts with respect to all *Accounts* where payment arrangements are being met according to agreed upon terms, until conclusion of the payment arrangements; and (c) Client will pay ACH the Monthly Fee with respect to the collections referenced in (a) and (b) above regardless of when collections are received and whether received by Client or ACH.

5. CONFIDENTIALITY

5.1 Confidentiality of ACH Information. Client acknowledges that the System employed by ACH in providing Accounts Receivable Outsourcing Services is confidential and the sole property of ACH. Client agrees not to disclose to any persons or entities other than ACH, any information it receives concerning ACH business practices or other secrets deemed to be confidential by ACH.

5.2 Confidentiality of Client Information. ACH agrees not to disclose to any persons or entities not affiliated with ACH, any information about Client or any of Client's patients received by ACH in the course of providing the Accounts Receivable Outsourcing Services except as required to provide the Accounts Receivable Outsourcing Services or as otherwise legally required. Notwithstanding the preceding sentence, Client agrees that ACH may use Client information for statistical compilation purposes so long as Client and patient identifying information is kept confidential in accordance with applicable laws, rules and regulations.(See Exhibit II)

5.3 Confidentiality of Contract Terms. Without ACH' prior written consent, Client will not in any manner or form, disclose, provide or otherwise make available to any third parties, in whole or in part, this Agreement or any terms hereof.

6. DISCLAIMER OF WARRANTIES

Client acknowledges that ACH has the incentive to perform Accounts Receivable Outsourcing Services in a timely and efficient manner. Client acknowledges however, that the timing and amounts of collections generated through the Live Treat Services are subject to numerous variables beyond ACH' control. **THEREFORE, EXCEPT FOR THE EXPRESS REPRESENTATIONS AND WARRANTIES SET FORTH IN THIS AGREEMENT, ACH DISCLAIMS ANY AND ALL REPRESENTATIONS AND WARRANTIES, EXPRESS, IMPLIED, OR STAUTORY, PERTAINING TO THE PERFORMANCE OF THE ACCOUNTS RECEIVABLE OUTSOURCING SERVICES HEREUNDER.**

7. LIMITATION OF LIABILITY

In no event will ACH be liable for lost profits or be responsible for the uncollectibility of any *Account*.

8. INDEMNIFICATION

Each party agrees to indemnify, defend and hold harmless the other party, their directors, officers, employees and agents from and against any claim, liability, loss or expense (including without limitation attorney's fees) arising directly or indirectly out of an act by a party or its directors, officers, employees or agents in connection with either party's duties or performance under this Agreement.

9. NON-INDUCEMENT

During the term of this Agreement and for a period of one (1) year thereafter, neither ACH nor Client will, without the prior written consent of the other, either directly or indirectly, on its own behalf or in the service of others, solicit, divert, or hire away, or attempt to solicit, divert, or hire away, any person employed by the other, whether or not such employee is a full-time, part-time, or temporary employee and whether or not such employee is pursuant to a written agreement, is for a determined period, or is at-will without the prior written consent of the parties.

10. ACCESS TO BOOKS, DOCUMENTS, AND RECORDS

The provisions of this Section 9 are included in this Agreement because of possible application to Section 1861(v)(1)(I) of the Social Security Act. If such section is not applicable to this Agreement, whether now or in the future, then this Section 9 will be deemed not part of this Agreement and will, or will thereafter, be considered null and void. If such provision is applicable to this Agreement, ACH agrees with the Client that until the expiration of four (4) years after furnishing the Accounts Receivable Outsourcing Services under this Agreement, ACH will make available to the Secretary of the United States Department of Health and Human Services (the "Secretary"), and the United States Comptroller General, and their duly authorized representatives, this contract and all books, documents and records necessary to certify the nature and extent of the costs of these services. If ACH carries out the duties of this Agreement through a subcontract worth $10,000 or more over a 12 month period with a related organization, the subcontract will also contain and access clause to permit access by the Secretary, the United States Comptroller General and their representatives to the related organization's books and records.

11. MISCELLANEOUS

11.1 Entire Agreement. This Agreement and the Exhibits referenced herein describe the entire agreement between the parties and will be binding upon and inure to the benefit of their successors and permitted assigns only with the express written consent of Client. This Agreement supercedes all prior written and oral agreements and understandings between ACH and Client pertaining to Accounts Receivable Outsourcing Services and can only be changed in writing executed by the parties against whom such change is sought to be enforced.

11.2 Notices. Any notice to be given under this Agreement will be in writing and will be effective on date of receipt if sent or delivered to:

If to ACH:	If to Client:
Boyce Reitterer President Accounts Clearing House, LLC 300 Hospital Drive, Suite 30 Glen Burnie, Maryland 21061	Dennis Scanlon Vice President, Finance Doctor's Community Hospital 8118 Good Luck Road Lanham, Maryland 20706

or in either case to such other address or individual as the party to be notified, by proper notice hereunder have directed.

11.3 Severability. If any provision of this Agreement, or portion thereof, is declared invalid, the remaining provisions will remain in full force and effect.

11.4 Assignment. This Agreement is binding upon and inures to the benefit of and is enforceable by ACH, Client and their respective legal representatives, permitted assigns and successors of interest. This Agreement will not be assigned or transferred, in whole or in part, by Client and may only be assigned by ACH with the express written consent of Client.

11.5 Governing Law. This Agreement is made and entered into and will be construed and interpreted in accordance with the laws of the State of Maryland.

11.6 Authority to Sign. ACH and Client acknowledge that they are duly authorized by appropriate corporate action to enter into this Agreement and that the Agreement is being signed by duly authorized agents authorized to act for their respective parties.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date executed by the duly authorized representative of ACH.

CLIENT: DOCTOR'S COMMUNITY HOSPITAL	ACCOUNTS CLEARING HOUSE, LLC
By:	By:
Title: Vice President, Finance	Title: President
Date: 1/31/06	Date: 1/31/06

EXHIBIT I

ACCOUNTS:

Phase I Accounts-

Those pr tient accounts and balances that are identified by financial class as Self Pay, Commercial, HMO, MCO, Worker's Compensation or any other Insurance accounts identified by Client.

Client represents that monthly Self Pay accounts are profiled as of 12/15/05 as follows:

Aging:	# of Accounts	Gross Assignments	Contractuals/Writeoff %
0-30 days	3,700	$1,100,000	N/A
31-60 days			
61-90 days			
91-120 days			
121-150 days			
151-180 days			
181 + days			

Client represents that monthly Commercial accounts are profiled as of 12/15/05 as follows:

Aging:	# of Accounts	Gross Assignments	Contractuals/Writeoff %
0-30 days			
31-60 days			
61-90 days			
91-120 days	300	$250,000	N/A
121-150 days			
151-180 days			
181 + days			

Client represents that monthly Secondary accounts are profiled as of 12/15/05 as follows:

Aging:	# of Accounts	Gross Assignments	Contractuals/Writeoff %
0-30 days			
31-60 days	TBD	TBD	
61-90 days			
91-120 days			
121-150 days			
151-180 days			
181 + days			

The above-referenced amounts are an estimate and represent an accumulated backlog of insurance accounts. Client may, at its discretion make additional placements at time intervals to be determined.

FEE SCHEDULE:

Self Pay Accounts. Client agrees to assign to ACH, for a minimum of at least the first six months from the effective date of the Agreement, 100 % of all Self Pay Accounts. Client agrees to pay ACH a monthly fee of nine and one-quarter percent (9.25%) of all monies collected from the accounts identified as Self Pay. After the first six months, should Client only assign to ACH fifty-percent of the Self Pay Accounts, the fee shall the be nine and one-half (9.5 %) of all monies collected from the accounts identified as Self Pay. It is further agreed that the determination for changing the assignment percentage from 100% to 50% shall be predicated on a mutually agreed upon performance baseline as agreed upon by Client and ACH. Any payments received within five calendar days from the date of placement shall not be subject to any fee.

Commercial Accounts. Client agrees to pay ACH a monthly fee of six percent (6%) of all monies collected from the accounts identified as Commercial Accounts. Any payments received within seven calendar days from the date of placement shall not be subject to any fee.

Secondary Accounts. Client agrees to pay ACH a monthly fee of five percent (5%) of all monies collected from the accounts identified as Secondary Accounts. Any payments received within seven calendar days from the date of placement shall not be subject to any fee.

ADDITIONAL SERVICES

ACH will provide for the licensed use of the AegisEDI remit management and follow-up systems (ARIS) as described in attached AegisEDI Subscription Agreement.

Upon termination client shall reserve the right to continue use of ARIS. Fees for use will be the same as described in attached AegisEDI Subscription Agreement.

Should client decide to enforce the fifty percent assignment protocol on Self Pay Accounts as described in the Fee Schedule referenced above, ACH agrees to allow Client to retain the ARIS system at no charge. The only event that shall occur that will allow AegisEDI to implement the Fee Schedule in the Aegis EDI Subscription Agreement will be the termination of the Accounts Receivable Outsourcing Agreement or an assignment level on Self Pay Accounts lower than fifty percent of the total Self Pay Accounts.

ACH agrees to assume the ARIS Setup Costs as described in Exhibit A of the AegisEDI Subscription Agreement.

CLIENT: DOCTOR'S COMMUNITY HOSPITAL	ACCOUNTS CLEARING HOUSE, LLC
By:	By:
Title: VP Finance	Title: President
Date: 1/3/06	Date: 1/31/06

EXHIBIT H

INDEPENDENT CERTIFICATION AND AGREEMENT OF COMPLIANCE

I hereby certify that I am a duly authorized officer of the independent contractor named below ("Contractor). On behalf of Contractor and its officers, directors, employees, and agents, I certify that I have received and read the "Compliance Program Policy Manual" dated _____ of *Doctor's Community Hospital* and fully understand the requirements set forth in that document. I certify that Contractor shall act in full accordance with all rules and policies of *Doctor's Community Hospital*. These rules and policies include *Doctor's Community Hospital's* commitment to comply with all applicable federal and state laws, and *Doctor's Community Hospital's* commitment to conduct its business in compliance with the highest ethical standards.

To this end, Contractor expressly agrees that the *Doctor's Community Hospital* "Compliance Program Policy Manual" shall be incorporated within and made a part of the Contractor's Agreement with *Doctor's Community Hospital* and shall survive termination of this Agreement for any reason. Any failure of Contractor to comply with the rules and policies set forth in *Doctor's Community Hospital* "Compliance Program Policy Manual" or to report violations of these rules and policies may result in immediate termination by *Doctor's Community Hospital* of its Agreement with Contractor.

CLIENT: DOCTOR'S COMMUNITY HOSPITAL	ACCOUNTS CLEARING HOUSE, LLC
By: _____	By: _____
Title: VP Finance	Title: President
Date: 1/31/06	Date: 1/31/06

Debt Collection/financial Assistance Report

FYE 2014

Hospital Name: Doctors Commuity Hospital

Hospital Numb: 210051

1. Collection Agency Name

a. Accounts Receivable Clearing House
b.
c.
d.
e.
f.
g.
h.

2. Number of liens

i. 0

3. Number of extended payment plans

j. 1,823

FINANCIAL ASSISTANCE

4. Number of applications for financial assistanc received

k. 231

5. Number of applications for financial assistance approved

218

Note: represents number of applications not number of accounts

attach: DCH Policies and Procedures for assigning a debt to a collection agent for collection and for compensating such a collection agent for services rendered. (PDF format)

HSCRC

General Billing Information

About four days after receiving medical services, you will receive a Summary Bill in the mail. To request an itemized bill or if you have any questions, contact the Business Office:

7404 Executive Place, Suite 300 A
Seabrook, MD 20706
301-552-8093

While you are still at the hospital, you may pose your questions to the following:

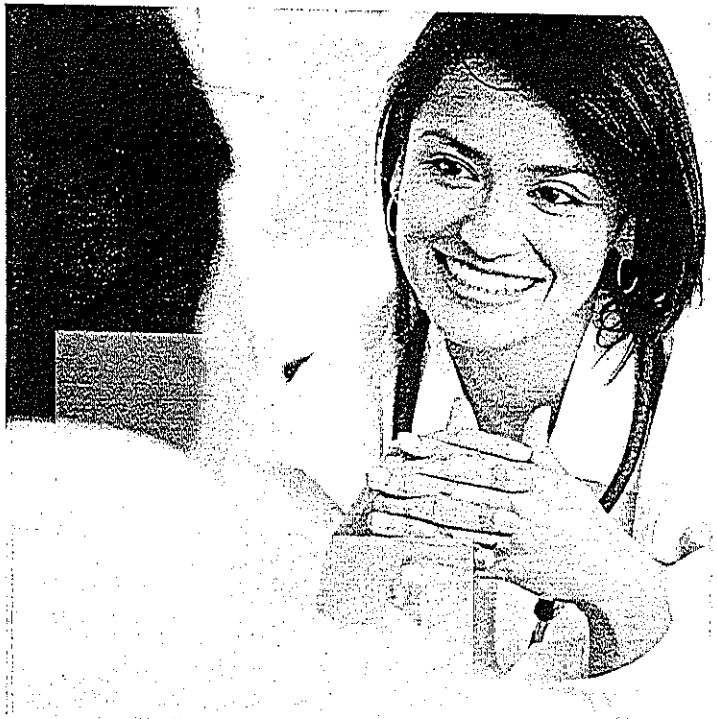
- **Outpatient Registration Department**
  Main Hospital, 2nd Floor
  Monday to Friday, 8:00 a.m. to 4:30 p.m.
- **Emergency Department Registration Office**
  Main Hospital, 1st Floor
  24 hours a day

Patient Obligation

- Pay your bills timely
- Provide your correct insurance information
- Notify the Business Office if your financial status changes and will impact your ability to pay the bill

Patient Rights

- Doctors Community Hospital or Medicaid may provide assistance to patients who meet the financial assistance criteria
- Patients who believe they were wrongly referred to a collections agency have the right to contact the Business Office to discuss this matter



How Does Health Insurance Billing Work?

After receiving services, we will bill your health insurance. To ensure that the claim was properly submitted, we will make a copy of your current identification and insurance cards.

Insurance companies require that we supply them with complete information on the person who carries the coverage. This information includes name, address, telephone number, date of birth, employment and social security number.

Incomplete information could cause a denial by your insurance provider, and you could be responsible for the balance.

If you are unable to provide complete insurance and subscriber information, we will not be able to bill your insurance.

Financial Assistance

Financial assistance is available for patients who receive services at Doctors Community Hospital. Patients may qualify for free care or partial care based on their family's gross income as applied to the Federal Poverty Guideline.

Applications for financial assistance may be obtained at emergency registration or outpatient registration at the hospital. **You can also call the Business Office at 301-552-8186 to have an application mailed to you.**

Mail the completed application as well as proof of family income and expenses to the following:

Doctors Community Hospital
Patient Financial Services
8118 Good Luck Road
Lanham, MD 20706

Maryland Medical Assistance

Doctors Community Hospital provides case workers to assist patients who received inpatient or emergency outpatient care with Maryland Medical Assistance applications. Patients who received inpatient care, and do not have insurance, may contact one of the telephone numbers listed below.

LAST NAME BEGINNING WITH:		
A-J	DECO	301-552-8116
K-Z	MEDLAW	301-552-8682

Additional Assistance

Emergency Outpatient Services

- **Contact DECO at 301-552-8116**

Medical Medicaid Applications for Other Outpatient Services

- **Contact the Maryland Department of Social Services at 800-332-6347, TTY 800-925-4434**

Servicios no facturados por Doctors Community Hospital

Es posible que su tratamiento en Doctors Community Hospital requiera los servicios de proveedores que facturan por separado. Estos proveedores le facturarán a su proveedor de seguros. Sin-embargo, si por algún motivo la compañía de seguros no paga por los servicios, es posible que usted reciba una factura. Si tiene preguntas respecto de las facturas de estos proveedores, comuníquese directamente con ellos. A continuación, se proporciona la información de contacto de algunos de los proveedores.

Para servicios profesionales:

- Clinical Laboratory Associates
- Diagnostic Imaging Associates
- Doctors Emergency Physicians
- Elliott & Wargotz Pathology
- Matrix House Physicians

Contacto:

- **Meridian Financial Management**
  301-498-2922

Para servicios profesionales:

- Joslin Diabetes Center
- The Center for Wound Healing

Contacto:

Asistencia financiera

Se encuentra disponible asistencia financiera para los pacientes que reciben atención para servicios de urgencias o emergencias. Se proporciona atención gratuita para los pacientes cuyo ingreso bruto familiar sea del 200% de las Pautas federales de pobreza, o menos.

Las solicitudes de Asistencia financiera pueden obtenerse en el Departamento de registro de emergencias o en el Departamento de registro de pacientes ambulatorios, o llamando a la Oficina comercial al *301-552-8186*.

Si se solicita, se enviará al paciente una solicitud por correo. A fin de reunir los requisitos, el solicitante también debe presentar comprobantes del ingreso y de los gastos familiares.

Asistencia médica de Maryland

Para los pacientes que han recibido atención para pacientes hospitalizados o atención ambulatoria de emergencia, Doctors Community Hospital ofrece trabajadores de casos que ayudan a estos pacientes con las solicitudes de Asistencia médica de Maryland. Los pacientes que hayan recibido atención para pacientes hospitalizados y no cuenten con un seguro pueden llamar a uno de los siguientes números de teléfono:

Si su apellido comienza con:

	Contacto	Núm. de teléfono
A-J	DECO	*301-552-8116*
K-Z	MEDI AW	301-552-8682