

January 15, 2014

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Via Email and Hand Delivery

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

Offices In
Maryland
Washington, D.C.
Virginia

Re: Seasons Hospice and Palliative Care of Maryland, Inc.
Matter No. 13-24-2346

Response to Second Set of Completeness Questions

Dear Kevin:

With this letter we are submitting the required ten (10) copies of our responses to the second set of Completeness Questions regarding the above-referenced project.

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

Sincerely,



Howard L. Sollins

HLS:tjr

Enclosures

cc: Paul Parker, Director
Joel Riklin, Program Manager
Suellen Wideman, Assistant Attorney General
Oxiris Barbot, M.D., Health Commissioner - Baltimore City
Mr. Todd Stern
Mr. Dean H. Forman
Joel I. Suldán, Esquire
Mr. Andrew L. Solberg
John J. Eller, Esquire

**Seasons Hospice
Responses to Second Completeness Questions
Received on 11/26/13**

1. Regarding Question #6, please provide the following information;

- a. **Submit a revised line diagram, as requested, that identifies the room number for the twelve beds for the inpatient hospice program. Please show on this line diagram the assigned location for the room designated as a resting area for family members, and the two rooms designated for bereavement support and viewings, as well as the dining area.**

Rooms 287 and 288 will be designated for bereavement support and viewings.

Room 286 will be designated as a resting area for family members. Please see Exhibit

1.

- b. **Explain how the reduction in beds from 15 to the 12 reduces the cost of the project as stated on page 4.**

Seasons meant that, rather than make costly renovations to the unit in order to use the rooms of other functions, it will use the three rooms in the manner described in the response. The three extra rooms will be used for:

1. A family member who wants to stay overnight can use a room as a resting area.
2. After a patient passes away, standard practice is to allow four hours to let the family view the patient. Bereavement support continues during this period. These rooms can be used for this purpose, allowing Seasons to fill its licensed beds more quickly with a patient who is waiting for an empty bed.

2. Regarding Question # 18, please respond to the following:

- a. **Revise the policy to indicate that Seasons Hospice will provide individual notice to patients and family regarding the charity care policy and notices of the policy will be posted in the business office of the hospice and on the hospice's website.**

Please see Exhibit 2. Seasons Hospice and Palliative Care of Maryland does not have its own website. The Seasons website (<http://www.seasons.org/>) is a

national website, and all policies on that site are generic to Seasons Hospice nationally, and does not have variants for specific states. Consequently, the revised policy is not posted on the Seasons website. However, the Maryland policy will be posted in all Seasons business offices in Maryland and will be provided to each individual patient family. Further, Seasons will post a notice in the newspaper that Seasons provides charity care for eligible families.

- b. Submit a specific plan for achieving the charity care goal of "... the greater of 1 of the site's overall census or 2 patients" for charity care, as required by COMAR 10.24.13.05(J)(d4)(b).**

The revised Charity Care Policy (Exhibit 2) includes the following provision.

Commitment to Charity Care and Payment Options:

1. Seasons Hospice strives to maintain relationships with community health partners to collaborate and identify patients & populations with imminent and underserved care needs.
2. The needs of low income families are taken into consideration with Seasons of Maryland's strategic planning, including: (a) hiring a community liaison in 2014; (b) operating general in-patient level of care beds at Sinai Hospital; and (c) and adding a location in Prince George's County to expand usage of hospice amongst a broader demographic, where data indicates there is a higher percentage of uninsured and thus a larger instances charity care.

Seasons of Maryland will hire a community liason to assure that Seasons meets its charity care commitment.

- 3. Regarding Question #27, you report zero referrals from physicians to the Northwest Hospital hospice program in either Table A or B. Please reconcile this result with your response to Question # 17 that Seasons contacted approximately 100 physicians between April and June of 2013, with 59 admissions from 40 distinct physicians.**

The reference to 59 referrals from physicians in response to Completeness Question 17 reads:

Seasons contacts physicians on a regular basis to make them aware of the services that Seasons provides. For example, between April and June of 2013, Seasons contacted approximately 100 physicians. This generated 67 referrals and 59 admissions. The 59 admissions came from 40 distinct physicians. Seasons does not collect information on the physicians who may have been involved in referrals from long term care facilities, assisted living facilities or hospitals. Only information on physician direct referrals are captured this way.

The reference to 59 admissions referred to all levels of care. This did not mean that there were 59 admissions to Seasons' IPU at Northwest Hospital.

When a hospital or nursing home inpatient is transferred to Seasons' IPU, the source of that transfer is recorded as being from a hospital or nursing home, not as a physician referral, no matter how much the physician may have influenced the transfer.

Direct physician referrals to an IPU level of care coming from their offices are rare. Patients who are able to make an office visit and are hospice appropriate are probably a late referral and are usually sent to the Emergency Room (and thereby recorded as a transfer from a hospital). Almost all IPU referrals come from a hospital's ICU and the ED, not from physicians specifically. However, physician opinions do affect the families' willingness to choose hospice care for their loved ones. This is one reason why Seasons does contact physicians. Simply looking at the referral source data undervalues the effectiveness of coordinating with physicians.

4. Regarding Question #30 and Exhibit 10, please respond to the following:

- a. **As requested provide all assumptions that were made.**

See Exhibit 3.

- b. Explain why admissions for general inpatient hospice care in hospitals excluding GIP units are projected to continue to increase from 2013 through 2016, even as the GIP units at Franklin Square and the proposed unit at Sinai Hospital are opened.**

Completeness Exhibit 10 shows that Seasons Hospice of Maryland projects that its hospital inpatient hospice cases (excluding its IPUs) will exhibit only 3% annual growth per year (growing only from 264 admissions in 2013 to 288 admissions in 2016). This is in spite of increased acceptance of hospice in hospitals and the aging of the population. Please note that seasons estimated a decline of 98 cases between 2012 and 2013. Seasons believes that there will continue to be an increase in the number of families of patients in hospitals other than Northwest, Sinai, and Franklin Square who choose hospice, as evidenced by the growth between 2011 and 2012.

- c. When do you expect the 16-bed MedStar Franklin Square GIP Unit to start operating this GIP?**

Spring 2014

- d. Regarding the Average Length of Stay, the numbers reported for the nursing homes, and the GIP units at Northwest, Sinai, and Franklin Square do not equal the patient days divided by admissions. Please correct with calculations to the tenth or explain why the reported numbers and calculations are different. If the calculated ALOS is correct, correct or explain the response to question 29.**

We agree the data submitted in Table 1 in Seasons' Completeness submission were inaccurate. A corrected Table 1 is attached as Exhibit 4.

In Calendar year 2012, the ALOS at NWH was 5.9 days. The ALOS for respite care was 4.6 on respite care. Both were rounded up because of the time it takes to turn over a room from one patient to another following a death. It typically takes 4-6 hours to turn a room around because of family decisions and bereavement and housekeeping services to clean the room.

- e. Please provide the projected number of beds and the occupancy percentage for the Sinai and MedStar Franklin Square GIPs.

Sinai (Completeness Response, Exhibit 11, Table 2)

	2014	2015	2016
Beds	12	12	12
Occupancy	70.70%	72.0%	73.4%

FSH (CON Application, Table 1)

	2014	2015
Beds	16	16
Occupancy	61.60%	74.50%

5. In your response to question 31, the projections in Exhibit 11 (Table 2) are not consistent with the projections for the Sinai Hospital unit reported in Table 1 (Exhibit 10). Please correct or explain the inconsistency. In addition, please provide assumptions, as requested.

The ALOS for NWH calculates to over 8 days compared to the 5.7 days reported in response to question 29; the ALOS for the proposed unit at Sinai Hospital ranges from 10.4 to 12.3 days; and the approved unit at MedStar Franklin Square is 13.5 days for CY 2015 and 12.5 days for CY 2016.

As stated in the response to Question 4.d, we agree the Table 1 submitted in the Completeness response needed correction. Please see Exhibit 4 which includes a corrected Table 1.

6. Please respond to Questions #32, 33, and 34 from the October 29, 2013 MHCC correspondence, which replaced the three questions previously included in the October 15th letter from the Commission. These three questions requested the following:

32. Compare the cost per day of providing inpatient hospice services in the proposed project with the cost of a set of alternatives in the table provided below.

Setting	Cost per Day
Proposed project	\$536

Setting	Cost per Day
Seasons Northwest Hospital Unit	\$545
Contractual agreement (consistent with OHCQ licensure requirements and HSCRC "waiver" policy) with Sinai	\$667
Contractual agreement (consistent with OHCQ Licensure requirements and HSCRC "waiver" policy) with a hospital other than Sinai	\$650
Contractual agreement with a nursing home	\$450-\$650
Other	

- 33. "Cost-effectiveness" considers effectiveness as well as cost. Describe why the proposed project promises greater effectiveness in the provision of inpatient hospice care than other alternatives.**

Please see the responses to Questions 36, 37, and 38 in the Completeness submission.

- 34. Please provide specific information on how development of the proposed inpatient facility at Sinai Hospital will change Season's cost and revenue for providing inpatient hospice services at Sinai Hospital. Clearly state the assumptions made in developing the projections.**

Because the revenue is based on Medicare reimbursement rates for Baltimore City, the revenues would be the same. As noted in the response to Question 6 regarding a response to Question 32 from prior MHCC correspondence, the contractual relationship model at Sinai is the highest cost alternative. The assumptions in the calculation are rooted in the GIP contractual rate with Sinai for the room and board and

skilled nursing care for the GIP patient provided by Sinai nursing staff around the clock. Further adding to that cost is the additional labor Seasons provides by the hospice interdisciplinary team to serve the patients' needs and meet the Medicare Hospice Conditions of Participation. Since the closing of the unit at Sinai, Seasons serves an ADC of 1-2 patients at Sinai which requires that Seasons field clinical staff visits to coordinate care for the patients daily. It is an inefficient high cost model and the data reflects this.

With a unit dedicated to hospice care where the census is higher and labor can be scaled to meet patient needs in a dedicated space, the result is a lower cost per day as the patient days are significantly higher.

8. Regarding Question #40 and Exhibit 15, please respond to the following:

- a. Please explain why Contractual Allowances decrease between 2011 and 2013 (from \$52,957 for 2011, to \$39,091 for 2012 and to \$7,994 for 2013) but then are projected to increase to \$40,828 for 2014.**

Allowances for private pay adjustments posted to contractual adjustments in 2011 and part of 2012. 2012 mid-year these allowances started to be recorded against bad debt reserved. In 2014 there is a conservative estimate for unbillable patient care days recorded to this line.

- b. What accounts for the projected 45.1% increase in Charity Care from \$105,094 in 2013 to \$152,498 for 2014?**

The projected amount for Charity Care in 2013 followed the methodology of annualizing YTD charity care. The projected number for 2014 is based on a percentage of the revenue estimate for 2014, which is projected to be greater than 2013 revenues.

- c. **Given that you report other operating revenues of between \$493,377 and \$575,354 from 2011 through 2013, explain why no other operating revenues are projected from 2014 through 2016.**

The revenue 2011 through 2013 that is recognized in the "other operating revenue" line relates to billable physician hospice care visits. Consistent with Seasons budgeting practice physician revenue is not budgeted in 2014, 2015 or 2016.

- d. **Explain the reason for the 58% increase in Current Depreciation from 2012 to 2013.**

The increased depreciation is related to computer equipment capital expenditures.

- e. **Please specify what expenses are reported under *Other Direct Clinical* and *Other Direct Expenses*.**

Expenses included in Other Direct Clinical and Other Direct Expenses are as follows.

- a. Other Direct Clinical:
1. Medical Supplies
 2. Tube Feeding
 3. Laboratory
 4. X-Rays
 5. Uniforms
 6. DME
 7. Pharmacy
 8. Open Access
- b. Other Direct Expenses;
1. Bereavement
 2. Books & Training Materials
 3. Patient Transportation
 4. Security Escorts
 5. Translation Services
 6. Volunteer Supplies
 7. Therapy Related Expenses

8. Music Therapy Expenses
9. Dementia Program
10. Other Patient Related Expenses

9. Regarding Question #42, the Patient Mix by Gross Revenue by Payer reported in subpart C does not agree with the percentages reported in Exhibit 15. Please correct or explain why there is a difference in the percentage of Patient Mix between the two tables.

The table that was included in #42 C is a statistical mix of patient care days by payer and is consistent with the Exhibit 15 4B.

10. Regarding Question #43 and Exhibit 17, please respond to the following:

- a. **The total cost for salaries, wages, and benefits (\$17,200,072) for Seasons Hospice and Palliative Care of Maryland does not agree with the amount reported in Exhibit 15 for the year 2016. Similarly, the cost of \$1,117,287 for Seasons Hospice at Sinai does not agree with Exhibit 16. Please reconcile the cost of salaries, wages, and benefits for Tables 3, 4, and 5.**

Seasons agrees that the tables appeared inconsistent. Seasons has corrected both tables, and they now agree. Please see Exhibit 5, which is a corrected Table 4. Exhibit 6 includes a new Table 5. Exhibit 7 includes a corrected Table 3. Exhibit 8 includes a corrected Completeness Exhibit 12, Projected Expenses By Seasons IPU 2014-2016 (See Completeness Question 33).

- b. **The cost of salaries, wages, and benefits reported for Seasons Hospice at Sinai Hospital (2016) (\$1,117,287) does not agree with the calculated total of \$1,108,193. Please review these numbers for accuracy.**

Exhibit 6 includes a new Table 5.

c. Please provide a key for the five footnotes identified on this table.

Indicate method of calculating benefits: FICA (5.64% of Wages MD experience); Medicare Tax (1.37% of Wages); FUTA (.11%); SUTA (1.02%); Group Health Insurance (7.5% of wages); Paid Time Off (1.5% of Wages)

Indicate method of calculating staff replacement costs: 8.5% of annual wages

d. Please identify what is included with the \$65,018 in *Cost of Replacement Staff for Seasons Hospice at Sinai*.

\$65,018 Cost of Replacement staff is an estimation of wage costs associated with replacement staff for employees while they are utilizing paid time off.

11. Regarding your response to Question #45 quantify the expected increase in admissions to the Northwest Hospital's unit from population growth. Identify and explain the assumptions including any use rate assumptions.

Inpatient hospice unit admissions have continuously grown statewide each year. Table A shows the growth between 2008 and 2011. Seasons could have included years before 2008, but the opening of the NWH IPU in January 2008 would have had a disproportionate impact on the growth. Between 2008 and 2011, the number of inpatient admissions grew by 27.2%. ($4,160/3,271=1.272$). The compound average growth rate ("CAGR") is 8.34% per year.

Table A
Statewide Admissions to Inpatient Hospice Units
2008-2011

Year	Admissions	CAGR
2008	3,271	
2009	3,565	
2010	3,992	
2011	4,160	8.34%

Source: MHCC Public Use Data

Seasons believes that the growth rate for inpatient hospice is a more predictive measure for projecting forward just on population growth because it includes both population growth and the increased acceptance of inpatient hospice.

This annual growth has not been seen at NWH because the NWH unit has been at essentially full capacity since it opened and does not have the ability to grow. However, since the establishment of the Sinai unit will open up some capacity at NWH, the unit could accommodate the growth.

The 2013 estimated admissions in 2013 in the NWH IPU is 682. Applying an 8.34% annual growth rate would increase the number of admissions to 867 in 2016, or an increase of 185 potential admissions.

	2013	2014	2015	2016
Admissions	682	738.7	800.3	867.0

The addition of 185 admissions would almost equal the 195 admissions that Seasons anticipate will move to the Sinai IPU.

During the period that the Sinai clustered bed unit was operating, the NWH IPU daily census declined from an average of approximately 11 patients per day to approximately 10 patients per day, as the table below shows.

Year-Month		2012-12	2013-01	2013-02	2013-03	2013-04	2013-05	2013-06	2013-07	2013-08	2013-09
NWHOS	ADC	10.97	9.26	9.14	10.87	9.83	10.26	11.30	13.65	9.84	10.13
	Sinai ADC	-	3.77	7.82	8.19	6.53	6.03	-	-	-	-

The Sinai clustered bed unit did not yet reach the occupancy levels projected in the CON application because the ongoing regulatory question acted as a disincentive to some referring sources. However, after the Sinai clustered bed unit closed, the NWH

IPU ADC has averaged at 11.1, the same average during the months shown above that the Sinai unit was not open. This equals 4,068 patient days per year.

195 admissions we said Sinai would take from NW
X 5.9 ALOS
= 1,150.5 Patient days
4,068- 1,150=2,918
2,918/365 = 7.99 ADC at NW

Consequently, Seasons believes that the lowest ADC that the NW unit could experience is 8 patients, as a result of the opening of the proposed Sinai unit. However, the experience during the time that the Sinai clustered bed unit was open, together with the increase in population and increased acceptance of inpatient hospice would indicate that this is a very conservative (that is, low) estimate. During the one month that the Sinai clustered bed unit neared the 8.8 ADC projected in the CON application, the NWH unit had nearly an ADC of 10.87.

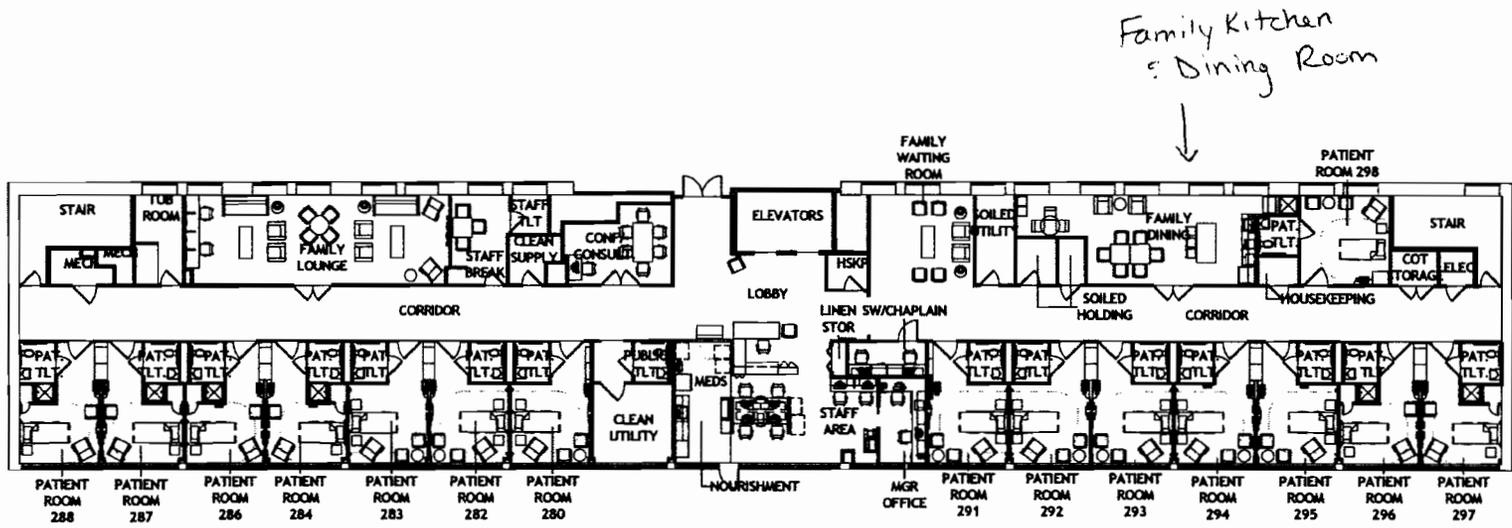
Consequently, Seasons believes that the actual impact of the loss of 195 admissions by the NWH unit to the proposed Sinai unit will be minimal. However, to be conservative, Seasons has projected an ADC of 8 (the low end of the range) at the NWH IPU in Table 1 in Exhibit 4 and in Table 3 in Exhibit 5 once the Sinai unit is open and at full utilization.

Exhibits

1. Unit Drawing
2. Revised Charity Care Policy
3. Statement of Assumptions
4. Corrected Table 1
5. Corrected Table 4
6. Table 5
7. Corrected Table 3
8. Corrected Completeness Exhibit 12, Projected Expenses By Seasons IPU 2014-2016 (See Question 33)
9. Affirmations

Exhibit 1
Unit Drawing

HOSPICE CARE SUITE - FLOOR PLAN



Family Resting/
Bereavement
Support
Rooms

Exhibit 2
Revised Charity Care Policy

Charity Care and Sliding Fee Scale

Purpose: Seasons Hospice & Palliative Care is committed to excellence in providing high-quality health care while serving the diverse needs of those living within our service area. We are dedicated to the view that medically-appropriate hospice care should be accessible, regardless of age, gender, sexual orientation, geographic location, cultural background, physical mobility, or ability to pay. For cases where third-party coverage is not available, a guideline is established each year for funds to be available for financial assistance that's equivalent to 1% of the hospice's average daily census or 2 patients, whichever is greater.

Determination of Eligibility for Charity Care:

1. Patients are assessed for services based on clinical appropriateness, rather than their ability to pay.
2. Patients/families may contact their insurance provider; or a representative of Seasons Hospice who can help determine the third-party payment source, or answer questions regarding alternate payment options. Patients with income below 200% of the federal poverty guidelines as established by the Department of Health and Human Services may apply for charity care
3. Wherever possible, a determination of eligibility for financial assistance will be initiated prior to, or at the time of admission by the intake department. A certain degree of judgment is required in determining whether an account is self-pay or charity. Such judgment will be made by the site's Charity Care Committee following the completion of all steps outlined in Seasons' written protocol for determining patient financial assistance.
4. A Charity Care Application must be completed and signed by the patient for each benefit period. Income level, assets and expenses will be taken into consideration in the evaluation process. Proof of income for the time of service, as well as the prior year's Federal income tax return, along with the W-2 form may be required. If eligible, patients must also apply for welfare assistance and be denied for any reason other than the following: (a) did not apply, (b) did not follow through with application process, and/or (c) did not provide requested verifications.
5. A determination of probable eligibility for charity care and/or reduced fees will be communicated to the patient/family within two business days of the initial request; initiation of application for medical assistance, or both.

Notice of Charity Care Services:

1. The hospice will inform individual patients and families regarding charity care and financial assistance options, when reviewing the liability for payment section of the consent packet that is signed by each patient or representative.

2. The hospice will inform the public-at-large through an annual public announcement posting in the classified section of regional newspaper in a format that is understandable to the service area population, as indicated:
 - a. *Seasons Hospice of Maryland offers a reasonable amount of care at no charge or at reduced rates to eligible persons who do not have insurance, Medicare, or Medical Assistance. In addition, qualifying patients may be able to participate in an extended payment plan without interest. Eligibility for free care reduced rates, and extended payment plans will be determined on a case by case basis for those who cannot afford to pay for care. If you think that you may be eligible for uncompensated care, you can receive further information from the administrative office at 888.533.6000.*
3. In addition, the hospice will maintain a posting of this policy displayed in the business office.

Sliding Scale and Time-Payment Plan:

1. Low-income patients who do not qualify for full charity care, but are still unable to bear the full cost of services can be offered a sliding scale fee or time-payment plan option.
2. Patients with income between 200-400% of the federal poverty guidelines as established by the Department of Health and Human Services may apply for partial financial assistance.
3. The most current sliding scale rates can be furnished upon request from the Seasons finance department.

Commitment to Charity Care and Payment Options:

3. Seasons Hospice strives to maintain relationships with community health partners to collaborate and identify patients & populations with imminent and underserved care needs.
4. The needs of low income families are taken into consideration with Seasons of Maryland's strategic planning, including: (a) hiring a community liaison in 2014; (b) operating general in-patient level of care beds at Sinai Hospital; and (c) and adding a location in Prince George's County to expand usage of hospice amongst a broader demographic, where data indicates there is a higher percentage of uninsured and thus a larger instances charity care.

Exhibit 3
Statement of Assumptions

Table 1 Item**Assumptions****1. Admissions****a. Hospital excluding GIP Units**

Historical are actual. Projections based on 3% growth/year

b. Nursing Homes

Historical are actual. Projections based on 3.5% growth/year

c. General Inpatient Hospice

Northwest Hospital Unit

See Response to Question 11

Sinai Hospital Unit

See CON Application

MedStar Franklin Square Unit

See FSH CON Application

GIP Total

d. Other (Specify)**e. TOTAL ADMISSIONS****2. Patient Days****a. Hospitals**

Historical are actual. Projections based on 5.0 ALOS

b. Nursing Homes

Historical are actual. Projections based on 4.2 ALOS

c. General Inpatient Hospice

Northwest Hospital Unit

Historical are actual. Projections based on 5.9 ALOS

Sinai Hospital Unit

Projections based on 5.9 ALOS

Medstar Franklin Square Unit

Projections based on 5.9 ALOS

GIP Total

d. Other (Specify)**e. TOTAL PATIENT DAYS**

Table 1 Cont.

Calendar Year**3. Average Length of Stay****a. Hospitals GIP**

Historical are actual. Projections based on 5.0 ALOS

b. Nursing Homes GIP

Historical are actual. Projections based on 4.2 ALOS

c. General Inpatient Hospice

Northwest Hospital Unit

Historical are actual. Projections based on 5.9 ALOS

Sinai Hospital Unit

Projections based on 5.9 ALOS

MedStar Franklin Square Unit

Projections based on 5.9 ALOS

GIP Total

d. Other (Specify)**e. TOTAL ADMISSIONS**

**4. Occupancy Percentage
(General Inpatient Hospice
Beds only)**

General Inpatient Units	
Northwest Hospital Unit	Patient Days/(# Beds X 365)
Sinai Hospital Unit	Patient Days/(# Beds X 365)
Medstar Franklin Square Unit	Patient Days/(# Beds X 365)
GIP Total	

**5. Number of Beds (General
Inpatient Hospice Beds only)**

Northwest Hospital Unit	Actual
Sinai Hospital Unit	See CON
Medstar Franklin Square Unit	See FSH CON
GIP Total	

Table 1 Cont.

Calendar Year

6. General Hospice Programs

a. RN visits	Based on Actual Historical Ratios
b. C.N.A visits	Based on Actual Historical Ratios
c. Social Work visits	Based on Actual Historical Ratios
d. Physician visits	Based on Actual Historical Ratios
e. Chaplain visits	Based on Actual Historical Ratios
f. Other staff visits	Based on Actual Historical Ratios

7. Total Patients Served

Anne Arundel	Based on Actual Historical Ratios
Baltimore County	Based on Actual Historical Ratios
Baltimore City	Based on Actual Historical Ratios
Carroll	Based on Actual Historical Ratios
Cecil	Based on Actual Historical Ratios
Harford	Based on Actual Historical Ratios
Howard	Based on Actual Historical Ratios
Prince George's Co.	Based on Actual Historical Ratios
Total Patients Served	

Exhibit 4
Corrected Table 1

Table 1	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years		
	2011	2012		2013	2014	2015
Calendar Year						
1. Admissions						
a. Hospital excluding GIP Units	131	362	264	272	280	288
b. Nursing Homes	108	88	53	55	57	59
c. General Inpatient Hospice						
Northwest Hospital Unit	732	685	682	526	495	495
Sinai Hospital Unit	0	0	0	521	531	541
MedStar Franklin Square Unit	0	0	0	600	725	725
GIP Total						
d. Other (Specify)						
e. TOTAL ADMISSIONS	971	1,135	999	1,974	2,088	2,108
2. Patient Days						
a. Hospitals	601	2,083	1,384	1,425	1,468	1,512
b. Nursing Homes	443	400	223	231	239	248
c. General Inpatient Hospice						
Northwest Hospital Unit	4,244	4,046	4,050	3,102	2,918	2,918
Sinai Hospital Unit	0	0	0	3,095	3,155	3,214
Medstar Franklin Square Unit	0	0	0	3,600	4,350	4,350
GIP Total						
d. Other (Specify)						
e. TOTAL PATIENT DAYS	5,288	6,529	5,657	11,453	12,130	12,242

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years		
	2011	2012		2013	2014	2015
Calendar Year						
3. Average Length of Stay						
a. Hospitals	4.4	5.3	4.9	5.0	5.0	5.0
b. Nursing Homes	4.1	4.6	4.2	4.2	4.2	4.2
c. General Inpatient Hospice						6.0
Northwest Hospital Unit	5.8	5.9	5.9	5.9	5.9	5.9
Sinai Hospital Unit	0	0	0	5.9	5.9	5.9
MedStar Franklin Square Unit	0	0	0	6	5.9	5.9
GIP Total						

d. Other (Specify)						
e. TOTAL ADMISSIONS	5.5	5.8	5.7	5.7	5.7	5.7
4. Occupancy Percentage (General Inpatient Hospice Beds only)						
General Inpatient Units						
Northwest Hospital Unit	78.6%	78.6%	78.6%	78.6%	78.6%	78.6%
Sinai Hospital Unit				70.70%	72.0%	73.4%
Medstar Franklin Square Unit					61.6%	74.5%
GIP Total						
5. Number of Beds (General Inpatient Hospice Beds only)						
Northwest Hospital Unit	14	14	14	14	14	14
Sinai Hospital Unit				12	12	12
Medstar Franklin Square Unit				16	16	16
GIP Total	14	14	14	42	42	42

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years		
	2011	2012		2013	2014	2015
6. General Hospice Programs						
a. RN visits	43,425	46,561	42,038	43299	44598	45936
b. C.N.A visits	43,402	43,072	45,123	46477	47871	49307
c. Social Work visits	8,141	8,610	7,148	7362	7583	7811
d. Physician visits	1,990	1,866	1,955	2014	2074	2136
e. Chaplain visits	5,288	5,257	5,221	5378	5539	5705
f. Other staff visits	7,634	7,162	10,178	10483	10798	11122
7. Total Patients Served						
Anne Arundel	187	174	208	215	221	228
Baltimore County	369	1,239	1,279	1317	1357	1397
Baltimore City	1,373	582	655	674	695	715
Carroll	46	50	75	77	80	82
Cecil	294	319	293	302	311	321
Harford	163	192	155	160	165	170
Howard	88	85	92	95	98	101

Prince George's Co.	104	57	95	98	101	104
Total Patients Served	2,624	2,698	2,853	2,939	3,027	3,118

Exhibit 5
Corrected Table 4

	Two Most Actual Ended Recent Years		Current	Projected Years		
			Year	(ending with first full year at full utilization)		
	Projected					
CY or FY (Circle)	20	20	20	2,014	2,015	2,016
I. Revenue						
a. Inpatient services				2,194,355	2,236,895	2,278,726
b. Outpatient services						
c. Gross Patient Service Revenue				\$ 2,194,355	\$ 2,149,295	\$ 2,189,493
d. Allowance for Bad Debt				\$ (21,944)	\$ (21,493)	\$ (21,895)
e. Contractual Allowance				-	-	-
f. Charity Care				\$ (10,972)	\$ (11,184)	\$ (11,394)
g. Net Patient Services Revenue				2,161,440	2,041,830	\$ 2,080,019
h. Other Operating Revenues (Specify)						
i. Net Operating Revenue				\$2,161,440	\$2,041,830	2,080,019

Table 3 Cont.	Two Most Actual Ended Recent Years		Current	Projected Years		
			Year	(ending with first full year at full utilization)		
	Projected					
CY or FY (Circle)	20	20	20	\$ 2,014	\$ 2,015	\$ 2,016
Expenses						
a. Salaries, Wages, and Professional Fees, (including fringe benefits)				\$ 1,117,287	\$ 1,117,287	\$ 1,117,287
b. Contractual Services				\$ 232,125	\$ 236,625	\$ 241,050
c. Interest on Current Debt						
d. Interest on Project Debt						
e. Current Depreciation						
f. Project Depreciation				\$ -	\$ -	\$ -
g. Current Amortization						
h. Project Amortization						
i. Supplies				\$ 61,900	\$ 63,100	\$ 64,280
j. Other Expenses (Rent & Admin Overhead)				\$ 300,000	\$ 300,000	\$ 300,000
k. Total Operating Expenses				\$ 1,711,312	\$ 1,717,012	\$ 1,722,617

3. Income						
a. Income from Operation				\$ 450,128	\$ 324,818	\$ 357,402
b. Non-Operating Income						
c. Subtotal				\$ 105,022	\$ 138,785	\$ 171,959
d. Income Taxes						
e. Net Income (Loss)				\$ 105,022	\$ 138,785	\$ 171,959

Exhibit 6
Table 5

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration					
Team Assistant	0	1	\$40,428	Employee	\$40,428
Unit Director	0	1	\$91,455	Employee	\$91,455
Direct Care					
CNA	0	2.63	\$29,366	Employee	\$77,232
Nurse	0	9.29	\$68,843	Employee	\$639,546
LPN	0	0	\$0	Employee	\$0
Replacement for Vacation Staff	0	0	\$65,018		\$65,018
Support					
Social Worker	0	0.5	\$58,918	Employee	\$29,459
				Subtotal	\$943,139
				Benefits	\$174,148
				TOTAL	\$1,117,287

Exhibit 7
Corrected Table 3

Fiscal Year	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)		
	2011	2012	2013	2014	2015	2016
I. Revenue						
a. Inpatient Services	\$ 3,799,468	\$ 4,652,087	\$ 4,509,203	\$ 6,932,307	\$ 7,853,508	\$ 8,103,624
b. Outpatient Services	\$ 19,151,977	\$ 19,985,631	\$ 22,145,973	\$ 23,453,791	\$ 23,372,760	\$ 24,303,288
c. Gross Patient Services Revenues	22,951,444	24,637,717	26,655,176	30,386,098	31,226,268	32,406,912
d. Allowance for Bad debt	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
e. Contractual Allowance	\$ (52,957)	\$ (39,091)	\$ (7,994)	\$ (39,314)	\$ (39,516)	\$ (41,064)
f. Charity Care	\$ (111,475)	\$ (135,097)	\$ (105,094)	\$ (151,727)	\$ (155,940)	\$ (161,832)
g. Net Patient Services Revenue	22,787,012	24,463,530	26,542,088	30,195,057	31,030,812	32,204,016
h. Other Operating Revenues (Physician Vistits)	\$ 493,377	\$ 512,476	\$ 575,354	\$ -	\$ -	\$ -
i. Net Operating Revenues	23,280,389	24,976,006	27,117,443	30,195,057	31,030,812	\$ 32,204,016

Table 3 cont.						
Fiscal Year	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)		
	2011	2012	2013	2014	2015	2016
2. Expenses						
a. Salaries, Wages. And Professional Fees, (including fringe benefits)	\$ 12,696,650	\$ 13,115,663	\$ 14,030,745	\$ 16,429,840	\$ 16,889,733	\$ 17,427,897
b. Contractual Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
c. Interest on Current Debt	\$ (5,544)	\$ 176	\$ 165	\$ -	\$ -	\$ -
d. Interest on Project Debt	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
e. Current Depreciation	\$ 117,782	\$ 126,160	\$ 200,124	\$ 153,195	\$ 153,195	\$ 153,195
f. Project Depreciation	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
g. Current Amortization	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
h. Project Amortization	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
i. Other Expenses (Specify)						
j. Direct Clinical	\$ 1,861,952	\$ 1,948,658	\$ 2,169,759	\$ 2,487,140	\$ 2,475,855	\$ 2,574,099
k. Other Direct	\$ 293,124	\$ 370,009	\$ 431,101	\$ 642,720	\$ 679,092	\$ 682,548
l. Mileage	\$ 437,339	\$ 446,896	\$ 523,362	\$ 560,077	\$ 562,896	\$ 584,988
m. Room & Board Expense	\$ 985,554	\$ 1,799,607	\$ 1,653,615	\$ 1,252,638	\$ 1,391,472	\$ 1,577,616
n. Facilities	\$ 718,887	\$ 667,555	\$ 745,415	\$ 1,102,933	\$ 1,230,444	\$ 1,236,108

Exhibit 8
Corrected Completeness Exhibit 12
Projected Expenses
By Seasons IPU
2014-2016
(See Question 33)

Unit	Year				
	<u>2014</u>	<u>2015</u>	<u>2016</u>		
Northwest Hospital	General Inpatient Revenue	2,199,318	2,068,862	2,068,862	
	Charity Revenue	(10,997)	(10,344)	(10,344)	
	Net Revenue	2,188,321	2,058,518	2,058,518	
	Labor - Direct	769,968	769,968	769,968	
	Labor - Indirect	130,236	130,236	130,236	
	Labor	900,204	900,204	900,204	
	Pharmacy	65,700	65,700	65,700	
	Other Direct	246,372	246,372	246,372	
	Other Operating Expense	23,292	23,292	23,292	
	Facilities	187,248	187,248	187,248	
	Contribution Margin	765,505	635,702	635,702	
	Sinai Hospital	General Inpatient Revenue	2,194,355	2,236,895	2,278,726
		Charity Revenue	(10,972)	(11,184)	(11,394)
Net Revenue		2,183,383	2,225,711	2,267,332	
Labor - Direct		769,968	769,968	769,968	
Labor - Indirect		130,236	130,236	130,236	
Labor		900,204	900,204	900,204	
Pharmacy		61,900	63,100	64,280	
Other Direct		232,125	236,625	236,625	
Other Operating Expense		23,292	23,292	23,292	
Facilities		300,000	300,000	300,000	
Contribution Margin		665,862	702,490	742,931	

Franklin Square Hospital	General Inpatient Revenue	1,358,679	2,329,164	2,329,164
	Charity Revenue	(6,790)	(11,640)	(11,640)
	Net Revenue	1,351,889	2,317,524	2,317,524
	Labor - Direct	449,148	769,968	769,968
	Labor - Indirect	75,971	130,236	130,236
	Labor	525,119	900,204	900,204
	Pharmacy	38,325	65,700	65,700
	Other Direct	153,300	262,800	262,800
	Other Operating Expense	13,587	23,292	23,292
	Facilities	175,000	300,000	300,000
	Contribution Margin	446,558	765,528	765,528
	Grand Total	1,877,926	2,103,719	2,144,161

NOTE: These tables do not include employee benefits.

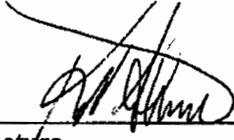
Exhibit 9
Affirmations

I hereby declare and affirm under the penalties of perjury that the facts stated in this Completeness and Additional Information response are true and correct to the best of my knowledge, information, and belief.

Dean A. Foxman
Signature

1/14/14
Date

I hereby declare and affirm under the penalties of perjury that the facts stated in this Completeness and Additional Information response are true and correct to the best of my knowledge, information, and belief.

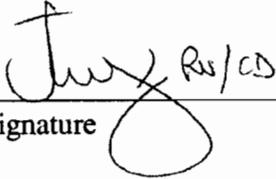
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Signature

1-14-2014

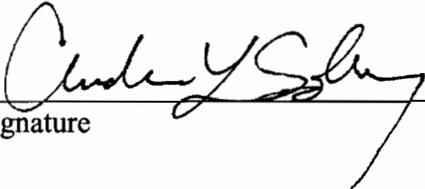
Date

I hereby declare and affirm under the penalties of perjury that the facts stated in this Completeness and Additional Information response are true and correct to the best of my knowledge, information, and belief.


Signature

1/14/14
Date

I hereby declare and affirm under the penalties of perjury that the facts stated in this Completeness and Additional Information response are true and correct to the best of my knowledge, information, and belief.


Signature

1/14/14
Date