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Offices In
Maryland
Washington, D.C.
Virginia

September 30, 2013

Via Hand Delivery

Joel Riklin, Acting Chief
Hospital Services Policy and Planning, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2229

Re: **Certificate of Need Application for**
Establishment of an Inpatient Hospice Unit

Dear Mr. Riklin:

Enclosed please find six copies of a Certificate of Need Application being filed on behalf of Seasons Hospice and Palliative Care of Maryland, Inc., to establish a 12 bed inpatient hospice unit at Sinai Hospital in Baltimore City. I hereby certify that a copy of the CON application has been provided to the local health department, as required by regulations.

Thank you.

Sincerely,

Howard L. Sollins

RECEIVED
SEP 30 2013
MARYLAND HEALTH
CARE COMMISSION

JJE/tjr
Enclosures
cc: Paul Parker, Director
Suellen Wideman, Assistant Attorney General
Oxiris Barbot, M.D., Health Officer - Baltimore City Health Department
Todd Stern
Dean H. Forman
Joel I. Suldan, Esquire
Andrew L. Solberg, CON Consultant
John J. Eller, Esquire

2696800.v1

MARYLAND HEALTH CARE COMMISSION

_____
MATTER/DOCKET NO.

_____
DATE DOCKETED

OTHER THAN HOSPITAL AND COMPREHENSIVE/ EXTENDED CARE SERVICES APPLICATION FOR CERTIFICATE OF NEED

ALL PAGES THROUGHOUT THE APPLICATION SHOULD BE NUMBERED CONSECUTIVELY.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1.a. Seasons Hospice & Palliative Care of Maryland, Inc.
Legal Name of Project Applicant
(ie. Licensee or Proposed Licensee)

b. 6934 Aviation Boulevard, Suite N
Street

c. Glen Burnie 21061 Anne Arundel
City Zip County

d. (410) 689-7400
Telephone No.

e. Todd Stern
Name of Owner/Chief Executive

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

b. _____
Street

c. _____
City Zip County

d. _____
Telephone

e. _____
Name of Owner/Chief Executive

3.a. Seasons Hospice Suites at Sinai Hospital of Baltimore
Name of Facility

b. 2401 W Belvedere Ave
Street (Project Site)

c. Baltimore 21215
City Zip County

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

5.a. _____
Representative of Co-Applicant

b. _____
Street

c. _____
City Zip County

d. _____
Telephone

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

a. Todd Stern, CEO **Name and Title** Seasons Hospice & Palliative Care	**a.** Howard L. Sollins, Atty **Name and Title** Ober, Kaler, Grimes, & Shriver
b. 6400 Shafer Court, Suite 700 **Street**	**b.** 100 Light Street **Street**
c. Rosemont / 60018 / IL **City / Zip / County**	**c.** Baltimore / 21202 / Baltimore City **City / Zip / County**
d. (847) 692-1127 **Telephone**	**d.** 410-347-7369 **Telephone**
e. (847) 692-1001 **Fax No.** **Email:** tstern@seasons.org	**e.** 443-263-7569 **Fax No.** **Email:** hlsollins@ober.com
a. Andrew L. Solberg **Name and Title** A.L.S. Healthcare Consultant Services	**a.** Joel Suldan, Esq. Vice President and Legal Counsel Lifebridge Health
b. 5612 Thicket Lane **Street**	**b.** 2401 W. Belvedere Ave
c. Columbia / 21044 / Howard **City / Zip / County**	**c.** Baltimore / 21215
d. 410-730-2664 **Telephone**	**d.** (410) 601-9670 **Telephone**
e. 410-730-6775 **Fax No.** **Email:** asolberg@earthlink.net	**e.** (410) 601-8801 **Fax No.** jsuldan@lifebridgehealth.org

7. Brief Project Description (for identification only; see also item #14):
Establishment of a 12 bed inpatient hospice unit for pain control, symptom management, and respite purposes in currently vacant space at Sinai Hospital.

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

a. Governmental ___
Proprietary ✓
Nonprofit ___

b. Sole Proprietorship ___
Partnership ___
Corporation ___
Subchapter "S" ✓

c. To be Formed ___
Existing ✓

9. Project Services (check below, if applicable):

Service	Included in Project
ICF-MR	
ICF-C/D	
Home Health Agency	
Residential Treatment Center	
Ambulatory Surgery	
Other (Inpatient Hospice)	✓

10. Current Capacity and Proposed Changes:

Service	Unit Description	Currently Licensed/ Certified	Units to be Added or Reduced	Total Units if Project is Approved
ICF-MR	Beds	___/___		
ICF-C/D	Beds	___/___		
Residential Treatment	Beds	___/___		
Ambulatory Surgery	Operating Rooms			
	Procedure Rooms			
Home Health Agency	Counties	___/___		
Hospice Program	Counties	___/___		
Other (Inpatient Hospice)	Beds	14 / 16	12	42
TOTAL		14 / 16	12	42

11. Project Location and Site Control:

A. Site Size 9,125 sq. ft. ____ acres

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

No land use approvals are required.

C. Site Control:

(1) Title held by: _____

(2) Options to purchase held by: _____
(i) Expiration Date of Option _____
(ii) Is Option Renewable? _____ If yes, Please explain
_____
_____
(iii) Cost of Option _____

(3) Land Lease held by: _____
(i) Expiration Date of Lease _____
(ii) Is Lease Renewable _____ If yes, please explain
_____
_____
(iii) Cost of Lease _____

(4) Option to lease held by: _____
(i) Expiration date of Option _____
(ii) Is Option Renewable?_____ If yes, please explain
_____
_____
(iii) Cost of Option _____

(5) If site is not controlled by ownership, lease, or option, please explain how site control will be obtained Both Seasons and Sinai have agreed to the terms of a lease for the space at Sinai Hospital. Both parties will sign the lease on CON approval.

(INSTRUCTION: IN COMPLETING ITEMS 12, 13 & 14, PLEASE NOTE APPLICABLE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

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

A. Obligation of Capital Expenditure ____0____ months from approval date.
B. Beginning Construction _____0_____ months from capital obligation.
C. Pre-Licensure/First Use _____0_____ months from capital obligation.
D. Full Utilization _____12_____ months from first use.

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

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

14. Project Implementation Target Dates (for projects not involving capital expenditures):

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

15. Project Description:
Provide a summary description of the project's construction and renovation plan and all medical services to be establish, expanded, or otherwise affected if the project receives approval. Please attach this description as a separate sheet or section to your application.

Please see page 6.

Project Description

Seasons Hospice & Palliative Care of Maryland, Inc. ("Seasons") was founded in 2003 and acquired the hospice service of VNA of Maryland. Seasons currently offers home hospice care in Anne Arundel, Baltimore, Carroll, Cecil, Harford, Howard, and Prince George's Counties and Baltimore City. Seasons also operates a 14 bed inpatient hospice unit at Northwest Hospital in Baltimore County and recently received a CON to establish a 16 bed unit at MedStar Franklin Square Medical Center.

Seasons now proposes to replicate the model it operates at Northwest Hospital in Sinai Hospital ("Sinai"), in Baltimore City. In 2012, Sinai decided to cluster the acute care beds at Sinai in which it was already providing hospice care into one unit. These beds continued to be licensed as acute care medical surgical beds. This unit was renovated (at a cost that was substantially under the CON Threshold for Capital Expenditure), and the clustered bed unit opened on January 15, 2013. The unit operated as such until May 15, 2013 when, in compliance with guidance from the Office of Health Care Quality and the MHCC, the unit ceased admitting residents until the receipt of the CON for which this application applies (and the related extension of Seasons' hospice license to it). Sinai only provides inpatient hospice services in unclustered beds around the hospital. The proposed unit, to be licensed by Seasons as hospice beds and managed by Seasons in leased space at Sinai, will include 12 hospice beds and will be located on the 2nd floor of the hospital's Mt Pleasant wing.

Clinical Programs

Seasons has developed a large array of clinical programs, which include:

Inpatient Unit Programs - Seasons began operating Hospital Based Inpatient Units in 2003. Seasons currently operates 60 inpatient beds, across 5 hospital

locations. The only hospital based unit that Seasons operates in Maryland is at Northwest Hospital Center, and the unit at MedStar Franklin Square Medical Center is under development. The Seasons Hospice & Palliative Care Unit (or "Seasons Hospice Suites") provides a caring environment where patients can go to get help with their symptoms. It is a place where loved ones may spend hours or days in the patient's room, providing the warmth and comfort that family and friends can offer. They are welcome to share the room 24 hours a day, 7 days a week. There is a kitchen facility for family use. These convenient amenities are vital to the comfort of both patient and family. During this critical time, a patient's loved ones can truly "be there" - which can be the most important thing to the patient.

The comforting setting and a team of highly skilled hospice professionals at the Seasons Hospice & Palliative Care Unit help the patient meet any challenges they may encounter with their particular hospice diagnosis. Some reasons for inpatient hospice care may include:

- Symptom management control
- Pain management
- Open Access interventions:
- Intravenous antibiotics
- Palliative chemotherapy and radiation treatments
- Other advanced medical interventions
- Psycho/social support:
    - To provide time and assistance if there is a breakdown in family dynamics
    - To provide time and assistance regarding long term care placement
- Ventilator Care

The patient must meet the following Medicare criteria for inpatient hospice such as one of these clinical situations:

- Agitation requiring medication change
- Uncontrolled pain requiring dosage changes
- Blood transfusions
- Seizures intractable, requiring observation/medication titration
- Ventilator Weaning for Terminal Extubations

- Wound care - draining, malodorous, requiring frequent dressing changes
- Respiratory distress, requiring skilled respiratory interventions
- Cardiac failure - requiring frequent medication administration
- Intractable bleeding
- Medication titration or adjustments, requiring close monitoring
- Decreased blood pressure
- Decreased urine output
- Intractable nausea
- Severe vomiting and/or diarrhea

The patient's referring physician can continue to follow the patient. Season's hospice physician rounds every day as appropriate.

A person can stay in the unit as long as necessary based on a physician's assessment to get symptoms under control or to make arrangements for care in another setting based on a safe discharge plan. Typically, patients stay for 5-7 days. The average length of stay for calendar year 2012 at the Northwest Hospital IPU was 5.7 days.

The Seasons staff includes a highly skilled interdisciplinary care team, including doctors, nurses, social workers, certified nursing assistants, chaplains, volunteers and music therapists who help patients to meet any challenge they may encounter with their particular diagnosis.

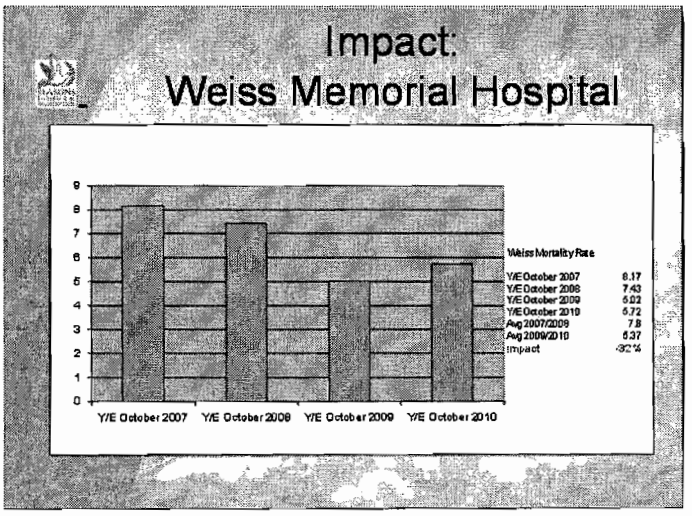
When patients go to the unit, it does not necessarily mean they will die there. Studies show that often when a patient's needs are met, whether they are emotional, spiritual or physical, the patient lives longer. The goal of hospice care is to alleviate the pain, loneliness, and fear, to add quality to the patient's life, and to honor the patient's end of life wishes.

At Northwest Hospital, Seasons offers a comprehensive plan of care for patients and families facing a terminal illness. The hospice unit at Northwest Hospital includes 14 beds, all in private rooms, with the ability to accommodate family members or close

friends overnight, should they wish to stay around the clock with the patient. Designed with a home-like atmosphere, the patient rooms are adjacent to a shared family room, kitchen and eating area for family members and friends.

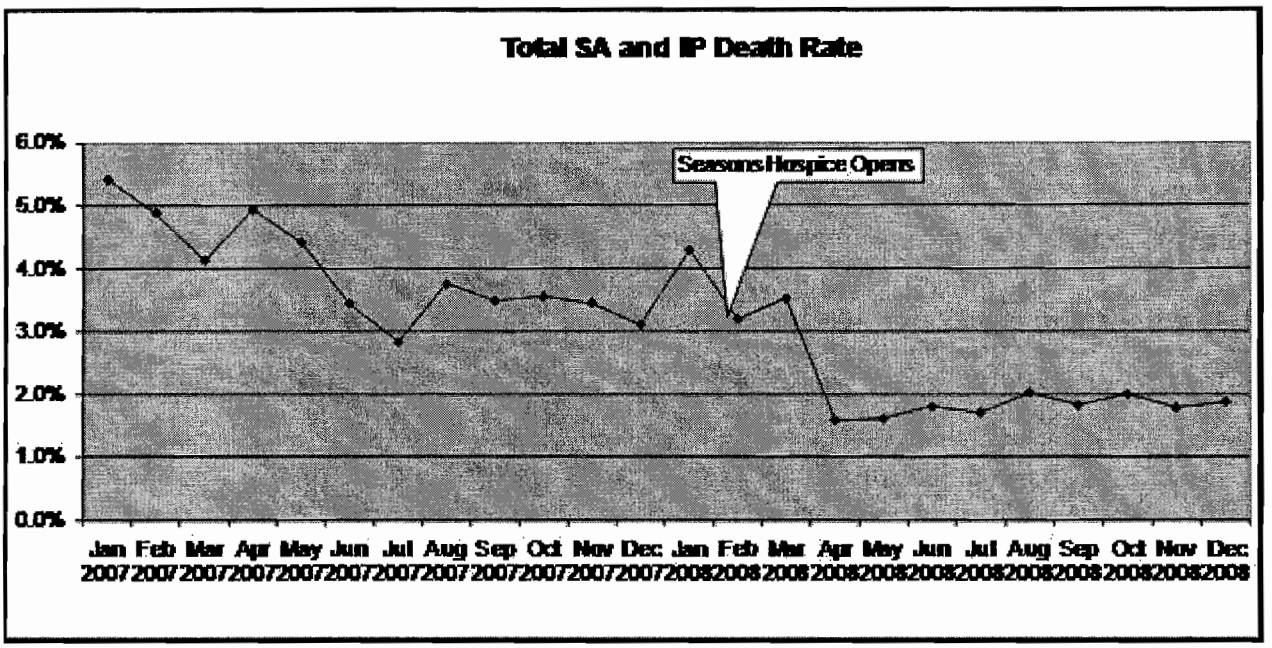
Two examples demonstrate the impact on a hospital when a Seasons unit opens. At Weiss Memorial Hospital in Chicago, the mortality rate for the hospital declined by 32% in the year following the opening of the Seasons unit there in early 2009, as the setting for those hospice-appropriate patients changed. This is shown in Figure 1.

Figure 1
Hospital Mortality Rate
Weiss Memorial Hospital
2007 - 2010



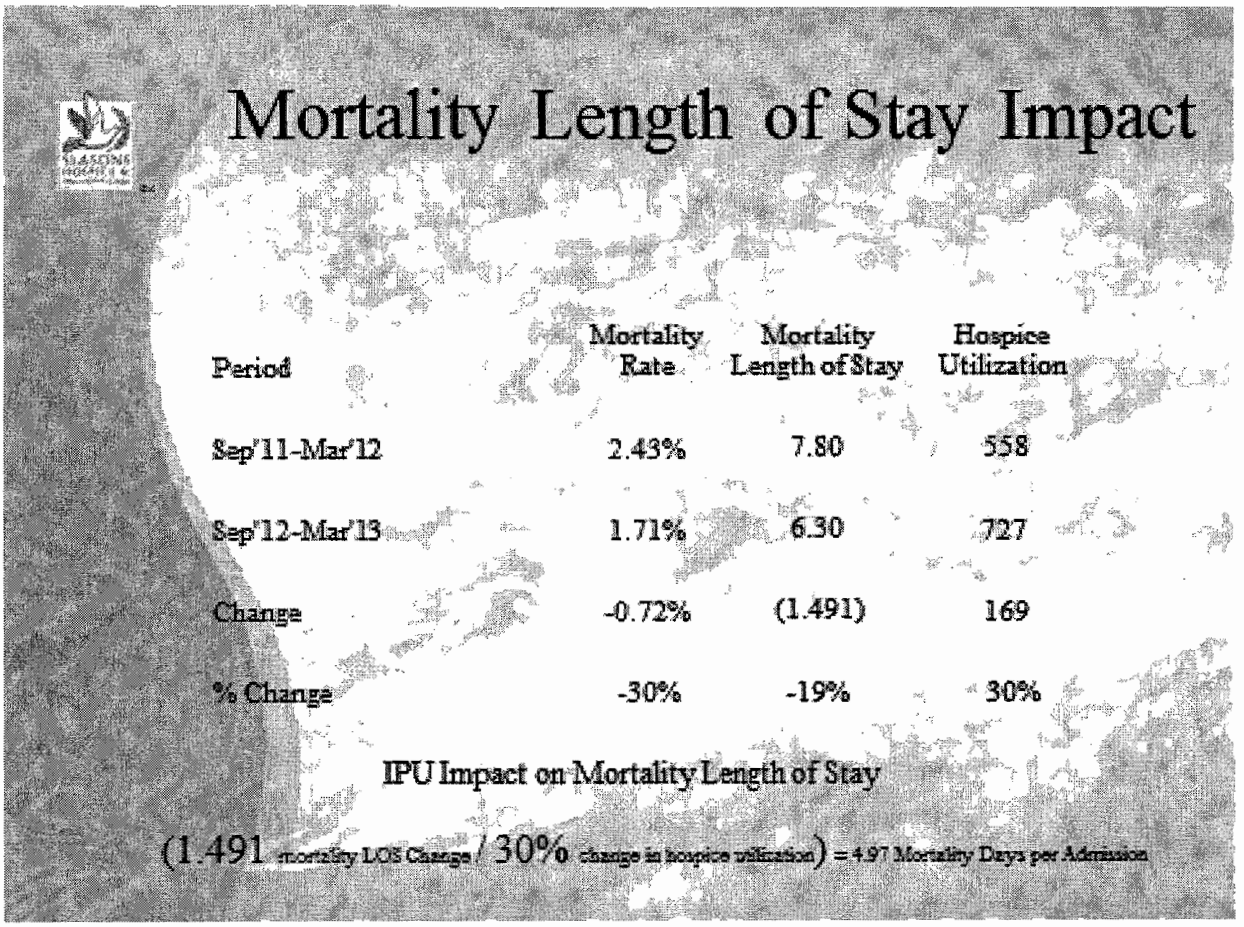
Similarly, at Northwest Hospital in Baltimore County, the mortality rate at the hospital declined by 52% following the opening of the Seasons unit, as the setting for those hospice-appropriate patients changed. This is shown in Figure 2.

Figure 2
Hospital Mortality Rate
Northwest Hospital
January 2007 – December 2008



Furthermore, at Christiana Hospital in Newark, Delaware, Seasons opened a twelve bed inpatient unit on August 16, 2012. The unit reached capacity almost immediately. The mortality in acute beds declined by 30 percent within six months after the opening of the unit. Data for the twelve month period following opening of the unit show that the Average Daily Census ("ADC") was 11.85 patients. The impact would have been greater if the unit had more than 12 beds and not operating at full capacity.

Figure 3
Impact on Hospital Mortality and Length of Stay
Christiana Hospital
September 2011– March 2013



Mortality Length of Stay Impact

Period	Mortality Rate	Mortality Length of Stay	Hospice Utilization
Sep'11-Mar'12	2.43%	7.80	558
Sep'12-Mar'13	1.71%	6.30	727
Change	-0.72%	(1.491)	169
% Change	-30%	-19%	30%

IPU Impact on Mortality Length of Stay

(1.491 mortality LOS Change / 30% change in hospice utilization) = 4.97 Mortality Days per Admission

Lastly, even during the four months that Seasons operated a clustered unit at Sinai, the percentage that hospice deaths comprised of total deaths reached 50%.

Table 1
Deaths in Acute Beds and Hospice Deaths
Sinai Hospital of Baltimore
January-May 2013

Month	Hospital Deaths	Hospice Deaths	Tot Deaths	Hospice/Total
January	51	18	69	26.1%
February	35	25	60	41.7%
March	45	34	79	43.0%
April	42	29	71	40.8%
May	25	26	51	51.0%

Source: Sinai Hospital

Seasons anticipates that the Sinai Hospital unit will have a comparable impact on mortality within the hospital, as the setting for hospice-appropriate patients changes when terminally ill patients choose to spend their last days in hospice care.

Open Access is a hospice program that allows patients currently receiving medical treatments and/or experiencing intense psychosocial issues access to hospice services earlier; a blended model between curative and palliative care. The kinds of patients who can take advantage of the Open Access program include those with an advanced illness who have limited prognosis and patients who continue to receive medical treatments such as:

- Intravenous antibiotics
- Total Parenteral Nutrition
- Ventilator care for intubated patients electing compassionate extubations (performed by Respiratory Therapy)
- Respiratory Therapies: Oxygen mask, High Flow Nasal Cannula, 100% Bipap support
- Intravenous Opioid Med Administration (continuous drips & Intravenous push)
- Intravenous Antibiotic Administration
- Total Parenteral Nutrition combined with Lipids
- Cardiac Intravenous Meds:
    - Anti-arrhythmic Intravenous drip meds (Amiodarone, Dopamine, Verapamil, Diltiazem) for patients hospitalized with irregular heart rhythms
    - Anti-hypertensive Intravenous drip meds (Remodulin)
    - Anti-hypotensive & Vasopressor Intravenous drip meds (Dobutamine, Epinephrine) for patients with low blood pressure. This is typically weaned

off in the Hospice Inpatient Unit

- Seizure Intravenous Meds (Keppra, Ativan)
- Intracranial Pressure Drain (ICP Drain) for patients with hemorrhagic stroke who are no longer electing or responding to aggressive treatment
- Paracentesis & Thoracentesis for fluid accumulation in the abdomen & lungs
- Chest Tubes
- Surgical drains (JP drains)
- Interventional Radiology procedures to facilitate comfort:
    - Nephrostomy tube replacement
    - Biliary drain replacement
    - PEG tube replacement
- Blood Transfusions to facilitate comfort
- Laboratory and microbiology testing
- Portable X-rays
- Portable ultrasound
- Cardiac drips
- Tube feedings
- Hemo/peritoneal dialysis for non-hospice diagnosis
- Palliative radiation
- Biological response modifiers i.e., Procrit®, Neupogen®, Epogen®
- Patients who need additional time to be stabilized for safe transfer to Routine level of hospice care

Many of these procedures are not performed in freestanding hospice units but can be safely performed in a hospital based unit. For example, between 4/1/12 - 8/12/13, 66 patients admitted to the NWH unit received compassionate extubation who would have otherwise likely died in the Intensive Care Unit. Here is a portion of a case study of a patient who was compassionately extubated on the Sinai clustered bed unit when it was open.

> 60 year old was a resident of a group home and was found to be unresponsive with left hemiparesis. Resident was brought to Sinai Emergency Department and had a CT of the head which showed a large right basal ganglia hemorrhage. Repeat CT of the head showed extension of the hemorrhage with more increased size of the basal ganglia hemorrhage and some midline shift. Patient was taken to the ICU for close observation and management. Patient was started on nicardipine drip and 2% normal saline for control of Hypertension and intracranial pressure. The next day, another CT showed worsening edema with hemorrhage, and the patient was intubated. The following day, an intraventricular catheter was placed by neurology to decrease intracranial pressure. This was removed in three days. The patient was made a No Code and No Defibrillation, and the decision was made by the patient's primary healthcare decision maker to transition care to Seasons Hospice. The Patient was admitted to Seasons

Hospice Services at Sinai Hospital clustered bed unit. At the time of hospice admission, it was noted that patient was unresponsive to any stimuli. Breathing was per ventilator. There was no nutritional intake, diminished bowel sounds noted. The patient's brother-in-law, the patient's primary healthcare decision maker, came in to see the patient and asked many questions pertaining to patient's current health status. Per social work, he was having a hard time having to make the decision as to when to extubate the patient. He appeared to be comfortable and satisfied with the answers he received; stated that music therapy might be nice to have in the room during the extubation. He also stated that he was happy to see the patient appearing comfortable and at peace. The next day, the brother in law visited and stated that the compassionate extubation could be scheduled the following day. He expressed his concern that the patient might be uncomfortable during the process, so the hospice staff explained the compassionate extubation process and that it would not take place until the patient was comfortable. The following day, the brother in law visited and wanted to extubate. The physician assessed the patient and gave the order to extubate. Music therapy was called per request. Respiratory therapist arrived, and Morphine drip was increased per physician orders for comfort related to respiratory distress. Respiratory therapist extubated the patient, and much suctioning was performed to clear thick secretions. The brother-in-law was left with the patient per request until he came out for help, and the patient was assessed by 2 hospice nurses to be without a pulse and respirations.

The following is a portion of a case study of a patient who received compassionate extubation at the NWH unit earlier this year.

81 year old was in usual health until choking on a piece of meat in a restaurant. A witness at the restaurant performed CPR until EMS arrived. Patient was found in asystole by EMS, and was brought to NWH ED, where the patient was given two doses of Epinephrine, and hypothermic protocol was initiated. The patient coughed up the piece of meat and was intubated. Neuro exam on 07/19 showed episodes of myoclonus, grimace to sternal rub, but no withdrawal to painful stimuli. Patient's prognosis was deemed extremely poor, and the patient's sons felt that the patient would not want prolonged life support if his chances for recovery were grim. The family opted for compassionate extubation at the NWH Inpatient Hospice Unit. The Patient was then admitted to Seasons Hospice Services in the Hospice Inpatient Unit at NWH for compassionate extubation. As the patient was Catholic, Sacrament of the sick was administered. The patient was a resident of an assisted living facility, since dementia and bipolar disorder progressed several years ago. The family seemed to be accepting of the patient's prognosis and were coping as well as can be expected. They asked that Seasons SW assist with the VA benefit process if possible. The patient received Final Blessing. The patient was extubated in the Seasons Hospice Inpatient Unit per the patient's family's request. The patient remained GIP on Hospice Services for Respiratory Management post-extubation for two more days. The patient was unresponsive to verbal and tactile stimulation. The

> patient required frequent suctioning of blood-tinged sputum. Patient's lung sounds were rhonchorous, and was mouth breathing. The following day, the patient was assessed by 2 hospice nurses as being completely unresponsive, with no pulse or respirations present. The family was notified and were grieving appropriately but were educated on Seasons Hospice bereavement support services.

These patients would have likely remained in the hospital due to the complexity of their care, and their families would not have received 13 months of bereavement support required by Medicare for Hospice.

Seasons Hospice Open Access program also allows time for patients and families to engage in advance care planning and mentally prepare for issues related to the end stages of advanced illness while utilizing services. It allows patients to receive hospice support services earlier, providing them with more assistance in care planning, so the patient can be safely transferred to Routine level of hospice care in their preferred setting. Open Access encourages strong collaborative relationships with the referral source during difficult communications with patients and families and enables supportive care or hospice while patients are making the transition from curative to palliative and hospice care. Seasons Open Access Program also allows patients and families time to comprehend the futility of some aggressive treatment interventions that their Primary Care Practitioner or hospital attending physician has explained are no longer effective (Benefit vs Burden). Lastly, because more patients choose hospice when there is a unit in the hospital, it reduces length of stay in the acute care setting, which reduces health care delivery system costs both because of lower per diem costs in a hospice unit rather than in an acute care bed hospital and because of the elimination of the need for readmission to the hospital for patients that need these services and comfort.

A study conducted by Wayne State University School of Medicine of the Seasons inpatient unit ("IPU") at Sinai-Grace Hospital ("SGH") in Detroit Michigan (see Exhibit 1) found:

> After admission to the IPU, mean pain scores were significantly reduced from 5.0 to 2.1 ($p < .0001$, scale 0-10). By discharging these patients to the IPU, the hospital realized an estimated $904,449 over the 6 month period.

and

> The study reveals that the Rhea Heil IPU of SGH permits the enrollment of patients dying of acute illness with severe symptoms, and 62% of visits end with the death of the patient during their IPU stay. In the past, these patients have typically been excluded from hospice enrollment due to the severity and acuity of their illnesses. Our preliminary results suggest that IPUs can improve access and quality for patients, and cost and mortality outcomes for hospitals.

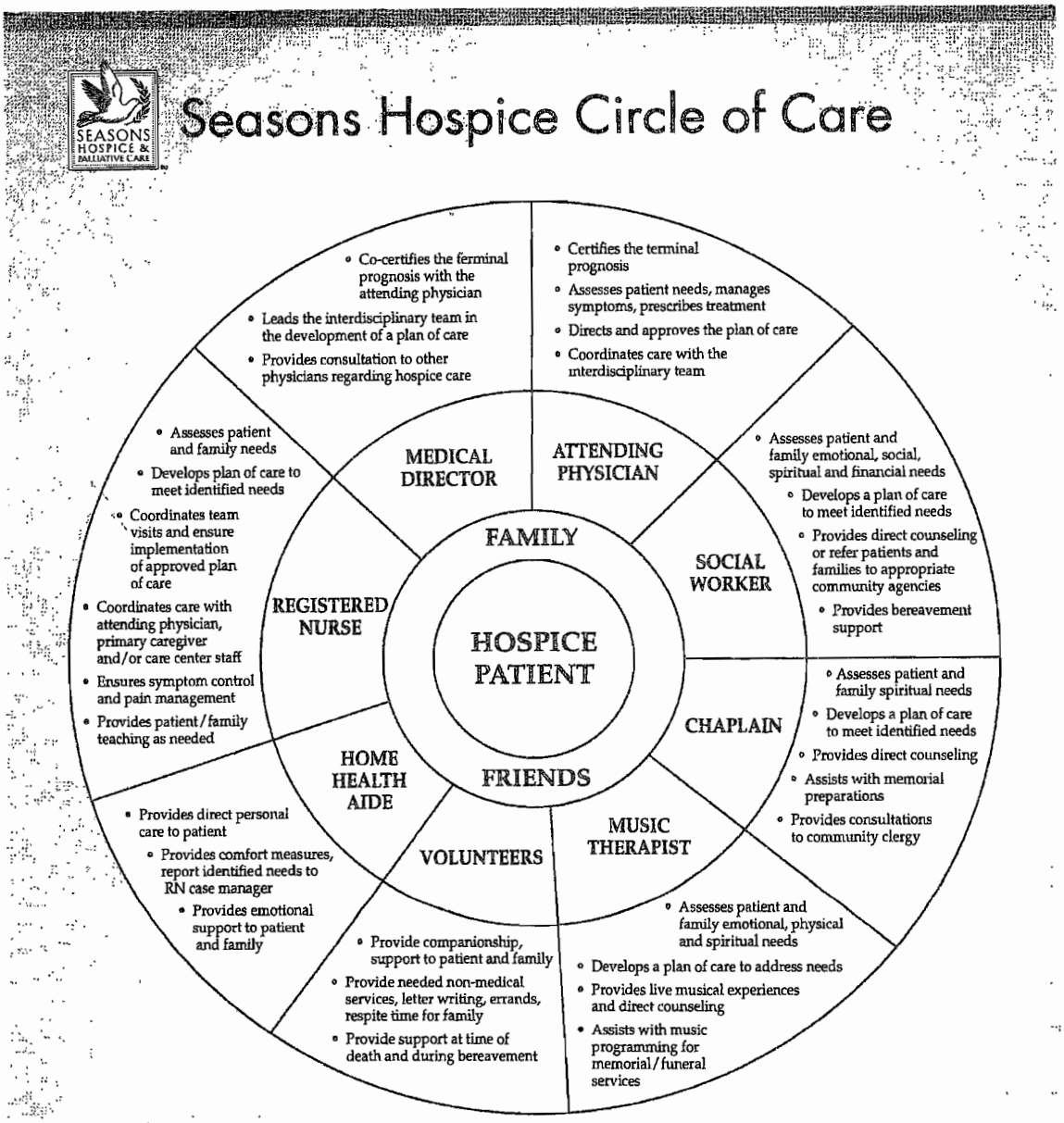
Potential savings due to the difference in the cost of hospitalization and the cost of hospice care are estimated in this application.

Seasons Hospice provides services to a very diverse population reflecting the full spectrum of demographic communities within its service area. By the same token, the inpatient hospice unit at Sinai proposed in the application is an important part of the health care delivery system serving the needs of Baltimore's Jewish community. Within LifeBridge, Sinai Hospital of Baltimore in particular is located within and has cultural linkages to and supports focused on meeting the needs of the Jewish community. Sinai's Mission Statement provides, in part: "As an organization founded and supported by the Jewish community, it carries out its mission with sensitivity to the needs of Jewish patients and staff, and asserts traditional Jewish values of excellence, compassion and community concern for all."

Sinai is Maryland's only hospital with a kosher kitchen. It has special experience with needs of observant individuals with particular needs during the Sabbath and holidays and has strong ties to the various clergy and community services that are also

connected through The Associated Jewish Community Federation of Baltimore. Seasons' inpatient hospice unit at Sinai will provide, in a dedicated location within the hospital, a place where families from all backgrounds, including the Jewish community, can with comfort stay overnight, eat together, have faith community support and other culturally appropriate social services support for bereavement and otherwise, in this setting.

Figure 4
Seasons Hospice Circle of Care



The Seasons Hospice Circle of Care depicts the holistic continuum of care rendered by hospice professionals and trained volunteers working together as a team 24 hours per day, 7 days per week to assess and meet the patients' and families' unique needs as the end of life draws near.

Music Therapy - Seasons Hospice created a comprehensive Music Therapy Department to help our patients and their families through holistic palliative care. Full-time board-certified Music Therapists serve as integral members of our staff. Throughout life, sound positively and negatively affects our physical and emotional well-being. It affects the bodily functions that we think are beyond our control. These include heart rate, blood pressure and release of the body's natural painkilling chemicals (endorphins).

Even when people are no longer conscious or speaking, we can console and comfort them with music. Research has shown that music is the first outside sensation that registers with a developing fetus and the last that registers with a dying patient.

A Touch for All Seasons is a highly specialized program for patients in the advanced stage of dementia and other neurological illnesses. A Touch for All Seasons was designed by Joyce Simard, MSW, an internationally recognized dementia expert. A Touch for All Seasons uses person-centered approaches to improve quality of life through meaningful sensory activities that stimulate the senses, promote relaxation, and offer comfort and serenity to those living with dementia. Although specifically designed for people with advanced dementia, the sensory approaches used in A Touch for All Seasons enhance the lives of infants, children and people with other diseases as well as providing moments of peace and tranquility to family caregivers.

Touch for All Seasons approaches are provided by all members of the hospice interdisciplinary staff and volunteers. Certified Nursing Assistants provide bathing, dressing, grooming and hydration as meaningful activities rather than task completion. Other disciplines and volunteers are involved with providing gentle hand massages,

spiritual reading, music and reminiscence. Seasons Hospice promises that with A Touch for All Seasons, each person's individuality is respected, approach to care is offered to maximize pleasure and comfort, and all care by all staff and volunteers is offered with a loving touch.

A Touch for All Seasons staff design person-centered care approaches as meaningful activities to individualize care based on the Lifestyle Assessment. They use sensory stimulation to help soothe and evoke feelings of comfort. The program creates a calm, relaxing environment for the provision of care. It teaches loved ones ways to interact with the patient with advanced dementia and adds a layer of professional caregivers to the existing team.

Bereavement Services recognizes that no one can prepare someone else for the personalized experience of grief and loss. Each person reacts differently to the loss of a loved one. Grief is unique, and it can feel devastating. The loss of a loved one changes someone's life. Even if we believe we are strong or well-prepared, the feelings of grief can be intense. Sorrow, anxiety, fear, and anger emerge at the time of a loved one's death and often continue for many months. During this time of grief, people may find relationships changing. Daily routines and roles may be altered, and basic assumptions about life may change temporarily, or even permanently. People often face the anxiety and unexpected adventure of reshaping their lives. They may not know where to turn for support, care, and help along such an uncharted journey.

The professional staff at Seasons are prepared to walk with families on their journey through grief and bereavement. Seasons offers a variety of bereavement services, which can include the following:

- Person-to-person support – Seasons is available for counseling, companionship, or conversation -- whether in person, by phone, e-mail, or postal

correspondence, from the time of patient death until thirteen months after the death. A personal visit request begins with a simple phone call.

- Memorial services - Seasons offers a Celebration of Remembrance that is ecumenical and inter-faith in perspective. We focus on remembering the meaning, purpose, and impact of a patient's life, regardless of religious affiliation.

- Educational support groups - Seasons provides a safe and supportive place for bereaved people to share experiences of loss with each other, to learn from each other about ways to cope and heal, and to form new friendships.

- Written resources - Seasons has a library of materials available that can help you understand and follow your journey through grief

Social Work – Seasons' Master's level Social Workers are specially trained in end-of-life care issues. They help our patients and families in a multitude of ways, including counseling, education, help with accessing community resources and grief support. In addition, they assist those in need of alternate residential settings, individuals experiencing financial crises, as well as those who require referrals to outside social service agencies. During the Social Worker's visit, he or she will assess the needs of the patient and family and focus on maximizing their quality of life. As part of the interdisciplinary team, the Social Worker collaborates with all involved in a patient's care with clarification of hospice goals. In short, the Social Worker helps patients and families determine how hospice can best serve them.

Spiritual Care - Seasons does not believe spiritual concerns are only for those who are religious. Spiritual life is most directly expressed and experienced in human connection, and spiritual concerns are intertwined with every facet of our lives. Spiritual dimensions of our lives often provide us with our most profound experiences of awe, wonder, joy, fulfillment, and unity. Spiritual dimensions may also express themselves in some of our most difficult experiences of fear, terror, guilt, and brokenness. All of these experiences are important and valid – and they shape our lives in many untold ways.

During times of upheaval and change in life, we all may experience periods of deep doubt and questioning. We may feel uprooted, set adrift, and utterly alone. Sometimes we respond with deep sadness, other times with numb silence, and still other times with rapid activity and an effort to prove to ourselves that we are still in control.

Culturally Diverse Services - Disparities in the use of hospice and palliative care is a concern that Seasons is actively combating. Seasons promotes community outreach and educational training in communities underserved in end-of-life care. Seasons encourages the awareness and respect for diversity in our staff and among our patients and their families. We have a no-tolerance policy for stereotyping, prejudice, discrimination or racism. Seasons provides continuous diversity education and training to all employees. Seasons Hospice is already well above the national average for various ethnic groups, and we are dedicated to even greater diversity.

Volunteer Services – Seasons recognizes the importance of the volunteer in hospice care. A Hospice Volunteer is a special and necessary member of the Hospice Team, is caring, open, and understands the challenges that face families and patients when confronted with a life-limiting illness.

Direct Care Volunteers are required to participate in initial Hospice Volunteer training as well as basic orientation. Training is offered in different formats and locations throughout the Seasons service areas. Specific skill sets may require additional interviews, selection and program training. Indirect Care Volunteers receive basic orientation, training specific to task undertaking, and are encouraged to attend initial hospice volunteer training. Volunteer training and orientation give volunteers an opportunity to learn new skills and become aware of skills they already possess. Some of the areas of training include:

- Hospice mission, history and philosophy of care
- Role of the volunteer and the interdisciplinary team
- Spiritual and cultural diversity
- Confidentiality
- Listening and communication skills
- Patient care
- Disease processes
- Self care
- Precautions
- Grief and bereavement
- Resources

Additional Staff support meetings or patient/family meetings and educational opportunities are offered throughout the year as well as ongoing personal support and social gatherings.

Ask the Pharmacist – Hospice pharmacists are available to answer drug-related questions raised by patients, families, caregivers, nurses, doctors and all members of the hospice health care team. Pharmacists inform health care providers about new drugs on the market, especially medications that will help relieve pain and other symptoms at end of life.

Tender Legal Care™ was designed to help patients make informed decisions about their end of life care so loved ones know exactly how the hospice patients want to be treated. Even though it is uncomfortable to think about, Seasons knows it will be more difficult later, when loved ones are forced to make these tough decisions for patients without knowing what they really wanted. Seasons has developed a booklet that guides patients and their families on how to legally honor the patient's end of life wishes. The booklet includes information regarding legal terms as they relate to health care, as well as medical information related to end of life care. After becoming more familiar and comfortable with information contained in the booklet, patients are able to state their own choices, in their own words. Their loved ones will find peace of mind, for

the patients have already taken care of the most important decisions regarding life and death.

Technology – Seasons believes that technology is an important tool in improving the way we provide hospice care. Seasons uses an Electronic Medical Record for both its patients and for participating in research. Seasons has the highest use of Telecommunications in the industry. Seasons uses Quality Dashboards for daily accountability, Plan of Care goal measurement, and Compliance monitoring. Seasons also has opened a Physician/Referral Source Portal to make it easier for families to access hospice care. Many of Seasons technological tools for improving hospice are custom designed.

16. Project Drawings:

Projects involving renovations or new construction should include architectural schematic drawings or plans outlining the current facility (if applicable), the new facility (if applicable) and the proposed new configuration for inpatient facilities. These drawings should include:

1) the number and location of nursing stations,
2) approximate room sizes,
3) number of beds to a room,
4) number and location of bath rooms,
5) any proposed space for future expansion, and
6) the "footprint" and location of the facility on the proposed or existing site.

For free-standing (including office-based) ambulatory surgical facilities, these drawings should include:

1) dimensions of major architectural features and equipment of all operating rooms and procedure rooms, existing and proposed,
2) clear demarcation of restricted sterile corridor,
3) any proposed space for future expansion, and
4) the "footprint" and location of the facility on the proposed or existing site.

See Exhibit 2.

17. Features of Project Construction:

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

B. Explain any plans for bed expansion subsequent to approval which are incorporated in the project's construction plan.
None

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

Baltimore City Water Supplied from two locations on the site. Electricity is provided by Baltimore Gas and Electric by two feeders from separate substations. Natural gas is provided by Baltimore Gas and Electric. Sewage is provided by Baltimore County.

Chart 1. Project Construction Characteristics and Costs

Base Building Characteristics	New Construction	Renovation
Class of Construction		
Class A		X
Class B		
Class C		
Class D		
Type of Construction/ Renovation		
Low		
Average		
Good		X
Excellent		
Number of Stories		2nd floor wing
Total Square Footage		
Ground Floor		
First Floor		
Second Floor		9,125 SF
Third Floor		
Perimeter in Linear Feet		
Ground Floor		
First Floor		
Second Floor		467.6 feet
Third Floor		
Wall Height (floor to eaves)		
Ground Floor		
First Floor		
Second Floor		8 feet
Third Floor		
Elevators: New in Hospital Type Number		existing hydraulic 2
Sprinklers (Wet or Dry System)		existing wet system
Type of HVAC System		existing VAV system

Type of Exterior Wall		existing precast concrete with brick veneer
Costs		
Site Preparation	Costs	-
	Normal Site Preparation	
Demolition		
Storm Drains		
Rough Grading		
Hillside Foundation		
Terracing		
Pilings		
Roads		
Utilities	Roads	
Jurisdictional Hook-up Fees	Utilities	
Signs		
Utilities		
Jurisdictional Hook-up Fees		
Signs		
Landscaping		
Canopy		

*As defined by Marshall Valuation Service. Copies of the definitions may be obtained by contacting staff of the Commission.

PART II - PROJECT BUDGET

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

A. Use of Funds

1. Capital Costs:

a.	New Construction	
(1)	Building	
(2)	Fixed Equipment (not included in construction)	
(3)	Land Purchase	
(4)	Site Preparation	
(5)	Architect/Engineering Fees	
(6)	Permits, (Building, Utilities, Etc.)	
SUBTOTAL		0
b.	Renovations	
(1)	Building	$0
(2)	Fixed Equipment (not included in construction)	
(3)	Architect/Engineering Fees	-
(4)	Permits, (Building, Utilities, Etc.)	-
SUBTOTAL		-
c.	Other Capital Costs	
(1)	Major Movable Equipment	
(2)	Minor Movable Equipment	0
(3)	Contingencies	
(4)	Other (Specify)	
	Misc	
Subtotal of c		0
TOTAL CURRENT CAPITAL COSTS		0

(a - c)

d.	Non Current Capital Cost	
1	Interest (Gross)	
2	Inflation (4%/year X 9 months)	0
	MVS Cost Index % Change 5/10-5/11	
TOTAL PROPOSED CAPITAL COSTS		0

(a - d)

2. Financing Cost and Other Cash Requirements:

a.	Loan Placement Fees	
b.	Bond Discount	
c.	Legal Fees (CON Related)	30,000
d.	Legal Fees (Other)	20,000
e.	Printing	
f.	Consultant Fees	
	CON Application Assistance	20,000
g.	Liquidation of Existing Debt	
h.	Debt Service Reserve Fund	
i.	Principal Amortization Reserve Fund	
j.	Other (Asset Management Fees, Phase 1)	
TOTAL (a - h)		70,000

3. Working Capital Startup Costs

TOTAL USES OF FUNDS (1 - 3) 70,000

B. Sources of Funds for Project:

1. Cash 70,000
2. Pledges: Gross_____.
   less allowance for

uncollectables_____

= Net _____

3. Gift, bequests _____
4. Interest income (gross) _____
5. Authorized Bonds _____
6. Mortgage _____
7. Working capital loans _____
8. Grants or Appropriation
   (a) Federal _____
   (b) State _____
   (c) Local _____
9. Other (Specify) _____

TOTAL SOURCES OF FUNDS (1 - 9) 70,000

Lease Costs:

a. Land	$_____	x	_____	= $_____
b. Building	$ 20,000	x	12	= $ 240,000
c. Major Movable Equipment	$_____	x	_____	= $_____
d. Minor Movable Equipment	$_____	x	_____	= $_____
e. Other (Specify)	$_____	x	_____	= $_____

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

(INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G. Each criterion is listed below.)

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

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

.13 Certificate of Need Docketing Rules: Hospice
The Commission will use rules in this section to determine whether an application for hospice services meets the necessary criteria to allow initiation of Certificate of Need (CON) review by docketing.

A. General Docketing. Except as noted in .13(B)(1) below, if the maximum net number of additional hospice clients to be served in a jurisdiction, calculated in accordance with the methodology consistent with .15H of this Chapter, is below the calculated volume threshold in the target year, the Commission will not docket an application to provide additional hospice services in that jurisdiction.

Not applicable. Seasons Hospice is already a provider of hospice services in Baltimore City.

B. Sole Provider.
(1) If a hospice agency that is the sole provider of hospice services to a jurisdiction should cease operations, the Commission may docket applications to serve that jurisdiction, even if the net need is less than the calculated volume threshold.
(2) If a hospice agency that is the sole provider of hospice services to a jurisdiction is unable to serve a patient, it may request authorization from the Commission to permit a licensed Maryland hospice in a contiguous Maryland jurisdiction to serve that patient. The Commission's authorization is limited to that specific patient and does not authorize the hospice agency in the contiguous jurisdiction to serve any other patients in that jurisdiction.

Not applicable.

.14 Hospice Standards. The Commission will use the following standards to

review Certificate of Need proposals to establish a new general hospice program, or expand an existing hospice program to one or more additional jurisdictions.

A. Service Area. An applicant shall designate the jurisdiction in which it proposes to provide services.

Baltimore City

B. Admission Criteria. An applicant shall identify:
(1) Its admission criteria; and
(2) Proposed limits by age, disease, or caregiver.

As an existing hospice, Seasons has established Admission Criteria. Patients are accepted for care and treatment on the basis of reasonable criteria and under the expectation that the physical, emotional, social and spiritual needs of patients and families can be met adequately by Seasons.

1. The patient must have a terminal illness which is expected to result in a prognosis of six months or less if the disease runs its normal course as certified by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician if the individual has an attending physician. This decision will be based on prognostic indicators (Local Coverage Determinations) and information from the patient, family, attending physician and any available past medical records.

2. Seasons admits patients only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician (if any).

3. The patient/legal representative must make an informed decision to forego curative treatment for the terminal illness in preference for palliative treatment/services.

4. For Medicare or Medicaid beneficiaries, the patient/legal representative must make an informed decision to forfeit all treatment for the terminal illness under the Medicare Part A or Medicaid plan and to elect the Medicare or Medicaid Hospice Benefit.

5. A Do Not Resuscitate (DNR) order and Advanced Directives are not required for admission to Seasons.

6. At the time of admission to Seasons and thereafter, a patient/family must be under the care of a physician who shall be responsible for medical care.

7. Seasons does not require that the patient have a primary caregiver. If there is no primary caregiver, the hospice team will start discussions upon admission with the patient to make plans for his/her care when he/she is no longer able to make decisions for himself or herself.

8. Physical facilities must be adequate for proper care and a safe environment for patient and hospice staff.

9. The patient must live in the geographic areas served by Seasons Hospice.

   Seasons does not admit pediatric patients.

C. Minimum Services.

(1) An applicant shall provide the following services directly:

(a) Physician services and medical direction;

Seasons employs a Medical Director who is a medical doctor and is licensed to practice medicine in Maryland. The Medical Director reports directly to the Executive Director. The Medical Director, along with the Team Physicians, will:

- Assume overall responsibility for the clinical and medical component of the hospice's patient care program and for ensuring achievement and maintenance of quality standards of professional medical care;
- Participate in the development and implementation of the policies related to the care provided by the Interdisciplinary Group;
- Provide medical services to a patient if the patient does not have an attending physician;
- Make patient visits at a frequency not less than that described in the written plan of care or as otherwise required to meet the patient/family needs;
- Consult with Attending Physicians regarding pain and symptom control, ethical issues, and concerns or conflicts;
- Ensure that the general medical needs of the patients are met to the extent that these needs are not met by the attending physician;
- Approve all admissions by ensuring the terminal status and eligibility of each patient;
- Ensure that medications are utilized within accepted standards of practice;
- Ensure that a system is established and maintained to document the disposal of controlled drugs;
- Provide liaison as necessary between the core team and the Attending Physician.
- Act as the medical resource for the interdisciplinary team; and
- Designate a physician to contact in case the medical director/team physician is unavailable.

(b) Skilled nursing care;

Nursing care and services, focusing on the management and relief of pain and other symptoms, is provided by or under the supervision of a registered nurse who is licensed to practice in Maryland and is qualified by education and experience to direct hospice nursing care. The registered nurse will, at a minimum:

- Conduct the initial assessment of the patient;
- Perform a home care environment assessment;
- Perform a dietary evaluation and provide dietary counseling to meet the needs of the patient;
- Regularly re-evaluate the patient's nursing needs;
- Initiate the plan of care and update as needed;
- Provide education and support to the patient and family;
- Provide nursing services in accordance with each patient's interdisciplinary plan of care and according to the standards of nursing practice;
- Teach, supervise and evaluate other nursing personnel, including Licensed Practical Nurses and Hospice Aides;
- Document all findings in the patient's medical record;
- Inform the patient and family in regard to the patient's nursing needs; and
- Inform the Attending Physician and other team members of changes in the patient's condition and needs, including the patient's response to care, treatment and services.

A registered nurse case manager will be assigned to each patient to coordinate the patient's care, and integrate and provide continuity of patient/family care in conjunction with other services to assure physician orders are followed.

Nursing services will be staffed to assure that the nursing care needs of the patients will be met and the staffing will be based on:

- An assessment of patient and family care needs;
- The experience level of the nursing staff available to provide services; and
- Available assistance from support staff.

(c) Counseling or social work;

Seasons provides counseling services which address the needs of patients and

families for counseling that is reasonable and necessary for the palliation and management of the terminal illness and related conditions and in accordance with the plan of care.

Social Services, including advocacy, referral, problem-solving and intervention related to personal, family, business and financial issues are available to the extent necessary to meet the needs of patients and their families for care that is reasonable and necessary for the palliation and management of the terminal illness and related conditions.

Medical Social Services are provided by a qualified social worker, licensed to practice in Maryland and under the direction of a physician. The Social Worker will, at a minimum:

- Assist the interdisciplinary team in understanding the significant social and emotional factors related to the terminal illness;
- Evaluate the patient's psychosocial needs, including environment, religious background, spiritual needs, financial needs, family support system, and psychological needs;
- Regularly re-assess the patient and family's psychosocial needs;
- Provide services in accordance with the patient's interdisciplinary plan of care with the goal of assisting the patient and family in adjusting to the psychosocial aspects of the terminal illness;
- Document all findings in the patient's medical record;
- Link the patient and family with needed community resources to meet ongoing social, emotional and/or economical needs; and,
- Provide social work services in accordance with recognized standards of social work practice.

(d) Spiritual services;

Spiritual Services are offered to all patients and their families upon admission and will continue to the extent desired by the patient and their family. Seasons does not impose the dictates of any value or belief system on our patients. The Spiritual Services will:

- Be provided by a qualified Interdisciplinary Group member and/or through an arrangement with clergy and/or other spiritual counselors in the community. Seasons documents reasonable efforts to arrange for visits of clergy and other members of spiritual and religious organizations in the community to patients/families who request such visits and will advise all patients/families of this opportunity;
- Assist the Interdisciplinary Group in understanding the significant spiritual factors related to the terminal illness;
- Be based on an initial and ongoing assessment of the spiritual needs of the patient and family and be consistent with the plan of care. There shall be documentation of ongoing communication between the clergy and/or other spiritual counselors and the Interdisciplinary Group members;
- Include consultation and education to the patient/family and the Interdisciplinary Group members;
- Be consistent with the patient and family's customs, religious preferences, cultural background, ethnicity, beliefs and desires; and,
- Be documented in the patient's medical record.

(e) Nutritional counseling; and

Dietary Services by provided by a registered dietician may include:

- Assessment of nutritional needs and food patterns;
- Planning diets appropriate for meeting patient needs and preferences; and,
- Providing nutrition education and counseling to meet patients needs as identified in the interdisciplinary plan of care, as well as necessary consultation to hospice employees;

(f) On-call nursing response

As an inpatient hospice unit, nursing staff are on site 24 hours a day.

(2) An applicant shall also provide the following services, either directly or through contractual arrangements:

(a) Personal care;

Seasons provides Hospice Aide services adequate in frequency to meet the needs of the patients. The Hospice Aide meets the training, attitude and skill requirements specified in Sec. 484.36, Chapter IV, Title 42 of the Code of Federal Regulations.

Hospice Aide services will:

- Be assigned by a registered nurse in the plan of care;
- Be provided by a Hospice Aide who is subject to an on-site supervision visit by a registered nurse at least every two weeks;
- Consist of, but not be limited to, assisting patients with personal hygiene, dressing, ambulation/transfer, prescribed exercises, food/fluid intake, and self-administration of medication;
- Include the Hospice Aide reporting changes in the patient's condition and needs; and,
- Include timely and accurate documentation by the Hospice Aide of the care provided

(b) Volunteer services;

Volunteer Services are utilized to promote the availability of care, meet the broadest range of patient and family needs and affect the financial economy in the operation of the hospice. Seasons uses volunteers, in defined roles, under the supervision of a designated hospice employee. Volunteers will be qualified to participate in the hospice program after completion of the orientation/training program.

Direct patient care volunteers shall:

- Have the necessary qualifications and skills to provide the prescribed services; any volunteer functioning in a professional capacity shall meet the standards of the appropriate profession;
- Be aware of the patient's condition and treatment as indicated on the written plan of care;
- Provide services in accordance with the written plan of care which may include, but is not limited to, providing support and companionship to the patient and family, caregiver relief, running errands, light chores, visiting and bereavement services; and,
- Document their care on the appropriate form.

Seasons will:

- Provide appropriate orientation and on-going training that is consistent with acceptable standards of hospice practice; successful completion of training and orientation will be documented;
- Use volunteers in administrative or direct patient care roles;
- Keep the volunteer informed of a patient's condition and treatment to the extent necessary to carry out his/her function;

(c) Bereavement services;

Bereavement services provide support to enable an individual/family to adjust to experiences associated with death and will be provided under the direction and supervision of a person qualified by training and experience for the development, implementation and assessment of a plan of care to meet the needs of the bereaved. The Bereavement program includes:

- Bereavement counseling and services to the families of hospice patients for not less than (13) months after the patient's death, to the extent desired by the family;
- Bereavement services consistent with a bereavement plan of care which reflects the family's needs, recognizing their social, religious and cultural values and describing the type and frequency of services to be provided;
- Documentation of all bereavement services that have been provided;
- Orientation and training to individuals providing bereavement services to assure that there is continuity of care;
- Assignment, supervision and evaluation of individuals performing bereavement services;
- Coordination with the family's clergy if so desired;
- Referrals of family members to community programs when appropriate (e.g., problems with mental health, substance abuse or family dynamics that prevent them from grieving appropriately); and
- A Memorial Service for the families of patients who have died on the Seasons program.

(d) Pharmacy services;

The licensed pharmacy will agree:

- To provide an inventory of pharmaceuticals sufficient in scope and quantities to meet the patients' needs twenty four (24) hours a day, seven (7) days a week; and,
- To allow their licensed pharmacists to collaborate with the Interdisciplinary Group in individual medication management;

(e) Laboratory, radiology, and chemotherapy services as needed for palliative care;

Laboratory, radiology, and chemotherapy services as needed for palliative care will be provided by Sinai Hospital per contractual agreement.

(f) Medical supplies and equipment; and

Durable Medical Equipment and suppliers will provide an inventory of equipment and/or supplies twenty four (24) hours a day, seven (7) days a week, sufficient in scope and quantities to meet the needs of the patients;

(g) Special therapies, such as physical therapy, occupational therapy, speech therapy, and dietary services.

The following services are available through a contractual arrangement as needed for the palliation and management of the terminal illness and related conditions and will be provided in accordance with the plan of care:

- Physical Therapy; Occupational Therapy; Speech and Language Pathology; and Respiratory Therapy;

(3) An applicant shall provide bereavement services to the family for a period of at least one year following the death of the patient.

Seasons provides such bereavement services for no less than 13 months following the patient's death.

D. Setting. An applicant shall specify where hospice services will be delivered: in a private home; a residential unit; an inpatient unit; or a combination of settings.

This application is to provide hospice services in an inpatient unit. Seasons is already certified to provide Home Hospice Services in Baltimore City and County.

E. Volunteers. An applicant shall have available sufficient trained caregiving volunteers to meet the needs of patients and families in the hospice program.

Seasons has an active volunteer program.

F. Caregivers. An applicant shall provide, in a patient's residence, appropriate instruction to, and support for, persons who are primary caretakers for a hospice patient.

If the patient is discharged to home, Seasons will provide instruction and support to the primary caregiver in the person's home through Seasons Home Hospice.

G. Financial Accessibility. An applicant shall be licensed and Medicare-certified, and agree to accept clients whose expected primary source of payment is Medicare or Medicaid.

Seasons and Sinai Hospital, as existing providers, are already Medicare and Medicaid certified.

H. Information to Providers and the General Public.

(1) General Information. An applicant shall inform the following entities about the program's services, service area, reimbursement policy, office location, and telephone number:

(a) All hospitals, nursing homes, and assisted living providers within its proposed service area;

(b) At least five physicians who practice in its proposed service area;

(c) The Senior Information and Assistance Offices located in its proposed service area; and

(d) The general public in its proposed service area.

(2) Fees. An applicant shall make its fees known to clients and their families before services are begun.

Seasons already informs all hospitals, nursing homes, senior information and assistance offices, the general public and many physicians of its program's services, service area, reimbursement policy, office location, and telephone number. It does so for both its Home Hospice and Inpatient Unit at Northwest Hospital Center.

Seasons currently make its fees known to clients and their families before services are begun. It will continue to do so.

I. Time Payment Plan. An applicant shall:

(1) Establish special time payment plans for individuals unable to make full payment at the time services are rendered; and

(2) Submit to the Commission and to each client a written copy of its policy detailing time payment options and mechanisms for clients to arrange for time payment.

As an existing Hospice, Seasons has established special time payment plans for individuals unable to make full payment at the time services are rendered. [See Exhibit 3, Payment for Services Policy (Policy 609)] The Policy states that Seasons shall accept appropriate patients and families regardless of their ability to pay for hospice services. Per the Policy, Seasons has an extended payment plan; however, when these situations arise, the charges are usually simply considered charity care.

Seasons submits a written copy of its policy to each client.

As referenced in Policy 5 of the Payment for Services Policy, all clients are eligible for extended payment options. In Seasons' experience, the need, factors, and details affecting each patient/family are so different that putting limitations or further details into the policy would make Seasons' options too restrictive. For example, some families must wait until probate is completed, others may wish Seasons to wait to sell a house, still others may wish Seasons to wait for a life insurance claim to be completed, while others may be waiting for requests for Veterans' benefits to be resolved (which may take a long time). It is not simply a case of patients/families spreading the cost of hospice care over a year. Seasons considers the individual facts in each family's request and works with the family to craft an individualized payment plan which may be unique to that family's ability and needs.

J. Charity Care and Sliding Fee Scale. Each applicant for hospice services shall have a written policy for the provision of charity care for uninsured and under-insured patients to promote access to hospice services regardless of an individual's ability to pay. The policy shall include provisions for, at a minimum, the following:

(1) Provide documentation of financial estimates of the amount of charity care that it intends to provide annually;
(2) Provide documentation of a written policy for the provision of complete and partial charity care for indigent and other persons unable to pay for services;
(3) Provide documentation of a written policy for the provision of sliding fee scales for clients unable to bear the full cost of services;
(4) Provide a written copy of its charity care and sliding fee scale policies to each client before services are begun;
(5) Provide documentation that an individual notice of charity care is provided to each person who seeks services in the hospice program; and
(6) Make a determination of probable eligibility for charity care and/or reduced fees within two business days of the client's initial request.

Exhibit 3 includes Seasons' Payment for Services Policy. The vast majority of Seasons' patients are insured by Medicare, Medicaid, or other insurance. Generally, when a patient has private insurance, the insurance will cover all costs. Those costs not covered by insurance are typically considered charity care by Seasons. Patients not covered by Medicare, Medicaid, or private insurance are provided care by Seasons, and the care is considered charity care. Seasons' extended payment plan includes reduced, or sliding scale, fees.

Seasons makes a determination of probable eligibility for charity care and/or reduced fees within two business days of the client's initial request.

A written copy of the Policy and notice of the availability of charity care is provided to each person who seeks services in the hospice program.

K. Quality. An applicant shall document ongoing compliance with all federal and state quality of care standards.

As an existing hospice, Seasons is in compliance with all federal and state Quality of Care standards.

L. Linkages with Other Service Providers.

(1) An applicant shall identify how inpatient care will be provided to patients, either directly, or through a contract with an inpatient provider that ensures continuity of patient care.

(2) An applicant shall agree to document, before licensure, that it has established links with hospitals, nursing homes, home health agencies, assisted living providers, Adult Evaluation and Review Services (AERS), Senior Information and Assistance, adult day care programs, the local Department of Social Services, and home delivered meal programs located within its proposed service area.

Seasons will provide inpatient care directly. Seasons already has established links with hospitals, nursing homes, home health agencies, assisted living providers, Adult Evaluation and Review Services (AERS), Senior Information and Assistance, adult day care programs, the local Department of Social Services, and home delivered meal programs located within its proposed service area.

M. Respite Care. An applicant shall document its system for providing respite care for the family and other caregivers of clients.

The Seasons inpatient unit will provide respite care and enable family members and other caregivers the opportunity to have a respite.

Currently, respite is predominantly provided in Skilled Nursing Facilities with which Seasons contracts for this service. Seasons has contracts with dozens of nursing homes within our region to provide this service. However, it is expected that respite care will be provided in the Seasons Hospice Unit at Sinai once the unit is open and if space

is available. Respite services will be billed at the respite Medicare respite rate whereas, general inpatient hospice services will be billed at the Medicare GIP rate.

The Medicare criteria for Inpatient Respite Care or General Inpatient Care are the same in terms of the setting requirements. General Inpatient Care requires a clinical need for aggressive symptom management by the patient, where Respite Care requires the need for family/caregiver respite. If a patient meets Medicare criteria for hospice care and requires a respite stay, the requirements are the same at either a nursing home or inpatient hospice unit which includes 24 hour RN coverage. Medicare will reimburse for Inpatient Respite Care for up to 5 days at a time and must be provided in a Medicare approved facility. There is no limit to the number of 5 day periods, though they cannot be consecutive. A patient must meet the Medicare criteria for hospice for Medicare to provide reimbursement for all levels of hospice care.

N. Public Education Programs. An applicant shall document its plan to provide public education programs designed to increase awareness and consciousness of the needs of dying people and their caregivers.

As an employer of professionals, Seasons is a provider for Continuing Educational (CE) courses so that nurses and social workers have access to courses which provide CE credit needed for licensure, and to assist them with acquiring specialized certifications. Opening these classes to other professions and to those who are not employees, are used to continue public education and outreach about hospice, its services, and how palliative services are used when curative care no longer is an option.

Education occurs using many different venues to get the hospice website address and toll-free telephone number to the public. On its website, Seasons has

information to frequently asked questions about hospice and our services, and serves as a self-directed educational opportunity to each person visiting the website. The toll-free number provides access 24 hours a day, 7 days a week, further showing that hospice is there for each person who seeks it.

Some of our sites have committees for different ethnic groups in order to educate and increase access to hospice. Attendance at senior fairs and community events get the word out to the general public also.

Seasons conducts extensive education in the form of in-services and presentations beforehand with numerous hospitals, Skilled Nursing Facilities, Assisted Living Facilities, Physician Groups, governmental agencies, professional agencies/groups and religious groups to educate all clinical and non-clinical disciplines on aspects of end of life care. Details regarding some of our community and outreach initiatives can be viewed at:

- http://www.seasons.org/page/News

A review of the website www.seasons.org, will showcase the variety of materials that serve to educate the public on a one-to-one basis. This type of access, with follow-up available, often is an important way a member of the public can find out information at home, and without the pressures of feeling that questions asked may not be taken seriously.

O. Patients' Rights. An applicant shall document its compliance with the patients' rights requirements of COMAR 10.07.21.21.

Compliant with the patients' rights requirements of COMAR 10.07.21.21, Seasons has a policy (Policy 101, Patient/Family Rights and Responsibilities) which

includes:

1. Before services are provided, patients and families will be informed, both orally and in writing of their rights and responsibilities related to the care or services provided. This information will be provided in a language and manner that the patient understands and will be repeated, as needed, during the course of care by Seasons Hospice.

Both Policy 101 and a list of Patient Rights and Responsibilities are included as Exhibit 4.

10.24.01.08G(3)(b). Need.

For purposes of evaluating an application under this subsection, the Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

Please discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. For applications proposing to address the need of special population groups identified in this criterion, please specifically identify those populations that are underserved and describe how this Project will address their needs.

Seasons is licensed to serve both Baltimore City and Baltimore County, and Seasons anticipates receiving referrals from both jurisdictions, just as the existing Seasons unit in Northwest Hospital Center receives referrals from Baltimore City and County.

Projections of patients in the IPU are based on five different sources of data:

- Sinai Deaths
- Sinai Non-Deaths
- Other Facility Referrals
- Routine Home Hospice Transfers

- Respite Patients

Seasons has calculated the patient population in each of these categories that likely would have come to the IPU for CY 2012 had the unit existed.

Sinai Deaths

In calendar year 2012, Sinai experienced 552 deaths according to data provided by Sinai Hospital. Seasons has assumed that it would have captured 50 percent of the deaths. As described in the Project Description, this is based on Seasons' experience at Northwest Hospital Center ("Northwest"), Weiss Memorial Hospital in Chicago, Christiana Hospital in Newark, Delaware, and Sinai Hospital, itself (during the four months that Seasons operated a clustered bed unit). Therefore, an IPU would have had 276 admissions from Sinai based on the number of deaths that actually occurred. (552 X 0.5 = 276)

Sinai Non-Deaths

In addition to the deaths experienced at Sinai, there will be some patients who will come to the IPU from Sinai's hospital patient population who do not die on the unit but receive GIP care for symptom management and, then, when symptoms become stable, transfer to Routine hospice care in the community. At NWH, the number of patients who did not die in the unit calculated to 4.2% of the patients who were admitted from NWH to the Seasons NW hospice inpatient unit who died on the unit. (11/259 = 0.042). At Sinai, this would be 12 patients. (0.042 X 276 = 11.592)

Other Facility Referrals

Table 2 shows the referrals from other facilities to the NWH hospice inpatient unit in CY 2012. It does not include referrals from physicians, the Seasons Call Center,

Transfers (i.e., hospice patients who convert from Routine Hospice to Inpatient), Respite Care, or other patients not transferred from a facility.

Table 2
Admissions to NWH IPU
By Referral Source
CY 2012

Referral Facility	Referrals
Arlington West Nursing And Rehab	1
Baltimore County Department Of Aging	1
Bon Secours Hospital	4
Bradford Regional Medical Center	1
Carroll Hospital Center	2
Emeritus At Pikesville	2
Franklin Square Hospital Center	6
FutureCare Irvington	1
Genesis Loch Raven Center	1
Good Samaritan Hospital	3
Harbor Hospital Center	1
Inova Fairfax Hospital	1
Johns Hopkins Bayview Medical Center	3
Johns Hopkins Hospital	2
Laurel Regional Hospital	1
Levindale Hebrew Geriatric Center	5
ManorCare Springhouse ALF	1
Maryland General Hospital	2
Mercy Medical Center	16
Northwest Hospital Center	270
Prince George's Hospital Center	2
Riverview Rehab & Health Center	1
Sinai Hospital Of Baltimore	15
Southern Maryland Hospital Center	1
St. Agnes Cancer Institute	1
St. Agnes Hospital	39
St. Joseph - Cancer Institute	1
St. Joseph Medical Center	2
Union Memorial Hospital	5
University Specialty Hospital	3
University of Maryland - Cancer Center	1
University of Maryland Medical Center	61
VA Maryland Health Care System	1

Referral Facility	Referrals
VNA Home Health of Maryland	2
Elmbrook Hospital	1
Total	460

As Table 2 shows, the two major referring facilities to the NWH hospice inpatient unit, aside from NWH, were University of Maryland Medical Center ("UMMC") and St. Agnes Hospital. Seasons analyzed the patient information on the admissions to the IPU from these two referral sources.

Table 3 shows the admissions referred by UMMC who resided in Baltimore City. The table shows that 35 of the 61 referrals from UMMC were residents of Baltimore City.

Table 3
NWH IPU Admissions Referred from UMMC
CY 2012

Pt Home Zip	Baltimore City Regions	Count
21201	Baltimore City- Downtown	1
21202	Baltimore City- Downtown	2
21231	Baltimore City- Downtown	1
21205	Baltimore City- East	1
21214	Baltimore City- East	1
21212	Baltimore City- North	1
21218	Baltimore City- North	1
21227	Baltimore City- South	1
21230	Baltimore City- South	1
21216	Baltimore City West	4
21217	Baltimore City West	4
21207	Baltimore City- West	1
21208	Baltimore City- West	1
21209	Baltimore City- West	1
21215	Baltimore City- West	3
21223	Baltimore City- West	5
21228	Baltimore City- West	3

Pt Home Zip	Baltimore City Regions	Count
21229	Baltimore City- West	3
Total		35
Baltimore City- East		2
Total		33

Seasons believes that the Baltimore City referrals from UMMC will prefer to go to the Sinai hospice inpatient unit because it is within Baltimore City and closer to where the patients live.[1] Therefore, Seasons believes that it would have received 33 referrals from UMMC to the Sinai hospice inpatient unit.

Similarly, Table 4 shows the admissions referred by St. Agnes Hospital who resided in Baltimore City. The table shows that 33 of the 39 referrals from St. Agnes were residents of Baltimore City.

Table 4
NWH IPU Admissions Referred from St. Agnes Hospital
CY 2012

Pt Home Zip	Baltimore City Regions	Count
21207	Baltimore City- West	4
21215	Baltimore City- West	2
21216	Baltimore City- West	1
21217	Baltimore City- West	2
21223	Baltimore City- West	2
21227	Baltimore City- South	4
21228	Baltimore City- West	8
21229	Baltimore City- West	6
21230	Baltimore City- South	4
Total		33

[1] However, Seasons assumed that the two residents who lived in Baltimore City-East would go to the Franklin Square Hospital IPU.

Seasons believes that the Baltimore City referrals from UMMC will prefer to go to the Sinai hospice inpatient unit. None of the referrals from St. Agnes lived in Baltimore City-East. Therefore, Seasons believes that it would have received 33 referrals from St. Agnes Hospital to the Sinai hospice inpatient unit.

Of course, UMMC and St. Agnes would not be the only referral sources. Table 5 shows only the Baltimore City referral sources listed in Table 2. It also shows which of these sources Seasons expects to receive referrals to the Sinai hospice inpatient unit. Table 5 shows that Seasons is not double counting referrals from UMMC and St. Agnes Hospital. Nor is Seasons expecting to get referrals from any of the Medstar hospitals, which Seasons expects to refer to the Franklin Square hospice inpatient unit. Further, Seasons is not expecting to receive referrals from hospitals in the eastern part of the city. In all, Seasons expects that it would have received 30 admissions from these "other" Baltimore City referral sources.

Table 5
Admissions to NWH IPU
By Referral Source in Baltimore City
CY 2012

Referral Facility	Referrals	Other Referrals Counted
Bon Secours Hospital	4	4
FutureCare Irvington	1	1
Genesis Loch Raven Center	1	1
Good Samaritan Hospital	3	
Harbor Hospital Center	1	
Johns Hopkins Bayview Medical Center	3	
Johns Hopkins Hospital	2	
Levindale Hebrew Geriatric Center	5	5
Maryland General Hospital	2	2

Referral Facility	Referrals	Other Referrals Counted
Mercy Medical Center	16	16
Sinai Hospital Of Baltimore	15	
St. Agnes Cancer Institute	1	
St. Agnes Hospital	39	
Union Memorial Hospital	5	
University Specialty Hospital	3	
University of Maryland - Cancer Center	1	
University of Maryland Medical Center	61	
VA Maryland Health Care System	1	1
Subtotal for Incoming Referrals:	472	30

Therefore, in total, Seasons believes that a Sinai hospice inpatient unit would have received 96 patients from other Baltimore City facilities in 2012. (33 from UMMC + 33 from St. Agnes + 30 from "other" facilities = 96)

This is generally consistent with the experience at the Sinai clustered bed unit during the four months that it operated. Table 6 shows the sources of referrals to the Sinai clustered bed inpatient unit during that four month period.

Table 6
Admissions to Sinai Clustered Bed Unit
By Referral Source
1/15/13 to 5/15/13

Referral Facility	Referrals
Franklin Square Hospital Center	4
Good Samaritan Hospital	1
Harbor Hospital Center	1
Levindale Hebrew Geriatric Center	3
Mercy Medical Center	4
Milford Manor Nursing & Rehab Center	1
Northwest Hospital Center	1
Severna Park Medical Associates	1
Sinai Hospital - Cancer Institute	1
Sinai Hospital Of Baltimore	64
St. Agnes Hospital	7
University of Maryland Medical Center	16
Washington Hospital Center	1
Total:	**105**

Though a four month period during the opening of a unit is difficult to draw specific conclusions from, Table 6 shows that UMMC and St. Agnes were the largest referring facilities to the Sinai clustered bed inpatient unit (excluding Sinai). While St. Agnes referred only 7 patients to the unit, Seasons believes that the number would increase as time went on. Excluding referrals from Sinai, itself, the unit experienced 41 referrals from other facilities. This would indicate that Seasons' total projection of 96 is conservative.

Routine Hospice Transfers

According to internal Seasons Data, there were 107 residents of Baltimore City who were Seasons hospice patients and "transferred" from Routine Hospice Care to general inpatient level of care at Seasons' NWH inpatient unit in 2012. These are existing Seasons patients in need of a higher level of care Seasons is obligated to provide per Medicare Conditions of Participation. These are shown in Table 7. However, 23 of these patients who transferred to inpatient level of care resided in Baltimore City-East, and Seasons believes that they will prefer to go to the Franklin Square hospice inpatient unit. Consequently, Seasons believes that the Sinai inpatient hospice unit will receive 84 patients from this population.

Table 7
Transfers of Seasons Hospice
Routine Hospice Patients to NWH Inpatient Hospice Unit
By Zip Code in Baltimore City
CY 2012

Admission Zip Code	Baltimore City Zips (By Region)	Count
21202	Baltimore City- Downtown	3
21231	Baltimore City- Downtown	1
21205	Baltimore City- East	1
21206	Baltimore City- East	6

Admission Zip Code	Baltimore City Zips (By Region)	Count
21214	Baltimore City- East	2
21219	Baltimore City- East	1
21222	Baltimore City- East	4
21224	Baltimore City- East	7
21234	Baltimore City- East	1
21237	Baltimore City- East	1
21211	Baltimore City- North	2
21212	Baltimore City- North	1
21218	Baltimore City- North	1
21239	Baltimore City- North	2
21225	Baltimore City- South	5
21227	Baltimore City- South	4
21230	Baltimore City- South	8
21207	Baltimore City- West	6
21208	Baltimore City- West	12
21209	Baltimore City- West	2
21215	Baltimore City- West	14
21216	Baltimore City- West	4
21217	Baltimore City- West	10
21223	Baltimore City- West	3
21228	Baltimore City- West	1
21229	Baltimore City- West	5
Count		107
Reduction of Baltimore –East patients		23
Total		84

Respite Patients

Lastly, Season's Inpatient Units also usually serve respite patients nationally, when the patients' usual caregivers need a break from the daily responsibilities of caring for their loved ones, and when space in the unit is available. In CY 2012, Seasons provided 36 respite stays to residents of Baltimore City in contracted Medicare approved skilled nursing facilities as the NWH Inpatient Unit rarely has availability for respite patients. See Table 8. Of these, 5 were from Baltimore City-East. Seasons believes that these respite patients will choose to go to the Franklin

Square Seasons hospice inpatient unit. Consequently, Seasons believes that the Sinai inpatient unit would have had 31 Respite stays in CY2012 from Baltimore City as Seasons will have increased inpatient unit bed capacity to accommodate respite patients when needed.

Table 8
Respite Stays
Seasons Hospice
By Zip Code in Baltimore City
CY 2012

Home Zip	Baltimore City Region	Total Number Respite Stays/Zip Code
21202	Baltimore City- Downtown	1
21237	Baltimore City- East	1
21206	Baltimore City- East	1
21224	Baltimore City- East	3
21211	Baltimore City- North	1
21212	Baltimore City- North	2
21218	Baltimore City- North	1
21239	Baltimore City- North	1
21225	Baltimore City- South	2
21230	Baltimore City- South	2
21227	Baltimore City- South	1
21229	Baltimore City- West	8
21207	Baltimore City- West	7
21216	Baltimore City- West	3
21215	Baltimore City- West	1
21208	Baltimore City- West	1
Count		36
Reduction of Baltimore –East patients		5
Total		31

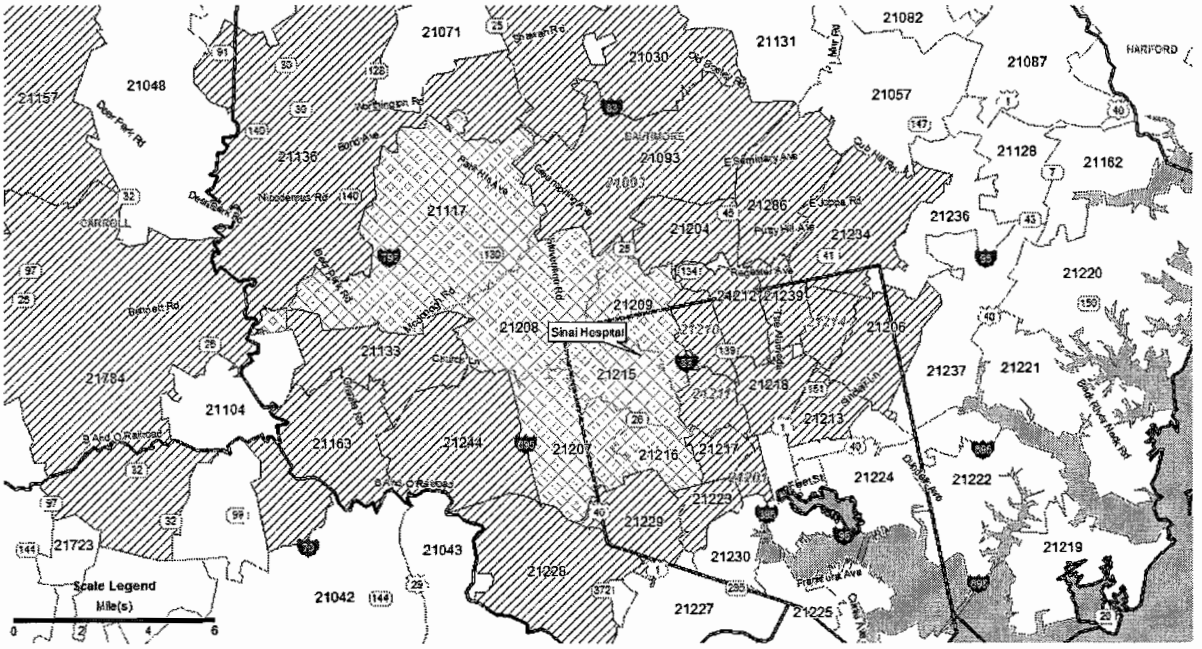
In summary, Seasons believes that a Sinai hospice inpatient unit would have received 499 admissions in 2012, based on these sources. This summary is shown below:

	2012 Count
Sinai Deaths	276
Sinai Non-Deaths	12
Other Facility Referrals	96
Routine Hospice Transfers	84
Respite Patients	31
Total	499

Population Growth

Sinai Hospital's Service Area for patients age 65 and older is very broad and includes most of Baltimore City and much of Baltimore County. It is shown graphically in Figure 4. The cross hatch shaded Zip Codes comprise the Primary Service Area (top 60% of admissions), and the diagonally shaded Zip Codes comprise the Secondary Service Area (through 85% of admissions).

Figure 4
Sinai Hospital's Primary and Secondary Service Areas
Patients Age 65 and Older
FY 2013



The data showing the number of admissions from these Zip Codes and how the Service Area was calculated are shown in Table 9.

Table 9
Inpatient Admissions, Age 65+
Sinai Hospital
By Zip Code
FY 2013

Rank	Pat Home Zip 5 Digit Base	Admissions Age 65+	% of Total	Running % of Total	65+ Service Area
1	21215	2,520	26.6%	26.6%	PSA
2	21208	1,032	10.9%	37.5%	PSA
3	21207	791	8.4%	45.9%	PSA
4	21209	675	7.1%	53.0%	PSA
5	21216	433	4.6%	57.6%	PSA
6	21117	412	4.4%	62.0%	PSA
7	21133	271	2.9%	64.8%	SSA

Rank	Pat Home Zip 5 Digit Base	Admissions Age 65+	% of Total	Running % of Total	65+ Service Area
8	21136	206	2.2%	67.0%	SSA
9	21217	184	1.9%	68.9%	SSA
10	21244	184	1.9%	70.9%	SSA
11	21211	143	1.5%	72.4%	SSA
12	21093	124	1.3%	73.7%	SSA
13	21229	105	1.1%	74.8%	SSA
14	21784	104	1.1%	75.9%	SSA
15	21212	89	0.9%	76.9%	SSA
16	21228	76	0.8%	77.7%	SSA
17	21210	74	0.8%	78.5%	SSA
18	21157	68	0.7%	79.2%	SSA
19	21286	68	0.7%	79.9%	SSA
20	21206	63	0.7%	80.6%	SSA
21	21218	63	0.7%	81.2%	SSA
22	21234	60	0.6%	81.9%	SSA
23	21223	58	0.6%	82.5%	SSA
24	21204	40	0.4%	82.9%	SSA
25	21163	36	0.4%	83.3%	SSA
26	21239	34	0.4%	83.6%	SSA
27	21158	32	0.3%	84.0%	SSA
28	21030	31	0.3%	84.3%	SSA
29	21015	30	0.3%	84.6%	SSA
30	21122	29	0.3%	84.9%	SSA
31	21201	29	0.3%	85.2%	SSA
32	21213	29	0.3%	85.5%	SSA
33	21214	29	0.3%	85.8%	SSA
	331 Other Zip Codes	1,340	14.2%		
	Total	9,462		100.0%	

In order to project the number of admissions to the proposed IPU from Sinai Hospital (based on the number of Sinai patients who died on the inpatient unit and those who transferred to Routine hospice) in 2016, Seasons obtained Zip Code population from Claritas (2000, 2013, and 2018) and interpolated the projections (using the Compound Average Growth Rate, or CAGR) to calculate population estimates and projections for 2012 and 2016. Table 10 shows that the 65+ population in Sinai's

Service Area is projected to grow by 9.6% between 2012 and 2016. (The majority of Seasons' inpatient unit patients are age 65 and older.)

Table 10
Population Age 65+
by Zip Code
Sinai Hospital's Inpatient Age 65+ Primary and Secondary Service Areas
2000, 2012, 2016, and 2018
Claritas Data

	2000 Census	2012 Interpolated	2013 Estimate	2014 Interpolated	2015 Interpolated	2016 Interpolated	2018 Projection
21215	11,194	10,484	10,427	10,556	10,686	10,818	11,086
21208	7,115	8,332	8,444	8,624	8,807	8,994	9,381
21207	6,155	6,949	7,020	7,201	7,386	7,576	7,971
21209	3,849	4,249	4,284	4,365	4,448	4,533	4,707
21216	6,178	4,516	4,403	4,464	4,525	4,588	4,715
21117	2,665	5,054	5,348	5,630	5,927	6,240	6,916
PSA Subtotal	37,156	39,583	39,926	40,839	41,780	42,749	44,776
21133	3,128	3,819	3,884	4,025	4,170	4,321	4,640
21136	2,897	4,296	4,445	4,632	4,827	5,030	5,462
21217	5,259	4,528	4,473	4,590	4,709	4,832	5,087
21244	2,472	3,368	3,459	3,620	3,789	3,965	4,343
21211	2,706	2,555	2,543	2,597	2,652	2,709	2,825
21093	6,565	8,800	9,024	9,243	9,467	9,697	10,173
21229	7,012	6,681	6,654	6,792	6,933	7,077	7,373
21784	3,366	4,871	5,029	5,212	5,402	5,599	6,015
21212	4,606	4,440	4,427	4,544	4,665	4,788	5,045
21228	9,219	9,117	9,109	9,298	9,491	9,688	10,094
21210	2,389	2,598	2,616	2,672	2,730	2,789	2,910
21157	4,466	5,625	5,736	5,892	6,052	6,217	6,559
21286	4,862	4,138	4,084	4,147	4,210	4,275	4,407
21206	5,793	5,410	5,379	5,605	5,841	6,086	6,609
21218	5,542	5,770	5,789	5,942	6,100	6,261	6,597
21234	9,987	12,712	12,976	13,262	13,554	13,853	14,470
21223	3,683	2,921	2,866	2,921	2,978	3,035	3,154
21204	4,007	4,154	4,166	4,219	4,272	4,327	4,437
21163	476	1,344	1,479	1,559	1,643	1,732	1,924
21239	3,472	3,873	3,909	4,017	4,129	4,243	4,482
21158	2,069	2,942	3,032	3,122	3,216	3,311	3,512
21030	2,902	3,474	3,527	3,630	3,736	3,845	4,072
21015	1,989	3,576	3,766	3,926	4,093	4,267	4,637
21122	5,222	7,480	7,715	8,052	8,404	8,771	9,554
21201	2,121	2,002	1,992	2,047	2,103	2,161	2,281

	2000 Census	2012 Interpolated	2013 Estimate	2014 Interpolated	2015 Interpolated	2016 Interpolated	2018 Projection
21213	4,643	3,756	3,691	3,796	3,904	4,016	4,248
21214	3,092	2,452	2,406	2,496	2,589	2,685	2,889
SSA Subtotal	113,945	126,701	128,176	131,858	135,658	139,578	147,799
Total	143,366	166,284	168,102	172,698	177,438	182,327	192,575
Growth Since 2012						9.6%	15.8%

To project the number of admissions from Other Facility Referrals, Routine Hospice Transfers, and Respite Patients, (which are primarily Baltimore City residents) Seasons calculated the Baltimore City population growth, based on population estimates and projections developed by the Maryland Department of Planning ("MDP"). MDP projections are for 2010, 2015, and 2020. Seasons interpolated the 2012 and 2016 population using the CAGR. Table 11 shows that MDP projects that the Baltimore City age 65+ population will grow by 7.1% between 2012 and 2016.

Table 11
Baltimore City Population Age 65+
2010, 2012, 2015, 2016, 2020
Maryland Department of Planning Data

	2010 Estimate	2011 Interpolated	2012 Interpolated	2013 Interpolated	2014 Interpolated	2015 Projection	2016 Interpolated	2020 Projections
Baltimore City	72,810	73,867	74,939	76,027	77,130	78,250	80,247	88,760
Growth Since 2012							7.1%	

Seasons then applied the two population growth rates calculated above to the 2012 counts to obtain the number of projected admissions in 2016, as shown in Table 12.

Table 12
Sinai Hospice Inpatient Unit
Projected Admissions
2016

	2012 Count	Population Growth 2012-2016	2016 Count
Sinai Deaths	276	9.6%	302
Sinai Non-Deaths	12	9.6%	13
Other Facility Referrals	96	7.1%	103
Routine Hospice Transfers	84	7.1%	90
Respite Patients	31	7.1%	33
	499		541

Seasons projects that the Average Length of Stay ("ALOS") will be 6 days for all of the patients except the Respite Care Patients, for whom the ALOS will be 5 days. Seasons projects that the Sinai inpatient unit will see 3,214 patient days in 2016. At 75% occupancy, this calculates to a need for 12 beds.

Table 13
Bed Need
Sinai Hospice Inpatient Unit
2016

	2012 Count	Population Growth 2012-2016	2016 Count	ALOS	Patient Days	ADC	Beds @ 75% Occ.
Sinai Deaths	276	9.6%	302	6	1,815		
Sinai Non-Deaths	12	9.6%	13	6	76		
Other Facility Referrals	96	7.1%	103	6	617		
Routine Hospice Transfers	84	7.1%	90	6	540		
Respite Patients	31	7.1%	33	5	166		
Total	499		541		3,214	8.81	11.74

[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]

TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	2013	2014	2015	2016
1. Admissions							
a. ICF-MR							
b. RTC-Residents							
Day Students							
c. ICF-C/D							
d. Other (Inpt. Hospice)				510	521	531	541
e. TOTAL							
2. Patient Days							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Inpt. Hospice)				3,030	3,095	3,155	3,214
e. TOTAL							

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	2013	2014	20__	20_
3. Average Length of Stay							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Inpt. Hospice)				5.9	5.9	5.9	5.9
e. TOTAL							
4. Occupancy Percentage*							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Inpt. Hospice)				69.1%	70.7%	72.0%	73.4%
e. TOTAL							
5. Number of Licensed Beds*							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Inpt. Hospice)				12	12	12	12
e. TOTAL							
6. Home Health Agencies							
a. SN Visits							
b. Home Health Aide							
c. Other Staff							
d.							
e. TOTAL							

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
7. Hospice Programs							
a. SN visits							
b. Social work visits							
c. Other staff visits							
d.							
e. Total patients srvd.							
8. Ambulatory Surgical Facilities							
a. Number of operating rooms (ORs)							
• Total Procedures in ORs							
• Total Cases in ORs							
• Total Surgical Minutes in ORs**							
b. Number of Procedure Rooms (PRs)							
• Total Procedures in PRs							
• Total Cases in PRs							
• Total Minutes in PRs**							

*Number of beds and occupancy percentage should be reported on the basis of licensed beds.
**Do not include turnover time.

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT
(INSTRUCTION: All applicants should complete this table.)

NOTE; Seasons has not completed this table, based on guidance from the CON Director on previous CON applications. Seasons acknowledges that the MHCC has the right to ask that it be completed at a later time.

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___
1. Admissions				
a. ICF-MR				
b. RTC-Residents				
Day Students				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
2. Patient Days				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
3. Average Length of Stay				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
4. Occupancy Percentage*				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				

e. TOTAL				

Table 2 Cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___
5. Number of Licensed Beds				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
6. Home Health Agencies				
a. SN Visits				
b. Home Health Aide				
c.				
d.				
e. Total patients served				
7. Hospice Programs				
a. SN Visits				
b. Social work visits				
c. Other staff visits				
d. Total patients served				
8. Ambulatory Surgical Facilities				
a. Number of operating rooms (ORs)				
• Total Procedures in ORs				
• Total Cases in ORs				
• Total Surgical Minutes in ORs**				
b. Number of Procedure Rooms (PRs)				
• Total Procedures in PRs				
• Total Cases in PRs				

• Total Minutes in PRs**				

*Do no include turnover time

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

For purposes of evaluating an application under this subsection, the Commission shall compare the cost-effectiveness of providing the proposed service through the proposed project with the cost-effectiveness of providing the service at alternative existing facilities, or alternative facilities which have submitted a competitive application as part of a comparative review.

Please explain the characteristics of the Project which demonstrate why it is a less costly or a more effective alternative for meeting the needs identified.

For applications proposing to demonstrate superior patient care effectiveness, please describe the characteristics of the Project that will assure the quality of care to be provided. These may include, but are not limited to: meeting accreditation standards, personnel qualifications of caregivers, special relationships with public agencies for patient care services affected by the Project, the development of community-based services or other characteristics the Commission should take into account.

The February 8, 2010 issue of *Advance for Nurses* had a cover story on the Seasons inpatient unit at Northwest Hospital ("When Worlds Unite"). (See Exhibit 5.) In the article, Gary Applebaum, M.D. is quoted:

> '"People do well what they do often," said Gary E. Applebaum, MD, Executive Director of Seasons Hospice. "Hospitals do a great job of taking care of acute patients, in making them healthy and getting them home. Hospitals do not do as well when the goal is comfort rather than cure. Tending to a patient's symptoms is what we do well. We are enormously aggressive about providing high-technology care to make the patient as comfortable as possible."'

This is one of the benefits of having the hospice unit in the hospital. Seasons can continue to have access to higher level technology that can be used to ease the patients' pain, but the care and environment are controlled by Seasons. The article continues:

"I've seen many families in the process of making a hospice decision. And when they step onto our unit, that's often when they make the decision, because the environment is so warm," Fisher said.

The capacity to be there for families at the "transition point" when they decide to move loved ones from hospital to hospice, is unique to being attached to a hospital.

Consequently, the patient benefits from being moved out of the hospital acute care unit (typically, the busy, high stress intensive care unit) into the quieter, more relaxed, more family friendly hospice unit, where all of the nursing care is provided by trained hospice staff, while still having access to the higher specialized palliative care.

Furthermore, because the unit is in the hospital, patients who have been intubated can elect for compassionate extubation with the assistance of licensed Respiratory Therapists, something that is not typically performed in a freestanding unit because an endotracheal tube is considered a temporary airway designed to be in place only until the patient is stable for extubation, elects for tracheostomy placement (usually 7-14 days max after intubation), or the patient or family elects for compassionate extubation while still at the hospital.

Because Sinai Hospital has available vacant space which Seasons can lease for the hospice inpatient unit, it offers an opportunity for the addition of a hospice program within the hospital. This option is certainly more cost effective than constructing new space on the hospital campus.

As stated previously, Seasons anticipates that the impact on Sinai will be that the number of deaths in acute beds will decline by half, just as it did at Northwest Hospital when Seasons opened its hospice inpatient unit at that hospital. Many of the patients who transfer to the hospice unit are transferred from the Hospital's Intensive Care Unit.

This results in shorter acute care lengths of stay for the hospital patients.

The existence of the hospice inpatient unit in the hospital increases the willingness of patients and their families to elect hospice care. This is evidenced by the fact that so many of the patients die in the hospital if there is not such a unit because they are too unstable for transfer in an ambulance to be discharged to a facility in the community. The increased choice of hospice is due to families and patients having the confidence that the level of care will be what they expect in a hospital, and that the services that patients may need for pain relief and comfort care are available on site. It is also due to the culture change that occurs in hospitals with hospice units on site, as the hospital staff become more comfortable with recommending the hospice option for end of life care.

If Seasons does not establish the unit, patients will remain in the more expensive hospital acute care beds (typically the Intensive Care Unit) for longer lengths of time. The cost of a day in the hospice unit is considerably less than the average cost of a day in the Intensive Care Unit. According to HSCRC data, Sinai Hospital had inpatient Med/Surg Intensive Care Unit revenue of $27,669,555 on 8,149 patient days in FY 2012, or $3,395.45 per patient day.[2] Similarly, Sinai Hospital had inpatient MSGA general unit revenue of $88,454,803 on 81,473 patient days, or $1,085.69 per patient day. In comparison, Seasons projects total revenue (see Table 3) of $2,166,845 on 3,214 patient days (see Table 1), or $674.19 per patient day.

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[2]ttp://www.hscrc.state.md.us/documents/Hospitals/ReportsFinancial/FinancialData/RevenueVolumeSummary/FY12/HospitalSummaryExperienceReportFY2012-0925.pdf

Project Costs

As discussed above, there are no capital costs for this project.

10.24.01.08G(3)(d). Viability of the Proposal.

For purposes of evaluating an application under this subsection, the Commission shall consider the availability of financial and non-financial resources, including community support, necessary to implement the project within the time frame set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Please include in your response:

a. Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. The availability of each source of funds listed in Part II, B. Sources of Funds for Project, must be documented.

b. Existing facilities shall provide an analysis of the probable impact of the Project on the costs and charges for services at your facility.

c. A discussion of the probable impact of the Project on the cost and charges for similar services at other facilities in the area.

d. All applicants shall provide a detailed list of proposed patient charges for affected services.

No letter from an accountant attesting that Seasons has adequate funds to make the equity contribution identified in the Project Budget is included because there are no capital costs for this project. A Statement of Assumptions is in Exhibit 6. Letters of Support are in Exhibit 7.

The only hospice facility that this project would impact would be Seasons' hospice inpatient unit at Northwest Hospital Center, which is on the western side of Baltimore County. Seasons does not anticipate that the reduction of admissions in its

Northwest hospice inpatient unit will be problematic. Seasons is confident that the short term and long term viability of that unit is strong.

In terms of the unit's impact on Sinai Hospital, Seasons anticipates that the number of deaths in acute beds at Sinai will decline as a result of this unit, as the setting for those hospice-appropriate patients will change. Referrals of patients to the hospice unit will also likely decrease acute average lengths of stay for patients referred to the unit. As demonstrated previously, the cost of hospice care is considerably lower than the cost of inpatient hospitalization.

(INSTRUCTIONS: Table 3, "Revenue and Expenses - Entire Facility (including the proposed project)" is to be completed by existing facility applicants only. Applicants for new facilities should not complete Table 3. Table 4, "Revenues and Expenses - Proposed Project," is to be completed by each applicant for the proposed project only. Table 5, "Revenues and Expenses (for the first full year of utilization", is to be completed by each applicant for each proposed service in the space provided. Specify whether data are for calendar year or fiscal year. All projected revenue and expense figures should be presented in current dollars. Medicaid revenues for all years should be calculated on the basis of Medicaid rates and ceilings in effect at the time of submission of this application. Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses.)

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

(INSTRUCTION: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS)

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)		
CY or FY (Circle)	20___	20___	20___	2014	2015	2016
1. Revenue						
a. Inpatient services				2,086,578	2,127,062	2166845
b. Outpatient services						
c. Gross Patient Service Revenue				2,086,578	2,127,062	2,166,845
d. Allowance for Bad Debt				31,299	31,906	32,503
e. Contractual Allowance				41,732	42,541	43,337
f. Charity Care				31,299	31,906	32,503
g. Net Patient Services Revenue				1,982,249	2,020,709	2,058,503
h. Other Operating Revenues (Specify)						

i. Net Operating Revenue				1,982,249	2,020,709	2,058,503

Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)		
CY or FY (Circle)	20___	20___	20___	2014	2015	2016
Expenses						
a. Salaries, Wages, and Professional Fees, (including fringe benefits)				1,234,870	1,234,870	1,234,870
b. Contractual Services				201,175	205,075	208,910
c. Interest on Current Debt						
d. Interest on Project Debt						
e. Current Depreciation						
f. Project Depreciation				0	0	0
g. Current Amortization						
h. Project Amortization						
i. Supplies				61,900	63,100	64,280
j. Other Expenses (Rent & Admin Overhead)				400,000	400,000	400,000
k. Total Operating Expenses				1,897,945	1,903,045	1,908,060
3. Income						
a. Income from Operation				84,304	117,664	150,443

b. Non-Operating Income						
c. Subtotal				84,304	117,664	150,443
d. Income Taxes						
e. Net Income (Loss)				84,304	117,664	150,443

Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)		
CY or FY (Circle)	20___	20___	20___	2014	2015	2016
4. Patient Mix:						
A. Percent of Total Revenue						
1. Medicare				85%	85%	85%
2. Medicaid				5%	5%	5%
3. Blue Cross				3%	3%	3%
4. Commercial Insurance				2%	2%	2%
5. Self-Pay				5%	5%	5%
6. Other (Specify)				0%	0%	0%
7. TOTAL	100%	100%	100%	100%	100%	100%
B. Percent of Patient Days/Visits/Procedures (as applicable)						
1. Medicare				85%	85%	85%
2. Medicaid				5%	5%	5%
3. Blue Cross				3%	3%	3%
4. Commercial Insurance				2%	2%	2%
5. Self-Pay				5%	5%	5%
6. Other (Specify)				0%	0%	0%
7. TOTAL	100%	100%	100%	100%	100%	100%

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTION: Each applicant should complete this table for the proposed project only)

NOTE; Seasons has not completed this table, based on guidance from the CON Director on previous CON applications. Seasons acknowledges that the MHCC has the right to ask that it be completed at a later time.

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___
1. Revenues				
a. Inpatient Services				
b. Outpatient Services				
c. Gross Patient Services Revenue				
d. Allowance for Bad Debt				
e. Contractual Allowance				
f. Charity Care				
g. Net Patient Care Service Revenues				
h. Total Net Operating Revenue				
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)				
b. Contractual Services				
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation				
f. Project Depreciation				
g. Current Amortization				
h. Project Amortization				
i. Supplies				
j. Other Expenses (Specify)				
k. Total Operating Expenses				

Table 4 Cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___
3. Income				
a. Income from Operation				
b. Non-Operating Income				
c. Subtotal				
d. Income Taxes				
e. Net Income (Loss)				
4. Patient Mix: A. Percent of Total Revenue				
1. Medicare				
2. Medicaid				
3. Blue Cross				
4. Commercial Insurance				
5. Self-Pay				
6. Other (Specify)				
7. TOTAL	100%	100%	100%	100%
5. Ambulatory Surgical Facilities				
1. Medicare				
2. Medicaid				
3. Blue Cross				
4. Commercial Insurance				
5. Self-Pay				
6. Other (Specify)				
7. TOTAL	100%	100%	100%	100%

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

To meet this subsection, an applicant shall demonstrate compliance with all conditions applied to previous Certificates of Need granted to the applicant.

List all prior Certificates of Need that have been issued to the project applicant by the Commission since 1995, and their status.

Seasons has only received one prior CON, on July 18, 2013, to implement a Hospice Inpatient Unit at Franklin Square Hospital. Seasons is in the process of implementing that unit.

10.24.01.08G(3)(f). Impact on Existing Providers.

For evaluation under this subsection, an applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers.

Indicate the positive impact on the health care system of the Project, and why the Project does not duplicate existing health care resources. Describe any special attributes of the project that will demonstrate why the project will have a positive impact on the existing health care system.

Complete Table 5

1. **an assessment of the sources available for recruiting additional personnel;**

Seasons uses various avenues to recruit candidates for open positions. Positions are posted on the Seasons website as well as job boards, unemployment office and professional organization websites. In addition, Seasons recruits candidates through employee referrals. Interested parties apply by submitting their resume via email. A member of Human Resources reviews the resumes to determine eligibility and will contact candidates for a phone screen. Human Resources coordinates in-person

interviews with the candidates and managers. If the interviews are successful, candidates may be asked to complete a Share Day, where they have an opportunity to spend time with a Seasons employee in the same position. The Share Day allows the candidate to see first-hand what the position entails so they can determine if the position is right for them and Seasons can determine fit. If the Share Day is successful, the candidate may be asked to complete a final interview or submit release forms for a background check. If the background check is clear, an offer is made, and start date set.

2. recruitment and retention plans for those personnel believed to be in short supply;

For positions in short supply, additional outreach is conducted to recruit qualified candidates including the use of recruiting agencies, advertising in additional publications and contact with applicants from previous years.

Seasons retains employees by providing a comprehensive orientation program which includes classroom and virtual education as well as hands-on training with a preceptor. Seasons provides continuing education and timely feedback on job performance including competency assessments and regular reviews. Seasons promotes career development by communicating open employment opportunities to all employees.

3. for existing facilities, a report on average vacancy rate and turnover rates for affected positions,

Inapplicable, as there is not a Hospice Inpatient Unit at Sinai.

4. Impact on existing facilities.

This unit will reduce volumes at Seasons' NWH Hospice Inpatient Unit, since

many patients are currently going to that unit.

It will have the following impact on the NWH Hospice Inpatient Unit.

Table 2 in the discussion under "10.24.01.08G(3)(b) Need" showed that Sinai referred 15 admissions to the NWH Hospice Inpatient Unit in 2012. These will now stay at Sinai.

Tables 2-5 show that Seasons anticipates that 96 referrals from Other Baltimore City Providers would have been referred to a Sinai Hospice Inpatient Unit in 2012 if it had existed.

Table 7 showed that 84 Baltimore City patients who transferred from Routine Hospice level of care to Inpatient level of care at the NWH Hospice Inpatient Unit would have gone to the Sinai IPU had it existed.

The NWH Hospice Inpatient Unit has generally not admitted Respite level of care patients because it has not had the capacity to accommodate them.

The projected impact at the NWH Hospice Inpatient Unit totals 195 admissions (15+96+84 = 195).

Seasons believes that this will enable the NWH Hospice Inpatient Unit to admit Respite level of care patients and accommodate continued growth in Hospice care. Seasons does not believe that it will adversely impact its NWH Hospice Inpatient Unit.

As stated previously, Seasons currently has contracts with dozens of Medicare-approved nursing homes in which it currently provides respite care. Table 14 shows the facilities in which Seasons provided the 35 respite stays for residents of Baltimore City in 2012. The 31 patients (excluding 5 residents who lived in the Baltimore City East region) for whom Respite level of hospice care was provided were distributed among

many facilities. Seasons does not believe that the 155 lost days at these facilities due to respite care being provided at the Sinai Hospice Inpatient Unit will adversely impact any individual facility. (31 X 5 days ALOS = 155 days)

Table 14
Respite Care Placements
Seasons Hospice
CY 2012

Total Number Respite Visits	Name of Nursing Home where Pt. Went to Respite
2	(1st) Holly Hill & (2nd) Future Care Charles Village
2	(1st) Ivy Hall NH & (2nd) Manor Care Ruxton
7	Milford Manor
8	Milford Manor
3	Envoy of Pikesville
1	Future Care Charles Village
2	Future Care Lochearn
1	Genesis Hamilton- Harford Rd
1	Genesis Knollwood Manor
1	Glen Burnie Health & Rehab
3	Holly Hill NH
1	Ivy Hall NH
1	Milford Mannor
3	Stella Marris NH
36	Total

In a filing in the case of Seasons' CON application to establish a hospice unit at Franklin Square Hospital, Stella Maris showed that Sinai Hospital referred only 6 patients to Stella Maris' inpatient unit in 2009. During the exceptions hearing in that case, Stella Maris' legal counsel stated that Stella Maris is not concerned about the proposed Sinai Inpatient Hospice Unit. Seasons asked Sinai if it could provide the number of inpatient hospice referrals by hospice provider. According to Sinai, it made 176 total inpatient hospice referrals to hospice providers in FY 2012, 88.6% of which were to Seasons. In FY 2013, Sinai admitted 181 total inpatient hospice to hospice

providers, 85.1% of which were to Seasons. Sinai admitted only 27 patients for inpatient hospice to all the other hospice providers combined in FY 2013. Based on these admission patterns, there will not be a material impact on Stella Maris, Gilchrist, or any other provider due to the establishment of a Seasons unit at Sinai.

Table 4
Total Patients Admitted To Hospice
Patients Admitted to Seasons Hospice
Sinai Hospital
FY 2012 and 2013

Inpatient Hospice Placements	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Apr 12	May 12	Jun 12	FY 12
Total	10	10	12	11	13	14	23	15	11	20	21	16	176
Seasons Hospice Placements	8	7	10	9	12	14	21	13	10	17	20	15	156
% of total hospice placements to Seasons	**80%**	**70%**	**83%**	**82%**	**92%**	**100%**	**91%**	**87%**	**91%**	**85%**	**95%**	**94%**	**88.6%**

Inpatient Hospice Placements	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13	Apr 13	May 13	Jun 13	FY 13
Total	16	13	16	22	4	12	16	16	17	17	18	14	181
Seasons Hospice Placements	14	12	11	18	3	9	14	13	16	15	17	12	154
% of total hospice placements to Seasons	**88%**	**92%**	**69%**	**82%**	**75%**	**75%**	**88%**	**81%**	**94%**	**88%**	**94%**	**86%**	**85.1%**

Source: Sinai Hospital

Furthermore, the establishment of an inpatient hospice unit at Sinai should not have a negative impact on other hospice programs because the new unit makes the public more comfortable with and knowledgeable about hospice care. Just as Seasons volumes in all settings increased in Baltimore County and Baltimore City since the opening of the hospice unit at Northwest in January 2008, the hospice volume at non-Seasons hospice programs also grew, as the following three tables demonstrate.

While Seasons hospice has had very strong growth (in all settings) over the last three years, non-Seasons agencies have grown by 15.2% between 2007 and 2011. (4,966/4,311 = 1.152)

Table 5
Total of All Patients Served
Baltimore City and Baltimore County
2007-2011

	Baltimore City		Baltimore County		Total	
	#	% Change	#	% Change	#	% Change
2007	1,810		3,208		5,018	
2008	2,006	10.8%	3,590	11.9%	5,596	11.5%
2009	2,062	2.8%	4,168	16.1%	6,230	11.3%
2010	1,840	-10.8%	4,479	7.5%	6,319	1.4%
2011	1,842	0.1%	4,899	9.4%	6,741	6.7%

Source: MHCC Public Use Hospice Database

Table 6
Total of All Patients Served
Baltimore City and Baltimore County
Seasons Hospice
2007-2011

	Baltimore City		Baltimore County		Total	
	#	% Change	#	% Change	#	% Change
2007	191		516		707	
2008	329	72.3%	918	77.9%	1,247	76.4%
2009	431	31.0%	1,134	23.5%	1,565	25.5%
2010	426	-1.2%	1,308	15.3%	1,734	10.8%
2011	407	-4.5%	1,368	4.6%	1,775	2.4%

Source: MHCC Public Use Hospice Database

Table 7
Total of All Patients Served
Baltimore City and Baltimore County
All Other Hospice Agencies
2007-2011

	Baltimore City		Baltimore County		Total	
	#	% Change	#	% Change	#	% Change
2007	1,619		2,692		4,311	
2008	1,677	3.6%	2,672	-0.7%	4,349	0.9%
2009	1,631	-2.7%	3,034	13.5%	4,665	7.3%
2010	1,414	-13.3%	3,171	4.5%	4,585	-1.7%
2011	1,435	1.5%	3,531	11.4%	4,966	8.3%

Source: MHCC Public Use Hospice Database

The *Maryland Comprehensive Cancer Control Plan* addresses Hospice and Palliative Care in Chapter 15. It states:

> "Currently, patients and their families remain undereducated about advanced care planning, palliative, and hospice care.[20] This is attributed to the general cultural attitude in which death is rejected as an option and conversations about death and dying are uncomfortable for patients and their families. Work should be done to raise expectations about the education patients receive. Increased knowledge of palliative and hospice care may result in patient conversations with healthcare providers they might not have had otherwise. [21] This awareness will empower the patient and family to take an active role in conversations about goals of treatment and expected outcomes, and to have a clearer understanding of options should treatment fail to cure or control the cancer. An integral part of these conversations should be the completion of advanced directive documents with the subsequent sharing of the documents with family as well as healthcare providers."
>
> 20 Foley KM, Gelband H, editors. Improving palliative care for cancer. Washington (DC): Institute of Medicine and National Research Council, National Cancer Policy Board, National Academy Press; 2001.
>
> 21 Ibid."
>
> Source: http://fha.maryland.gov/cancer/cancerplan/plan2011/chapter15palliative.pdf

As stated previously, the existence of the unit in the hospital increases the awareness and willingness of patients and their families to choose hospice care. This is evidenced by the fact that so many of the patients die in the acute care beds if there is not such a unit. The increased choice of hospice is due to families and patients having the confidence that the level of care will be what they expect in a hospital, and that the services that patients may need for pain relief are available on site. It is also due to the culture change that occurs in hospitals with hospice units on site as the continuum of care is increased, as the hospital staff become more aware of and comfortable with recommending the hospice option for end of life care.

Seasons believes that the existence of hospice units in hospitals, such as that proposed in this project, increases the use of hospice care in all settings. Healthcare professionals become more comfortable recommending hospice care and as the public (1) has more exposure to and education about hospice services and (2) has different options in settings for obtaining hospice care so that they can have access to the best option for themselves or their loved ones.

Seasons' contention that dedicated inpatient hospice units in hospitals, such as the one proposed, are culture changing is supported by others, as well. The previously mentioned article in Advance For Nurses includes such verification from Diane Meier, MD, Director of the Center to Advance Palliative Care.

> Looking at Seasons and Northwest from an outsider's perspective, Diane Meier, MD, said the hospice's location alone within the hospital "legitimizes palliative care" and leads to an increased number of appropriate hospice referrals.
>
> "Hospitals and hospices are used to working in very different cultural and professional silos; that's been one of the big problems," said Meier, director of the Center to Advance Palliative Care. "Physicians train in acute care settings, and only really know about acute care. Some have never even seen a hospice patient. They don't know what hospice is or how to refer people to it. Right now more than 30 percent of hospice referrals live less than a week, because they're referred so late.
>
> "Having a unit like this in the midst of an acute care hospital changes the culture," she added. Physicians hear and learn more about hospice; it's in the front of their minds when faced with a patient who can benefit from it.
>
> A hospital, whose physicians are making more appropriate hospice referrals, frees up acute care beds for patients who have a hope of recovery - a dual benefit to the hospital and community.
>
> "If 10 of your 12 ICU beds are filled with people who are not going to leave the hospital alive, your hospital can't take new patients from the ED," Meier said. "That is why you see EDs stacked to the rafters and surgeries that don't take place because the ICU is full. Having a hospice unit on-site opens up acute care beds - and the hospital is now matching the needs of its patients and better serving the community."

This last comment identifies another benefit of establishing the unit. Maryland Institute for Emergency Medical Services ("MIEMSS") County Hospital alert Tracking System[3] ("CHATS") data for Northwest Hospital from April 1, 2007 to March 31, 2008 show that Northwest had 1,016.18 hours of Red Alert (i.e., the hospital has no ECG monitored beds available and requests that patients who are likely to require this type of care, not be transported to their facility) status. Looking at Figure 2 in the CON application, one can see that the hospice unit's impact on deaths in Acute Care beds began achieving a significant reduction in April 2008. MIEMSS CHATS data for April 1, 2008 through March 31, 2009 show that the number of Red Alert hours were reduced to 385.6.

[3] http://www.miemss.org/home/Hospitals/HospitalAlertsCHATS/tabid/125/Default.aspx

(INSTRUCTION: FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours.

TABLE 5. MANPOWER INFORMATION

(INSTRUCTION: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project.)

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration					
Team Assistant	0	1	$39,600	Employee	$39,600
Unit Director	0	1	$90,000	Employee	$90,000
Direct Care					
CAN	0	3	$30,900	Employee	$92,700
Nurse	0	8	$67,300	Employee	$538,400
LPN	0	2	$52,500	Employee	$105,000
Unit Medical Director*	0	1	$24,000	(Contracted)	$24,000
Support					
Social Worker	0	1	$60,200	Employee	$60,200
				Subtotal	$949,900
				Benefits	$284,970
				TOTAL	$1,234,870

* The Salary reflects the Administrative component of the position, which would be augmented by clinical reimbursement .

(INSTRUCTION: Indicate method of calculating benefits percentage):
Benefits include all health insurance contributions, applicable payroll taxes, and vacation provided. This amounts to 30% of the direct labor cost.

PART IV - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND SIGNATURE

1. List the name and address of each owner or other person responsible for the proposed project and its implementation. If the applicant is not a natural person, provide the date the entity was formed, the business address of the entity, the identity and percentage of ownership of all persons having an ownership interest in the entity, and the identification of all entities owned or controlled by each such person.

   Marshall Scott, Director of Business Operations
   6934 Aviation Boulevard
   Suite N
   Glen Burnie, MD 21061

   Date The Entity Was Formed: January 17, 2003
   Business Address: 6934 Aviation Blvd, Suite N-R, Glen Burnie, MD 21061

   Owners:

TODD ANDREW STERN TRUST DTD 10/31/01	9049 N KARLOV, SKOKIE, IL 60076	15.0%
MAURICE AARON	4024 W GROVE, SKOKIE, IL 60076	8.6%
FRED AARON	6640 N CENTRAL PARK, LINCOLNWOOD, IL 60712	3.5%
ROBERT HARTMAN DELTA TRUST	3451 W GLENLAKE, CHICAGO, IL 60659	9.4%
ORIOLE TRUST	40 N SKOKIE BLVD, SUITE 105, NORTHBROOK, IL 60062	2.1%
MARSHALL MAUER	6440 ST LOUIS AVE, LINCOLNWOOD, IL 60712	8.6%
MARCIA NORMAN	2129 W HAVEN ST, MT PROSPECT, IL 60056	3.0%
JONATHAN B. STERN TRUST DTD 10/31/01	9049 N KARLOV, SKOKIE, IL 60076	5.0%
SUSAN STERN	9049 N KARLOV, SKOKIE, IL 60076	25.0%
THE EVAN M STERN TRUST DTD 7/17/05	9049 N KARLOV, SKOKIE, IL 60076	5.0%
RAJCHENBACH FAMILY TRUST U/A/D 1/4/94	6633 N LINCOLN AVE, LINCOLNWOOD, IL 60712	9.4%
GARY APPLEBAUM	2130 POPLAR RIDGE RD, PASADENA, MD 21122	5.5%
		100.0%

   For entities owned or controlled by these individuals, please see Exhibit 8.

2. Is the applicant, or any person listed above now involved, or ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each facility, including facility name, address, and dates of involvement.

   No

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Questions 1 and 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owner or other person responsible for implementation of the Project was not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

No

4. Is any facility with which the applicant is involved, or has any facility with which the applicant or other person or entity listed in Questions 1 & 2, above, ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to an action to suspend, revoke or limit the licensure or certification at any facility. If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition reached by the applicable governmental authority.

No

5. Has the applicant, or other person listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense connected in any way with the ownership, development or management of the applicant facility or any health care facility listed in response to Question 1 & 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

No

9-5-13
Date

Signature of Owner or
Authorized Agent of the Applicant

Exhibits

1. Poster on Wayne State University Study
2. Project Drawings
3. Payment for Services Policy
4. Patient Rights and Responsibilities
5. *Advance for Nurses* cover story on the Seasons Unit at Northwest Hospital Center ("When Worlds Unite")
6. Statement of Assumptions
7. Letters of Support
8. Entities Owned or Controlled by Owners of Seasons
9. Affirmations

Exhibit 1
Poster on Wayne State University Study

Too Sick For Outpatient Hospice?

Diagnoses, outcomes for patients admitted to an Inpatient Hospice Unit(IPU)

Zalenski R*+ Courage C* Waselewsky D* Beemath A*+ Natarajan B+ Simpson T+ Stern T+

*Division of Palliative Medicine, Dept. of Emergency Medicine, Wayne State University, Detroit, MI. +Seasons Hospice & Palliative Care, Chicago IL

INTRODUCTION

CONTEXT: Hospice and Palliative Medicine was approved by the American Board of Medical Specialties in September, 2006 as a new subspecialty . Shortly thereafter, the American Board of Emergency Medicine approved Hospice and Palliative Medicine as its 5th subspecialty , complementing Toxicology, Sports Medicine, Pediatrics, and Hyperbaric and UnderSea Medicine.

:

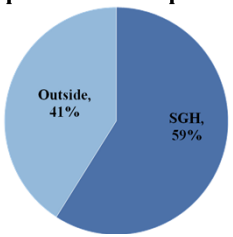
Although typical hospice patients have chronic, incurable fatal illness , there is another important set of patients with acute fatal illness who se disease severity prevents transfer from the hospital setting to home /facility based hospice. These patients, in the past, have been effectively barred from access to hospice, a Medicare benefit, because of both their limited time of survival and the intensity of specialized services , such as IV medication and mechanical ventilation, that are needed to relieve their suffering. The opening of the Rhea Heil Seasons Inpatient Hospice Unit (IPU) at Sinai-Grace Hospital (SGH) has permitted such patients to access the Medicare Hospice Benefit. The 10 bed -IPU cares for patients directly transferred from SGH as well as home hospice patients that were transferred after being refractory to home management.

OBJECTIVE: Describe clinical characteristics and outcomes, and cost implications of caring for patients referred from an inner-city academic hospital to the IPU. Pain control, hospice mortality, cost offsets and DRG enhancement are some of the outcomes considered.

METHODS

A retrospective review of the IPU's patients during a 6-month period between July and December 2010. Both clinical chart abstraction and data extraction from hospital and hospice clinical databases were used. Cost estimates were obtained from SGH hospital and the literature.

Case Mix: Proportion of referrals from Sinai Grace Hospital to IPU versus those sent to IPU from home hospice or other hospitals.

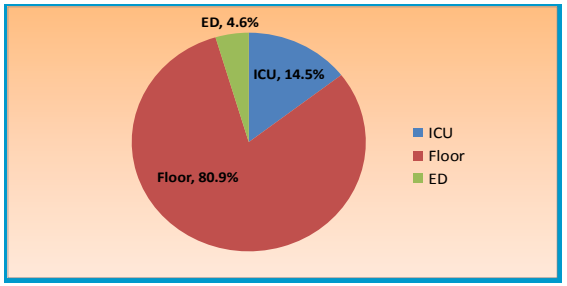


RESULTS

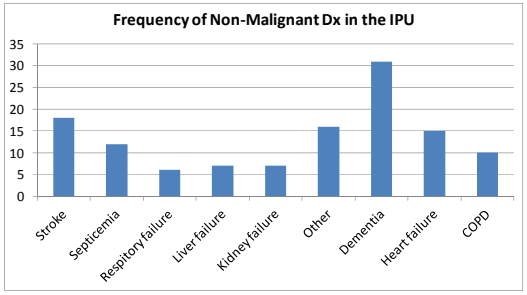
A total of 191 patients made 221 visits to the IPU from July to December 2010. Their average age was 69 years (range 22-98); there were 105 male and 116 female admissions; 72% were of African American ethnicity. The average IPU length of stay was 6 days. 62% of visits ended with the death of the patient at the IPU.

Although most of these patients had non-malignant conditions (56%; n=146), advanced cancer was the single most common diagnosis (44%, n=75), followed by dementia (14%; n=31) and stroke (8%; n=18). SGH referred 130 patients to the IPU (59% of total IPU patients). After admission to the IPU, mean pain scores were significantly reduced from 5.0 to 2.1 ($p < .0001$, scale 0-10). By discharging these patients to the IPU, the hospital realized an estimated $904,449 over the 6 month period.

Referral source of SGH patients admitted to the IPU.



Distribution of Non-Cancer Diagnoses in the IPU



DISCUSSION

Patients cared for in the IPU were mostly transfers from SGH, from its contiguous hospital floors, ICUs, and ED. The range of admission diagnoses represented a spectrum of organ failure, cancer, and overwhelming sepsis. Most patients completed their lives by dying in the IPU surrounded by family, hospice-style comfort, with the enhancements of music therapy and spiritual care , provided by collaborative efforts of Hospice and Hospital Chaplains. Improved care was indicated by the marked reduction in pain scores of those afflicted with this symptom.

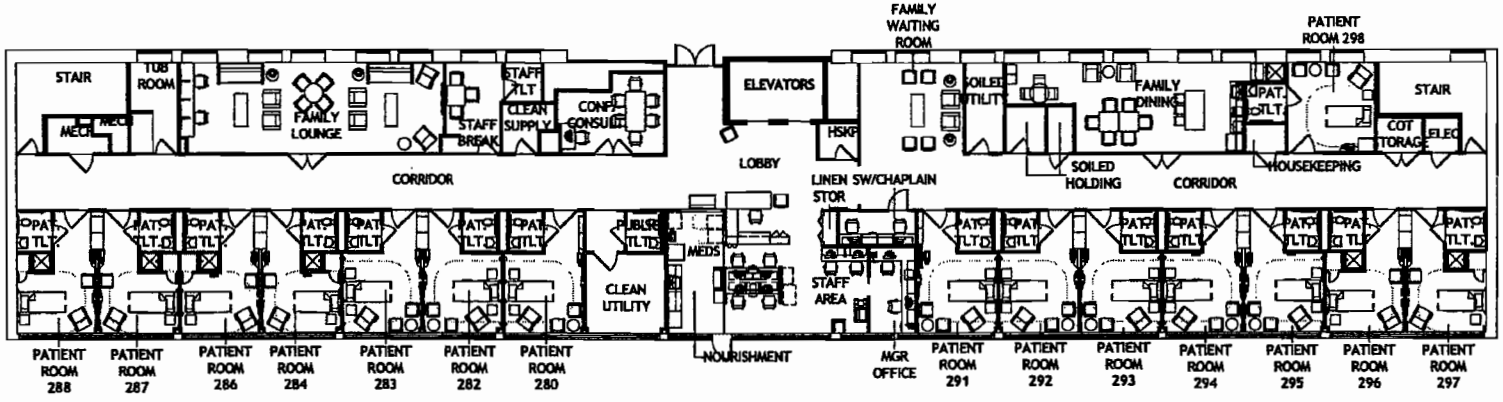
Aside from these benefits to patients and families, the IPU led to measurable improvements at the hospital level. By permitting safe and appropriate discharge of the most critically ill patients of SGH to a setting optimized for comfort and life completion, the IPU referrals reduced SGH's overall length of stay. By discharging patients with expected death, SGH lowered its mortality rate by excluding those patients whose death was both anticipated and appropriate. By allowing the dying patients to be cared for on the hospice medicare budget, SGH reduced its financially uncompensated costs by an estimated total of 780 patients-days in the 6 month study period. By freeing up beds when (37% of days for the medical floor and 42% of days for the ICU) the hospital was at capacity (>/= 80% occupancy), the IPU improved SGH throughput , lessened ED overcrowding , and enhanced patient/family satisfaction , quality of care (reduced pain scores) and possibly DRG revenues by increasing capacity for acute admissions. .

CONCLUSION

The study reveals that the Rhea Heil IPU of SGH permits the enrollment of patients dying of acute illness with severe symptoms, and 62% of visits end with the death of the patient during their IPU stay. In the past, these patients have typically been excluded from hospice enrollment due to the severity and acuity of their illnesses. Our preliminary results suggest that IPUs can improve access and quality for patients , and cost and mortality outcomes for hospitals. Although further research is needed to demonstrate the effectiveness of these units, IPUs may be an excellent strategy for the contemporary, high volume acute care hospital in the U.S. to achieve some remarkable and significant outcomes.

Exhibit 2
Project Drawings

HOSPICE CARE SUITE- FLOOR PLAN *



HOSPICE CARE SUITE
2401 W. BELVEDERE AVE. BALTIMORE, MD 21215

11.07.2012

hord | coplan | macht
750 East Pratt Street, Suite 1100 Baltimore MD 21202
410.837.7311 www.hcm2.com
© Hord Coplan Macht, Inc.

*This is the floor plan that was used for the Sinai Clustered Bed Unit. While it shows the capacity for 14 beds, only 12 beds will be licensed for the Seasons project.

Exhibit 3
Payment for Services Policy

PAYMENT FOR SERVICES 609

POLICY:

Seasons Hospice shall accept appropriate patients and families regardless of their ability to pay for hospice services.

PROCEDURES:

1. All clinical decisions for services will be made based on the needs of the patient/family and not on cost to the agency.

2. Patients who are eligible for Medicare or Medicaid Hospice benefits do not require a financial assessment. The payment received from these reimbursement sources shall be considered payment in full. Seasons Hospice will not charge a patient for services for which the patient is entitled to have payment made under Medicare/Medicaid or for services for which the patient would be entitled to payment. Payments for all levels of care are made on the basis of the geographic location where the service is provided.

3. Patients with private insurance or other third-party payers are responsible for their bills for hospice services. Seasons Hospice will bill private insurance and other third-party payers monthly. Patients and families will be responsible for all charges not paid by their insurance or other third-party payers based upon their ability to pay which will be determined by a financial assessment conducted by the hospice staff.

4. Patients with no private insurance or a private insurance without a hospice benefit will be responsible for their bills for hospice services based upon their ability to pay. A financial assessment must be made by hospice staff to determine their ability to pay.

5. When necessary, Seasons Hospice will use extended payments or a claim on an estate for the payment of hospice services. Regardless of payment source or ability to pay, once Seasons Hospice has accepted a patient/family, all appropriate services will be provided.

6. A financial assessment will be done on appropriate patient/families to determine a patient/family's ability or inability to pay for services. The specific goals of a financial assessment include:

   - Determining the level and continuity of monthly income;
   - Determining the significance of debt;
   - Determining the presence of life insurance; and,
   - Determining the availability of uncommitted monthly income.

PAYMENT FOR SERVICES 609

7. A per diem rate is the preferred schedule of fees acceptable from any payer source.

8. There is no refund policy because bills are submitted after services are rendered.

Effective: 3/12/02

Revised:	1/23/06	3/9/06	5/31/06	2/20/10						
Reviewed:	5/15/02	3/11/03	5/18/04	6/3/05	5/10/06	4/24/07	12/19/08	7/9/09	11/22/10	

Exhibit 4
Patient Rights and Responsibilities

PATIENT/FAMILY RIGHTS AND RESPONSIBILITIES 101

POLICY:

The patient has the right to be informed of his or her rights. Seasons Hospice is committed to protecting and promoting the exercise of these rights.

PROCEDURES:

1. Before services are provided, patients and families will be informed, both orally and in writing of their rights and responsibilities related to the care or services provided. This information will be provided in a language and manner that the patient understands and will be repeated, as needed, during the course of care by Seasons Hospice.

2. A signature of the patient or representative will be obtained to verify that they have received and understand this information. The patient has the right to have assistance in understanding and exercising his/her rights.

3. Seasons Hospice will educate all employees and volunteers during orientation and annually about the rights of patients and families and will ensure that all employees and volunteers respect these rights.

4. The list of rights and responsibilities will be redistributed to patients and / or their representative following any revisions or modifications.

5. If the patient has been adjudged incompetent under state law, the rights of the patient are exercised by any legal representative or the person appointed by the court to act on the patient's behalf.

Effective: 2/18/1997

Revised:	1/10/99	3/23/00	11/27/01	9/14/07	12/2/08	2/20/10			
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	10/17/06
Reviewed:	10/26/07	12/19/08	7/9/09	12/13/10					

Exhibit 5
***Advance for Nurses* Cover Story on the Seasons Unit at Northwest Hospital Center ("When Worlds Unite")**

advance FOR NURSES
WWW.ADVANCEWEB.COM/NURSES
FEBRUARY 8, 2010 • VOL. 12 • NO. 3

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Two Worlds Unite

Inpatient Hospice at Northwest Hospital

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Two Worlds Unite

Hospice and hospitals often exist as two separate silos. What happens when the two meet under the same roof?

BY AINSLEY MALONEY DI DUCA

PETS, PRAYERS, SUPPORT: With the opening of Seasons Hospice and Palliative Care of Maryland at Northwest Hospital, Randallstown, MD, acute and hospice care [illegible] the hospice unit right in the hospital, allows patients to be transferred easily from hospital to hospice. Although it's a hospice unit, life is celebrated in many ways. Social worker Jane C. Fisher, MSW, and chaplain Kathi Storey role play a typical pet visit with a patient.

Over the years, hospice and hospitals have come to exist as something like two separate nations, each with its own culture and values. Hospitals save lives, hospices ease the pain of death. Hospitals find cures, hospices comfort. Hospitals seek quantity of life; hospices seek quality at the end of life.

So what happens when a hospital adds a hospice unit and these two worlds combine? Northwest Hospital, part of LifeBridge Health, discovered this in February 2008 when, in partnership with Seasons Hospice and Palliative Care of Maryland, it became the first hospital in the state to open a fully dedicated hospice unit.

Here, Seasons staff and an outside expert from the hospice field explore the various ways a strong hospital/hospice relationship can benefit everyone — from the hospital and hospice, to the patient and his family, and even the community, in this case, in and around Randallstown, MD.

When Hospice Isn't 'Home'

To most people, hospice is synonymous with the word "home." It is thought of as an alternative to hospitals; as a way for patients to die peacefully in the comfort of home.

But at times this is not always best for everyone. Sometimes, a patient's symptoms become so acute he needs more aggressive pain management than can be provided at home.

For him, inpatient hospice is the only way to find comfort and pain relief near the end of life.

All hospice companies must offer access to inpatient services under the Medicare Hospice Conditions of Participation. To do this, some hospices might lease beds at a nearby hospital and transport acute patients there. However this isn't always ideal.

"Patients and families were starting to say, 'I needed inpatient hospice care but I really didn't want to be in a hospital.' Or, 'I really wanted a place that was more home-like,'" explained Judi Lund Person, MPH, vice president of regulatory affairs and state leadership, National Hospice and Palliative Care Organization.

So some hospices, such as Seasons, decided that if more than 300 at-home hospice patients ever needed inpatient care, it would do more than lease a few beds: It would partner with a hospital to build an entire hospice unit — and one that is completely different from the hospital in look, feel and mindset.

Home-Like Atmosphere

When visitors open the frosted-glass doors to Northwest Hospital's 14-bed inpatient hospice unit, they are transported out of a hospital into a warm, home-like atmosphere, explained Michele Parisi, BSN, RN, team director of the unit.

The unit, run by Seasons Hospice staff, offers all-private rooms with flat panel TVs and walls decorated in soft yellows and warm greens. It offers a shared family room, kitchen and eating area for family and friends, who are welcome 24/7.

Herein lays the first benefit an on-site hospice unit offers a hospital: It's the perfect solution for patients who need inpatient care, but would rather spend their final months in a place that looks and feels like home. "The air is different on this unit," Parisi said. "When people come here, they instantly feel a sense of calm."

The Right Expertise

In addition to the right atmosphere, Seasons Hospice also offers the right expertise to Northwest patients who are near the end of life.

"People do well what they do often," said Gary E. Applebaum, MD, executive director of Seasons Hospice. "Hospitals do a great job of taking care of acute patients, in making them healthy and getting them home. Hospitals do not do as well when the goal is comfort rather than cure. Tending to a patient's symptoms is what we do well. We are enormously aggressive about providing high-technology care to make the patient as comfortable as possible."

Easing a patient's pain is more than physical, however. It also requires emotional, psychosocial

and spiritual support, said Jane Fisher, social worker. Seasons offers a variety of services a patient would rarely see in an acute care setting. This includes a therapy dog who snuggles with and calms patients, board-certified music therapists who use instruments and song to provide comfort and relieve stress, a chaplain who visits daily to help with all things spiritual, and volunteers who sit with patients and listen to their stories.

This raises an interesting question. If hospitals have separate units for each niche — a unit for surgery (an OR), a unit for traumas and acute illness (an emergency department), and a unit for births (labor/delivery) — why doesn't every hospital have a unit that specializes in end of life, and managing the physical and emotional pain that comes with it?

Northwest Hospital can now say it does, and by having this hospice unit, has "added a needed dimension of care to our hospital that completes the life cycle in a compassionate, caring way," said Candace Hamner, vice president for care management at Northwest.

Support for Grieving Families

Seasons Hospice helps not only Northwest Hospital's patients, but their families, by providing them with the right support to make tough end-of-life decisions.

Imagine a young woman on a busy ICU whose mother just suffered a catastrophic stroke. Her mother is on a ventilator, brain dead. The daughter now has to make the very difficult decision about how and when to let her mother go. But as the noise and busyness of the ICU flows around her, her brain feels scattered; her emotions in chaos.

At Northwest Hospital, this woman can instead be moved — with her mother still on the ventilator — from the busy ICU to the calm, quiet environment of Seasons, where staff can provide as much time and support as the daughter needs.

"I've seen many families in the process of making a hospice decision. And when they step onto our unit, that's often when they make the decision, because the environment is so warm," Fisher said.

The capacity to be there for families at the "transition point" when they decide to move loved ones from hospital to hospice, is unique to being attached to a hospital.

"In outpatient hospice, the family has already made that decision [to accept hospice care] and have come to terms with the fact their loved one isn't going to recover," said Applebaum. "Our staff helps family through very high-stress situations: maybe their loved one has gone into renal failure and decides he doesn't want dialysis. We have the resources to help them through this crisis."

Meeting Community Needs

Looking at Seasons and Northwest from an outsider's perspective, Diane Meier, MD, said the hospice's location alone within the hospital "legitimizes palliative care" and leads to an increased number of appropriate hospice referrals.

"Hospitals and hospices are used to working in very different cultural and professional silos; that's been one of the big problems," said Meier, director of the Center to Advance Palliative Care. "Physicians train in acute care settings, and only really know about acute care. Some have never even seen a hospice patient. They don't know what hospice is or how to refer people to it. Right now more than 30 percent of hospice referrals live less than a week, because they're referred so late.

"Having a unit like this in the midst of an acute care hospital changes the culture," she added. Physicians hear and learn more about hospice; it's in the front of their minds when faced with a patient who can benefit from it.

A hospital, whose physicians are making more appropriate hospice referrals, frees up acute care beds for patients who have a hope of recovery — a dual benefit to the hospital and community.

"If 10 of your 12 ICU beds are filled with people who are not going to leave the hospital alive, your hospital can't take new patients from the ED," Meier said. "That is why you see EDs stacked to the rafters and surgeries that don't take place because the ICU is full. Having a hospice unit on-site opens up acute care beds — and the hospital is now matching the needs of its patients and better serving the community." ■

Ainsley Maloney Di Duca is a freelance writer for *ADVANCE*.

EXCELLENCE IN CARE: Staff at Seasons Hospice and Palliative Care of Maryland hospice unit at Northwest Hospital, Randallstown, MD, believe in all that hospice care has to offer, including pain management, dignity at the end of life, family support and music therapy. **Above:** Music therapist Terel Jackson, NMT, MT-BC (left), and Bode Alabi, RN (center), demonstrate how music therapy fits into hospice care. **Center photo below:** Ike Onachuna, RN, checks a patient's vital signs. **Bottom photo:** Hospice staff include (seated from left), Jane C. Fisher, MSW, Antonie E. Gayle, chaplain, and Sherry Davis, CNA, (standing from left) Alanna Aiello, MT-BC, LCAT, music therapist, Jackson, Alabi, Royce E. Jones, chaplain, and Onachuna.

Exhibit 6
Statement of Assumptions

Statement of Assumptions

Admissions: Admissions were calculated as described in the need section

Patient Days: An average length of stay of 6 days was assumed, based on experience at other Seasons units.

Revenue

Gross Revenue: Charges of approximately $701.25 Per Day for General Inpatient Care and $170.93 per day for Respite Care, plus charges for additional services, based on Seasons' experience at other units and Medicare Reimbursement.

Contractual Allowance: Seasons experiences 2% of Gross Revenues as Contractual Allowances in its other units.

Charity Care: Seasons experiences 1.5% of Gross Revenues as Charity Care in its other units.

Expenses

Salaries, Wages and Professional Fees: See Table 5, which is based on Seasons' experience at its other units.

Contractual Services: This includes service contracts with Sinai Hospital for services such as housekeeping, dietary, etc. It also includes other contractual services and is based on experience at Seasons' other units.

Project Depreciation: Seasons' Calculation based on experience in other projects

Supplies: $20/Patient Day based on experience at other units

Other Expenses (Rent & Admin Overhead): Based on the rent identified in the Project Budget and Seasons' Corporate Overhead

Payor Mix Based on Seasons experience at other units

Exhibit 7
Letters of Support

DIVISION OF GENERAL INTERNAL MEDICINE

DEPARTMENT OF MEDICINE
INPATIENT HOSPITALIST SERVICE

UNIVERSITY OF MARYLAND
SCHOOL OF MEDICINE

Wednesday, July 10, 2013

To Whom It May Concern:

I am writing in support of the opening of the Seasons Hospice Inpatient Unit at Sinai. I work at the University of Maryland as the Director of our Medical Intermediate Care Unit. Unfortunately, due to the complexity, acuity and often advanced age of our patients we often require transition to a hospice setting. While we understand that home hospice is preferable, it is the acuity of our patients that unfortunately often demands inpatient care whether it be for pain control, oxygen supplementation or even compassionate ventilator weaning.

Often there can be delays in the transfer of our patients to appropriate inpatient hospice units simply due to a lack of bed availability. These delays in transfers can be frustrating for patients and their families who are ready to move on to the next phase of their illness. While I take pride in our care of our patients, inpatient hospice units offer an expertise in the complex management of the end of life that is difficult to offer in an acute care hospital setting. Anything that could be done to reduce the wait time for inpatient hospice beds would be of direct benefit to those at this most sensitive time of life.

I have worked with Seasons Hospice for many years, though not exclusively. I refer mostly to them for a multitude of reasons including their compassion, their expertise and their efficiency. I was excited to learn of their proposed Sinai inpatient hospice unit as I had hoped it would help to reduce the numbers of our terminal patients who need to pass in acute care hospital settings.

I hope that this letter can serve in support of their efforts to obtain a Certificate of Need for an inpatient unit at Sinai Hospital. I know we sure need it.

Sincerely,

Brian E. Edwards, MD
Director, Medical IMC
Assistant Professor of Medicine
University of Maryland School of Medicine.

University of Maryland Medical System • 22 South Greene Street, Room N13W46 • Baltimore, Maryland 21201 • 410 328 7605 • 410 328 7607 *fax*

SINAI HOSPITAL

August 1, 2013

To Whom It May Concern:

I am writing this letter in support of the reopening and re-establishment of the inpatient hospice unit at Sinai Hospital of Baltimore with our partner Seasons Hospice & Palliative Care. For the past four years I have served as the Inpatient Oncology Social Worker here at Sinai, therefore consultations related to end of life concerns are central to my work with patients and patient families. In addition, as a Social Worker I serve as an advocate and it is our profession's highest calling to give voice to the needs and resource gaps of the individuals and communities that we serve.

Sinai Hospital operates within a unique geographic location – straddling the line between significant affluence and dire poverty. Situated in the neighborhood of Park Heights, many of our community members struggle daily with access to basic needs and are further adversely impacted by social disparities such as but not necessarily limited to:

- Educational and employment gaps (~42% of having less than a high school diploma)
- Significantly high homicide rate (~8 times the national average)
- Primarily female heads of households with little to not additional support present
- ~30% of community members are legally disabled thus living below the poverty line
- Reduced access to personal vehicles/ dependent on the public transportation system

While our patients access our services due to medical concerns, we often find almost immediately that their health concerns are layered amidst innumerable psycho-social challenges. Given that many of our patients have been dis-serviced by a fragmental welfare system, development of trusting relationships with our patients and their families must occur parallel to the formation of a treatment plan.

I am sure that my letter thus far prompts the question of *what does all of this have to do with reopening a hospice unit*? In fact it has everything to do with a hospice unit. It has everything with developing a type of community program that closes a much needed resource gap – that offers a place of support that is immediate and accessible to our community members. It has everything to do with the reality that the next closest and equivalent services are several miles away, multiple bus transfers at varying hours away if you are able-bodied, and a variable transfer away via Mobility if one is disabled.

Sinai Hospital / Case Management Department / 2401 West Belvedere Avenue / Baltimore, MD 21215 / 410.601.5578 phone / 410.601.5576 fax

SINAI HOSPITAL
a Lifebridge Health center

It has everything to do with the need for families to be able to access their loved ones at their most fragile moments and most vulnerable times. It has everything to do with the psychological impact and trauma of sudden loss and the additional psychological stress and delays in medical care that occur when families are forced to give trust to yet another set of strangers to care for their declining and imminent loved ones.

Sinai Hospital is in a position to offer a tremendous resource to our community – to offer a tremendous presence and source of comfort that is intricately connected with building on the relationships and alliances already established with our community and with our families. As a Social Worker and as an advocate I cannot word strongly and emphatically enough for the profound need that exists here to re-establish this inpatient hospice unit.

Please let us care for our people in this way as we have cared for them when they were born, when they grew, when they were diagnosed, when they grieved the injustice, when the family meetings transpired, and when they made the brave and honest decision to at last be at peace. Please let us offer the option of bereavement and support to those that remain, to those that were the caregivers, the decision makers and the ones that will be left with the equally profound need to draw perspective and to heal from the scars of grief.

I thank you in advance for reading this letter, for considering this need and I sincerely hope that we can bring this powerful service once again in a more immediate and accessible way to our community.

Respectfully,

Susan C. Westgate, MSW, LCSW-C
Sinai Hospital of Baltimore
2401 West Belvedere Avenue
Baltimore, MD 21215
Phone: 410-601-6767
Email: swestgat@lifebridgehealth.org

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

July 31, 2013

Dear Mr. Steffen,

I am writing to express to you my support for the approval of a certificate of need for Season's Hospice and Palliative care to provide Inpatient Hospice Services at Sinai Hospital. I am the Intensive Care Social Worker and Pulmonary Social Worker at Sinai Hospital. I have worked closely with all the hospice programs in the area. From my experiences I selfishly ask for you to support the program. Let me explain to you my challenge in delivering end-of-life care in the ICU.

Often families are faced with very difficult decisions including the decision to remove someone from a ventilator. When this occurs in the ICU, our services to the family stop after they leave the hospital. Today, I am waiting for a family to come to Sinai to remove their 40 year old daughter from the ventilator. Over the past 20 days we have worked hard to save her life and now are moving to support the family through this extremely difficult decision. The family will crowd into a room not set up to receive them. Their nurse will be coming in and out of the room as she has another critically ill patient to care for in the ICU. They would not have had the support of the music therapist. Once the patient passes away, I will call to check on the family sometime next week, however, my service ends there. The family will not have access to bereavement support on an ongoing basis over the next year.

We are good at saving lives and critical care. I have had limited success in having families accept hospice at Northwest with the Season's Program for terminal extubation, but most families are worried to transport their loved one and are even more afraid they will die in transit. When Season's was open briefly, I was able to refer families on a regular basis for terminal extubation. They were lovingly supported in a therapeutic environment with compassion and dignity. This is the value of Hospice and this is the gift that can be given to them when we have nothing else to offer.

If you need data, know that over the past two months our ICU has worked with slightly more than 20 patients and their families who could have received terminal extubation and end-of-life care. These patients were all on ventilators and families were faced with not escalating care or turning off the ventilator. Now, these twenty families have no bereavement support and will struggle through this next year without social work support, pastoral support, and bereavement counseling.

Please strongly consider that families are in need of this valuable service her at Sinai Hospital. Please support the certificate of need for Season's Hospice to open an inpatient unit here at Sinai. Thank you for the opportunity to advocate one last time for my terminally ill patients and their families.

Respectfully,

Kris Butcher, LCSW-C

Kris Butcher, LCSW-C
Intensive Care Social Worker

August 13, 2013

Ben Steffen
Executive Director Maryland Health Care Commission
4160 Patterson Ave
Baltimore MD 21215

RE: Seasons Hospice and Palliative Care Certificate of Need Application

Dear Director Steffen:

I am writing as an inpatient social worker on the Intermediate Care Unit (IMC) at Sinai Hospital to express my support for the approval of the certificate of need (CON) application from Seasons Hospice and Palliative Care to provide hospice services at Sinai Hospital. You have no doubt received letters citing statistics and numbers that concretize the need for this service. My letter speaks to the heart of this issue and why having an on-site hospice unit is so important to our patients.

As a social worker on the IMC at Sinai Hospital I coordinate services for and with many patients and families in need of the specialized care that hospice provides to those with end-stage and terminal conditions. Deciding to accept hospice care is not easy for most patients and families, as it symbolizes an acceptance of the futility of medical care and the looming reality that death is near. Having an on-site hospice unit allows us to ease families into this transition as they can tour the unit and talk with hospice staff thereby increasing confidence in their decision prior to discharge.

Families also recognize the risks and discomforts associated with transferring a loved one from Sinai to an outside hospice provider once hospice is accepted. Similarly, patients often want to remain near the physicians that have provided their care in the hospital. Even though these physicians do not manage hospice care, they are able to visit patients to provide support and a sense of continuity. For these reasons, patients and families often want to remain at Sinai to receive inpatient hospice services.

Approving the CON application for Seasons Hospice and Palliative Care goes beyond statistics and data; the heart of the matter is providing compassionate

Sinai Hospital / Case Management Department / 2401 West Belvedere Avenue / Baltimore, MD 21215 / 410.601.5578 phone / 410.601.5576 fax

services and seamless transition from one level of care to another so that patients and families know that they are being accompanied and supported on their difficult journey. As an inpatient social worker who is honored to walk with patients on this journey I appreciate your support through approval of the CON application.

Sincerely,

D. Vaughan, LCSW-C

Diana Vaughan, LCSW-C
Inpatient Social Worker

August 14, 2013

Ben Steffen
Executive Director
Maryland Healthcare Commission
4160 Patterson Ave.
Baltimore, MD 21215
(410) 764-3460

Dear Mr. Steffen,

I recently learned that the Seasons Hospice Inpatient Unit at Sinai Hospital closed in May. I was shocked and extremely disappointed. My dear friend, Gerald Letwin, was admitted to this facility on March 31, 2013. He died there on April 8, 2013. Seasons Hospice provided excellent care to Mr. Letwin, and it assisted his family and friends at a difficult time.

I understand that the facility is applying for a Certificate of Need so that it can be reopened to serve hospice patients at Sinai Hospital and the local community. Because of my experience with Seasons Hospice, I am writing to support its application to the Maryland Healthcare Commission.

After physicians at Harbor Hospital told us there was no further treatment for Mr. Letwin due to his advanced cancer, his sister and I began looking for a hospice facility. Home hospice was not an option because Mr. Letwin lived alone and his family was in New York. During the weekend, I called several facilities. None returned my call until Monday afternoon. When we contacted Sinai, they acted immediately and facilitated Mr. Letwin's transfer from the hospital to the Sinai Hospice Unit. The care this facility provided to Mr. Letwin and the consideration the staff extended to his family was remarkable. The staff at this facility was extremely competent and professional. To a person, they did their best to help Mr. Letwin, his family, and me through a traumatic and exhausting experience.

I am deeply concerned that other people in the situation we faced in April will not have the support that this facility extended to Mr. Letwin, his family, and me. When we look back and realize that this facility was open only from January to May, we recognize how fortunate we were that it was there when we needed it. This facility is needed in Baltimore. I hope my letter will assist the Commission in its consideration of the Seasons Hospice's application for a Certificate of Need.

Marcia E. Bove
1305 Towson Street
Baltimore MD 21230
410 752-3425 (home)
202 693-5598 (office)

Exhibit 8
Entities Owned or Controlled by Owners of Seasons

Ownership Interest or Stockholder

SUSAN L. STERN

PROVIDER	EFF. DATE OF OWNERSHIP
Seasons Hospice & Palliative Care of Michigan Inc 2755 John R, Ste. 100 Madison Heights, MI 48071	7/05
Seasons Hospice and Palliative Care of Texas, Inc. 5237 Riverside Dr. Ft. Worth, TX 76137	11/06
Seasons Hospice & Palliative Care of Massachusetts, LLC 275 Grove St. Three Riverside Plaza Ste. 3-100 Newton, MA 02416	6/07
Seasons Hospice & Palliative Care of Indiana, LLC 8888 Keystone Crossing Suite 1300 Indianapolis, IN 46240-4200	3/08
Seasons Hospice & Palliative Care of California LLC 2700 Foothill Blvd Ste. 300 Pasadena, CA 91107	07/08
Seasons Hospice & Palliative Care California-Orange, LLC 750 The City Dr. South Ste. 120 Orange, CA 92868	03/09
Seasons Hospice & Palliative Care of California-San Diego LLC 16745 West Bernardo Drive, Suite 140 San Diego, CA 92127-1908	
Seasons Hospice & Palliative Care of Southern Florida, Inc. 5200 NE 2nd Ave.	09/20/2010

PROVIDER	EFF. DATE OF OWNERSHIP
Miami, FL 30022	
Seasons Hospice & Palliative Care of Georgia, LLC 8560 Holcomb Bridge Road, Suite 110 Alpharetta, GA 30022-5988	01./31/201
Waterfront Terrace, Inc. 7750 South Shore Drive Chicago, IL 60649	04/83
Warren Park Nursing Pavilion, 6700 North Damen Chicago, IL 60645	03/90
Arbour Health Care Center, Inc. 1512 W. Fargo Chicago, IL 60626	12/88
Hickory Nursing Pavilion, Inc. 9246 South Roberts Road Hickory Hills, IL 60457	03/87
Seasons Hospice 606 Potter Road Des Plaines, IL 60016	07/02
Seasons Hospice and Palliative Care of Maryland 7008 Security Blvd. Suite 300 Baltimore, MD 21244	12/03
Seasons Hospice and Palliative Care of Wisconsin 4650 North Port Washington Rd. Milwaukee, WI 53212	11/02

SUSAN L. STERN OWNS LESS THEN A 5% INTEREST IN THE FOLLOWING ENTITIES:

The Renaissance at Hillside, Inc. 4000 North Frontage Road Hillside, IL 60162	07/97

Wood Glen Pavilion, L.L.C. 201 West North Avenue West Chicago, IL 60185	06/98
The Renaissance at South Shore 2425 East 71st Chicago, IL 60649	11/98
Renaissance at 87th Street 2940 West 87th Street Chicago, IL 60652	07/99
The Renaissance at Midway 4437 South Cicero Avenue Chicago, IL 60632	06/00
Cahokia Nursing & Rehabilitation Centre, Inc. 2 Annable Court Cahokia, IL 62206	11/00
Caseyville Nursing & Rehabilitation Centre, Inc. 601 West Lincoln Caseyville, IL 62232	11/00
Virgil Calvert Nursing & Rehabilitation Centre, Inc. 5050 Summit Avenue East St. Louis, IL 62202	11/00
Woodbridge Nursing Pavilion, Ltd. 2242 North Kedzie Chicago, IL 60647	11/00
Windmill Nursing Pavilion, Ltd. 16000 South Wabash South Holland, IL 60473	11/00
Sterling Pavilion, Ltd. 105 East 23rd Street Sterling, IL 61081	11/00
Atrium Health Care Center, Inc. 1425 West Estes Chicago, IL 60626	07/88
Countryside Healthcare Center, Inc. 1635 East 154th Street Dolton, IL 60419	11/90
Boulevard Care Center, Inc. 3405 South Michigan Chicago, IL 60616	05/87
Gilman Nursing Pavilion, LLC Route 45 South Gilman, IL 60938	11/00

Susan Stern as Trustee of the Todd A. Stern Trust 2001

Hospice/Address	Date of Interest
Seasons Hospice, Inc. 606 Potter Rd. Des Plaines, IL 60016	07/02
Seasons Hospice & Palliative Care of Maryland 7008 Security Blvd. Suite 300 Baltimore, MD 21244	12/03
Seasons Hospice & Palliative Care of Wisconsin 6737 W. Washington Street Suite 2150 West Allis, WI 53214	11/02
Seasons Hospice & Palliative Care of Delaware, LLC 200 Continental Dr. Ste 101 Newark, DE 19713	9/09
Seasons Hospice & Palliative Care of Michigan 2755 John R, Ste. 100 Madison Heights, MI 48071	7/05
Seasons Hospice & Palliative Care of Texas, Inc. 5237 N. Riverside Dr., Ste. 220 Ft. Worth, TX 76137	11/06
Seasons Hospice & Palliative Care of Massachusetts, LLC 275 Grove St. Ste. 3-100 Three Riverside Plaza Newton, MA 02416	6/2007
Seasons Hospice & Palliative Care of Indiana, LLC 8350 S. Emerson, Ste. 140 Indianapolis, IN 46237	3/2008
Seasons Hospice & Palliative Care of Pennsylvania, LLC 700 S, Henderson Rd. Ste 225 King of Prussia, PA 19406	8/08
Seasons Hospice & Palliative Care of California LLC 2700 Foothill Blvd Ste. 300 Pasadena, CA 91107	07/08
Seasons Hospice & Palliative Care California-Orange, LLC	03/09

750 The City Dr. South Ste. 120 Orange, CA 92868	
Seasons Hospice & Palliative Care of California-San Diego LLC 16745 West Bernardo Drive, Suite 140 San Diego, CA 92127-1908	11-2009
Seasons Hospice & Palliative Care of Southern Florida, Inc. 5200 NE 2nd Ave. Miami, FL 30022	09/2010
Seasons Hospice & Palliative Care of Georgia, LLC 8560 Holcomb Bridge Road, Suite 110 Alpharetta, GA 30022-5988	01/2011

Susan Stern, and her successors, as Trustee of the Jonathan Bryan Stern Trust

Hospice/Address	Date of Interest
Seasons Hospice, Inc. 606 Potter Rd. Des Plaines, IL 60016	07/02
Seasons Hospice & Palliative Care of Maryland 7008 Security Blvd. Suite 300 Baltimore, MD 21244	12/03
Seasons Hospice & Palliative Care of Wisconsin 6737 W. Washington Street Suite 2150 West Allis, WI 53214	11/02
Seasons Hospice & Palliative Care of Delaware, LLC 200 Continental Dr. Ste 101 Newark, DE 19713	9/09
Seasons Hospice & Palliative Care of Michigan 2755 John R, Ste. 100 Madison Heights, MI 48071	7/05
Seasons Hospice & Palliative Care of Texas, Inc. 5237 N. Riverside Dr., Ste. 220 Ft. Worth, TX 76137	11/06
Seasons Hospice & Palliative Care of Massachusetts, LLC	6/2007

275 Grove St. Ste. 3-100 Three Riverside Plaza Newton, MA 02416	
Seasons Hospice & Palliative Care of Indiana, LLC 8350 S. Emerson, Ste. 140 Indianapolis, IN 46237	3/2008
Seasons Hospice & Palliative Care of Pennsylvania, LLC 700 S, Henderson Rd. Ste 225 King of Prussia, PA 19406	8/08
Seasons Hospice & Palliative Care of California LLC 2700 Foothill Blvd Ste. 300 Pasadena, CA 91107	07/08
Seasons Hospice & Palliative Care California-Orange, LLC 750 The City Dr. South Ste. 120 Orange, CA 92868	03/09
Seasons Hospice & Palliative Care of California-San Diego LLC 16745 West Bernardo Drive, Suite 140 San Diego, CA 92127-1908	11-2009
Seasons Hospice & Palliative Care of Southern Florida, Inc. 5200 NE 2nd Ave. Miami, FL 30022	09/2010
Seasons Hospice & Palliative Care of Georgia, LLC 8560 Holcomb Bridge Road, Suite 110 Alpharetta, GA 30022-5988	01/2011

Susan L. Stern, Trustee of the Evan Michael Stern 2005 Trust

Hospice/Address	Date of Interest
Seasons Hospice, Inc. 606 Potter Rd. Des Plaines, IL 60016	07/02
Seasons Hospice & Palliative Care of Maryland 7008 Security Blvd. Suite 300 Baltimore, MD 21244	12/03
Seasons Hospice & Palliative	11/02

Care of Wisconsin 6737 W. Washington Street Suite 2150 West Allis, WI 53214	
Seasons Hospice & Palliative Care of Delaware, LLC 200 Continental Dr. Ste 101 Newark, DE 19713	9/09
Seasons Hospice & Palliative Care of Michigan 2755 John R, Ste. 100 Madison Heights, MI 48071	7/05
Seasons Hospice & Palliative Care of Texas, Inc. 5237 N. Riverside Dr., Ste. 220 Ft. Worth, TX 76137	11/06
Seasons Hospice & Palliative Care of Massachusetts, LLC 275 Grove St. Ste. 3-100 Three Riverside Plaza Newton, MA 02416	6/2007
Seasons Hospice & Palliative Care of Indiana, LLC 8350 S. Emerson, Ste. 140 Indianapolis, IN 46237	3/2008
Seasons Hospice & Palliative Care of Pennsylvania, LLC 700 S, Henderson Rd. Ste 225 King of Prussia, PA 19406	8/08
Seasons Hospice & Palliative Care of California LLC 2700 Foothill Blvd Ste. 300 Pasadena, CA 91107	07/08
Seasons Hospice & Palliative Care California-Orange, LLC 750 The City Dr. South Ste. 120 Orange, CA 92868	03/09
Seasons Hospice & Palliative Care of California-San Diego LLC 16745 West Bernardo Drive, Suite 140 San Diego, CA 92127-1908	11-2009
Seasons Hospice & Palliative Care of Southern Florida, Inc. 5200 NE 2nd Ave.	09/2010

Miami, FL 30022	
Seasons Hospice & Palliative Care of Georgia, LLC 8560 Holcomb Bridge Road, Suite 110 Alpharetta, GA 30022-5988	01/2011

Jack Rajchenbach

Bridgeview Health Care Ctr. Ltd 8100 S. Harlem Avenue Bridgeview, IL 60455	Jan-94
Carlton Associates Ltd. Partnership 6633 North Lincoln Avenue Lincolnwood, Illinois 60712	Aug-93
Claridge Imperial, Ltd. 6633 North Lincoln Avenue Lincolnwood, Illinois 60712	Jan-92
Claridge Lincoln Park, Ltd. 6633 North Lincoln Avenue Lincolnwood, Illinois 60712	Jan-92
Clark Manor Associates D/B/A Clark Manor Convai. Center 7433 North Clark Street Chicago, Illinois 60626	Nov-77
Clark Manor Conv. Center Inc. 7433 North Clark Street Chicago, Illinois 60626	Nov-97
Glenview Terrace Property LLC 1511 Greenwood Road Glenview, IL 60025	Dec-75
Grove Healthcare Properties LLC 9000 Lavergne Ave. Skokie, IL 60077	2008
Grove at Lincoln Park Living & Rehab Cente 2732 N. Hampden Court Chicago, IL 60614	2008

ROBERT HARTMAN

Medicare/Medicaid Ownership Schedule

NAME & ADDRESS OF FACILITY	DATE AQUIRED
CALIFORNIA GARDENS NURSING AND REHABILITATION CENTER 2829 South California Boulevard Chicago, Illinois 60608	7/94
CHEVY CHASE NURSING AND REHABILITATION CENTER 3400 South Indiana Avenue Chicago, Illinois 60616	7/94
CLAREMONT EXTENDED HEALTHCARE 150 Weiland Road Buffalo Grove, IL 60089	12/05
HARMONY NURSING & REHAB. CENTER 3919 West Foster Avenue Chicago, Illinois 60625	6/94
CLARIDGE IMPERIAL, LTD. dba THE IMPERIAL NURSING & REHAB 1366 West Fullerton Avenue Chicago, Illinois 60614	1/92

CLARIDGE LINCOLN PARK, LTD. dba THE IVY APARTMENTS AT THE IMPERIAL 2437 N. Southport Avenue Chicago, Illinois 60614	1/92
JACKSON SQUARE NURSING AND REHABILITATION CENTER 5130 West Jackson Boulevard Chicago, Illinois 60644	7/94
MONORE PAVILION HEALTH AND TREATMENT CENTER 1400 West Monroe Street Chicago, Illinois 60632	7/94
SEASONS HOSPICE, INC. 606 Potter Road Des Plaines, IL 60016	1/97
SEASONS HOSPICE & PALLIATIVE CARE OF CALIFORNIA, INC. 973 Vale Terrace, Suite 300 Pasadena, CA 91107	07/08
SEASONS HOSPICE & PALLIATIVE CARE OF DELAWARE, INC. 20 Continental Drive, Suite 101 Newark, DE 19713	08/08

SEASONS HOSPICE & PALLIATIVE CARE OF INDIANA, INC. 8350 S. Emerson Avenue, Suite 140 Indianapolis, IN 46237	7/17/2009
SEASONS HOSPICE & PALLIATIVE CARE OF MARYLAND, INC. 7008 Security Boulevard Baltimore, MD 21244	12/1/2003
SEASONS HOSPICE & PALLIATIVE CARE OF MASSACHUSETTS, INC. 275 Grove Street, Suite 3-100 Newton, MA 02466	5/23/2007
SEASONS HOSPICE & PALLIATIVE CARE OF PENNSYLVANIA HOLDING, INC. 700 Henderson Road, Suite 225 King of Prussia, PA 19406	08/08
SEASONS HOSPICE & PALLIATIVE CARE OF MICHIGAN, INC. 27355 John R Road, Suite 100 Madison Heights, MI 48071	01/06
SEASONS HOSPICE & PALLIATIVE CARE OF WISCONSIN, INC. 4650 N. Port Washington Rd. Milwaukee, WI 53212	11/02

SEASONS HOSPICE & PALLIATIVE CARE OF SOUTHERN FLORIDA, INC.	9/20/2010
SEASONS HOSPICE & PALLIATIVE CARE OF TEXAS, INC. 5237 N. Riverside Drive, Suite 220 Ft. Worth, TX 76137	05/08
SEASONS HOSPICE & PALLIATIVE CARE OF WISCONSIN, INC. 4650 N. Port Washington Road Milwaukee, WI 53212	11/02

Marshall A. Mauer

PROVIDER NAME:
Woodbridge Nursing Pavilion, Ltd. 2242 North Kedzie Boulevard Chicago, Illinois 60647
Waterfront Terrace, Inc. 7750 South Shore Drive Chicago, Illinois 60649
Windmill Nursing Pavilion, Ltd. 16000 Wabash South Holland, Illinois 60473
Warren Park Nursing Pavilion, Ltd. 6700 North Damen Avenue Chicago, Illinois 60645
Bridgeview Health Care Center, Ltd. 8001 South Harlem Avenue Bridgeview, Illinois 60455
Willow Crest Nursing Pavilion, Ltd. 515 North Main Street Sandwich, Illinois 60548
Sterling Pavilion, Ltd. 205 East 23rd Street Sterling, Illinois 61081
Ottawa Pavilion, Ltd. 800 East Center Street Ottawa, Illinois 61350
Gilman Nursing Pavilion, LLC 1390 South Crescent Street Gilman, Illinois 60938
The Renaissance at Hillside, Inc. 4600 Frontage Road Hillside, Illinois 60162
The Renaissance at South Shore

PROVIDER NAME:
2425 East 71st Street Chicago, Illinois 60649
Renaissance at 87th Street 2940 West 87th Street Chicago, Illinois 60652
Hickory Nursing Pavilion, Inc. 4437 South Cicero Avenue Chicago, Illinois 60632
Lincoln Medical Supplies, Inc. 3359 West Main Street Skokie, Illinois 60076
Provider Name
Seasons Hospice 606 Potter Road Des Plaines, IL 60016
Seasons Hospice & Palliative Care of Wisconsin 4650 North Port Washington Rd. Milwaukee, WI 53212
Seasons Hospice & Palliative Care of Maryland 7008 Security Blvd – Ste. 300 Baltimore, MD 21244
Seasons Hospice & Palliative Care of Michigan, Inc 27355 John R Road, Suite 100 Madison Heights, MI 48071
Seasons Hospice & Palliative Care of Texas, Inc 5237 Riverside Dr. Ft. Worth, Tx 76137

Maurice I. Aaron

PROVIDER NAME:
Cahokia Nursing & Rehabilitation Centre, Inc. Two Annabelle Court Cahokia, Illinois 62206
Caseyville Nursing & Rehabilitation Centre, Inc. 601 West Lincoln Avenue Caseyville, Illinois 62232
Virgil Calvert Nursing & Rehabilitation Centre, Inc. 5050 Summit Avenue East St. Louis, Illinois 62205
Woodbridge Nursing Pavilion, Ltd. 2242 North Kedzie Boulevard Chicago, Illinois 60647
Waterfront Terrace, Inc. 7750 South Shore Drive Chicago, Illinois 60649
Windmill Nursing Pavilion, Ltd. 16000 Wabash South Holland, Illinois 60473
Warren Park Nursing Pavilion, Ltd. 6700 North Damen Avenue Chicago, Illinois 60645
Bridgeview Health Care Center, Ltd.

PROVIDER NAME:
8001 South Harlem Avenue Bridgeview, Illinois 60455
Willow Crest Nursing Pavilion, Ltd. 515 North Main Street Sandwich, Illinois 60548
Sterling Pavilion, Ltd. 205 East 23rd Street Sterling, Illinois 61081
Ottawa Pavilion, Ltd. 800 East Center Street Ottawa, Illinois 61350
Arbour Health Care Center, Inc. 1512 West Fargo Chicago, Illinois 60626
Hickory Nursing Pavilion, Inc. 4437 South Cicero Avenue Chicago, Illinois 60632
Countryside Healthcare Center, Inc. 1635 East 154th Street Dolton, Illinois 60419
Boulevard Care Center, Inc. 3405 South Michigan Avenue Chicago, Illinois 60616
Gilman Nursing Pavilion, LLC 1390 South Crescent Street Gilman, Illinois 60938
Renaissance at 87th Street 2940 West 87th Street Chicago, Illinois 60652
The Renaissance at Hillside, Inc. 4600 Frontage Road Hillside, Illinois 60162
The Renaissance at South Shore 2425 East 71st Street Chicago, Illinois 60649
Lincoln Medical Supplies, Inc. 3359 West Main Street Skokie, Illinois 60076
Seasons Hospice 606 Potter Road Des Plaines, IL 60016
Seasons Hospice & Palliative Care of Wisconsin 4650 North Port Washington Rd. Milwaukee, WI 53212
Seasons Hospice & Palliative Care of Maryland 7008 Security Blvd – Ste. 300 Baltimore, MD 21244

Fred L. Aaron

PROVIDER NAME:
Woodbridge Nursing Pavilion, Ltd. 2242 North Kedzie Boulevard Chicago, Illinois 60647
Warren Park Nursing Pavilion, Ltd.

PROVIDER NAME:
6700 North Damen Avenue Chicago, Illinois 60645
Willow Crest Nursing Pavilion, Ltd. 515 North Main Street Sandwich, Illinois 60548
Sterling Pavilion, Ltd. 205 East 23rd Street Sterling, Illinois 61081
Gilman Nursing Pavilion, LLC 1390 South Crescent Street Gilman, Illinois 60938
Lincoln Medical Supplies, Inc. 3359 West Main Street Skokie, Illinois 60076
Seasons Hospice 606 Potter Road Des Plaines, IL 60016
Seasons Hospice & Palliative Care of Wisconsin 4650 North Port Washington Rd. Milwaukee, WI 53212
Seasons Hospice & Palliative Care of Maryland 7008 Security Blvd – Ste. 300 Baltimore, MD 21244

Exhibit 9
Affirmations

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

Signature

9/9/13
Date

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

Signature

9-5-13

Date

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

Gary Appleberm MD

Signature

9/9/13

Date

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

RN/CD

9/5/13

Signature

Date

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

Signature

9/4/2013
Date