MARYLAND HEALTH CARE COMMISSION

12-16-2334
MATTER/DOCKET NO.

June 29, 2012
DATE DOCKETED

HOSPITALS
UPDATED APPLICATION FOR CERTIFICATE OF NEED

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

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1.a. Fort Washington Medical Center
Legal Name of Project Applicant
(i.e. Licensee or Proposed Licensee)

b. 11711 Livingston Road
Street

c. Ft. Washington 20744 Pr. George's
City Zip County

d. 301-686-9010
Telephone

e. Verna S. Meacham, President and CEO
Name of Owner/Chief Executive

3.a. Fort Washington Medical Center
Name of Facility

b. 11711 Livingston Road
Street (Project Site)

c. Ft. Washington 20744 Pr. George's
City Zip County

4. Nexus Health, Inc.
Name of Owner (if different than applicant)

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

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.	Verna S. Meacham President and CEO Name and Title	a. Name and Title
b.	174 Waterfront Street, Suite 225 Street	b. Street
c.	Oxon Hill 20745 Prince George's City Zip County	c. City Zip County
d.	301-686-9010 Telephone No.	d. Telephone No.
e.	301-686-1539 Fax No.	e. Fax No.
f.	vmeacham@nexushealth.org E-mail Address	f. E-mail address

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

This updated project involves new construction and renovation on the existing campus of Fort Washington Medical Center, an acute care general hospital licensed for 31 beds. A new two story addition will be built onto the front of the Hospital to house an expanded Emergency Department on the first level, and 14 additional patient rooms on the second level. At the rear of the Hospital, a new energy building and surgery addition will be built. Additional new construction will also be undertaken for an expanded front entrance/lobby addition, and an expanded cafeteria and new Hospital kitchen. Renovations will be undertaken in areas located adjacent to the new construction, as well as in selected clinical and support areas of the existing Hospital building. Only two changes have been made to the Project: first, the budget has been updated to reflect the increased cost of the project, and $35,000 of kitchen equipment will be installed in the hospital prior to the completion of the project.

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

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

9. Current Physical Capacity and Proposed Changes: (Staff will also provide separately a detailed spreadsheet on which the applicant will display current and proposed physical bed capacity by location.) **See Detailed Spreadsheet at Attachment 1.**

Service	Current Physical Beds	Beds to be Added or Reduced	Total Beds if Project is Approved
M/S/G/A	33	+14	47
Pediatrics			
Obstetrics			
ICU/CCU Care	4		4
Psychiatry			
TOTAL BEDS	37	+14	51

10. Project Location and Site Control:

A. Site Size 8.94 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.)

C. Site Control:

(1) Title held by: Ft. Washington Medical Center, Inc.

(2) Options to purchase held by: **Not Applicable**
(i) Expiration date of option _____
(ii) Is option renewable? _____ If yes, please explain
_____
_____
(iii)Cost of Option _____

(3) Land Lease held by: **Not Applicable**
(i) Expiration date of lease _____
(ii) Is lease renewable _____ If yes, please explain
_____
_____
(iii)Cost of Lease _____

(4) Option to lease held by: **Not Applicable**
(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 **Not Applicable**

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

11. Project Implementation Target Dates (for construction or renovation projects):
    - A. Obligation of Capital Expenditure **12** months from approval date.
    - B. Beginning Construction **1** months from capital obligation.
    - C. Pre-Licensure/First Use **24** months from capital obligation.
    - D. Full Utilization **12** months from first use.

12. 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.

13. Project Implementation Target Dates (for new service projects not involving a capital expenditure):
    - 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. Describe the project's construction and renovation plan, and all services to be provided following completion of the project.

    See Attachment 2 for updated description of the project's construction and renovation plan.

15. Project Drawings:

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

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

    Project Drawings have not changed from those previously submitted.

16. Features of Project Construction:

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

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

Not Applicable

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.

Not Applicable. Currently sufficient availability and capacity.

UPDATED Chart 1. Project Construction Characteristics and Costs*			
Base Building Characteristics	Complete if Applicable		
	NEW CONSTRUCTION		
	ED Addition	Surgery Addition	MS Bed Addition
Class of Construction			
Class A	X	X	X
Class B			
Class C			
Class D			
Type of Construction/Renovation			
Low			
Average			
Good	X	X	X
Excellent			
Number of Stories	1	1	1
Total Square Footage			
First Floor	8,127	1,660	
Second Floor			6,617
Third Floor			
Perimeter in Linear Feet			
First Floor	435	200	
Second Floor			435
Third Floor			
Wall Height (floor to eaves)			
First Floor	13	16	
Second Floor			13
Third Floor			
Elevators			
Type *Passenger Freight*			
Number			
Sprinklers (Wet or Dry System) Wet			
Type of HVAC System	Central/VAV w/Reheat	Central/VAV w/Reheat	Central/VAV w/Reheat
Type of Exterior Walls	Curtainwall & Brick Veneer	Curtainwall & Brick Veneer	Curtainwall & Brick Veneer

UPDATED Chart 1. Project Construction Characteristics and Costs*			
Base Building Characteristics	Complete if Applicable		
	NEW CONSTRUCTION		
	Lobby/Front Entrance	Energy Building	Dietary/Kitchen
Class of Construction			
Class A	X	X	X
Class B			
Class C			
Class D			
Type of Construction/Renovation			
Low			
Average			
Good	X	X	X
Excellent			
Number of Stories	1	1	1
Total Square Footage			
First Floor	1,238	3,000	2,267
Second Floor			
Third Floor			
Perimeter in Linear Feet			
First Floor	257	265	303
Second Floor			
Third Floor			
Wall Height (floor to eaves)			
First Floor	14	20	14
Second Floor			
Third Floor			
Elevators			
Type *Passenger Freight*			
Number			
Sprinklers (Wet or Dry System) Wet			
Type of HVAC System	Central/VAV w/Reheat	Central/VAV w/Reheat	Central/VAV w/Reheat
Type of Exterior Walls	Curtainwall & Brick Veneer	Curtainwall & Brick Veneer	Curtainwall & Brick Veneer

UPDATED Chart 1. Project Construction Characteristics and Costs*			
Base Building Characteristics	Complete if Applicable		
	RENOVATIONS		
	ED Addition	Surgery Addition	MS Bed Addition
Class of Construction			
Class A	X	X	X
Class B			
Class C			
Class D			
Type of Construction/Renovation			
Low			
Average			
Good	X	X	X
Excellent			
Number of Stories	1	1	1
Total Square Footage			
First Floor	1,102	1,112	
Second Floor			450
Third Floor			
Perimeter in Linear Feet			
First Floor	435		
Second Floor			435
Third Floor			
Wall Height (floor to eaves)			
First Floor	13	16	
Second Floor			13
Third Floor			
Elevators			
Type *Passenger Freight*			
Number			
Sprinklers (Wet or Dry System) Wet			
Type of HVAC System	Central/VAV w/Reheat	Central/VAV w/Reheat	Central/VAV w/Reheat
Type of Exterior Walls	Curtainwall & Brick Veneer	Curtainwall & Brick Veneer	Curtainwall & Brick Veneer

UPDATED Chart 1. Project Construction Characteristics and Costs*			
Base Building Characteristics	Complete if Applicable		
	RENOVATIONS		
	Lobby/Front Entrance		Dietary/Kitchen
Class of Construction			
Class A	X		X
Class B			
Class C			
Class D			
Type of Construction/Renovation			
Low			
Average			
Good	X		X
Excellent			
Number of Stories	1		1
Total Square Footage			
First Floor	2,856		2,590
Second Floor			
Third Floor			
Perimeter in Linear Feet			
First Floor	270		303
Second Floor			
Third Floor			
Wall Height (floor to eaves)			
First Floor	14		14
Second Floor			
Third Floor			
Elevators			
Type *Passenger Freight*			
Number			
Sprinklers (Wet or Dry System) Wet			
Type of HVAC System	Central/VAV w/Reheat		Central/VAV w/Reheat
Type of Exterior Walls	Curtainwall & Brick Veneer		Curtainwall & Brick Veneer

*Project Space Allocations and Specifications have not changed from those previously submitted.

Chart 1. UPDATED Project Construction Characteristics and Costs (cont.)**		
	New Const. Costs	Renovation Costs
Site Preparation Costs	$	
Normal Site Preparation*	34,123	
Demolition	30,834	
Storm Drains	7,708	
Rough Grading	7,709	
Relocate Existing Utilities	47,536	
Relocate Existing Trailers	25,695	
Relocate Existing Donor Wall	15,417	
Site Paving Repairs	16,702	
Offsite Costs		
Roads		
Utilities		
Jurisdictional Hook-up Fees	51,390	
Signs	5,139	
Landscaping	30,834	
Site Lighting	35,973	
Extended Run from Oxygen Farm	25,695	
Extended Run from Central Plant	52,675	21,121
Replace Existing 125kW Generator Capacity		96,356
Rezone Existing Sprinkler/Fire Alarm		18,500
Temporary Waiting Area		128,347
Extraordinary Costs	$282,825	$338,300

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

****Current cost estimates updated to June, 2014 to correspond to most currently applicable MVS.**

PART II – UPDATED PROJECT BUDGET (JUNE, 2014 DOLLARS)
(INSTRUCTION: All estimates for 1.a.-d., 2.a.-h., and 3 are for current costs as of the date of application submission* and should include the costs for all intended construction and renovations to be undertaken. DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. Use of Funds

1. Capital Costs:

a.	New Construction		
(1)	Building	$	7,400,449
(2)	Fixed Equipment (not included in construction)	$	1,057,201
(3)	Land Purchase	$	
(4)	Site Preparation	$	604,302
(5)	Architect/Engineering Fees	$	1,087,429
(6)	Permits, (Building, Utilities, Etc)	$	181,240
SUBTOTAL		**$**	**10,330,621**
b.	Renovations		
(1)	Building	$	1,887,515
(2)	Fixed Equipment (not included in construction)	$	96,363
(3)	Architect/Engineering Fees	$	238,420
(4)	Permits, (Building, Utilities, Etc.)	$	39,737
SUBTOTAL		**$**	**2,265,035**
c.	Other Capital Costs		
(1)	Major Movable Equipment	$	1,531,680
(2)	Minor Movable Equipment	$	522,230
(3)	Contingencies	$	1,558,563
(4)	Other (Specify)	$	
	Furnishings	$	359,760
	Signs	$	63,870
	IT Services	$	159,670
	Relocation Expense	$	154,180
	Security System	$	95,800
	Certifications, Testing & Inspections	$	51,390
	Other Misc.	$	51,390
SUBTOTAL		$	**4,548,533**
TOTAL CURRENT CAPITAL COSTS (a. + b. + c.)		$	**17,144,189**
d.	Non Current Capital Cost		
(1)	Interest (Gross)	$	737,825
(Amount Related to Post Construction)		$	(160,000)
(2)	Inflation (2.7% for 2012 – 2014 Midpoint of construction)	$	930,986
SUBTOTAL		**$**	**1,508,811**
TOTAL PROPOSED CAPITAL COSTS		$	**18,653,000**

2. Financing Cost and Other Cash Requirements:

a.	Loan Placement Fees	$ 963,000
b.	Bond Discount	
c.	Legal Fees (CON Related)	
d.	Legal Fees (Other)	
e.	Printing	
f.	Consultant Fees	
	CON Application Assistance	$ 150,000
	Other (Specify)	
g.	Liquidation of Existing Debt	
h.	Debt Service Reserve Fund	
i.	Principal Amortization Reserve Fund	
j.	Other (HUD AMPO Fund)	384,000
	TOTAL (a - j)	$ 1,497,000
3.	Working Capital Startup Costs	$
4.	Amount Borrowed for Interest Payments Following Completion of Construction	160,000
	TOTAL USES OF FUNDS (1 - 3)	$ 20,310,000

B. Sources of Funds for Project:

1.	Cash	$ 560,000
2.	Pledges: Gross _____, less allowance for uncollectables _____ = Net	
3.	Gifts, bequests	
4.	Interest income (gross)	
5.	Authorized Bonds	
6.	Mortgage	19,190,000
7.	Working capital loans	
8.	Grants or Appropriation	
	(a) Federal	
	(b) State Grant for ED Project	560,000
	(c) Local	
9.	Other (Specify)	
	TOTAL SOURCES OF FUNDS (1-9)	$ 20,310,000

Lease Costs:

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

*** Current cost estimates Updated to June, 2014 to correspond to most currently applicable MVS.**

Notes to Project Budget:

1. The $1,558,563 in contingencies (line 1c(3)) represents 10% of the total current capital costs.

2. The CON Project Budget presents $577,825 as capitalized construction period interest based on 5.0% interest during the construction period applied to the cumulative balance of the HUD Construction Mortgage. Issuance costs of $1,113,000 (total of Project Budget Line 2a Loan Placement Fees - $963,000; and Line 2f CON Application Assistance -$150,000) are assumed to be funded at closing through $560,000 by FWMC cash/equity and $553,000 by the HUD Construction Mortgage. Project construction expenditures funded by the HUD Construction Mortgage amount to $17,515,155 (Project Budget Lines 1(a-c) Current Capital Costs - $17,144,169; plus Line 1(d)(2) Inflation Allowance - $930,986; less Line B(3) State of Maryland ED Grant - $560,000) and are assumed to be level over the 15.40 month construction period. The AMPO fund is assumed to be funded at the end of the construction period.

3. The Project Budget Line 1d(1) includes $160,000 for two months of post construction period interest that is assumed to be funded by the HUD Construction Mortgage. The interest expense for the first two months after the end of the construction period is approximately $80,000 per month based on amortizing the Taxable FHA/GNMA Debt at level debt service over a term of 25 years (300 months) at 5.0% interest. Monthly debt service amounts to $112,183. The $160,000 of post construction period interest expense allowed to be funded by the HUD Construction mortgage is also shown as a working capital use of funds on the Project Budget Line A3 and is included in the total Taxable FHA/GNMA Debt of $19,190,000 on Project Budget Line B6.

4. In this Project financing plan, trustee-held funds are not funded at closing or during the construction period; therefore, interest income was not included as a source of funding for this project. Funding for the Mortgage Reserve Fund required by the Taxable FHA/GNMA Debt will start after the end of construction. The required funding was projected in amounts sufficient to build to one annual mortgage payment after 5 years and 2 annual mortgage payments after 10 years. The HUD AMPO Fund is fully funded by the HUD Construction Mortgage at the very end of the construction period.

5. Chart 2: Interest Rate Assumption Update:

Total Current Capital Costs		Current	Inflation	Allowance
excludes permits; A&E fees		$ 13,836,497	14,790,770	$ 954,273
Inflation				
2013	2.7%	14,210,082		
2014	2.7%	14,593,754		
2015	1.4%	14,790,770		

6. The HUD AMPO Fund is a restricted fund required to be funded by the Taxable FHA/GNMA Debt proceeds (and is disclosed on the Project Budget Line 2j - $384,000). The HUD AMPO Fund generally is available to reimburse the hospital for equipment purchases after the project is operational.

A portion of the $1,000,000 of capital acquisitions projected during year 2015 is assumed to be funded by the $384,000 balance in the HUD AMPO Fund. (HUD requires a contingency type of fund just in case overruns are incurred in order to make the project operational; these contingency type funds are assumed to be spent for non-Project equipment which is usually how the funds are expended).

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

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

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

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

GENERAL STANDARDS
COMAR 10.24.10.04

A. General Standards.
The following general standards encompass Commission expectations for the delivery of acute care services by all hospitals in Maryland. Each hospital that seeks a Certificate of Need for a project covered by this Chapter of the State Health Plan must address and document its compliance with each of the following general standards as part of its Certificate of Need application. Each hospital that seeks a Certificate of Need exemption for a project covered by this Chapter of the State Health Plan must address and demonstrate consistency with each of the following general standards as part of its exemption request.

(1) Information Regarding Charges.
Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:
(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;
(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and
(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

FWHC's Updated Response to Standard (1) Information Regarding Charges.

Upon request, FWMC provides a Representative List of Services and Charges and will readily respond to individual requests for current charges for specific services and procedures. The Representative List is kept current whenever prices change. The Hospital has adopted procedures for promptly responding to individual request for prices, and training the staff to ensure adequate handling of these inquiries. These procedures and policies have not changed since previously submitted procedures and policies were submitted.

The Hospital's website, www.fortwashingtonmedicalcenter.org, shows the estimated average hospital charges for common procedures, and is updated quarterly.

See Attachment 3 for the charge disclosure policy and the current Representative List of Charges.

(2) Charity Care Policy.
Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.
(a) The policy shall provide:
(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.
(ii) Minimum Required Notice of Charity Care Policy.
1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;
2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital; and
3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.
(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

FWMC's Updated Response to Standard (2) Charity Care Policy.

The Hospital's Financial Assistance Policy addresses all the requirements of the Standard and is found at Attachment 3. Notices regarding the Hospital's charity care policy are posted in the admissions office, business office, and emergency department areas within the Hospital.

With respect to the level of charity care, as defined in the Standard, FWMC's level was 3.2% in FY 2013 in the most recent HSCRC Community Benefit Report (HSCRC website accessed on August 28, 2014), as compared to 3.8% for all of the Maryland hospitals regulated by the HSCRC.

(3) Quality of Care.
An acute care hospital shall provide high quality care.
(a) Each hospital shall document that it is:
(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;
(ii) Accredited by the Joint Commission; and
(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.
(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

FWMC's Updated Response to Standard (3) Quality of Care.

FWMC is licensed by the Maryland Department of Health and Mental Hygiene, is accredited by the Joint Commission, and is in compliance with the conditions of participation of the Medicare and Medicaid programs. FWMC's licensure and accreditation status has not changed since previously documented in the record of this project review.

FWMC has reviewed the measure values for the Quality Measures included in the most recent update of the Maryland Hospital Performance Evaluation Guide.

FWMC performed over the 90% level on all but one of the 16 quality measures for which data are available in the most recent publication of the MHCC's Maryland Hospital Performance Evaluation Guide published on the MHCC website.[1]

The scores are shown below:

Chart 3. FWMC Measure Values

	Measure	FWMC Performance
Heart Attack (AMI) Performance Over Time		
	Giving Aspirin – Arrive	N/A
	Giving Aspirin – Leave	N/A
	Giving Recommended Meds	N/A
	Beta Blockers – Leave	N/A
	Time to PCI	N/A

1 http://184.80.193.37/consumerinfo/hospitalguide/index.htm

Heart Failure Performance Over Time		
	Giving Instructions – Leave	100%
	Performing Heart Test	99%
	Giving Recommended Meds	96%
Immunization		
	Pneumococcal Immunization	93%
	Influenza Immunization	90%
Pneumonia (PN)		
	Blood Cultures	94%
	Appropriate Antibiotic	100%
Surgical Care Improvement Project (SCIP) Performance		
	Prophylactic Antibiotic	100%
	Antibiotic Selection	99%
	Antibiotic Discontinuation	92%
	Cardiac Surgery	N/A
	Surgery Patient Hair Removal	100%
	Urinary Catheter Removal	92%
	Surgery Patients Temp. Manage.	100%
Managing Heart Drugs		
	Surgery Patient Beta-Blocker	88%
Preventing Blood Clots		
	Treatment to Prevent Blood Clots	100%
	Appropriate Time to Prevent Clots	100%

FWMC has taken steps to address core quality measure performance. The relevant steps for the measure for which FWMC performed under 90% are addressed below:

[COMPLETE RESPONSE TO BE SUBMITTED IN SUPPLEMENTARY FILING]

B. Project Review Standards.
The standards in this section are intended to guide reviews of Certificate of Need applications and exemption requests involving acute care general hospital facilities and services. An applicant for a Certificate of Need must address, and its proposed project will be evaluated for compliance with, all applicable review standards. An applicant for a Certificate of Need exemption must address, and its proposed project will be evaluated for consistency with, all applicable review standards.

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(1) Geographic Accessibility.
A new acute care general hospital or an acute care general hospital being replaced on a new site shall be located to optimize accessibility in terms of travel time for its likely service area population. Optimal travel time for general medical/surgical, intensive/critical care and pediatric services shall be within 30 minutes under normal driving conditions for 90 percent of the population in its likely service area.

FWMC's Updated Response Standard (1) Geographic Accessibility.

Although this project is not a new acute care general hospital, or the replacement of a new acute care general hospital on a new site, the State Health Plan travel time access standard is currently met for 90% of FWMC's service area population, and will continue to be met if the proposed project is approved and implemented.

(2) Identification of Bed Need and Addition of Beds.
Only medical/surgical/gynecological/addictions ("MSGA") beds and pediatric beds identified as needed and/or currently licensed shall be developed at acute care general hospitals.
(a) Minimum and maximum need for MSGA and pediatric beds are determined using the need projection methodologies in Regulation .05 of this Chapter.
(b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients is included in the MSGA need projection.
(c) Additional MSGA or pediatric beds may be developed or put into operation only if:
(i) The proposed additional beds will not cause the total bed capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital made pursuant to Health-General §19-307.2; or
(ii) The proposed additional beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter; or
(iii) The proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection; or
(iv) The number of proposed additional MSGA or pediatric beds may be derived through application of the projection methodology, assumptions, and targets contained in Regulation .05 of this Chapter, as applied to the service area of the hospital.

FWMC's Updated Response to Standard (2) Identification of Bed Need and Addition of Beds.

There are currently 595 licensed MSGA beds located in the five acute care general hospitals in Prince George's County. The minimum jurisdictional MSGA bed need projection adopted by the Commission for 2022 is 487; the maximum is 663. The Minimum and Maximum Net MSGA bed need is -108 and +68, respectively.

FWMC is not proposing to add licensed MSGA beds as part of this project. Currently, FWMC is licensed for 31 MSGA beds. The 29 licensed MSGA beds that will be put into operation at FWMC in 2019 is projected to be 2 fewer than the number currently licensed. (See TABLE 1.) Therefore, this standard is not applicable.

(3) Minimum Average Daily Census for Establishment of a Pediatric Unit.
An acute care general hospital may establish a new pediatric service only if the projected average daily census of pediatric patients to be served by the hospital is at least five patients, unless:
(a) The hospital is located more than 30 minutes travel time under normal driving conditions from a hospital with a pediatric unit; or
(b) The hospital is the sole provider of acute care general hospital services in its jurisdiction.

FWMCs Updated Response (3) Minimum Average Daily Census for Establishment of a Pediatric Unit.

This Standard is not applicable.

(4) Adverse Impact.
A capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The Commission will grant a Certificate of Need only if the hospital documents the following:
(a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and
(b) If the project reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish, for the population in the primary service area, the availability or accessibility to care, including access for the indigent and/or uninsured.

FWMCs Updated Response to Standard (4) Adverse Impact.

The proposed project will not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The Hospital will agree not to seek a rate increase for the capital costs associated with this Project consistent with the terms of the Global Budget Revenue Agreement between FWMC and the HSCRC (July 16, 2014). See Attachment 4. The Project will likely have no impact on the costs and charges at other hospitals in the area.

The Project will increase, not reduce, the potential availability and accessibility to care for residents of the Hospital's service area population.

(5) Cost-Effectiveness.
A proposed hospital capital project should represent the most cost effective approach to meeting the needs that the project seeks to address.
(a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:
(i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;
(ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and
(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.
(b) An applicant proposing a project involving limited objectives, including, but not limited to, the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization, may address the cost-effectiveness of the project without undertaking the analysis outlined in (a) above, by demonstrating that there is only one practical approach to achieving the project's objectives.
(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:
(i) That it has considered, at a minimum, an alternative project site located within a Priority Funding Area that provides the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);
(ii) That it has quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed project site;
(iii) That it has detailed the capital and operational costs associated with implementing the project at each alternative project site and at the proposed project site, with a full accounting of the cost associated with transportation system and other public utility infrastructure costs; and
(iv) That the proposed project site is superior, in terms of cost effectiveness, to the alternative project site or sites located within a Priority Funding Area.

FWMC's Updated Response to Standard (5) Cost-Effectiveness.

The primary objectives of the project are to improve the facilities of FWMC to provide inpatient and outpatient community hospital services, and to expand the capacity to do so in order to address the needs of patients who come to FWMC for their care.

The proposed Project represents a second plan for expanding and improving the facilities of FWMC and has been determined to be the most cost-effective approach to meeting the need that the Project seeks to address in maximizing quality and access to care for the service population. The first plan, a CON-approved project involving the construction of several large additions to the Hospital, was not able to be implemented.

The Project that was approved by the Commission in 2006 is considered one alternative for achieving these objectives. The second alternative considered and rejected by the leadership of FWMC was to only improve and expand the Emergency Department of the Hospital. The third, and preferred alternative, is the project currently under review.

In many respects, the current project described in this application, seeks to achieve the same objectives reviewed and approved by the Commission for the previously submitted project. These include: expanding the number of private patient rooms in the hospital; expanding the capacity of the Emergency Department; and expanding and improving the surgical department of the Hospital.

As was the case with the earlier project, FWMC has identified numerous limitations of its current facility, some of which continue to impede its ability to address present and future needs and to improve its effectiveness in the delivery of its services. In addition, as before, the Hospital intends to address the changing demand for its services, both inpatient and outpatient, as well as address the patient and physician preferences for increased levels of privacy and confidentiality. These demands cannot be adequately met in the Hospital's existing facility, and will be addressed in the Project through a combination of new construction and renovations as proposed in this application.

Among the limitations to be corrected by this project are the following:

1) insufficient space and treatment rooms/bays to accommodate the

projected number of emergency room visits;

2) an insufficient number of single patient rooms to assure the level of privacy and dignity afforded to patients at other Maryland hospitals;
3) an insufficient amount of future expansion capacity for Hospital infrastructure that do not have sufficient capacity today;
4) an insufficient number of isolation rooms in the Hospital to address the needs of infectious patients;
5) lack of operating rooms of sufficient size to meet existing AIA standards;
6) insufficient storage space requiring equipment to be stored in hallways and temporary buildings; and
7) insufficient space in patient rooms to provide family-centered care

These deficiencies of the Hospital were discussed in the Recommended Decision, Fort Washington Medical Center, Expansion and Renovation Project, Docket No. 05-16-2171, We urge the Commission to take administrative notice of its earlier findings during the course of the review of this application.

Specifically, the Commission found that Fort Washington's existing physical plant is older than the statewide average of all Maryland hospitals, is small at less than 700 square feet per bed, and its inadequate size is most obvious in the nursing units, the Emergency Department, and the Surgery Department. The Hospital's nursing units were found to be "significantly below" the Commission's standards for both its Intensive Care Unit and its general Medical/Surgical Unit.

The Commission made specific findings with respect to the deficiencies of the existing FWMC surgery department. "With respect to the Surgery Department, FWMC's four operating rooms, originally designed and constructed in the early 1980s for ambulatory surgery, range in size from 248 square feet to 349 square feet" (p. 2). These dimensions were found to be well below the guidelines for the construction of new operating rooms published by the American Institute of Architects.

The Commission made specific findings with respect to the deficiencies of the existing FWMC Emergency Department in terms of overall size and the number of treatment rooms, and described the Emergency Department as "extremely busy" in FY 2005, when the hospital reported 1,922 visits per treatment space, which ranked third in the State, compared to a statewide average of 1,387.

Suffice it to say that since 2005, FWMC has gone well beyond being "extremely busy," if such a term is possible, as it reported over 41,000 visits in CY 2013, in the same undersized Department. It should be noted that the State grant awarded to the hospital by the State of Maryland has been extended to 2016 in order to facilitate the Department'

The third alternative for meeting the objectives in a more limited manner is the expansion of the Emergency Department only. With this option the hospital would add 14 new ED treatment bays and 6 observation beds, with the continued use of 14 existing ED treatment bays. The net outcome would be 28 treatment bays and 6 observation beds. The room size would go from the current 200 DGSF/treatment space to approximately 330 DGSF; the state's average is approximately 500 DGSF. While the capital outlay would be less it would fall far short of addressing the current inpatient needs of the hospital to provide an all private rooms to its patients and the community it serves, the continued documented need for an upgraded surgical department with additional floor space in the operating rooms, and the need for additional space for cooking, dining, and public waiting areas.

Despite the continued high utilization of FWMC in its existing physical plant, we do believe that some of the outpatient services provided there can be more cost-effectively provided in alternative settings in response to the financial incentives embodied in the GBA with the HSCRC.

For example, outpatient visits to the FWMC Emergency Department are forecasted to decline from 41,486 visits in CY 2013 to 37,931 visits in CY 2019, as

a result of declining utilization Level 2 visits.

CHART 4: FWMC Emergency Department Visits: 2013 - 2019

ED LEVEL	CY 2013	Reduction CY 2014*	CY 2014	Reduction CY 2015*	CY 2015	Reduction CY 2016*	CY 2016	Reduction CY 2017*	CY 2017	CY 2018	CY 2019	Total Change
1	1,985	-	2,024	-	2,064	-	2,104	-	2,145	2,187	2,230	245
2	15,639	(800)	15,130	(2,345)	13,036	(2,391)	10,854	(2,464)	8,554	8,722	8,893	(6,746)
3	15,385	-	15,687	-	15,994	-	16,307	-	16,627	16,953	17,285	1,900
4	5,950	-	6,067	-	6,186	-	6,307	-	6,431	6,557	6,686	736
5	2,526	-	2,576	-	2,626	-	2,677	-	2,729	2,782	2,837	311
	41,486	(800)	41,484	(2,345)	39,906	(2,391)	38,249	(2,464)	36,486	37,201	37,931	(3,555)

Source: FWMC.

The additional treatment rooms and space to be provided in the expanded FWMC Emergency Department are to permit the hospital to meet the ACEP standards, which are discussed in response to SHP Standard 14) Emergency Department Treatment Capacity and Space,.

The principal differences between the previously CON-approved project and the proposed project described in this application are the cost and scope. Although the objectives to be achieved by both projects are qualitatively identical, this project is less costly and does not provide the amount of new and renovated hospital facility space as was the case for the previous project. The CON-approved project would have increased both the number of private patient rooms and licensed MSGA beds of FWMC. In the current project, 14 additional private patient rooms will be added to the hospital. No increase in licensed MSGA beds are being proposed because the number of inpatient days at the hospital are projected to decrease 12.6% between CY 2013 and CY 2019. Currently, the 19 patient rooms (including the Hospital's 4 bed Critical Care Unit) occupy approximately 11,226 S.F., or 303 sf/bed.[2] The proposed project will increase the available square footage by adding 6,617 sf in new construction, resulting in 33 patient rooms occupying a total of 17,843 sf., or an increase to 350 sf/bed.[3] The

2 The current 4-bed ICU occupies 1,027sf, or 257 sf/bed.

3 At maximum physical capacity, 47 Medical/Surgical beds in 31 patient rooms will occupy 16,816 sf, or 358 sf/bed.

square footage of the existing 4-bed CCU will remain unchanged.

The estimated current capital cost of the Commission-approved CON-approved project was $45,168,000 (in 2006 dollars). In comparison, the estimated current capital cost of this more modest Project is $17,144,000 (in 2014 dollars).

In summary, the current project is significantly more cost-effective for addressing the future needs of FWMC than the previously CON-approved project that could not be implemented.

6) Burden of Proof Regarding Need.
A hospital project shall be approved only if there is demonstrable need. The burden of demonstrating need for a service not covered by Regulation .05 of this Chapter or by another chapter of the State Health Plan, including a service for which need is not separately projected, rests with the applicant.

FWMC's Updated Response Standard (6) Burden of Proof Regarding Need.

This Standard is addressed in response to COMAR 10.24.01.08G(3)(b). Need. below, with respect to the proposed consolidation, renovation and expansion of the FWMC surgery department. The proposed need for MSGA beds and additional treatment capacity in the FWMC Emergency Room (treatment bays and observation beds) are discussed under Regulation .05 of this Chapter.

The current operating rooms range in size around 250 SF. The most current AIA guidelines call for operating rooms to be a minimum of 400SF. The larger operating rooms allow for advances in technology and the more modernized, digitalized supporting equipment necessary to safely conduct general, gynecological and orthopedic surgery. All of which supports a more efficient operating room environment. FWMC's surgery cases consist mainly of the three listed surgical specialties listed above.

(7) Construction Cost of Hospital Space.
The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

FWMC's Updated Response to Standard (7) Construction Cost of Hospital Space.

As shown on the Project Budget, the updated new construction and renovation costs for the Project are estimated to be $13,926,038 for approximately 33,430 sf of new and renovated Hospital space, or approximately $416/sf. This total includes the five interrelated sections of the Project: 1) the two story addition; 2) the Expanded Dietary and Kitchen; 3) the Expanded Front Lobby and Waiting Area; 4) the Surgery Department Addition; and 5) the Energy Building.

In computing the benchmark cost of good quality Class A hospital construction given in the MVS guide, we adjusted the Project's estimated costs to remove the costs for certain cost elements. These are set forth on Chart 1. These total approximately $587,002.[4] We believe that these cost elements are not included in the MVS benchmarks applicable to this Project.

The updated computations showing the MVS standard applicable to the projected cost per square foot of each of the proposed hospital new construction sections is found at Attachment 5. We have calculated that the MVS standard for all five elements is approximately $15,532,832, or 12% above the Project's estimated

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4 The estimate for normal site preparation is not included in this total.

cost, with adjustments. The updated construction costs of the Project are not excessive.

(8) Construction Cost of Non-Hospital Space.
The proposed construction costs of non-hospital space shall be reasonable and in line with current industry cost experience. The projected cost per square foot of non-hospital space shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide for the appropriate structure. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the non-hospital space shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost. In general, rate increases authorized for hospitals should not recognize the costs associated with construction of non-hospital space.

FWMC's Updated Response to Standard (8) Construction Cost of Non-Hospital Space.

This Standard is not applicable.

(9) Inpatient Nursing Unit Space.
Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. If the Inpatient Unit Program Space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost for the space that exceeds the per bed square footage limitation in this standard or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

FWMC's Updated Response to Standard (9) Inpatient Nursing Unit Space.

The current Inpatient Nursing Unit Program Space is 11,226 sf. The Project involves both new construction (6,617 sf) and renovation of existing space (450 sf) for Inpatient Nursing Unit Space. This will result in 17,843 sf of combined space, or 350 sf/bed (including the existing Critical Care Unit), or 358 sf/bed (excluding the CCU).

The proposed inpatient unit program space per bed does not exceed 500 square feet per bed. This Standard is also not applicable because there will be no rate increase related to the capital cost of the Project consistent with the terms of the Global Budget Revenue Agreement between FWMC and the HSCRC (July 16, 2014). See Attachment 4.

(10) Rate Reduction Agreement.
A high-charge hospital will not be granted a Certificate of Need to establish a new acute care service, or to construct, renovate, upgrade, expand, or modernize acute care facilities, including support and ancillary facilities, unless it has first agreed to enter into a rate reduction agreement with the Health Services Cost Review Commission, or the Health Services Cost Review Commission has determined that a rate reduction agreement is not necessary.

FWMC Updated Response to Standard (10) Rate Reduction Agreement.

FWMC is not a high-charge hospital. This Standard is not applicable.

(11) Efficiency.
A hospital shall be designed to operate efficiently. Hospitals proposing to replace or expand diagnostic or treatment facilities and services shall:
(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in which the planning and design of the project took efficiency improvements into account; and
(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or
(c) Demonstrate why improvements in operational efficiency cannot be achieved.

FWMC's Updated Response to Standard (11) Efficiency.

The operational efficiency of FWMC will improve largely as a result of addressing the existing physical plant deficiencies and space constraints of the hospital, and in response of the hospital to the financial incentives incorporated in the Global Budget Revenue Agreement between FWMC and the HSCRC (July 16, 2014) to become more efficient by reducing utilization and costs. See Attachment 4.

FWMC is the smallest Maryland hospital located in a metropolitan area. As such, many of the fixed costs of operating the hospital are spread over a very small number of patients. By enlarging the facilities, and increasing treatment capacity for needed inpatient and outpatient services that should be provided in the hospital setting, particularly for inpatient, emergency, outpatient observation and surgical services, the use of hospital resources will become more efficient.

The gains in efficiency are largely tied to improving the productivity of existing human resources at the Hospital. These are most clearly shown on TABLE 5 that sets forth the changes in staffing that will be necessary to address the forecasted changes in patient admissions and visits as shown on TABLE 1 following the completion of the project in CY 2016.

The Project was designed with the following operational efficiencies in mind:

- **Improved Patient/Staff Safety**

- Bariatric room – Having a room specially equipped and designated for this purpose is safer for patients and staff because:
  - It will eliminate the high-risk associated with the current patient transfer method, which necessitates transferring the patient several times from an ED stretcher to a regular bed then onto a bariatric bed once it arrives from a vendor.
  - Most staff musculoskeletal injuries arise during patient transfers.
  - Fewer transfers will reduce the likelihood of staff and patient injury.
  - It will reduce patient length of stay by eliminating admission delays and ED bottlenecks associated with waiting for delivery of appropriate equipment from a vendor (specialty bed etc).

- Improved Patient Privacy and Quality Outcomes

  - Adding private Family Consultation Room allows for private discussions among patient/family, medical staff, and case managers. Currently discussions occur either in a semi-private room with insufficient privacy, or in another less ideal location.
  - Adding private rooms is more efficient than semi-private because:
    - It maximizes occupancy by eliminating the need to close the second bed in a semi-private room when a patient must be put on isolation.
    - It reduces the need to transfer patients to other hospitals due to acute care bed shortage when isolation room beds cannot be occupied.
    - Increased bed occupancy increases the opportunity to admit more patients.

- It reduces inconvenience and potential harm to sick ED patients when they can be admitted on site instead of being transferred.
- Research indicates that single occupancy patient rooms help reduce hospital-acquired infections and improve patient care satisfaction, which increases quality outcomes.

- Equipment Storage Area
  - Improves staff workflow and staff efficiencies by ensuring routinely used equipment is readily available on the unit. Without the dedicated space staff frequently has to search for wheelchairs, stretchers, etc. Simple tasks such as transport for a diagnostic test require double the amount of time because of the need to locate equipment which is now stored off the unit.
  -
- Additional Medication Pyxis Area – The new small pyxis machine will reduce the distance traveled by the nurse in the new space to prepare medication. This is key to maintaining safe medication practices on a busy medical surgical unit.

Emergency Department Expansion: The existing design and operational space of the Emergency Department limits efficiency. The new design and operational space requested in the CON application incorporates changes that will significantly improve the efficiency of the Emergency Department. The following is a list of the changes and the positive impact they will have.

- Additional Treatment Bays – On average, 113 patients per day are treated in the ED. On busy days, 150 patients per day are treated. Census has been as high as 180 patients seen in 24 hours. The proposed additional treatment bays and 6 observation beds in the FWMC Emergency Department will increase the ability to see our

patients sooner and more effectively handle surge when it occurs. This will help decrease wait times, decrease the need for and frequency of diversion, and provide a better experience for our patients.

- Triage Area - The current triage area is small and does not allow room or privacy for double triage when needed. An adjacent office space is used presently and this is not efficient. The expansion will improve the triage process and includes a private area where EKGs can be performed immediately to assist in the Triage designation.
- Allocation of a Dedicated Fast Track Area – The new design allocates some of the existing bays at the front of the ED for "fast track" patients. "Fast Track" cases are now seen in another space located outside of the ED footprint, which is an inefficient use of staff and resources. The relocation of the Fast Track Area within the ED proper allows for utilization of a more efficient throughput modality, such as a Rapid Medical Exam (RME) or a "Door 2 Doc." This configuration will facilitate the new goal of 10 minutes for arrival to provider times.
- Repurposing of Current Nurse's Station – After construction, the current ED Nurse's station will primarily serve the new Fast Track area and will provide dedicated space for the physicians, which is not possible now. Due to current space constraints there is only one Nurse's station in the ED. The one desk is shared by all disciplines - nurses, techs, physicians, unit secretaries, EMS, and visiting physicians. The expansion plan includes construction of a second Nurse's station. The additional space created by constructing a second Nurse's station will decrease the time it takes for staff to find a place to document as required.
- Second New Nurse's Station – The additional Nurse's Station is designed to provide greater visualization of the area so staff can easily monitor activity in this unit. The ED floor plan features a pass-through design between the New Medication Room and the New Staff Lounge. Among other features, this design allows staff to easily access medications, as well as improve staff access to the Lounge for quick

work breaks without leaving the Unit. This Station will increase staff satisfaction and efficiency.

- Family Consult Room – Currently, there is no space dedicated for this purpose within the ED. The new plan provides families in crisis with a quiet room where they can gather; creating a much-needed amenity that is not currently available. This will also reduce visitor crowding in the ED proper.
- EMS Room – Currently, Paramedics and EMTs gather at the one existing Nurse's station. The new plan provides a small, dedicated space for EMS personnel to complete their paperwork. This plan allows us the opportunity to serve our EMS providers more efficiently and provide more workspace for ED staff at the Nurse's stations.
- Storage – Currently, due to space limitations most ED supplies are stored in various areas outside of the department, which is very inefficient. In the new design, there are two dedicated supply storage areas. The rooms are larger than the current storage space and will allow for stocking needed par levels, and still have additional supplies within close proximity. This will increase operational efficiency. The plan is to incorporate a "lean, six sigma" approach to supply management and reduce cost through this process.
- Enclosed Medication Room – Currently, there is no dedicated medication room. Counter space behind the Nurse's station is used for this purpose. Supplies are stored in the cabinets above the counter and there is a Pyxis system stationed in another area of the ED, not adjacent to the supply area. There is a sink close to the counter but the workspace is very limited, making for a crowded and noisy area. The new design includes a dedicated and secure room to house the large primary Pyxis machine with all the supplies necessary for efficient medication administration. This will allow nurses to access and prepare medications in a clean, clutter free, quiet environment. We will be able to implement the "NO Interruption Zone" which has shown to decrease medication related incidents. The entrance to this room will be behind

the new primary Nurse's station, which will limit access to authorized personnel only.

- Additional Small Pyxis – A new small pyxis machine will be located at the front of the ED to serve the Triage and Fast Track areas. This will increase efficient operations when only oral medications or limited injectibles are needed.
- Isolation Rooms/Peds Rooms – The new plan provides two isolation rooms with anterooms. The current isolation rooms do not include anterooms. This new feature eliminates the need to don and doff PPE in the hallway and is much more practical and efficient. The two adjacent rooms are planned as pediatric areas. They are located close to the Nurse's station for monitoring, yet to the back of the ED to help decrease the noise caused by crying children.
- Staff Lounge – The current staff lounge is very small. The new lounge will provide adequate space for the staff to eat and relax during break time.
- Staff Locker/Rest Room - Currently, the locker area and staff bathroom are not in or close to the ED. The new plan will decrease staff time away from the unit.
- Decontamination Room - Currently, we do not have an enclosed area for limited (5 patients or less) decontamination. Patients must be decontaminated outside utilizing a small pool, a screen and a warm water source. The new plan provides a room that is built outside, attached to the building near the EMS entrance. The room is enclosed, contains a shower, is temperature controlled and has a drain to collect any contaminated water. This space will also allow staff to take equipment outside during the cold months to be deep cleaned (such as carts) in a comfortable environment.
- Directors Office - Currently, the Director's office is in a very busy area of the ED near the EMS entrance. It is noisy and provides little privacy for visiting with staff. It is small, and will not accommodate more than 3

people at one time. In the new plan, the office will be larger and is located at the back of the Department, under the stairwell.

OR Expansion: Consideration for operating room efficiency is mainly to be able to provide adequately sized operating rooms to accommodate the needs of the surgical staff and the hospital's patients who require surgery.

- The size scope and location of the new rooms allows for the hospital to add the appropriate equipment needed and requested by surgeons performing laparoscopic and orthopedic surgeries. Currently there is only have one room sized to meet the equipment needs of these types of surgeries. As a result, the hospital often must delay cases or fail to meet the surgeon's request for preferred dates resulting in surgeries being diverted to other facilities.
- The new design allows for greater access and convenience for both patients and physician.
- The location of the planned operating room takes into account the need for a continuous center core; which must be maintained for purposes of sterility.
- Improving on the sterilization space allows for better workflow for the surgical services staff and reduces the amount of walking that occurs.

With respect to the related support services of the Hospital, more specifically, the construction of a kitchen at the Hospital will enable all meals to be prepared on-site for patients, staff and guests to be prepared on-site. Currently, all meals are prepared off-site and transported to the Hospital multiple times each day.

The plan is to incorporate a "lean six sigma" approach to supply management and reduce costs through this process.

The hospital industry as a whole is increasingly embracing the lean six sigma approach to operations to effectively and efficiently perform certain procedures. This system was adopted from private industry, introduced by Motorola Company in the 1980s in an attempt to achieve less than three defects in more than a million opportunities in an organization and adopted by other industries on a larger scale in the 1990's.

An example of a lean six sigma inventory management case study at a large manufacturing plant can be found at http://www.sixsigmasystems.com/case-studies.php#02. Following is a summary of that case and the resuts:

Case: A major US corporation identifies a cash flow problem. Further analysis reveals that inventory levels are high and turns are below most major competitors. In addition a technology change and a proliferation of models amplify the issue.

The corporate goal is a reduction of inventory across the order fulfillment process in excess of 50% with no negative impact on service levels. Customer feedback reveals that a key to customer satisfaction is on time delivery and any deviation from promised dates has a negative impact on customer satisfaction.

Results: Inventory reduction post full implementation = $20,000,000.

FWMC is also embarking on an initiative to apply lean six sigma to operations and the emergency department will be part of that effort. Implementation has not yet begun but there are two individuals who are trained and certified at the black belt and green belt levels respectively who are working on this effort.

Hospitals have some obvious differences from a manufacturing plant but the approach can be just as effective. One potential functional area that could benefit from the system is inventory management, which could be optimized by assessing current constraints in the existing order fulfillment process and then changing the fundamental process.

In the current configuration of the ED, routine supplies and equipment used for daily patient care are located in three different places off the unit. Staff spend an average of 30 minutes of every 8-hour shift or 1.5 hours per 24-hr period per

person retrieving supplies, at an estimated cost of $30/hr. which adds up quickly over the course of a year (est. $16,425 per year, per person). This is time spent away from the patient, and the cost of non-productive work effort impacts the overall cost of each patient's episode of care. This recurring routine task results in resources being spent on an activity that adds no value to the care of the patient and can be avoided with proper workflow planning, modification to the physical layout, accurate PAR levels, and allocation of strategically placed dedicated storage space.

The availability of a larger supply storage area in the ED in closer proximity to the supply users is one aspect of achieving a productivity enhancement and a reduction of total emergency department inventory while improving quality service levels with no negative impact on service delivery. The lack of adequate storage space is only one of several challenges faced by ED staff that the proposed construction project is designed to address.

The lean methodology improves efficiency by creating standard work and eliminating waste wherever possible. The proposed new rooms would allow for standardization of supplies to be kept at the bedside. This in turn allows for better oversight of minimum PAR levels. Managing PAR levels reduces waste due to expired items and over stocking.

To date, no specific cost studies have been performed to determine the fiscal impact of optimized inventory management at FWMC but we anticipate taking every opportunity to reduce costs no matter how small; adapting the lean six sigma approach to hospital operations is one such opportunity, which could produce a cost benefit from optimizing inventory management.
With respec to the expected cost savings expected from preparing meals on-site,

(12) Patient Safety.
The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety. A hospital proposing to replace or expand its physical plant shall provide an analysis of patient safety features included for each facility or service being replaced or expanded, and document the manner in which the planning and design of the project took patient safety into account.

FWMC's Updated Response to Standard (12) Patient Safety.

The following elements of the proposed design of the expansion and renovation were taken into account to enhance and improve patient safety:

- **Create a "Zone of Refuge" (NFPA 101) on the MSG floor, in addition to exit stairs.**
- **New Ambulance Bay canopy – EMT's focus on patient safety without weather factor.**
- **New Bio-Hazard room conveniently within route from ambulance to E.D.**
- **All private MSG rooms – reduces potential for cross infections, med mix-ups, etc.**
- **Hard walls between E.D. beds except for special rooms.**
- **Two Airborne Infection Isolation rooms in E.D. and one MSG floor, for protection of all E.D. patients, inpatients and staff**
- **Auxiliary Nurse Stations in E.D. and on MSG floor to provide more ready contact and observation of patients by caregivers.**
- **New Bariatric facilities in E.D. and on MSG floor for patients and special equipment for benefit of those patients with convenient parking rooms for that special equipment, to minimize corridor obstructions for all patients.**
- **Private Medication Prep Room in E.D., for more safe administrations.**
- **New complete dietary system, in-house, to provide greater food quality/safety assurance for patients.**

(13) Financial Feasibility.
A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.
(a) Financial projections filed as part of a hospital Certificate of Need application must be accompanied by a statement containing each assumption used to develop the projections.
(b) Each applicant must document that:
(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;
(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;
(iv) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals; and
(iv) The hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate that overall hospital financial performance will be positive and that the services will benefit the hospital's primary service area population.

FWMC's Updated Response to Standard (13) Financial Feasibility.

The proposed project is financially viable as presented in Updated Table 3. The assumptions used in establishing the utilization projections, revenue estimates, staffing and overall expense projections are included in the notes to Updated Tables 1 and 3 (See Attachment 6) and Table 5.

To summarize, the Global Budget Revenue Agreement between FWMC and the HSCRC (July 16, 2014), provides a foundation for sufficient hospital revenues to implement this Project. Hospital expenses, including the projected $1,346,194 annual debt service on the $19,190,000 HUD Insured Debt, will be managed to assure profitable operations.

Please see Attachment 7 for the most current two years of audited financial

statements.

14) Emergency Department Treatment Capacity and Space.
(a) An applicant proposing a new or expanded emergency department shall classify service as low range or high range based on the parameters in the most recent edition of *Emergency Department Design: A Practical Guide to Planning for the Future* from the American College of Emergency Physicians. The number of emergency department treatment spaces and the departmental space proposed by the applicant shall be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians *Emergency Department Design: A Practical Guide to Planning for the Future*, given the classification of the emergency department as low or high range and the projected emergency department visit volume.
(b) In developing projections of emergency department visit volume, the applicant shall consider, at a minimum:
(i) The existing and projected primary service areas of the hospital, historic trends in emergency department utilization at the hospital, and the number of hospital emergency department service providers in the applicant hospital's primary service areas;
(ii) The number of uninsured, underinsured, indigent, and otherwise underserved patients in the applicant's primary service area and the impact of these patient groups on emergency department use;
(iii) Any demographic or health service utilization data and/or analyses that support the need for the proposed project;
(iv) The impact of efforts the applicant has made or will make to divert non-emergency cases from its emergency department to more appropriate primary care or urgent care settings; and
(v) Any other relevant information on the unmet need for emergency department or urgent care services in the service area.

FWMC Updated Response to Standard (14) Emergency Department Treatment Capacity and Space.

The Hospital provided 43,660 ED visits in CY 2013, including visits by patients who were admitted to the Hospital, and projects that the number of visits will decrease to 39,662 in CY 2019, a decrease of approximately 1-2% per year. This projected decrease is wholly based on the anticipated positive impact on patient access related to the proposed increase in the number of primary care physicians practicing in the FWMC service area between 2014 and 2019. Some of that increase in the number of practicing physicians will be the result of FWMC's and UMMS' success in recruiting 4 new primary care physicians (family practice/internal medicine) to the FWMC Medical Staff during that period. The FMWC/UMMS Recruitment Plan is shown below:

CHART 5: UMMS/FWMC Physician Recruitment Plan

Specialty	Incremental Number of Physicians Recruited 2014	2015	2016	2017	2018	2019	Cumulative Recruited through 2019
Family Practice/ Internal Medicine	0.3	1.7	1.0	1.0	-	-	4.0
Cardiology	-	0.5	1.0	0.5	0.5	-	2.5
Gastroenterology	-	0.5	0.5	0.5	0.5	-	2.0
Neurology	-	0.5	0.5	-	-	-	1.0
General Surgery	0.5	0.5	0.5	-	-	-	1.5
Orthopedic Surgery	-	-	1.0	0.5	0.5	-	2.0
Otolaryngology (ENT)	-	-	1.0	0.5	0.5	-	2.0
Totals	0.8	3.7	5.5	3.0	2.0	-	15.0
Cumulative Total	0.8	4.5	10.0	13.0	15.0	15.0	

Source: FWMC.

Our expectation is that their active presence in the community will provide a measurable increase in local accessibility to and utilization of routine, office-based primary care services. Such utilization is projected to decrease the use of the FWMC ED for Level 2 visits in particular, as shown below:

CHART 4: FWMC Emergency Department Visits: 2013 - 2019

ED LEVEL	CY 2013	Reduction CY 2014*	CY 2014	Reduction CY 2015*	CY 2015	Reduction CY 2016*	CY 2016	Reduction CY 2017*	CY 2017	CY 2018	CY 2019	Total Change
1	1,985	-	2,024	-	2,064	-	2,104	-	2,145	2,187	2,230	245
2	15,639	(800)	15,130	(2,345)	13,036	(2,391)	10,854	(2,464)	8,554	8,722	8,893	(6,746)
3	15,385	-	15,687	-	15,994	-	16,307	-	16,627	16,953	17,285	1,900
4	5,950	-	6,067	-	6,186	-	6,307	-	6,431	6,557	6,686	736
5	2,526	-	2,576	-	2,626	-	2,677	-	2,729	2,782	2,837	311
	41,486	(800)	41,484	(2,345)	39,906	(2,391)	38,249	(2,464)	36,486	37,201	37,931	(3,555)

Source: FWMC.

Nevertheless, even at those decreased visit volumes, the demands for space in the FWMC ED will continue to justify the proposed expansion of 14 treatment bays and six observation beds in this Project, which is woefully undersized.

CHART 6: Existing and Proposed Changes to the FWMC Emergency Department

TREATMENT SPACES	EXISTING	PROPOSED	CHANGE
General	14	26	+12
Isolation	0	2	+2
Observation	0	6	+6
TOTAL	14	34	+20

The AEP Guidelines describe a range of between 25 and 33 treatment bays and between 21,875 and 28,875 Departmental Gross SF for an Emergency Department with 40,000 projected annual emergency room visits. Currently, the FWMC ED has only a small fraction of that recommended range with 14 treatment bays, and 2,800 SF. The project will increase to 10,927 SF for 34 treatment bays, still well below the recommended AEP Guidelines.

The historic and projected volumes of patient visits and admissions at FWMC is shown below:

CHART 7. Emergency Department Visits: FWMC, CY 2009 – 2019					
	Admissions Through ED			Total ED Visits	
Year	Admissions	% Change	% Total ED Visits	Visits	% Change
ACTUAL					
2009	2,850		6.0%	47,506	8.13%
2010	2,831	-.07%	6.1%	45,743	-3.71%
2011	2,158	-23.8%	4.6%	46,799	2.31%
2012	2,166	3.7%	4.5%	48,338	0.41%
2013	2,174	.37%	4.9%	43,660	-9.68%
PROJECTED					
2014	2,109	-2.99	4.8%	43,593	-0.15%
2015	1,932	-8.39	4.6%	41,838	-4.03%
2016	1,780	-7.87	4.4%	40,029	-4.32%
2017	1,717	-3.54	4.5%	38,198	-4.57%
2018	1,696	-1.22	4.4%	38,897	1.83%
2019	1,731	2.06	4.4%	39,662	1.97%

Source: FWMC.

Currently FWMC's ED operates in or above the "high range" in accordance with the ACEP Guidelines.

Its undersized ED is so far below the Departmental Gross Area Guidelines that it could reduce its visit volume by 20,000 visits and still be too small. Its 14 treatment bays would meet the Guidelines for a Hospital with 10,000 visits at the high range, or 20,000 visits at the low range. Its ratio of visits/bed (3,357) is not even found in the low or high range Guidelines for any sized ED.

By other measures, the result is the same: long lengths of stay, no available observation beds located in the ED itself, excessive times to admit, all point to an ED that finds itself in or above the "high range" for lack of available facility space at current and future levels of demand.

CHART 8: American College of Emergency Physicians (ÀCEP`) Guide
Emergency Department Design
``Low`` and ``High`` Range Thresholds
FWMC Emergency Department Characteristics: Current and Proposed

			FWMC	
Threshold	Low	High	Current	Proposed
ALOS	<2.5 Hours	> 3.5 Hours	> 3.5 Hours	<2.5 Hours
Location of Observation Beds	Outside ED	Inside ED	Outside ED	Inside ED
Time to Admit	< 60 Minutes	> 90 Minutes	> 90 Minutes	< 60 Minutes
Turnaround time for Diagnostic Tests	<60 Minutes	> 90 Minutes	< 90 Minutes	<60 Minutes
% Admitted Patients	<18%	>23%	<18%	<18%
Urgent/Non-Urgent Ratio	<1.1/1	>1.1/1	<1.1/1	<1.1/1
Age of Patient	<20% Age 65+	>25% Age 65+		
Admin/Teaching Space	Minimal	Extensive	Minimal	Minimal
Imaging within ED	No	Yes	No	No
Specialties	No	Yes	No	No
Flight/Trauma Services	No	Yes	No	No

Source: FWMC.

Nevertheless, the goal of this project is to move FWMC out of the high range and into the "low range" for all, if not most, measures suggested in the ACEP Guidelines.

(15) Emergency Department Expansion.
A hospital proposing expansion of emergency department treatment capacity shall demonstrate that it has made appropriate efforts, consistent with federal and state law, to maximize effective use of existing capacity for emergent medical needs and has appropriately integrated emergency department planning with planning for bed capacity, and diagnostic and treatment service capacity. At a minimum:
(a) The applicant hospital must demonstrate that, in cooperation with its medical staff, it has attempted to reduce use of its emergency department for non-emergency medical care. This demonstration shall, at a minimum, address the feasibility of reducing or redirecting patients with non-emergent illnesses, injuries, and conditions, to lower cost alternative facilities or programs;
(b) The applicant hospital must demonstrate that it has effectively managed its existing emergency department treatment capacity to maximize use; and
(c) The applicant hospital must demonstrate that it has considered the need for bed and other facility and system capacity that will be affected by greater volumes of emergency department patients.

FWMC's Updated Response to Standard (15) Emergency Department Expansion.

FWMC proposes to expand its existing Emergency Department to address the significant need for additional treatment space and capacity there despite the forecasted decrease in visit between 2014 and 2019.

Unlike almost every hospital in the State, FWMC suffers from a recognized deficit in facility space to meet the current needs of its patients[5]. FWMC has made considerable efforts, consistent with federal and state law, to maximize effective use of its existing ED capacity.

For FWMC, the efforts to address the needs of ED patients that show up at its door, in cooperation with its medical staff, has been to maximize every square foot of available treatment hospital space regardless of whether that space has been designed to accommodate ED patients. For example, as early as 2005, FWMC placed into service (and included in its available inventory of ED treatment spaces) unoccupied rooms outside the ED in the adjacent endoscopy suite.

Any reasonable strategy to reduce utilization of its ED for non-emergency

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5 See Discussion on pp. 30-33, Recommended Decision, Fort Washington Medical Center, Expansion and Renovation Project, Docket No. 05-16-2171, August 30, 2006.

medical care or redirecting patients with non-emergent illnesses, injuries, and conditions in order to lower cost would involve alternative sources of primary care services on or near the FWMC campus. FWMC proposes to develop those services through the implementation of its physician recruitment plan with UMMS.

Because Prince George's County is a medically underserved area with respect to private practice primary care physicians, our discussions have been focused on recruiting and attracting additional private practice physicians to FWMC's service area, not extending the office hours of the private practice physicians who are already here for patients who present in the FWMC Emergency Department.

At several meetings of the Medical Executive Committee the hospital engaged the medical staff in a dialogue about office capacity to expand and additional capabilities required including which subspecialties the hospital should consider recruiting. During these discussions it was the general opinion of the medical staff that any additional space expansion of the emergency department and to some extent the in-patient units will further deepen the need for additional primary care practitioners in the service area.

This strategy is incorporated into the FWMC/UMMS Physician Recruitment Plan to replace and increase the number of physicians on the FWMC Medical Staff, including primary care physicians whose office-based practices may provide a more cost-effective alternative setting, and reduce demand for some ED services at FWMC. We have projected a reduction of 3,553 ED visits between 2014 and 2019 in anticipation of implementing this Plan.

In summary, the Hospital is forecasting that the demand for ED services will decrease during the period of 2014 through 2019 without a reduction of patient access. The existing capacity of the Hospital ED is woefully insufficient to accommodate existing levels of demand, and the projected decrease will still require additional space and treatment capacity in order to approach the recommended ACEP Guidelines.

(16) Shell Space.
(a) Unfinished hospital shell space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective.
(b) If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that:
(i) Considers the most likely use identified by the hospital for the unfinished space;
(ii) Considers the time frame projected for finishing the space; and
(iii) Demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.
(c) Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants shall provide information on the cost, the most likely uses, and the likely time frame for using such shell space.
(d) The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Service Cost Review Commission.

FWMC's Updated Response to Standard (16) Shell Space.

This Standard is not applicable.

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.

FWMC's Update Response COMAR 10.24.01.0G(3)(b). Need.

Among the services not discussed in Response to 10.24.01.08G(3)(a). The State Health Plan, are the surgical services of the Hospital. As is the case for all Maryland acute care general hospitals, FWMC provides both inpatient and outpatient surgery. The current inventory of surgical capacity of FWMC is three operating rooms and two procedure rooms. The design of this Project will not change the total capacity of the Hospital to provide surgery services.

[HISTORICAL AND PROJECTED SURGICAL CASES AND MINUTES AT FWMC TO BE SUBMITTED IN SUPPLEMENTARY FILING]

Consistent with the UMMS/FWMC Physician Recruitment Plan, FWMC intends to recruited additional physicians to the medical staff of the hospital to serve residents of the FWMC service area, in specialties highly dependent upon the technology, skilled clinical personnel, and modern facilities of the proposed expanded Hospital. In the meantime, support by several members of the FWMC medical staff of the proposed surgical department expansion has been documented.

In projecting the number of surgical cases and OR minutes, we considered a number of factors that might contribute to increasing or decreasing the utilization of the Hospital's operating rooms in the future. For example, as the number of

patients who are not transferred to other hospitals decreases, the number of inpatient and outpatient surgical cases are likely to increase. The number of surgeons who are successfully recruited to FWMC as a result of the FWMC/UMMS Physician Recruitment Plan is likely to increase the number of inpatient and outpatient surgical cases at FWMC. The willingness of the members of medical staff who perform surgery at FWMC in the future following the completion of the proposed Surgery Department upgrade will increase.

As shown on the chart below, of the 15 physicians to be recruited to the FWMC Medical Staff between 2014 and 2019, 7.5 will be surgeons: 2 Gastroenterologists, 1.5 General Surgeons, 2 Orthopedic Surgeons, and 2 Otolaryngologists.

CHART 5: UMMS/FWMC Physician Recruitment Plan

Specialty	Incremental Number of Physicians Recruited						Cumulative Recruited through 2019
	2014	2015	2016	2017	2018	2019	
Family Practice/ Internal Medicine	0.3	1.7	1.0	1.0	-	-	4.0
Cardiology	-	0.5	1.0	0.5	0.5	-	2.5
Gastroenterology	-	0.5	0.5	0.5	0.5	-	2.0
Neurology	-	0.5	0.5	-	-	-	1.0
General Surgery	0.5	0.5	0.5	-	-	-	1.5
Orthopedic Surgery	-	-	1.0	0.5	0.5	-	2.0
Otolaryngology (ENT)	-	-	1.0	0.5	0.5	-	2.0
Totals	0.8	3.7	5.5	3.0	2.0	-	15.0
Cumulative Total	0.8	4.5	10.0	13.0	15.0	15.0	

Source: FWMC

FWMC has estimated the impact of these factors collectively as increasing the likely demand for inpatient and outpatient surgical cases 2013 and 2019.

In summary, we consider the support of the current FWMC surgeons and the additional surgeons to be recruited to the FWMC medical staff between 2014 and 2019 to be a significant factor for the likely changes in the future demand for

surgical services. The number of operating rooms in the Hospital will not change, and the project is simply a replacement and expansion of the space dedicated to three existing operating rooms.

[(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)]

FWMC's Updated Response: See TABLE 1 and explanatory notes at Attachment 6.

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

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

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

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

FWMC's Updated Response 10.24.01.08G(3)(C) Availability of More Cost-Effective Alternatives:

Please refer to the discussion found at FWMC's Updated Response to Standard (5) Cost-Effectiveness.

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.

FWMC Updated Response to 10.24.01.08G(3)(d). Viability of the Proposal:

The Hospital's most recent audited financial statements are shown at Attachment 7.

The Hospital will agree not to seek a rate increase for the capital costs associated with this Project consistent with the terms of the Global Budget Revenue Agreement between FWMC and the HSCRC (July 16, 2014). The Project will likely have no impact on the costs and charges at other hospitals in the area.

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

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

FWMC's Updated Response: See TABLE 3 and explanatory notes at Attachment 6.

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

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

List all prior Certificates of Need that have been issued to the project applicant by the Commission since 1990, and their status.

FWMC Updated Response to 10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

The last Certificate of Need issued to FWMC was not implemented. Prior to that time, no Certificates of Need had been issued to FWMC in the previous sixteen years.

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.

FWMC's Updated Response to 10.24.01.08G(3)(f). Impact on Existing Providers:

FWMC agrees with the findings in the Recommended Decision, Fort Washington Medical Center, Expansion and Renovation Project, Docket No. 05-16-2171, that the project as proposed will have minimal impact on future levels of demand for services at Southern Maryland Hospital Center, and to a negligible extent, other Maryland hospitals.

In addition, under the terms of the Global Budget Revenue Agreement between FWMC and the HSCRC (July 16, 2014), FWMC has no incentive to increase its patient volumes and revenues above the current level inflated by the growth and aging of its service area population.

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

   FWMC Updated Response:

   Recruitment efforts to address the additional clinical openings projected in this application will be managed by the Hospital's Nursing Department in collaboration with the Hospital's Human

Resource Department. Sources available for recruiting additional personnel include, but are not limited to: Newspaper and magazine advertising; attendance at job fairs and career days; open houses; direct mailings; educational contacts and affiliations; internship programs; and word-of-mouth.

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

   The Hospital currently uses a variety of techniques to fill positions when vacancies occur for personnel which may in the future be in short supply, including a combination of web postings, newspaper advertising, employee referral programs and participation in job fairs.

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

   The positions to be affected by the Project are shown below, and the current turnover and vacancy rates for each in FY 2012.

   [COMPLETE RESPONSE TO BE SUBMITTED IN SUPPLEMENTARY FILING]

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.)
(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.
(INSTRUCTION: Indicate method of calculating benefits percentage):

Instruction: Complete Table 5-Manpower Information. 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. List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services required by this project.)

Table 5. Manpower Information

Position Title	Current Number of FTEs - 2013	Change in FTEs - to 2019	Average Salary-2019	Employee/ Contractor	Total Cost 2019
Administration					
Hospital Administration	9.41	0.02	$ 132,874	Employee	1,253,000
Medical Staff Administration	-	-		Employee	-
Nursing Administration	0.54	0.01	$ 166,727	Employee	91,700
Subtotal	9.95	0.03	$ 134,739		1,344,700
Direct Care					
Patient Care - inpatient units RNs, LPNs, patient care techs	31.23	0.03	$ 67,199	Employee	2,100,800
Patient Care - inpatient units RNs, LPNs, patient care techs	-	-	$ 67,199	Agency	-
Patient Care - ancillary services technicians & specialties	139.47	0.14	$ 75,934	Employee	10,601,000
Patient Care - ancillary services technicians & specialties	-	-		Agency	-
Subtotal	170.70	0.17	$ 74,340		12,701,800
Support					
Support Services Dietary, Laundry, Purchasing/Stores, Plant Ops Housekeeping, Central Supply, Pharmacy,	100.85	0.12	$ 45,506	Employee	4,594,700
Support Services	-	-		Agency	-
Subtotal	100.85	0.12	$ 45,510		4,594,700
TOTAL FTEs including Agency	281.50	0.32			
Less Agency FTEs	-	-			
TOTAL FTEs - employees	281.50	0.32			
			Subtotal (rounded to the nearest 1,000)		18,641,200
	Less Cost of Agency Personnel and physician professional fees				-
			Salary Expense - Employees		18,641,200
			Employee benefits and payroll taxes		3,355,400
		TOTAL Salary and Benefits (Employees) - Yr 2016			$ 21,996,600
Instruction: Indicate Method of Calculating Benefits Percentage:		18.00%	*of total salary expense.*		
Factor in converting Paid Hours to Worked Hours		87.50%			

Source: FWMC

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

1. List names and addresses of all owners and individuals responsible for the proposed project and its implementation.

   Verna Meacham, President/CEO, Fort Washington Medical Center

2. Are the applicant, owners, or the responsible persons listed above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

   St. Joseph Hospital West 100 Medical Plaza , Lake St. Louis, MO 66367 October 2007 - January 2009; Methodist Hospitals Inc. 600 Grant Street Gary, IN 46402 November 1981-1982 ; Connecticut Mental Health Center 34 Park Street New Haven , CT 06508 1977-6/1979.

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

   No

4. Are any facilities with which the applicant is involved, or have any facilities with which the applicant has in the past been involved (listed in response to Question 2, above) ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to actions to suspend the licensure or certification at the applicant's facility or facilities listed in response to Question 2? If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable governmental authority. No

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

No

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the proposed or existing facility.

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

9/2/2014
Date

Verna S. Meacham
Signature of Owner or
Board-designated Official

Verna S. Meacham
President/CEO

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing updated Certificate of Need Application and its attachments are true and correct to the best of my knowledge, information, and belief.

Joseph B Tucker
Name and Title
Sr. Vice President/CFO

9/2/14
Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing updated Certificate of Need Application and its attachments are true and correct to the best of my knowledge, information, and belief.

RT Coughman
Name and Title

9/2/14
Date

ATTACHMENT 1

9/3/2014

ATTACHMENT 1

Location	Existing Physical Capacity					Location	After Project Completion					
		Room Count			Bed Count			Room Count			Bed Count	
(Floor/Wing)	Hospital Service	Total Rooms	Semi-Private	Private	Physical Capacity	(Floor/Wing)	Hospital Service	Total Rooms	Semi-Private	Private	Physical Capacity	NOTES
2	Medical/ Surgical	17	16	1	33	2	Medical/ Surgical	31	1	30	47	
2	Critical Care	2	3*	1	4	2	Critical Care	2	3*	1	4	*Three beds in one CCU room
Total		19	16	2	37	Total		33	1	31	51	

Note: Physical capacity is the total number of beds that could be accommodated without significant renovations. A room with two headwalls and two sets of gasses is a semi-private room, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough, from a square footage perspective, to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain a single headwall that can be used to accommodate more than one patient (e.g., for psychiatric patients), report the physical capacity of such rooms as semi-private, and report the bed capacity as applicable.

ATTACHMENT 2

UPDATED DESCRIPTION OF FORT WASHINGTON MEDICAL CENTER RENOVATION AND EXPANSION PROJECT

This CON application proposes that the hospital facilities of Fort Washington Medical Center ("FWMC") be expanded and renovated. The Project's objectives are the same as those articulated in the Certificate of Need application approved by the Commission on September 21, 2006: to increase the treatment capacity of the Hospital for both inpatient and outpatient services resulting in a larger, more modern and functional physical plant.[1] We are confident that the Commission will see that the current Project addresses many of the same physical plant deficiencies identified in 2006, and will provide many of the same benefits to the public following its successful implementation.

In contrast to the previously submitted and approved Project, this Project is smaller and significantly less costly, yet addresses the very critical problem of FWMC's inability to meet the medical care needs of the residents of its service area. Specifically, the Hospital's existing Emergency Department, Lobby, Dining and Waiting Areas are woefully undersized. The Hospital has no kitchen. The Surgery Department, originally designed in the 1980's to support an outpatient treatment center, does not have sufficiently large operating rooms. The Hospital has no dedicated space in its Emergency Department to accommodate patients requiring observation services on an outpatient basis, many of whom stay over 24 hours. The Hospital has an insufficient number of beds located in private rooms.

Unfortunately, the previously approved Project was abandoned in 2008. This Project, more modest in scope and cost, will significantly improve the ability of FWMC to address future community needs.

New construction is proposed to be undertaken in five interrelated sections. The first section, (7,267 sf) involves the construction of a new two-story addition. The first story will house an expanded Emergency Department; the second story will house additional private patient rooms. Related renovations will be undertaken to assure a functional interface between the existing Hospital structure and the new addition.

[1] See MHCC Decision, Fort Washington Medical Center, Expansion and Renovation Project, Docket No. 05-16-2171.

The second section (4,857 sf) involves the construction of a new kitchen and an expanded dining area.

The third section (4,094 sf) involves an expanded Lobby and Waiting Area. This part of the Project will be staged, so as to permit the maximum accessibility for patients and visitors, and includes a plan for a temporary lobby.

The fourth section is an expanded surgery department, and the construction of one new Operating Room (3,522 sf). Existing facilities will be renovated and consolidated; the Hospital will continue to staff and use three operating rooms.

Finally, a new energy building will be added to the Hospital (3,000 sf). The design of this building incorporates some additional capacity for future facility demands for potential increasing energy use.

Approximately 8,400 sf of existing Hospital space will be renovated, to permit seamless "tie ins" to the proposed new construction, and to improve the functional status of existing clinical and support service areas.

The Project anticipates two types of renovations that will occur. First, there will be significant renovations that involve demolition of existing interior walls to create more useable space for existing departments. Second, there will be surface upgrades in areas adjacent to renovated areas and new construction.

The capacities of the general medical/surgical unit, the ED and the surgery department will change as set forth below:

1) Emergency Department and Observation Unit						
AREAS:			S.F.		TREATMENT BAYS	S.F. PER TREATMENT BAY
Existing			2,800 S.F		14	200
	After Completion		10,927 S.F		34	321

UPDATED DESCRIPTION OF FORT WASHINGTON MEDICAL CENTER RENOVATION AND EXPANSION PROJECT

	New Construction		8,127 S.F.			
	Renovation		1,102 S.F.			
	Adjacent Area Surface Upgrade		1,299 S.F.			
		1) a. Emergency Department (excluding Observation)				
		Existing	2,800 S.F.		14	200
		After Completion	9,250 S.F.		28	331
		New Construction	6,460 S.F.			
		1) b. Observation Unit				
					BEDS	S.F./BED
		All New Construction 1,677 S.F.			6	280
2) MSGA						
AREAS:			S.F.		BEDS[2]	S.F./BED
Existing			11,226 S.F		37	303
	After Completion		17,842 S.F		51	350
	New Construction		6,617 S.F.			
	Renovation		450 S.F.			
	Adjacent Area Surface Upgrade 901 S.F.					

[2] Physical Bed Capacity.

UPDATED DESCRIPTION OF FORT WASHINGTON MEDICAL CENTER RENOVATION AND EXPANSION PROJECT

3) Surgery Department						
AREAS:			S.F.		NUMBER of O.R.'s	
Existing			6,660 S.F		3	
	After Completion		8,320 S.F		3	
	New Construction		1,660 S.F.			
	Renovation		1,160 S.F.			

The current capital cost of the Project is estimated to be $17 Million. Under the current policies of the HSCRC, the Project is financially viable without a rate increase. The Project incorporates a State grant award of $560,000. The balance of the Project will be financed out of Cash Reserves and a FHA/HUD-insured mortgage. We anticipate the Project will be completed by December, 2016, with the two-story addition completed earlier.

It should be noted that one aspect of the proposed Project's construction and design has been updated. FWMC has contracted to install $35,000 of kitchen equipment in the current hospital dining and food serving area, and undertake modest renovations to that space to accommodate the equipment. The capital cost of the Project has been reduced to reflect this change, as the equipment will very likely remain at the hospital after the Project is completed.

In summary, this Project is being undertaken to assure that FWMC's existing and needed services remain available and accessible to its future patients.

ATTACHMENT 3

FWMC

Financial *Assistance* Program and Practices

FORT WASHINGTON MEDICAL CENTER
11711 LIVINGSTON ROAD
FORT WASHINGTON, MD 20744
Main Number: (301) 292-7000

For Financial Assistance: Visit the Insurance Verification Representative/Financial Counselor located in the Admitting Office or call 301-203-2271 or 2154.
If it is after hours, a holiday or a weekend, you can pick up/drop off an application at a Registration or Information desk. If you need additional assistance, please call and leave a message with a Financial Counselor and someone will return your call within three business days.
http://www.fortwashington-hospital.com

FWMC Form 1004 12/07

FINANCIAL ASSISTANCE PLAN

Fort Washington Medical Center (FWMC) follows a specific and compassionate policy for payment practices for financial assistance and uninsured billing. As a not-for-profit organization, one of the ways FWMC demonstrates its commitment to the community is through providing financial assistance to those in need. Our practices are an outgrowth of our mission and values.

FWMC'S RESPONSIBILITIES:

- FWMC will serve all patients regardless of ability to pay.
- Be respectful of the individual's personal dignity and his/her ability to pay.
- Treat all patients equitably, whether insured, underinsured or uninsured.
- Consider the financial resources of patients and their families when establishing a maximum annual patient responsibility.
- Be diligent in our efforts to keep patients notified of their payment options and the opportunities for assistance.
- Ensure that our policies are consistent with the guidelines that have been issued by the American Hospital Association, federal, state and local legislative bodies, and other organizations.
- Provide financial assistance to those in need.

PATIENT'S RESPONSIBILITIES:

- Follow through with the application process.
- Provide all required documents necessary in order to be granted financial assistance.

FWMC PROCEDURE SUMMARY:

1. An evaluation for financial assistance will be done when a:
   a. Patient with a self-pay balance due notifies Patient Accounts that he/she cannot afford to pay the bill and requests assistance.
   b. Patient presents at registration or a clinical area without insurance and states that he/she cannot afford to pay the medical expenses.
   c. Physician or other clinician refers a patient for a financial assistance evaluation.
2. A Financial Counselor/Insurance Verification Representative will meet with the patient, upon request, to give them instructions on the Financial Assistance Application. If it is after hours, a holiday or a weekend, provide the patient with a copy of the Financial Assistance Program brochure and ask the patient to call 301-203-2271or 2154 and someone will contact them within three business days.
3. A Letter of Conditional Approval for probable eligibility will be sent to the patient within three days of receipt of a completed application.
4. A Letter of Final Determination will be sent to the patient within 30 days to inform him/her eligibility for:
   a. Financial Assistance (Full or partial) or
   b. A Payment Plan (divided payments over two years).
5. During the application process, the patient must provide a copy of the following to the Financial Counselor:
   a. Most recent Federal Income Tax Return.
   b. Three most recent pay stubs (if employed).
   c. Medical Assistance Notice of Determination (if applicable).
   d. Proof of U.S. citizenship or permanent residence status
   e. Proof of disability income (if applicable).
   f. Reasonable proof of other declared expenses.
6. The following are necessary for a final determination:
   a. The patient must apply for Medical Assistance unless the Financial Counselor can readily determine that the patient would fail to meet the disability requirement.
   b. Review possibility of a reasonable payment plan agreement.
   c. The patient must be a United States of America citizen or permanent resident.
   d. All insurance benefits have been exhausted.
7. The completed Maryland State Uniform Financial Assistance Application and required forms will be forwarded from the Financial Counselor to the Director of Patient Accounts.
8. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses.
9. Once a patient is approved for Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to FWMC. If a patient does not make the required payment within 60 days, the Financial Assistance allowance will be reversed and the patient will owe the entire amount. It is recommended that the patient make a good faith payment at the beginning of the Financial Assistance period.

EXCLUSION: FWMC has the option to designate certain elective procedures for which no financial assistance option will be given.

TERMS OF AGREEMENT TO FINANCIAL ASSISTANCE:
Financial Assistance will remain valid for three months based on the initial date of the determination letter. For recurring patients, patients may qualify for Financial Assistance for up to six months on the basis of a single application.

All determinations of eligibility are solely at the discretion of FWMC

Fort Washington Medical Center (FWMC)
Estimated Average Charges for Common Procedures

The following information provides estimated average charges for common inpatient and outpatient procedures at Fort Washington Medical Center. This information is updated quarterly and is based on the patient charges actually incurred for these services during the previous six months. These amounts may be used by patients to estimate the charge for services that they may incur.

Please note that these are only estimates and are subject to change without notice. The actual cost of your procedure may be higher or lower based on factors specific to your case, such as your length of stay in the hospital and the complexity of your medical condition. If you have questions regarding an estimated charge, please contact a FWMC Financial Counselor at 301-203-2154.

These estimates reflect hospital charges only. They do not include physician or other provider fees that are billed separately from the hospital fees. You may receive bills from multiple physicians for their services, including but not limited to your anesthesiologist, hospitalist, pathologist, radiologist, cardiologist, emergency room physician, and other specialists who participate in your care. If you have questions regarding the bill for their services, please contact the individual provider.

MOST FREQUENT INPATIENT MEDICAL/SURGICAL CASES	Estimated Average Charge
392 ESOPHAGITIS GASTROENT & MISC DIGEST DISORDERS W/O MCC	$5,184.89
470 MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W	$27,491.17
292 HEART FAILURE & SHOCK W CC	$6,604.78
312 SYNCOPE & COLLAPSE	$8,136.35
194 SIMPLE PNEUMONIA & PLEURISY W CC	$9,267.18
293 HEART FAILURE & SHOCK W/O CC/MCC	$4,738.62
101 SEIZURES W/O MCC	$8,419.45
812 RED BLOOD CELL DISORDERS W/O MCC	$6,687.62
743 UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	$9,967.91
639 DIABETES W/O CC/MCC	$5,741.64

MOST FREQUENT OUTPATIENT SURGICAL CASES	Estimated Average Charge
4523 COLONOSCOPY	$910.56
8872 DX ULTRASOUND-HEART	$4,793.82
4542 ENDOSC POLYPECT OF LG INTESTINE	$1,215.04
4516 EGD WITH CLOSED BIOPSY	$1,564.04
5123 LAPARASCOPIC CHOLECYSTECTOMY	$6,963.36
8521 LOCAL EXCIS BREAST LES	$3,354.76
5732 CYSTOSCOPY NEC	$1,899.86
4525 ENDOSCOPIC LG BOWEL BX	$1,270.17
1341 CATARAC PHACOEMULS ASPIR	$2,222.70
863 OTHER LOCAL DESTRUC SKIN	$2,152.26

MOST FREQUENT LABORATORY SERVICES	Estimated Average Charge
CBC W/AUTO DIFF	$18.61
CHEM7 + CAL, (BMP)	$25.00
CK , BLOOD	$13.91
TROPONIN-I	$58.14
PT/INR	$17.97
SURG PATH GROSS MIC LE	$241.44
CKMB	$34.46
CHEM 12+CO2, (CMP)	$33.26
PARTIAL THROMBOPLASTIN	$18.11
CARDIO EVAL., LIPID PR	$43.71

DISCIPLINE	MOST FREQUENT IMAGING PROCEDURE BY DISCIPLINE	Estimated Average Charge
RADIOLOGY	71010 XR CHEST SINGLE 1V	$62.77
RADIOLOGY	71020 XR CHEST PA/LAT 2V	$94.87
RADIOLOGY	77057 MM MAMMO SCR BIL	$171.94
RADIOLOGY	93880 US CAROTID	$549.21
RADIOLOGY	76700 US RENAL	$281.43
RADIOLOGY	76700 US ABD COMP	$450.20
RADIOLOGY	76000 FLUORO TIME LESS THAN	$174.28
RADIOLOGY	74000 XR ABD SINGLE 1V	$95.92
RADIOLOGY	76856 US PELVIS GENERAL	$412.76
NUCLEAR MEDICINE	78451 NM CARDIOLITE WALL MOT	$966.54
NUCLEAR MEDICINE	78453 NM CARD THAL'M RSTN	$2,174.90
NUCLEAR MEDICINE	78454 NM CARDIOLITE STRESS D	$434.98
NUCLEAR MEDICINE	78452 NM CARDIOLITE STRESS	$2,996.53
NUCLEAR MEDICINE	78579 NM LUNG VENTILATION AE	$966.54
NUCLEAR MEDICINE	78580 NM LUNG SCAN PERFUSION	$870.04
NUCLEAR MEDICINE	78306 NM BONE SCAN TOTAL BOD	$1,594.92
NUCLEAR MEDICINE	78226 NM DISIDA-HEPATOBIL DU	$821.59
NUCLEAR MEDICINE	78315 NM BONE SCAN THREE PHA	$1,594.92
NUCLEAR MEDICINE	78215 NM LIVER/SPLEEN IMAGIN	$1,546.61
CAT SCAN	70450 CT HEAD WO CON	$64.91
CAT SCAN	74160 CT ABD W CON	$108.17
CAT SCAN	72193 CT PELVIS W CON	$108.17
CAT SCAN	71275 CT ANGIO CHEST	$178.15
CAT SCAN	72192 CT PELVIS WO CON	$73.57
CAT SCAN	74150 CT ABD WO CON	$72.51
CAT SCAN	71260 CT THORAX W CON	$108.17
CAT SCAN	71250 CT THORAX WO CON	$86.55
CAT SCAN	70486 CT MAX/FACIAL WO CON	$77.90
MRI	70548 MRA NECK WITH CONTRAST	$1,602.41
MRI	70551 MR BRAIN W/O CONT.	$696.83
MRI	70544 MRA HEAD W/O CONTRAST	$1,038.55
MRI	70553 MRI BRAIN W/WO CONTRAS	$1,254.06
MRI	73219 MRI UPPER EXTREMITY W	$905.71
MRI	70546 MRA HEAD W/WO CONTRAST	$1,950.76
MRI	70552 MR BRAIN W/CONT.	$905.87

ATTACHMENT 4

AGREEMENT

BETWEEN

THE HEALTH SERVICES COST REVIEW COMMISSION

AND

FORT WASHINGTON MEDICAL CENTER

REGARDING

GLOBAL BUDGET REVENUE AND NON-GLOBAL BUDGET REVENUE

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AGREEMENT
BETWEEN
THE HEALTH SERVICES COST REVIEW COMMISSION
AND
FORT WASHINGTON MEDICAL CENTER
REGARDING GLOBAL BUDGET REVENUE AND NON-GLOBAL BUDGET REVENUE

This Agreement, made this 14th day of July, 2014, between Fort Washington Medical Center (the "Hospital") and the MARYLAND HEALTH SERVICES COST REVIEW COMMISSION (the "Commission" or "HSCRC"), is subject to the following provisions:

I. Overview

The Global Budget Revenue ("GBR") model is a revenue constraint and quality improvement system designed by the Maryland Health Services Cost Review Commission to provide hospitals with strong financial incentives to manage their resources efficiently and effectively in order to slow the rate of increase in health care costs and improve health care delivery processes and outcomes. The GBR model is consistent with the Hospital's mission to provide the highest value of care possible to its patients and the communities it serves.

This Agreement is intended to promote the achievement of the goals of the Maryland All-Payer Model Agreement between the State of Maryland and the Center for Medicare & Medicaid Innovation (CMMI). The Hospital and HSCRC agree to modify this Agreement, if necessary, to ensure that it is consistent with the main provisions, objectives and requirements of the application that was filed with CMMI in October 2013, and meets the requirements of the final contract between CMMI and the State of Maryland.

The GBR model assures hospitals that adopt it that they will receive an agreed-on amount of revenue each year—i.e., the Hospital's "Approved Regulated Revenue" (Approved Regulated Revenue) under the GBR system-- regardless of the number of Maryland residents they treat and the amount of services they deliver provided that they meet their obligations to serve the health care needs of their communities in an efficient, high quality manner on an ongoing basis. The GBR model removes the financial incentives that have encouraged hospitals to increase their volume of services and discouraged them from reducing their levels of "Potentially Avoidable Utilization" (PAU) and marginal services. It provides hospitals with much-needed flexibility to use their agreed-on global budgets to effectively address the "Three Part Aim" objectives of better care for individuals, higher levels of overall population health, and improved health care affordability.

In accepting this Agreement, the Hospital agrees to operate within the GBR's financial constraints and to comply with the various patient-centered and population-focused performance standards that have been or will be established by the HSCRC, including all of the existing components of the Maryland

Hospital Acquired Conditions (MHAC) program, the Quality Based Reimbursement (QBR) program, the readmissions reduction program, and a number of other existing and future quality improvement programs. The Hospital agrees to cooperate with HSCRC in the collection and reporting of data needed to assess and monitor the performance of the GBR model and in the refinement of the GBR model and the related performance standards in the future. The HSCRC will delineate the performance standards and program refinements in policies that it will issue on a timely basis, and the Hospital agrees that it will comply with these policies.

The HSCRC will carefully monitor the Hospital's activities under this Agreement, including any service discontinuations, shifts of services from the Hospital to other related or non-related hospitals or non-hospital providers, changes in the Hospital's market share, and other relevant factors that are pertinent to the effective operation of the GBR model in accordance with the Three Part Aim and the final contract that is established by CMMI and the State of Maryland. The HSCRC will reasonably adjust the Hospital's Approved Regulated Revenue as it deems necessary to ensure that the Hospital receives the revenue it needs to meet its obligations under this Agreement.

The Hospital agrees to comply with the policies of the HSCRC with respect to any services it provides that are regulated by the HSCRC that are not covered under the GBR model. The services that are not covered by the GBR model are specified in Appendix B.

II. Term of Agreement

This Agreement will become effective on July 1, 2013 and will continue through June 30, 2014. On July 1, 2014, and each year thereafter, the Agreement will renew for a one year period unless it is canceled by the HSCRC or by the Hospital in accordance with Section XII.

III. Revenue Governed by Agreement

This Agreement will apply to all of the inpatient and outpatient revenues of the Hospital that are regulated by the HSCRC including those associated with services that are covered by the GBR model (i.e., the "GBR Revenue") and those that are not covered by the GBR model (i.e., the "Non-GBR Revenue). The services and revenues that are not covered by the GBR model are delineated in Appendix B. Any services and revenue which are excluded from the GBR model, as specified in Appendix B, will be subject to the policies of the applicable rate setting policies HSCRC regarding unit rates, quality, efficiency, readmissions, variable cost factors (VCFs), volume/case mix governors and other policies that the HSCRC establishes for hospitals (or categories of revenue) that are not covered by the GBR model.

This Agreement will establish the Approved Regulated Revenue of the Hospital, which shall mean the revenue for services covered by the GBR model, and the terms and provisions governing it and the revenue associated with services that are not covered by the GBR model, for each Rate Year. The Approved Regulated Revenue and the associated Unit Rates for the Hospital will be set forth in the

Hospital's Order Nisi for the particular Rate Year. Any revenues excluded from the GBR limits, pursuant to Section B, are specified in Appendix B and will be identified in the Order Nisi.

IV. Specification of the Approved Regulated Revenue of the Hospital

A. Overview

The Approved Regulated Revenue of the Hospital for the July 1, 2013 through June 30, 2014 period is specified in Appendix A. As shown in Appendix A, the Approved Regulated Revenue includes several components: the Permanent Base Revenue, which may include permanent positive or negative adjustments; and a series of other Annual or Periodic adjustments, assessments, and settlements. Appendix A also identifies the approved revenue for services that are not covered by the GBR model and the Order Nisi for the Hospital for the particular Rate Year. Appendix A and Appendix B will be updated as needed by the HSCRC on a periodic basis.

The Approved Regulated Revenue of the Hospital may include permanent or temporary rate adjustments designed to provide the Hospital with funds it needs to establish programs and capabilities that are essential to the effective implementation of the GBR model. These adjustments will be provided only to the extent that the Hospital demonstrates that it cannot reasonably afford to establish such activities without the additional resources. The amount, duration and purpose of any such adjustments will be clearly specified in Appendix B (and/or in accompanying documents) for the time period extending from the Effective Date of this Agreement through June 30, 2014. In addition, for any Rate Year beginning on or after July 1, 2014, the Hospital will provide the HSCRC with a prospective written description of the particular performance improvements it will seek to achieve through its use of the additional funds (if any) that are provided by these rate adjustments. The Hospital will also provide the HSCRC with credible, retrospective documentation of the performance improvements that it actually achieves by its use of the additional funds.

B. Detailed Description of the of the Basic Components of the Hospital's Approved Regulated Revenue

The HSCRC will develop the Approved Regulated Revenue of the Hospital for any particular Rate Year in the following way:

1. Initially, the HSCRC staff will determine the Base Approved Regulated Revenue of the Hospital by adjusting the Hospital's approved revenue for a specified historical base period to reflect settlements and adjustments. These adjustments may include additional funding to support programs and capabilities to be established by the Hospital that are necessary to permit it to operate efficiently and effectively in the public interest within the revenue constraints required by the GBR model.

2. The HSCRC staff will adjust the Base Approved Regulated Revenue of the Hospital that is subject to the GBR model to establish the Approved Regulated Revenue for the Rate Year(s) by applying a series of rate adjustments including the following:

a. The revenue will be adjusted to the Rate Year by multiplying it by 1 plus the annual Update Factor percentage(s) approved by the HSCRC for the Rate Year for hospitals operating under the GBR model. A portion of the revenues may not be updated, based on the policies then applicable, for revenues associated with Potentially Avoidable Utilization;

b. The revenue will be adjusted to reflect any performance-based purchasing rewards, penalties, scaling adjustments, and hospital improvement targets contained in Appendix C that are applicable at the time to GBR hospitals. The HSCRC expects to develop additional value-based policies that will apply to GBR hospitals in the future. These policies will be incorporated into the annual update factor adjustment process;

c. The revenue will also be adjusted to reflect changes in the mix of the Hospital's payers or changes in approved differential amounts and uncompensated care levels;

d. The revenue will be adjusted to reflect the reversal of any previous one-time adjustments that were in effect during the year;

e. The revenue will be adjusted to reflect any adjustments pursuant to programs such as the readmissions reduction program's prescribed savings adjustment;[1]

f. The revenue will be adjusted to reflect any targeted revenue adjustments, if any, designed to ensure compliance with the limits of the new All-Payer model or the savings requirements established for the Medicare program in the final contract between CMMI and the State of Maryland;

g. The revenue may include adjustments to reflect changes in the expected service volumes of the Hospital that are driven by changes in the demographics as described in Appendix D. The policies governing demographic adjustments may be modified from time to time by the HSCRC. The demographic allowance may not be applied to revenues for Potentially Avoidable Utilization based on policies then applicable;

h. The revenue may include adjustments to reflect the relative efficiency of the Hospital. The HSCRC staff and the relevant Work Group(s) will engage in efforts to develop appropriate methods to measure and compare efficiency under the GBR model including measurements that will be applied on a per capita basis to ensure that hospitals that reduce their unnecessary volumes are not penalized on the basis of comparisons that focus exclusively on per case or per unit definitions of efficiency;

---

[1] For SFY 2014 through 2018, the Hospital will be subject to a **Readmission Policy Adjustment.**

i. The revenue will be adjusted to reflect amounts or percentages that are imposed on the rates of all hospitals by the HSCRC to cover the costs of certain assessments.[2] These assessments will apply to the Hospital in the same manner in which they are applied to other hospitals;

j. The revenue will be adjusted to reflect revenue overages or underages pursuant to variances between the Hospital's actual revenue and its approved revenue for the previous Rate Year (as described in Section III. C.); and

k. The revenue may also be adjusted in other ways as needed to ensure that the revenue limits and performance improvements imposed by the final contract between CMMI and the State of Maryland are met.[3]

The result of these adjustments will be the amount of revenue which is herein referred to as the Approved Regulated Revenue of the Hospital for the Rate Year. The Approved Regulated Revenue may be further adjusted as described below for any Rate Year.

3. Other Adjustments

a. The HSCRC and the Hospital recognize that some services may be offered more effectively in an unregulated setting. When services covered by the GBR model are moved to an unregulated setting, the HSCRC staff will calculate and apply a reduction to the Hospital's Approved Regulated Revenue. At a minimum, the reduction will ensure that the shift provides a savings to the public and Medicare after taking into consideration the payment amounts likely to be made for the same services in an unregulated setting.

b. The HSCRC may initiate a review, or the Hospital may request, an adjustment to the Hospital's Approved Regulated Revenue to reflect changes in the market share of the Hospital. The HSCRC staff and the relevant Work Group(s) will be engaged during CY 2014 (and thereafter) in efforts to develop and refine rate setting policies to appropriately adjust for the impact of market share changes. These policies will be designed to separate the impact of reductions in avoidable volumes and volume increases, to the extent possible, from market share changes.

c. The HSCRC staff will work with the Hospital and with other hospitals that adopt the GBR model to calculate and evaluate any volume increases experienced by the Hospital and other hospitals that are induced by the expansion of health care coverage under the Affordable Care Act ("ACA") in 2014 and 2015, for insured populations under the age of 65, net of reductions in volumes for uninsured populations. Based on the

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[2] Health Care Coverage Fund, MHIP, Deficit Assessment, HSCRC and MHCC user fees, NSP, and CRISP are examples of such assessments currently in place and are subject to change by the Commission.

[3] For SFY 2014 through 2018, the Hospital will be subject to a **Readmission Policy Adjustment.**

findings of this evaluation, the HSCRC staff may provide a one-time adjustment to the Hospital's Approved Regulated Revenue.[4]

d. The HSCRC staff will consider one-time adjustments to the Hospital's regulated revenue for unanticipated events beyond the control of the Hospital that generate substantial increases in the Hospital's utilization levels, but only to the extent that the impact of such events on the Hospital materially and demonstrably exceeds the impact of similar events on other hospitals covered by the GBR model.

In summary, the GBR model is a new approach to hospital rate regulation in Maryland. The HSCRC and the Hospital agree to work together to address any significant unforeseen consequences of this Agreement to ensure that it meets the revenue constraints, savings targets and performance improvement requirements required by the final contract between CMMI and the State of Maryland.

V. Compliance

A. General Compliance Under the GBR Model

The Hospital will be subject to any rate adjustments that are necessary to bring it into compliance with the GBR's Approved Regulated Revenue. If the gross revenue charged by the Hospital exceeds the Approved Regulated Revenue, the difference between the gross revenue charged and the Approved Regulated Revenue will be subtracted from the Approved Regulated Revenue that would otherwise have been approved for the Hospital for the subsequent Rate Year. Conversely, if the gross revenue charged by the Hospital is less than the Approved Regulated Revenue, the difference will be added to the Approved Regulated Revenue of the Hospital for the subsequent Rate Year, except that undercharges below the corridor specified in Section B below will not be added to the Approved Regulated Revenue for the subsequent Rate Year.

B. Unit Rate Flexibility

The Hospital will be expected to monitor and adjust its unit charges on an ongoing basis to ensure that it operates within the Annual Regulated Revenue that is approved by the HSCRC under the GBR model and the revenue constraints that are applicable to its services that are regulated by the HSCRC and not covered by the GBR model. In order to facilitate the Hospital's compliance with these revenue constraints, the HSCRC will relax the rate unit rate compliance corridors that it generally applies to hospitals (and particular revenues) that are not governed by the GBR model. Specifically, the Hospital

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[4] National estimates are projecting modest or little growth in hospital volumes resulting from expansion of access under ACA. However, HSCRC recognizes that the impact is unknown and that it is the intent of the HSCRC to provide a timely revenue adjustment for the impact of volume increases arising from the expansion of access to insurance. HSCRC staff will develop a methodology to identify such volume increase and Hospital will have the opportunity to submit supporting information and request an adjustment to its GBR Revenue Base.

will be permitted to charge at a level up to five percent (5%) above the approved individual unit rates without penalty. This limit may be extended to ten percent (10%) at the discretion of the HSCRC staff if the Hospital presents satisfactory evidence that it would not otherwise be able to achieve its approved total revenue for the Rate Year. Similarly, the Hospital will be permitted to charge at a level up to five percent (5%) below the approved individual unit rates without penalty if it needs to lower its charges to meet its revenue constraints. This limit may be extended to ten percent (10%) at the discretion of the HSCRC staff if the Hospital presents satisfactory evidence that it needs this additional flexibility to meet its revenue constraints for the Rate Year. The Hospital will generally need to spread rate adjustments across all centers, avoiding adjustments concentrated in a few rate centers, unless it has received approval from HSCRC staff for an alternative approach. Charges beyond the corridors shall be subject to penalties as specified in HSCRC regulations.

C. Overall Compliance Corridors

The overall compliance corridors (overcharge and undercharge) for the total Approved Regulated Revenue and the revenue excluded from the Approved Regulated Revenue will be .5%, with such amount subject to change from time to time in accordance with HSCRC policies. The Hospital agrees that it will not overcharge the limits of the total Approved Regulated Revenue, and that it will take prompt action to gain compliance within the boundaries of unit rate compliance that are specified above. Charges beyond the corridors shall be subject to penalties as specified in HSCRC regulations.

VI. Monitoring of GBR Operation and Performance

The successful implementation of the GBR model will require strict adherence to the various revenue constraints, savings requirements and performance targets that are contained in the final contract between CMMI and the State of Maryland. Therefore, the HSCRC will engage in a variety of monitoring and evaluation efforts to determine whether all of these requirements are being met and to ensure that it introduces any corrective actions that may be needed on a timely basis.

1. Market Share

The HSCRC and the Hospital will monitor the Hospital's market share on an ongoing basis by analyzing and identifying changes in the levels of the Hospital's patient volumes that are derived from its Primary Service Area (PSA) or Secondary Service Area (SSA) as defined in Appendix E. The HSCRC staff and the Hospital will also monitor the total level of services and revenues which are provided by the Hospital to Maryland residents who live outside of the Primary and Secondary service areas of the Hospital, or to patients who live outside of Maryland in other states or foreign countries, and will track (to the extent possible) any changes in in-migration and out-migration patterns and their effects on the Hospital.

The HSCRC will make appropriate adjustments in the Hospital's Approved Regulated Revenue based on significant changes in the Hospital's market share or service levels; provided, however, that the HSCRC does not intend to provide increases in the Approved Regulated Revenue of individual hospitals based on market share analysis for volume increases that are not offset by reductions in the Approved Regulated Revenue(s) of other hospitals. The HSCRC also does not intend to make revenue adjustments based on market share changes that would discourage the Hospital from reducing its level of Potentially Avoidable Utilization.

2. Case Mix/Severity Levels

The HSCRC will pay close attention to the overall case mix index and the severity levels within DRGs at the Hospital. If requested, the Hospital will demonstrate to the HSCRC that any reductions in its case mix index or its severity levels are not the result of deliberate efforts by the Hospital to deny, for inappropriate financial reasons, any services to particular patients, or treatments for particular conditions that fall within the scope of the medical capabilities of the Hospital and its attending medical staff. The HSCRC plans to review data from multiple sources, including CRISP, in its evaluation of case mix and severity changes at the Hospital and, more generally, in the hospital industry.

3. Changes in Ownership and Control and Related Service Relocations

Significant changes in the health care delivery system in the Hospital's Primary and Secondary Service Areas could influence the appropriateness of the Approved Regulated Revenue established for the Hospital under this Agreement. Therefore, the Hospital agrees to declare and describe, in Appendix G, any financial interest (or control) it holds in other hospitals or entities that provide services, including non-hospital services, in the Hospital's Primary and Secondary Service Areas, as of the Effective Date of this Agreement.

In addition, the Hospital agrees to inform the HSCRC at least thirty (30) days in advance, in writing, or at the earliest practicable time thereafter, of any acquisitions or divestitures which it undertakes regarding such interests.[5] The HSCRC may request data from the Hospital, on a periodic or ongoing basis, regarding the utilization of the services provided by such related entities, to ensure that the Hospital complies with the GBR constraint through better management of its existing regulated services, and not by moving services from the HSCRC-regulated sector to unregulated sectors of the hospital or non-hospital environment in ways that do not comport with the objectives of the GBR model, the Three Part Aim, and the final contract between CMMI and the State of Maryland.

The Hospital will provide an annual disclosure and certification report, which is presented in Appendix F and Appendix G, regarding changes in the services it provides. The initial report will be due upon signing of this Agreement, and additional reports will due on an annual basis within 30 days after the end of each subsequent Rate Year.

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[5] This would include the purchase or divestiture of physician practices, joint-venture arrangements with other providers to establish unregulated services that duplicate or could substitute for regulated services currently provided by the Hospital (such as, but not limited to, unregulated clinic, urgent care, or ambulatory surgery services), or other non-hospital services.

4. Monthly Monitoring of Hospital

Within thirty (30) days after the end of every month during the Rate Years covered by this Agreement, the Hospital will provide the HSCRC with a brief written report designed to help the HSCRC to monitor the Hospital's compliance with this Agreement, to facilitate communication between the Hospital and the HSCRC staff, and to promote the success of the GBR model. This report should include the following information, which will be modified from time to time by HSCRC and the Hospital:

a. Year-to-date experience, for the current and prior year, for readmissions and comparisons of actual readmissions levels to targets, including inter-hospital readmissions experience from CRISP, for all payers combined and on a separate basis for Medicare;

b. Year-to-date experience for the current and prior year for MHACs/PPCs and associated comparisons to MHAC/PPC targets;

c. Changes in payer mix year-to-date versus prior year;

d. Changes in market share;

e. Compliance with the Hospital's GBR constraint and the Hospital's plan to eliminate any revenue overages through charge reductions in the remainder of the Rate Year;

f. Trends in Medicare charges for the Hospital and an assessment of whether the Hospital has been successful to date in achieving the needed Medicare payment reductions;

g. Trends in total regulated revenue for the Hospital broken out between revenues covered by the GBR model and revenues not covered by it with the revenues covered by the GBR model further segregated into Medicare and non-Medicare components divided between Maryland and out-of-state components;

h. Trends in revenue per Equivalent Inpatient Admission ("EIPA")/Equivalent Case Mix Adjustment Discharge ("ECMAD");

i. Trends in costs, including cost per EIPA/ECMAD, including a discussion of changes in costs relative to reductions in volumes; and

j. Other information that the Hospital wishes to report regarding the successes, failures and ongoing challenges of implementing the GBR model and its related population health strategy. This supplemental information may include brief descriptions of the efforts (such as the use of emergency room care coordinators, transition care coordinators, case management, integration with community based programs, nursing home interventions, and coordination with physician delivery system changes) that the Hospital has undertaken which have been effective (or

ineffective) in improving the efficiency, quality and/or processes of care. The objective of gathering such additional information is to develop a body of evidence that can be usefully shared with all Maryland hospitals that are operating under the GBR model.

The HSCRC recognizes that the collection and reporting of the information described above on a monthly basis may impose an unclear or excessive burden on the Hospital; therefore, the HSCRC staff intends to work with hospital representatives to refine the monthly information reporting requirements to ensure that the Hospital can provide the kinds of information needed by the HSCRC on a monthly basis without undue hardship.

VII. Evaluation of the Effectiveness of the GBR

As described above, the primary goal of the GBR model is to provide the Hospital with strong financial incentives to deliver medical care to its patients and its community in the most efficient and clinically effective ways that are consistent with the Three Part Aim.

The HSCRC staff shall evaluate the success of the GBR program established by this Agreement by measuring changes in the costs, quality and outcomes of medical care delivered by the Hospital. In these reviews, the HSCRC staff will pay particular attention to analyses of utilization trends pre-and post-implementation of the GBR model. The reviews will include evaluations of per capita hospital costs and, to the extent possible given data limitations, the total cost of health care in the Hospital's PSA and SSA. In addition, the HSCRC staff will examine the performance of the Hospital on the HSCRC's existing and future quality of care and outcomes metrics using existing standards and additional metrics that will be developed through the relevant Work Group(s).

The Hospital shall provide an annual report of its investment in infrastructure to promote the improvement of care delivery and reductions of Potentially Avoidable Utilization. This report will be due 90 days following the end of each fiscal year, and will include program descriptions, expenditures, and results.

VIII. Possible Future Modifications in the GBR Model to Achieve Improved Alignment of Incentives in the Health Care Delivery System

Under healthcare reform, a number of strategies are being considered to contain healthcare costs. For example, primary care medical homes, Accountable Care Organizations, and the bundling of services under single payment amounts are strategies that have been identified as possible ways to improve care while aligning providers for the efficient delivery of healthcare services. Health care reform efforts are progressing rapidly and may produce environmental changes that warrant some modifications to this Agreement. Therefore, the Hospital and the HSCRC staff agree to monitor such changes and to make changes in this Agreement, on a mutually acceptable basis, as needed in the future to accommodate or comply with future developments that are mandated or permitted by law and/or regulation.

IX. Other Potential Modifications

A. Approved Regulated Revenue Modifications

The Hospital may request a reevaluation of its Approved Regulated Revenue for any Rate Year by submitting its request in writing to the HSCRC staff and including the supporting rationale and documentation for its request to the HSCRC staff. The HSCRC staff will make a determination to approve, modify, or deny the request of the Hospital under this agreement. When it deems necessary, the staff will prepare a recommendation regarding the request, and the HSCRC will review the staff recommendation and render a decision. Similarly, the HSCRC may open discussions with the Hospital regarding modifications to the GBR constraint based on its ongoing review and monitoring of the Hospital's operations, performance, market share changes and other factors. The HSCRC staff reserves the right to modify the GBR constraint in accordance with the terms of this agreement.

B. Approved Regulated Revenue Modifications Related to CON Projects

The Hospital may apply for and receive a "Certificate of Need" (CON) approval to provide a new service or to undertake a major capital project. In such instances, the Hospital may elect to petition the HSCRC staff for an associated adjustment to the Hospital's Approved Regulated Revenue. The Hospital will be expected to demonstrate to the satisfaction of the HSCRC staff that it is unable to provide the new service or to fund the major capital project within its existing revenue constraints. Requests of this kind will be evaluated by the HSCRC staff on a case-by-case basis. However, the Hospital must recognize that the new All-Payer Model that will be established in the final contract between CMMI and the State of Maryland limits the total amount of hospital revenue that can be approved within the State for any given period of time, and that this constraint will require any approvals of additional revenue for individual hospitals to pass highly stringent tests of financial and clinical necessity and to be funded by reductions in the revenue approved for other hospitals.

The HSCRC staff will work with the relevant Work Group(s) and MHCC to develop and refine policies that will appropriately address the financial issues raised by CON projects and other capital and service expansions. The HSCRC staff will make recommendations to the HSCRC regarding any requests from the Hospital for additional revenues for these reasons, when necessary.

X. Out-of-Area and Out-of-State Volumes and Revenues

Significant changes in out-of-state volumes and volumes from outside the Hospital's PSA and SSA have the potential to positively or negatively affect the success of the GBR model. In FY 2013, approximately 11.28 percent (11.28%) of the Hospital's total revenue came from non-Maryland residents. If this percentage changes materially during the term of this Agreement, the HSCRC staff and the

Hospital will evaluate the causes of the change to ensure that the goals and objectives of this Agreement, the GBR model and the final contract between CMMI and the State of Maryland are not being undermined by such changes.

XI. Readmissions, Quality and Reductions of Potentially Avoidable Utilization

The new All-Payer Model established in the final contract between CMMI and the State of Maryland will include specific requirements for readmission reductions and quality improvements. In addition, the success of the new model depends on the effectiveness of the Maryland hospitals in achieving reductions in PAU in general and, in particular, for Medicare. By July 1, 2014, the HSCRC staff will establish targets for reductions in PAU. The achievement of these targets will be tied to payment in a way that is consistent with the Three Part Aim of improving care and reducing cost. Appendix C will contain the annual PAU reduction targets for the Hospital and the associated HSCRC payment adjustment policies.

As part of this process, the Hospital will prepare a periodic plan for Population Health Improvement and reductions on Potentially Avoidable Utilization. To the extent possible, the plans should rely on evidence based approaches to accomplish the goals. HSCRC will work with hospitals to promote evidence based, standardized, regionalized approaches in an effort to ensure effective means of providing needed infrastructure. HSCRC will also work with hospitals to develop processes to review these plans, provide evaluation and feedback on the results of the approaches, and to modify the approaches to improve the results.

XII. Termination and/or Renegotiation and Other Rights

A. Termination by the HSCRC

The HSCRC reserves the right to terminate this Agreement, with cause, at any time. For the purposes of this Agreement, "with cause" includes, but is not limited to, failure by the Hospital to provide high quality needed services as contemplated by this Agreement; the inappropriate shifting of hospital services to unregulated settings; failure to achieve total all payer or Medicare per capita revenue trends and/or performance targets that are consistent with the constraints and requirements imposed by the GBR model and the final contract between CMMI and the State of Maryland; or failure of the Hospital to comply with HSCRC regulations or policies.

The HSCRC will provide the Hospital with a reasonable opportunity to cure its failure to perform under this Agreement by adopting a corrective plan designed to eliminate the defects in its performance in a timely way. The corrective plan may include an immediate reduction in the Hospital's Approved Regulated Revenue; mandatory participation by the Hospital in a regional planning process focused on

achieving the requirements of the All-Payer model; or other identified actions.

If the Hospital is unwilling to adopt the corrective plan described above, the HSCRC will have the right to terminate the Agreement with due consideration to the need of the Hospital to transition out of this Agreement and the need to maintain overall compliance with the requirements imposed on the State of Maryland by the final contract with CMMI.

B. Termination by Hospital

The Hospital will have the right to transition to an alternative rate setting approach after giving six months of written notice to HSCRC staff of its intent to change as of a specific date. The notice will provide a description of the Hospital's chief reasons for the proposed termination. The HSCRC staff will work with the Hospital to resolve any issues, including the possible recapture of volume support provided under this agreement, where volumes were decreased during the course of the agreement, or where infrastructure funding or other incentives were removed from the revenue base. If the Hospital is transitioning to another model with a fixed revenue base, then these adjustments may not need to be evaluated. Any new agreement will need to be within the revenue limits and other performance tests and requirements imposed by the final contract between CMMI and the State of Maryland.

C. Other Rights

Nothing in this agreement should be construed to prevent the HSCRC or Hospital from undertaking any action that it is lawfully entitled to take, including exercising the right to initiate a full rate review by either the HSCRC or the Hospital.

D. Other Provisions Relative to the Hospital

1. The Hospital experienced certain physician retirements during the CY 2013. HSCRC has reduced revenues by 2.07% relative to this physician loss. HSCRC will consider reinstating the revenue when the physicians are replaced. In order to accomplish this, the price variance corridors will need to be tightened to align with the volume change expected; however, reductions regarding Potentially Avoidable Utilization (PAUs) are encouraged, and the corridors will be allowed to adjust for successful reductions to these PACs. This requires a technical calculation that the staff will work through with the Hospital upon request.

2. The Hospital will not be eligible for a demographic adjustment until FY 2015 due to its market share declines. At the discretion of the HSCRC staff, a health infrastructure adjustment of .65% may be placed in rates in FY 2015.

3. The Hospital has a CON application for improvements to its facilities; the CON is being modified to

incorporate the terms of this Agreement and to clearly indicate that additional licensed beds are not being requested. The $20 million project is for facilities improvements, including the addition of clinical and non-clinical square footage, and the conversion of semi-private patient rooms to private patient rooms. HSCRC staff will work with the Hospital and MHCC relative to these improvements. HSCRC staff has determined that there are extensive admissions for ambulatory sensitive conditions and is concerned about the bed need for the service area in light of the opportunities to reduce utilization through better community based care. HSCRC staff recognizes that the Hospital is working with University of Maryland Medical System to address some of these issues.

XIII. Definitions of Terms

Annual Update Factor: The update factor as approved by the Commission to apply to GBR hospitals in the State during the fiscal year, or a portion of the fiscal year.

Approved Regulated Revenue: For each Rate Year, the Hospital's approved revenue computed in accordance with this Agreement and specified in the Hospital's Order Nisi for the GBR for the particular Rate Year.

Approved Regulated Revenue Compliance and Related Adjustments: For each Rate Year, the Hospital's Approved Regulated Revenue will be compared to the Hospital's actual regulated revenue for the particular Rate Year. If the Approved Regulated Revenue exceeds the Hospital's actual regulated revenue, the amount of the excess will be added to the Hospital's Approved Regulated Revenue for the subsequent Rate Year as a One Time Adjustment.

If the Approved Regulated Revenue is less than the Hospital's actual regulated revenue, the amount of the shortfall will be subtracted from the Hospital's Approved Regulated Revenue for the subsequent Rate Year as a One Time Adjustment, except that undercharges below the corridor specified in subparagraph III. A will not be so included.

Base Approved Regulated Revenue: The total approved revenue of the Hospital for the initial year of the agreement as specified in Appendix A.

Demographic Adjustment: The Demographic Adjustment is the calculation described in Appendix D and the adjustment factors shown therein that provide an adjustment to the Approved Regulated Revenue for population and age related volume changes. This factor will be updated on an annual basis.

Maryland Hospital Acquired Conditions Initiative: The HSCRC's Maryland Hospital Acquired Condition ("MHAC") measurement methodology that compares a hospital's risk-adjusted actual rate of MHAC to an expected or predicted rate of MHAC based on state-wide experience.

One Time Adjustments: The HSCRC makes one-time adjustments to the Hospital's rates in deriving the Hospital's Approved Regulated Revenue for the particular Rate Year The HSCRC removes the One

Time Adjustments from the Approved Regulated Revenue in calculating Approved Regulated Revenue for a the subsequent Rate Year.

Potentially Avoidable Utilization ("PAU") includes utilization and revenue related to preventable admissions, readmissions (Inter and Intra hospital), Observation patients that would be reflected as a readmission if admitted, and Potentially Preventable Complications. Other categories of PAUs may be added by the HSCRC.

Quality-Based Reimbursement: The HSCRC's pay-for-performance initiative that links hospital performance (both relative and year-to-year) on a list of processes of care measures.

Rate Years: The Hospital's Rate Year corresponds to the State fiscal year that begins on July 1 each year and ends on June 30.

Readmission Policy Adjustment: In each Rate Year the derivation of the Hospital's Approved Regulated Revenue will include a Readmission Policy Adjustment calculated in accordance with HSCRC policies

Service Area: Primary and Secondary Service Areas represent the zip codes from which 75% of admissions are derived in the base period. This definition may be adjusted based on agreement between the Hospital and HSCRC.

Appendix E lists the Maryland zip codes and counties that make up the Hospital's Primary Service Area and its Secondary Service Area.

Unit Rates: The Approved Regulated Revenue per unit computed for each regulated revenue center in accordance with this Agreement as specified in the Hospital's Order Nisi for the particular Rate Year.

Unit Rate Compliance: The Hospital's compliance with its approved Unit Rate in each regulated revenue calculated pursuant to the HSCRC's Unit Rate compliance regulations; however, with relaxed corridors as described in this agreement.

In Witness whereof, the Parties have executed this Agreement and have this date caused their respective signatures to be affixed hereto:

Attest: _____ by _____ Date 7/14/2014

Chief Executive Officer
Hospital

Attest: _____ by _____ Date 7/16/2014

Executive Director
Health Services Cost Review Commission

Appendix A: Hospital's Base Revenue Components and Order Nisi

A.	**Base Approved Regulated Revenue**		**$ 46,796,285**
	1.	Approved Regulated Revenue	$ 46,796,285
	2.	Increment (If Any) for GBR Investments included in above amount	$
B.	**One Time Rate Adjustments and Annual Reversals (included in Approved Regulated Revenue above)**		
	1.	Assessments that Reverse Annually	$ 2,285,293
	2.	MHAC and QBR	$ 46,277
	3.	Other one-time adjustments	$
	4.	Total one-time adjustments	$ 2,331,570
C.	**Revenue Excluded from Approved Regulated Revenue Under GBR but Subject to Rate Regulation Description**		$ None
D.	**Total Approved Revenue Per Order Nisi (Equals A + C)**		$ 46,796,285

Appendix B: Revenues and Services Excluded from GBR Model and General Description of Rate Setting Requirements for Excluded Revenues

None

Appendix C: Potentially Avoidable Utilization Targets

Provided in HSCRC policy.

1. **Targets**

   a. Readmission and Re-Hospitalization Reduction Targets

   b. MHAC Targets

2. **Policy References**

3. **Description of Methodologies Linking Achievement of Targets and Payment Levels**

Appendix D: Demographic Adjustment

The Hospital will be eligible for a demographic adjustment starting July 1, 2015, so long as its market share is not declining.

Appendix E: Definition of Hospital's Service Area

The HSCRC will use zip codes and/or counties for market analysis.

1. The Primary Service Area (PSA) of the Hospital consists of the following zip codes (or counties):

_These are the zip codes that contribute more than 10% to the total FWMC discharges and where FWMC has 15% to 25% market dominance:

20744
20745
20748

2. The Secondary Service Area of the Hospital consists of the following zip codes (or counties):

___ These are zip codes that each contribute from 3% to 10% of total FWMC discharges and where FWMC has more than 5% market dominance:

20607
20032

Appendix F: Annual Disclosure and Certification Regarding Changes in Services Provided (Due 30 days after the end of the Rate Year)

Provided from approved HSCRC policies.

A. The following services were shifted in whole or in part to unregulated settings not regulated by the HSCRC:

None

B. The following services were shifted in whole or in part to the regulated activities of other hospitals:

None

C. Or: The Hospital is not aware of any services that were shifted in whole or in part to unregulated settings.

Verna S Meacham
Signature of Officer of Hospital

7/14/2014
Date

Verna S. Meacham
Name (Please Print)

President and CEO
Title

(301) 686-9010
Telephone Number

vmeacham@nexushealth.org
E Mail Address

Appendix G: Hospital Financial Interest, Ownership, or Control of other Hospital or Non-Hospital Services Provided Within the Service Area

The Hospital owns, has a substantial financial interest in, controls, or is financially or organizationally related to the following provider organizations or systems.

Fort Washington Medical Center, Inc. (the Hospital), was incorporated in Maryland in 1989 and is organized as a not-for-profit corporation. The Hospital is wholly owned by Nexus Health, Inc. (Nexus), formerly known as The Greater Southeast Community Hospital Foundation, Inc. As a wholly-owned subsidiary of Nexus, the Hospital is affiliated with Nexus's other subsidiaries, which include Carolyn Boone Lewis Health Care Center and Nexus Consulting, Inc.

On September 1, 2013, the Hospital entered into a management services agreement with University of Maryland Medical System Corporation (UMMS) whereby the Hospital's current Chief Executive Officer (CEO) and Chief Financial Officer (CFO) became direct employees of UMMS, and UMMS was tasked with providing management supervision for the operation and business development of the Hospital. The CEO and CFO report directly to the Board of Directors of the Hospital and are responsible for supervising the day-to-day operation, management, administrative supervision, and maintenance of the facility on behalf of the Hospital.

Appendix H: Calculation of Market Share

While the following calculation is not binding, it is suggested as a calculation that can be used to examine possible changes in market share given the complexities arising from evaluating shifts in market share under the incentives of population-based payment models. The HSCRC staff will instruct the appropriate Work Group(s) to examine this issue and to recommend policies to the HSCRC.

1. Volume of Services: In considering whether adjustments to the Hospital's Approved Regulated Revenue are warranted for shifts in market share, the changes in the service levels of the Hospital and of other hospitals in the Hospital's Service Area (i.e., its PSA and its SSA) will need to be calculated for selected services. These service levels will be calculated for the Base Year and for each Rate Year.

2. The measure of the volume of service will be calculated for the Hospital and for each other applicable Hospital separately for inpatient and outpatient services

3. The outpatient services will be converted to an inpatient equivalent volume of services.

4. For each hospital, including the GBR Hospital, which provides services in the particular category of service, the Hospital's Volume of Service will be calculated as follows:

   a. The Inpatient Volume of Services will equal the number of case mix adjusted discharges (CMADs) of the Hospital's inpatients whose services are included in the particular category; and

   b. The Outpatient Volume of Services will be computed as follows:

      i. The Hospital's Unit Charge will be calculated as the average charge per CMAD over all of the Hospital's inpatients, excluding outliers.

      ii. The outpatient equivalent CMADs (ECMADs) will be calculated as the Hospital's total charges, exclusive of the charges of inpatients included in the count of CMADs, divided by the Unit Charge.

5. The Hospital's volume of service for the particular category of services will equal the sum of the number of CMADs calculated in Step 4(a) and the number of ECMADs calculated in Step 4(b).

6. The calculations described above will be performed separately for PAUs, in recognition that a primary objective of the Agreement is to reduce PAUs. The HSCRC will ensure that the Hospital is not penalized for its PAU reductions in the market share calculation.

7. The total volume of service of a particular category of services which are provided by several hospitals will equal the sum of the volume of services for each hospital as calculated above.

The HSCRC will continue to work with the Hospital and the relevant Work Group(s) on the methods for calculating service level and market share changes. The parties recognize that this effort is a "work in progress" and they will work cooperatively to improve the methods of evaluating changes in market share and changes in efficiency levels.

Appendix I: Readmission Policy Adjustment

The Hospital's readmission savings requirement for the Rate Year 2014 was -.12%

ATTACHMENT 5

Calculations of Construction Costs of FWMC Project: New Addition, Expansion, and Renovations (June, 2014 Update)

A. General Hospital Benchmark Cost Estimate

Construction Class/Quality: Class A/Good Quality

	NEW CONSTRUCTION							RENOVATIONS					MVS Benchmarks
	ED Addition	Nursing Unit Addition	Dietary	Front Lobby	Surgery	Energy Building	Canopies	ED Addition	Nursing Unit Addition	Surgery	Front Lobby	Dietary	TOTAL
Number of Stories	1	1	1	1	1	1	1	1	1	1	1	1	
Square Feet	8,127	6,617	2,287	1,238	1,160	3,000	2,911	1,102	450	1,112	2,856	2,590	33,430
Floor Areas													
Perimeters	435	435	303	257	200	265		435	435	200	270	303	
Floor to Floor Height	13'	13'	14'	14'	16'	20'		13'	13'	16'	14'	14'	
Base Costs/Sq. Ft. (11/2013)	$354.99	$354.99	$354.99	$354.99	$354.99	$354.99	$50.00	$354.99	$354.99	$354.99	$354.99	$354.99	
Refined Cost													
Add Sprinklers (per square feet)	$3.48	$3.48	$3.48	$3.48	$3.48	$3.48		$3.48	$3.48	$3.48	$3.48	$3.48	
Add Elevator (per square feet)			-$8.24	-$8.24	-$8.24	-$8.24		-$8.24	-$8.24	-$8.24	-$8.24	-$8.24	
Total Refined Costs	$3.48	$3.48	-$4.76	-$4.76	-$4.76	-$4.76		-$4.76	-$4.76	-$4.76	-$4.76	-$4.76	
Total Adjusted Base Costs	$358.47	$358.47	$350.23	$350.23	$350.23	$350.23		$350.23	$350.23	$350.23	$350.23	$350.23	
Adjustments for Differential Cost/Department	1.18	1.06	1.52	0.8	1.89	0.7		1.18	1.06	1.89	0.8	1.52	
Multipliers													
Ceiling Height Multiplier	1.023	1.04	1.049	1.049	1.092	1.184		1.023	1.023	1.092	1.049	1.049	
Perimeter Multiplier	0.96	0.993	1.159	1.06	1.168	1.06		1.04	1.04	1.168	1.06	1.102	
Upcate/Location Multipliers													
Update: July, 2014	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	
Location	1.07	1.07	1.07	1.07	1.07	1.07	1.07	1.07	1.07	1.07	1.07	1.07	
Final Benchmark MVS Cost/Sq. Ft.	$462.27	$436.68	$720.23	$346.69	$939.50	$342.39	$55.64	$489.28	$439.53	$939.50	$346.69	$684.81	$464.64
Total Cost	$3,756,895.08	$2,889,478.85	$1,632,768.05	$429,202.70	$1,089,822.41	$1,027,181.82	$161,968.04	$539,191.50	$197,787.03	$1,044,726.31	$990,147.75	$1,773,662.14	$15,532,831.69

B. New Constructiona and Renovation Cost Estimate and Comparison (July, 2014 Dollars)

Project Budget Item: 2014 Cost Estimates	
Building	$9,288,014
Site Preparation	$604,302
Architectural/Engineering Fees	$1,325,849
Permits	$220,977
Capitalized Costruction Interest	$577,825
Contingencies	$1,558,563
Other	$937,510
TOTAL	$14,513,040
Adjustments for Extraordinary Costs*	$587,002
Adjusted Total for MVS Comparison	$13,926,038
Adjusted Cost/Sq. Ft.	$416.57
MVS Benchmark Cost/Sq. Ft.	$464.64
Total Over (Under) MVS Benchmark	-$48.06

*Most of these costs are for extraordinary costs for campus-wide site development and infrastructure (See Chart 1.)

ATTACHMENT 6

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.

Table 1. Statistical Projections - Entire Facility-Including Proposed Project

_X_CY or __ FY (Check)	Most Recent Ended Actual Years				Projected Years (ending with first full year at full utilization)					
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
1. Admissions										
a. M/S/G/A	2,758	2,085	1,884	2,087	2,001	1,833	1,688	1,620	1,602	1,634
b. Pediatric										
c. Obstetric										
d. Intensive Care	336	308	301	219	219	201	186	182	183	188
e. Coronary Care										
f. Psychiatric										
g. Rehabilitation										
h. Chronic										
i. Other (Specify)										
j. TOTAL	3,094	2,393	2,185	2,306	2,220	2,034	1,874	1,802	1,785	1,822
2. Patient Days										
a. M/S/G/A	9,933	7,931	7,265	7,375	7,539	6,899	6,381	6,238	6,271	6,456
b. Pediatric										
c. Obstetric										
d. Intensive Care	991	989	895	877	879	805	744	728	731	753
e. Coronary Care										
f. Psychiatric										
g. Rehabilitation										
h. Chronic										
i. Other (Specify)										
j. TOTAL	10,924	8,920	8,160	8,252	8,418	7,704	7,125	6,966	7,002	7,209
3. Average Length of Stay										
a. M/S/G/A	3.60	3.80	3.86	3.53	3.77	3.76	3.78	3.85	3.91	3.95
b. Pediatric										
c. Obstetric										
d. Intensive Care	2.95	3.21	2.97	4.00	4.01	4.00	4.00	4.00	3.99	4.01
e. Coronary Care										
f. Psychiatric										
g. Rehabilitation										
h. Chronic										
i. Other (Specify)										
j. TOTAL	3.53	3.73	3.73	3.58	3.79	3.79	3.80	3.87	3.92	3.96

(Continued)

Table 1. Statistical Projections - Entire Facility
Including Proposed Project - Continued

_X_CY or __ FY (Check)	Most Recent Ended Actual Years				Projected Years (ending with first full year at full utilization)					
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
4. Occupancy Percentage										
a. M/S/G/A	82.47%	65.84%	73.72%	74.84%	76.50%	70.01%	69.93%	68.37%	68.72%	70.75%
b. Pediatric										
c. Obstetric										
d. Intensive Care	67.88%	67.74%	61.30%	60.07%	60.21%	55.14%	50.96%	49.86%	50.07%	51.58%
e. Coronary Care										
f. Psychiatric										
g. Rehabilitation										
h. Chronic										
i. Other (Specify)										
j. Total	80.67%	65.87%	72.12%	72.93%	74.39%	68.09%	67.32%	65.81%	66.15%	68.11%
5. Number of Licensed Beds										
a. M/S/G/A	33	33	27	27	27	27	25	25	25	25
b. Pediatric										
c. Obstetric										
d. Intensive Care	4	4	4	4	4	4	4	4	4	4
e. Coronary Care										
f. Psychiatric										
g. Rehabilitation										
h. Chronic										
i. Other (Specify)										
j. Total	37	37	31	31	31	31	29	29	29	29
6. Outpatient Visits - regulated										
a. Emergency**	41,633	42,665	44,419	41,486	41,484	39,906	38,249	36,486	37,201	37,931
b. Clinical Services										
c. Other (Specify):										
Observation Extended Recovery	81	1,003	1,327	1,261	1,261	1,213	1,163	1,109	1,131	1,153
Same Day Surgery	2,271	2,070	2,381	2,132	2,092	2,070	2,064	2,082	2,088	2,094
Psych Day Care										
d. Total	43,985	45,738	48,127	44,879	44,837	43,189	41,476	39,677	40,420	41,178

** Number of Beds and occupancy percentage should be reported on the basis of licensed beds*

*** Excludes patients admitted to the Hospital following a visit to the Emergency Dept.*

FWMC Revised CON Submission September 2014

	Historical	Projected Years (ending with first full year at full utilization)					
	2013	2014	2015	2016	2017	2018	2019
Observation Visits	1,261	1,261	1,213	1,163	1,109	1,131	1,153
ALOS Observation Visit-days	1.50	1.50	1.50	1.50	1.50	1.50	1.50
Observation Days	1,892	1,891	1,819	1,744	1,664	1,696	1,729
% Observation Patients observed in ED	33.0%	33.0%	33.0%	50.0%	50.0%	50.0%	50.0%
% Observation Patients observed in MSGA Un	67.0%	67.0%	67.0%	50.0%	50.0%	50.0%	50.0%
Observation Days: ED	624	624	600	872	832	848	865
Observation Days: MSGA Unit	1,268	1,267	1,219	872	832	848	865
Total Observation Days	1,892	1,891	1,819	1,744	1,664	1,696	1,730
Total Observation Days in MSGA Unit	1,268	1,267	1,219	872	832	848	865
MSGA Days - admitted patients	7,375	7,539	6,899	6,381	6,238	6,271	6,456
ICU days	877	879	805	744	728	731	753
TOTAL all days	9,520	9,685	8,923	7,997	7,798	7,850	8,074
MSGA Beds	27	27	27	25	25	25	25
ICU Beds	4	4	4	4	4	4	4
Total Beds	31	31	31	29	29	29	29
ADC including Observation	26.1	26.5	24.4	21.9	21.4	21.5	22.1
% Occupancy including Observation	84.14%	85.59%	78.86%	75.55%	73.67%	74.16%	76.28%

EXPANATORY NOTES TO TABLE 1.

1. FY=CY
2. Between CY 2010 and CY 2013, FWMC saw a 25% reduction in inpatient admissions from 3,094 to 2,306.
3. During that same time period, FWMC saw a 20% reduction in inpatient days.
4. During 2013, 1,261 patients were provided outpatient observation services in the hospital, a significant (1,457%) increase in outpatient observation cases over the 81 visits reported in 2010.
5. Most of the observation days in 2013 were provided in the 33 bed inpatient unit of the hospital. On average 1.8 observation days per patient in 2010 were provided, decreasing to 1.5 observation days per patient in 2013.
6. Because of the increase in outpatient observation visits and days, the total number of patient days (both inpatient and outpatient) provided in the 33 bed inpatient unit of the hospital decreased 14% from 2010 through 2013, from 11,022 patient days to 9,520 patient days.
7. For the period ending June 30, 2012, approximately 578 inpatient discharges at FWMC were estimated by the staff of the HSCRC as "potentially avoidable," that is, hospital care that is unplanned and can be prevented through improved care coordination, effective primary care and improved population health.
8. As a result of the decrease in patient days, the number of licensed beds at the hospital has decreased from 37 in 2010 to 31 in 2013.
9. The FWMC service area comprises of 12 zipcodes located in Prince George's (7) and Charles County (3), Maryland, and the District of Columbia (2). A map of the FWMC service area is shown below.
10. The total adult population of the FWMC service area has grown from 278,360 in 2009 to 295,767 in 2013, a 9.6% increase. Among residents age 65+, the increase has been 27.9%. Based on population increases forecasts through 2018 provided by Nielsen/Claritas (and extended to 2019 by FWMC), the adult population of both cohorts will continue to increase by approximately 1% per year; with the age 65+ population increase forecasted at approximately 5% per year.
11. For the same 2009 through 2012 period, the number of MSGA discharges from Maryland and District of Columbia hospitals decreased from 34,107 to 31,638, a 7.2% decrease. Among adults age 15-64, the decline was 9.9%; among adult age 65+, the decrease was 2.2%
12. Based on these recent trends in declining MSGA utilization, FWMC projects that the decline in MSGA discharges from from Maryland and District of Columbia hospitals will continue through 2019, despite the projected growth in the adult population of the FWMC service area. Among all adult service area residents age 15-64, FWMC projects an 18.5% decrease in discharge rates between 2013 and 2019, an average annual decrease of 3% per year. A similar percentage decrease in discharge rates among residents age 65+ is also projected.
13. In projecting the decline in MSGA discharges, FWMC considered both the underlying trends in the utilization of MSGA services among residents of its service area, as well as factors that are specific to FWMC. For example, for State Fiscal Year 2012, the 578 MSGA discharges that were identified by the HSCRC staff as "potentially

avoidable" have not been included in the number of forecasted MSGA admissions on TABLE 1, which shows that the number of total admissions to FWMC is projected to decline from 2,306 to 1,822 for the period 2013 thought 2019, an average annual decline of 3.5%, slightly greater than the projected average annual decline in the MSGA discharges from Maryland and District of Columbia hospitals among residents of the FWMC service area.

Annual Changes in FWMC Inpatient Admissions: 2013 – 2019

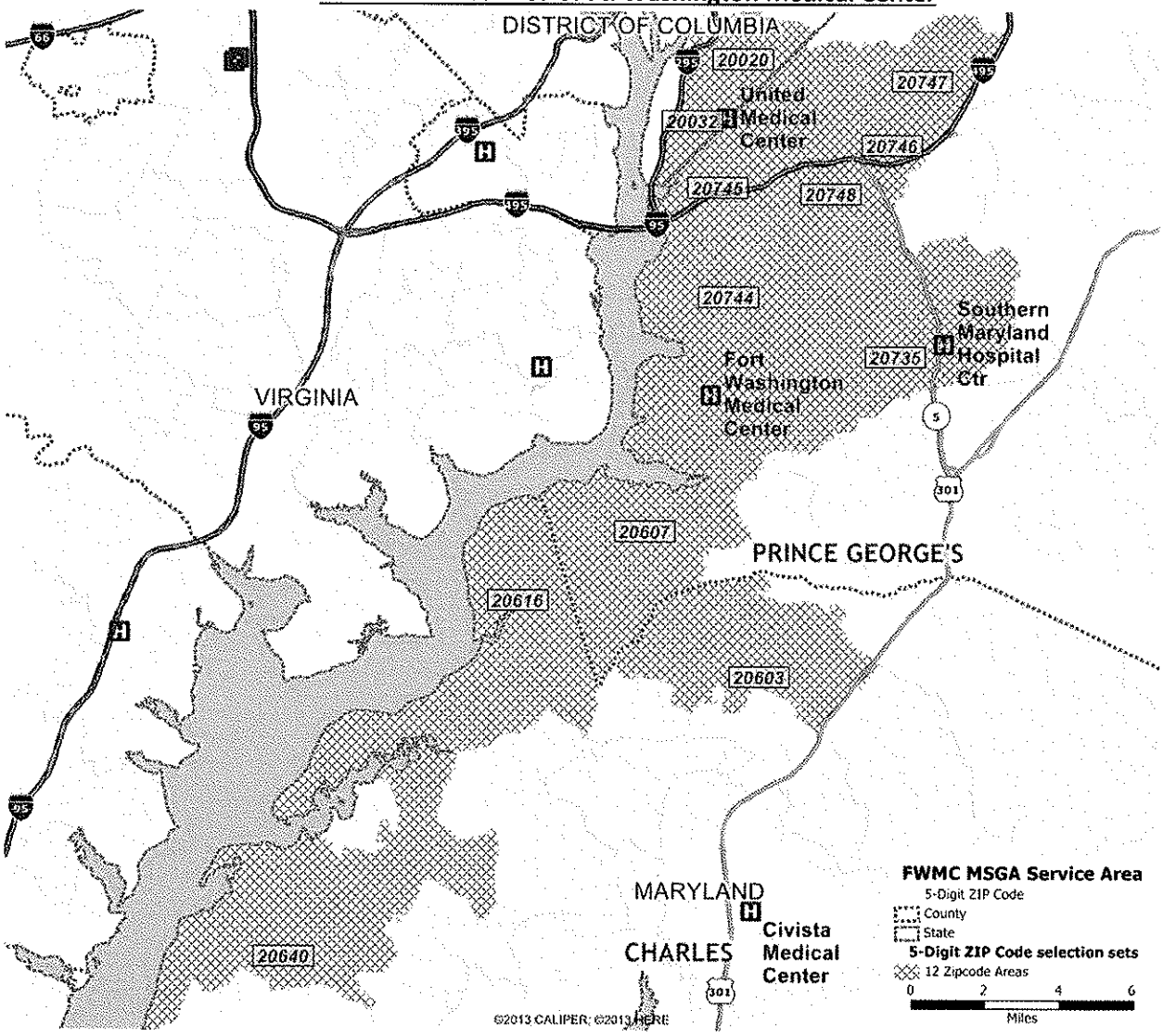
	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	Totals
Prior Year Admissions	2,306	2,220	2,034	1,874	1,802	1,785	2,306
Reductions - Due to Physician Retirements	(48)	(32)	(23)	(8)	(25)	(25)	(161)
Admissions - Recruited Physicians	26	19	34	52	62	62	255
Reductions - Potentially Avoidable Cases	(64)	(173)	(171)	(116)	(54)	-	(578)
Total Admissions	2,220	2,034	1,874	1,802	1,785	1,822	1,822

Source: FWMC.

14. With respect to forecasted patient days, FWMC assumed an increasing ALOS attributed to the change in case-mix related to the changes in MSGA admissions patterns to the hospital. These changes in admissions patterns are related to the successful implementation of the FWMC physician recruitment plan between 2013 and 2018 described in greater detail in other parts of this updated CON application (See CHART 5). Essentially, the FWMC plan seeks to replace retiring physicians, address the well-documented shortages of physicians throughout Southern Maryland, provide alternative private-practice settings for residents of the FWMC service area to the FWMC Emergency Department to access primary and urgent care services and decrease "potentially avoidable" admissions. In addition, the plan calls for an increase in surgical specialists to the FWMC medical staff and a commensurate increase in MSGA admissions and patient days for inpatient surgical services to FWMC. By 2019, FWMC is projecting a slight increase in MSGA admissions related to the completion of the recruitment plan and the full utilization of the additional physicians on the FWMC medical staff. The proposed renovations and construction of the FWMC surgery department, and the increase space and private patient rooms, are considered integral components of the FWMC physician recruitment plan.
15. With respect to outpatient services, FWMC is projecting a decrease in outpatient ED visits and outpatient observation visits between 2013 and 2017 for the same reasons described above. Upon implementation of the FWMC physician recruitment plan, FWMC is projecting that residents of the FWMC service area will seek and obtain services in primary care practice settings as an alternative to the FWMC Emergency Department. As, outpatient ED visits decline, FWMC anticipates a commensurate decline in outpatient observation visits as well. By 2019, when the implementation plan is completed, FWMC projects a slight increase in utilization of outpatient services.

16. With respect to outpatient observation services, this has been the fastest growing segment of FWMC's services since 2010. FWMC is projecting that outpatient observation visits and days will decline between 2013 and 2017, as the impact of the implementation of the FWMC physician recruitment plan is felt among residents of the FWMC service area. Nevertheless, the current physical plant of FWMC will remain inadequate to accommodate the 1,000+ outpatient observation patients forecasted for FWMC in future years. For that reason, the expanded Emergency Department will have 6 rooms available for observation patients, as well as unoccupied patient rooms located in the expanded medical/surgical unit. FWMC has assumed that following completion of the project, approximately 50% of its observation patients will be located in the expanded ED, and 50% will be located in the expanded medical/surgical unit. Of course, on any given day, that percentage may vary, depending upon the occupancy of observation beds in both locations.
17. FWMC has assumed that the number of licensed beds at FWMC will continue to decrease from 31 to 29 through 2019 consistent with the projected reduction in inpatient days. Despite this forecasted decrease, FWMC continues to believe that the 14 additional private patient rooms to be located in the medical/surgical unit, the six additional observation beds to be located in the expanded ED, and the proposed increase in the number of treatment rooms located in the expanded Emergency Department are needed to accommodate the forecasted volumes of both its inpatients and outpatients.

Current Service Area of Ft. Washington Medical Center



REVISED - Table 3. Revenue and Expenses - Entire Facility (Including Proposed Project) in thousands

_X_CY or __ FY Check	Most Recent Ended Actual Years				Projected Years (ending with first full year at full utilization)					
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
1. Revenue										
a. Inpatient	$ 23,220	$ 21,305	$ 17,619	$ 19,189	$ 18,775	$ 18,118	$ 17,680	$ 17,968	$ 18,175	$ 18,581
b. Outpatient	21,528	25,860	28,557	26,967	28,335	29,642	30,655	30,846	31,122	31,204
c. Gross patient service revenue	44,748	47,165	46,176	46,156	47,110	47,760	48,335	48,814	49,297	49,785
d. Allowance for bad debt expense	3,243	3,582	2,099	1,851	1,394	1,399	1,416	1,430	1,444	1,459
e. Contractual allowances	4,090	4,703	5,039	5,287	5,308	5,081	5,021	4,949	4,875	4,923
f. Charity care	603	688	1,497	1,660	1,695	1,718	1,739	1,756	1,773	1,791
g. Net patient service revenue	36,812	38,192	37,541	37,358	38,713	39,562	40,159	40,679	41,205	41,612
h. Other operating revenue (Specify):										
Other operating revenue - schedule attached	1,297	1,257	2,367	2,149	2,146	1,395	1,008	966	911	919
Interest income-trustee funds	-	-	-	-	8	8	9	10	11	13
i. Net operating revenue	$ 38,109	$ 39,449	$ 39,908	$ 39,507	$ 40,867	$ 40,965	$ 41,176	$ 41,655	$ 42,127	$ 42,544
2. Expenses										
a. Salaries, wages, and professional fees (including fringe benefits)	$ 21,345	$ 21,676	$ 22,348	$ 21,574	$ 21,970	$ 21,429	$ 20,861	$ 21,063	$ 21,522	$ 21,997
b. Contractual services - Purchased labor agency	6	-	-	1	-	-	-	-	-	-
c. Interest on current debt	637	613	610	557	395	375	355	336	318	300
d. Interest on project debt - including MIP and fees	-	-	-	-	-	-	1,046	1,023	1,000	975
e. Current depreciation	1,061	695	701	711	781	874	967	1,063	1,161	1,216
f. Project depreciation	-	-	-	-	-	-	901	901	901	901
g. Current amortization	90	90	90	90	90	90	90	90	90	90
h. Project amortization	-	-	-	-	-	-	73	72	70	68
i. Supplies	6,048	6,000	5,598	5,566	5,757	5,587	5,466	5,458	5,539	5,651
j. Other expenses:										
Insurance	860	874	873	893	921	912	903	896	897	901
Utilities	644	681	621	652	704	683	663	648	650	658
Physician professional fees	468	664	743	749	903	1,432	1,889	1,627	1,376	1,026
Contracted services	4,906	5,183	5,212	5,760	5,754	5,543	5,330	5,255	5,264	5,309
Rent	930	1,109	1,200	1,210	1,228	1,153	1,123	1,123	1,123	1,123
Other	718	895	810	1,169	1,224	1,201	1,044	1,030	1,031	1,040
k. Total operating expenses	$ 37,713	$ 38,480	$ 38,806	$ 38,932	$ 39,727	$ 39,279	$ 40,711	$ 40,585	$ 40,942	$ 41,255
3. Income										
a. Income from operations	$ 396	$ 969	$ 1,102	$ 575	$ 1,140	$ 1,686	$ 465	$ 1,070	$ 1,185	$ 1,289
b. Nonoperating income/expense:										
Interest income	5	4	1	1	10	18	23	28	33	39
Loss on debt extinguishment	-	-	-	-	-	-	-	-	-	-
c. Subtotal	401	973	1,103	576	1,150	1,704	488	1,098	1,218	1,328
d. Income Taxes	-	-	-	-	-	-	-	-	-	-
e. Net Income (Loss)	$ 401	$ 973	$ 1,103	$ 576	$ 1,150	$ 1,704	$ 488	$ 1,098	$ 1,218	$ 1,328

(Continued)

Table 3. Revenue and Expenses - Entire Facility (Including Proposed Project) - continued

_X_CY or __ FY Check		Most Recent Ended Actual Years				Projected Years (ending with first full year at full utilization)					
		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
4.	Patient Mix										
a.	Percent of Total Revenue										
(1)	Medicare	34.2%	33.8%	33.7%	34.6%	34.6%	34.6%	34.6%	34.6%	34.6%	34.6%
(2)	Medicaid	4.8%	4.0%	4.0%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%
(3)	Blue Cross	20.6%	20.7%	20.4%	21.2%	21.2%	21.2%	21.2%	21.2%	21.2%	21.2%
(4)	Commercial Insurance	16.4%	15.6%	15.0%	12.6%	12.6%	12.6%	12.6%	12.6%	12.6%	12.6%
(5)	Self-Pay	13.1%	13.3%	12.4%	13.6%	13.6%	13.6%	13.6%	13.6%	13.6%	13.6%
(6)	Other:										
	Medicaid/Medicare HMO	10.9%	12.6%	14.6%	14.2%	14.2%	14.2%	14.2%	14.2%	14.2%	14.2%
(7)	TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
b.	Percent of Patient Days\Visits\Procedures (as applicable)										
(1)	Medicare	34.2%	33.8%	33.7%	34.6%	34.6%	34.6%	34.6%	34.6%	34.6%	34.6%
(2)	Medicaid	4.8%	4.0%	4.0%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%
(3)	Blue Cross	20.6%	20.7%	20.4%	21.2%	21.2%	21.2%	21.2%	21.2%	21.2%	21.2%
(4)	Commercial Insurance	16.4%	15.6%	15.0%	12.6%	12.6%	12.6%	12.6%	12.6%	12.6%	12.6%
(5)	Self-Pay	13.1%	13.3%	12.4%	13.6%	13.6%	13.6%	13.6%	13.6%	13.6%	13.6%
(6)	Other:										
	Medicaid/Medicare HMO	10.9%	12.6%	14.6%	14.2%	14.2%	14.2%	14.2%	14.2%	14.2%	14.2%
(7)	TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

(INSTRUCTION: ALL APPLICANTS OPERATING EXISTING FACILITIES MUST SUBMIT THEIR MOST RECENT AUDITED FINANCIAL STATEMENTS)

Assumptions Used in Projecting All Revenues and Expenses:

1 2010-2013 are taken from FWMC's audited financial statements and HSCRC Annual Filing; Year 2014 is based on current operating results.

2 Charges:
Based on GBR Agreement executed in July 2014 - See Attached Schedule for detail of state fiscal year and calendar year projection for 2015 - 2019.

3 Deductions from Revenue, as a % of GPSR:
(See supplemental schedule for further detail)

	2011	2012	2013	2014	2015	2016	2017	2018	2019
Charity allowances	1.46%	3.24%	3.60%	3.60%	3.60%	3.60%	3.60%	3.60%	3.60%
Bad debt expense	11.83%	9.15%	10.03%	9.40%	8.71%	8.71%	8.71%	8.71%	8.71%
Uncompensated care fund	-4.23%	-4.61%	-6.02%	-6.44%	-5.78%	-5.78%	-5.78%	-5.78%	-5.78%
Subtotal - overall UCC Expense	9.05%	7.79%	7.61%	6.56%	6.53%	6.53%	6.53%	6.53%	6.53%
Contractual allowances	5.90%	6.28%	7.03%	7.03%	6.78%	6.53%	6.28%	6.03%	6.03%
Assessments - MHIP/BPW/HCCF/NSP	4.07%	4.64%	4.42%	4.23%	3.86%	3.86%	3.86%	3.86%	3.86%
Total	19.02%	18.70%	19.06%	17.82%	17.17%	16.92%	16.67%	16.42%	16.42%

Note: Projected Assessments and Uncompensated care fund receipts are based on recent assessment targets.
Projected Bad debt expense expected to decrease as a result of recent expansion in Medicaid program (PAC) and Affordable Care Act.

HSCRC has advised that it anticipates a reduction in bad debt expense because of the recent PAC expansion and has reduced targeted statewide and hospital specific uncompensated care as a result; the projected bad debt expenses herein reflects a comparable reduction.

Contractual allowances are projected to decline as a result of the elimination of a portion of denials and adjustments related to lack of medical necessity and unapproved charges based on elimination of PAU volumes and other issues that FWMC is currently working on internally.

4 Other Operating Revenue:
See attached schedule for detail components, assumed to vary with EIPAs; and includes projected EHR Incentive Attestation Revenue.

5 Operating Expenses - noncapital
Salaries, contracted services, insurance, utilities projected based on variability with volumes, as detailed below.

Volume Variability Factors	2014	2015	2016	2017	2018	2019
Projected Changes in EIPDs	6.4%	-3.8%	-4.1%	-2.8%	0.3%	1.7%
Projected Changes in CMA EIPDs	6.5%	-3.8%	-2.3%	1.5%	3.4%	3.4%
Projected Changes in CMA EIPAs	0.5%	-3.7%	-2.7%	-0.2%	1.9%	2.5%

Expense Volume Variability

Salaries	65.0% variability with EIPDs for 2015 and 2016;
Salaries	65.0% variability with CMA EIPDs for 2017, 2018 and 2019
Contracted Services	50.0% variability with EIPDs
Supplies and drugs	80.0% variability with CMA EIPAs
Insurance	25.0% variability with EIPDs
Utilities	75.0% variability with EIPDs
Other Expense	50.0% variability with EIPDs

Certain expense efficiencies, savings improvements have been projected for contracted services, equipment rent and other expenses. The total projected efficiencies amount to approximately $175,000 for 2015, and $262,000 for 2016, cumulative amount of $437,000.

Employee benefits factor at 18% of salaries, based on average of 2012 and 2013 actual results.
Rent expense projected with no volume variability.
Physician professional fees projected based upon Physician Recruitment Plan and 2014 existing physician professional fee structure. - See attached schedule

6 Capital Costs:

Project based on taxable FHA/GNMA Debt:

Taxable FHA/GNMA Debt	$ 19,190,000	25 years, level debt service
Interest rate on mortgage during and after construction	5.00%	
Mortgage Insurance Premium	0.50%	assessed on monthly average outstanding mortgage balance.
Weighted life of project	24.71	years, excluding capitalized interest
Interest earnings:		
Mortgage Reserve Fund	0.50%	Funded after construction to build to 1 annual mortgage payment after 5 years and 2 annual mortgage payments after 10 years.

Ongoing capital expenditures (nonproject) $ 1,000,000 per annum

2013 HUD Refinancing in July 2013

Interest Rate	3.95%	level debt service
Term	17.3 years, matures 12/1/2030	
Loan Refinanced	$ 9,492,000	

7 Interest earnings rate on average cash balances:

In excess of	$ 10,000,000	2.00%	per annum
Below	$ 10,000,000	0.50%	per annum

FORT WASHINGTON MEDICAL CENTER

PROJECTION GBR REVENUE - State Fiscal Year Basis

	SFY 6/30/2014 as of 7/1/2013	SFY 6/30/2015	SFY 6/30/2016	SFY 6/30/2017	SFY 6/30/2018	SFY 6/30/2019
Permanent Revenue, includes assessments	$ 47,020,000	$ 46,750,000	$ 47,626,000	$ 48,097,000	$ 48,573,000	$ 49,054,000
Full Inflation Provision	719,000	1,127,000	-	-	-	-
Subtotal	47,739,000	47,877,000	47,626,000	48,097,000	48,573,000	49,054,000
Population Adjustment	(989,000)	474,000	471,000	476,000	481,000	486,000
Subtotal	46,750,000	48,351,000	48,097,000	48,573,000	49,054,000	49,540,000
Slippage	-	(63,000)	-	-	-	-
Subtotal	46,750,000	48,288,000	48,097,000	48,573,000	49,054,000	49,540,000
GBR Investment	-	-	-	-	-	-
Subtotal	46,750,000	48,288,000	48,097,000	48,573,000	49,054,000	49,540,000
Change in Markup	-	(291,000)	-	-	-	-
Subtotal	46,750,000	47,997,000	48,097,000	48,573,000	49,054,000	49,540,000
Assessment Changes, (predominantly MHIP)	-	(371,000)	-	-	-	-
Subtotal Permanent GPSR	46,750,000	47,626,000	48,097,000	48,573,000	49,054,000	49,540,000
One Time Adjustments:						
MHAC/QBR Scaling	46,000	(203,000)	-	-	-	-
Undercharge at 6/30/2014; all recovered by 12/31/2014	(1,072,000)	1,072,000	-	-	-	-
Grand Total, Compliance GPSR	$ 45,724,000	$ 48,495,000	$ 48,097,000	$ 48,573,000	$ 49,054,000	$ 49,540,000

Convert GBR Revenue Target to CY	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
CY GBR Revenue Target	$ 47,109,500	$ 47,760,000	$ 48,335,000	$ 48,813,500	$ 49,297,000	$ 49,785,000
% Increase per Annum		1.38%	1.20%	0.99%	0.99%	0.99%

	SFY 6/30/2014	SFY 6/30/2015	SFY 6/30/2016	SFY 6/30/2017	SFY 6/30/2018	SFY 6/30/2019
Total Permanent Increase Per Annum	$ (270,000)	$ 876,000	$ 471,000	$ 476,000	$ 481,000	$ 486,000
Revenue Component Increase	1.529%	1.653%	0.000%	0.000%	0.000%	0.000%
Volume Component Increase	-2.103%	1.014%	0.989%	0.990%	0.990%	0.991%
Overall % Increase to Permanent Revenue	-0.574%	1.874%	0.989%	0.990%	0.990%	0.991%

Assumed Permanent Increases:	SFY 6/30/2014	SFY 6/30/2015	SFY 6/30/2016	SFY 6/30/2017	SFY 6/30/2018	SFY 6/30/2019
Full Inflation Provision	1.530%	2.410%	0.000%	0.000%	0.000%	0.000%
Population Adjustment	-2.071%	0.990%	0.990%	0.990%	0.990%	0.990%
Slippage	0.000%	-0.130%	0.000%	0.000%	0.000%	0.000%
GBR Investment	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%
Change in Markup	0.000%	-0.602%	0.000%	0.000%	0.000%	0.000%
Assessment Changes (predominantly MHIP)	0.000%	-0.790%	0.000%	0.000%	0.000%	0.000%
Total Permanent Changes	-0.541%	1.878%	0.990%	0.990%	0.990%	0.990%

FORT WASHINGTON MEDICAL CENTER

Projected and Historical Other Operating Revenue - Schedule for CON Table 3, Line H

	Historical for the Years Ending December 31,				Projected for the Years Ending December 31,					
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medical records	$ 28,799	$ 20,826	$ 20,900	$ 22,039	$ 22,600	$ 21,800	$ 20,800	$ 19,900	$ 19,700	$ 19,900
Unrestricted contributions and grants	30,000	60,955	70,000	298,428	305,700	294,300	281,200	268,700	265,700	267,900
Miscellaneous revenue*	461,143	461,414	480,171	483,216	494,900	120,400	115,000	109,900	108,700	109,600
Loss on disposal of property & equipment	-	(93,847)	-	-	-	-	-	-	-	-
Cafeteria	25,223	26,274	35,540	38,925	42,200	40,600	38,900	37,800	37,900	38,500
EHR incentive attestation revenue	-	-	1,195,000	915,710	500,000	250,000	-			
Maryland Medicaid EHR Incentive Revenue	-	-	-	-	230,000	138,000	46,000	46,000	-	-
Unregulated services - lab UR5	85,609	89,385	99,369	81,679	83,700	80,600	77,000	73,600	72,800	73,400
Unregulated services - physicians UR6	665,905	691,954	465,815	309,339	466,800	449,400	429,400	410,400	405,900	409,500
	$ 1,296,679	$ 1,256,961	$ 2,366,795	$ 2,149,336	$ 2,145,900	$ 1,395,100	$ 1,008,300	$ 966,300	$ 910,700	$ 918,600

*Eliminated Management fees from CBL Nursing Home starting in 2015 (from Misc Rev).

Supplemental Information for Deductions from Revenue

	Historical for the Years Ended December 31,				Projected for the Years Ending December 31,					
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Gross Patient Service Revenue - regulated	$ 44,747,960	$ 47,165,008	$ 46,176,442	$ 46,156,625	$ 47,110,000	$ 47,760,000	$ 48,335,000	$ 48,814,000	$ 49,297,000	$ 49,785,000
Deductions from GPSR:										
Bad debt expense	$ 5,263,590	$ 5,577,772	$ 4,226,166	$ 4,628,602	$ 4,428,510	$ 4,157,927	$ 4,207,986	$ 4,249,687	$ 4,291,736	$ 4,334,221
Uncompensated care fund receipts	(2,020,869)	(1,995,883)	(2,126,984)	(2,777,748)	(3,034,273)	(2,758,532)	(2,791,743)	(2,819,409)	(2,847,307)	(2,875,493)
Subtotal	3,242,721	3,581,889	2,099,182	1,850,854	1,394,237	1,399,395	1,416,243	1,430,278	1,444,429	1,458,728
Contractuals	2,621,914	2,782,082	2,898,376	3,246,469	3,313,526	3,239,844	3,158,012	3,067,273	2,974,380	3,003,824
Assessments	1,468,325	1,920,862	2,141,121	2,040,947	1,994,782	1,841,303	1,863,471	1,881,938	1,900,559	1,919,373
Subtotal	4,090,239	4,702,944	5,039,497	5,287,416	5,308,308	5,081,147	5,021,483	4,949,211	4,874,939	4,923,197
Charity	602,822	687,534	1,497,088	1,660,480	1,694,778	1,718,161	1,738,847	1,756,079	1,773,455	1,791,010
GRAND TOTAL	$ 7,935,782	$ 8,972,367	$ 8,635,767	$ 8,798,750	$ 8,397,323	$ 8,198,703	$ 8,176,573	$ 8,135,568	$ 8,092,823	$ 8,172,935
As a % of Gross Patient Service Revenue - regulated										
Bad debt expense	11.8%	11.8%	9.2%	10.0%	9.4%	8.7%	8.7%	8.7%	8.7%	8.7%
Uncompensated care fund receipts	-4.5%	-4.2%	-4.6%	-6.0%	-6.4%	-5.8%	-5.8%	-5.8%	-5.8%	-5.8%
Contractuals	5.9%	5.9%	6.3%	7.0%	7.0%	6.8%	6.5%	6.3%	6.0%	6.0%
Assessments	3.3%	4.1%	4.6%	4.4%	4.2%	3.9%	3.9%	3.9%	3.9%	3.9%
Charity	1.3%	1.5%	3.2%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%
	17.7%	19.0%	18.7%	19.1%	17.8%	17.2%	16.9%	16.7%	16.4%	16.4%

FWMC Revised CON Submission September 2014

Projected and Historical FTE Statistics
Fort Washington Medical Center, Inc.

	HISTORICAL				PROJECTED					
	Years Ended December 31,				Fiscal Years Ending December 31,					
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total FTEs	280.22	279.80	283.70	281.50	281.50	274.56	267.27	269.85	275.73	281.82
Percent Change in FTEs	-2.0%	-0.1%	1.4%	-0.8%	0.0%	-2.5%	-2.7%	1.0%	2.2%	2.2%
Equivalent Inpatient Days (EIPDs)	21,052	19,747	21,386	19,849	21,122	20,309	19,480	18,926	18,991	19,316
Percent Change in EIPDs	-4.90%	-6.20%	8.30%	-7.19%	6.41%	-3.35%	-4.08%	-2.84%	0.34%	1.71%
Average Daily Census	29.90	24.40	22.40	22.60	23.10	21.10	19.50	19.10	19.20	19.80
Adjusted Occupied Bed - EIPDs	57.52	54.10	58.59	54.38	57.71	55.64	53.37	51.85	52.03	52.92
FTE per average daily census - occupied bed	9.37	11.47	12.67	12.46	12.19	13.01	13.71	14.13	14.36	14.23
FTEs per adjusted occupied bed (EIPDs)	4.87	5.17	4.84	5.18	4.88	4.93	5.01	5.20	5.30	5.33
% Change per annum	3.4%	6.2%	-6.4%	7.0%	-5.8%	1.0%	1.6%	3.8%	1.9%	0.6%

Schedule Supporting UMMS Recruitment Plan Projected Expense for Expanded Physician Coverage

	Physician net subsidy per annum	Physicians Added	Projected UMMS Recruitment Plan Expense for Expanded Physician Coverage						
			2013	2014	2015	2016	2017	2018	2019
Year 1	$ 150,000	0.0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Year 2	$ 50,000	0.8	0	120,000	40,000	0	0	0	0
Year 3	$ -	3.7	0	0	555,000	185,000	0	0	0
		5.5	0	0	0	825,000	275,000	0	0
		3.0	0	0	0	0	450,000	150,000	0
		2.0	0	0	0	0	0	300,000	100,000
		15.0	$ -	$ 120,000	$ 595,000	$ 1,010,000	$ 725,000	$ 450,000	$ 100,000

	Incremental Number of Physicians Recruited						Cumulative
	2014	2015	2016	2017	2018	2019	Recruited through 2019
Family Practice/Internal Medicine	0.30	1.70	1.00	1.00	-	-	4.00
Cardiology	-	0.50	1.00	0.50	0.50	-	2.50
Gastroenterology	-	0.50	0.50	0.50	0.50	-	2.00
Neurology	-	0.50	0.50	-	-	-	1.00
General Surgery	0.50	0.50	0.50	-	-	-	1.50
Orthopedic Surgery	-	-	1.00	0.50	0.50	-	2.00
Otolaryngology (ENT)	-	-	1.00	0.50	0.50	-	2.00
Totals	0.80	3.70	5.50	3.00	2.00	-	15.00
Cumulative Total	0.80	4.50	10.00	13.00	15.00	15.00	

REVISED - Table 3. Revenue and Expenses - Entire Facility (Including Proposed Project) in thousands

_X_CY or __ FY Check	Most Recent Ended Actual Years				Projected Years (ending with first full year at full utilization)					
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
1. Revenue										
a. Inpatient	$ 23,220	$ 21,305	$ 17,619	$ 19,189	$ 18,775	$ 18,387	$ 18,409	$ 19,133	$ 19,795	$ 20,698
b. Outpatient	21,528	25,860	28,557	26,967	28,335	30,081	31,918	32,849	33,896	34,760
c. Gross patient service revenue	44,748	47,165	46,176	46,156	47,110	48,468	50,327	51,982	53,691	55,458
d. Allowance for bad debt expense	3,243	3,582	2,099	1,851	1,394	1,420	1,475	1,523	1,573	1,625
e. Contractual allowances	4,090	4,703	5,039	5,287	5,308	5,156	5,228	5,270	5,309	5,484
f. Charity care	603	688	1,497	1,660	1,695	1,744	1,811	1,870	1,932	1,995
g. Net patient service revenue	36,812	38,192	37,541	37,358	38,713	40,148	41,813	43,319	44,877	46,354
h. Other operating revenue (Specify):										
Other operating revenue - schedule attached	1,297	1,257	2,367	2,149	2,146	1,423	1,054	1,039	1,012	1,052
Interest income-trustee funds	-	-	-	-	8	8	9	10	11	13
I. Net operating revenue	$ 38,109	$ 39,449	$ 39,908	$ 39,507	$ 40,867	$ 41,579	$ 42,876	$ 44,368	$ 45,900	$ 47,419
2. Expenses										
a. Salaries, wages, and professional fees (including fringe benefits)	$ 21,345	$ 21,676	$ 22,348	$ 21,574	$ 21,970	$ 21,848	$ 21,694	$ 22,343	$ 23,287	$ 24,276
b. Contractual services - Purchased labor agency	6	-	-	1	-	-	-	-	-	-
c. Interest on current debt	637	613	610	557	395	375	355	336	318	300
d. Interest on project debt - including MIP and fees	-	-	-	-	-	-	1,046	1,023	1,000	975
e. Current depreciation	1,061	695	701	711	781	874	967	1,063	1,161	1,216
f. Project depreciation	-	-	-	-	-	-	901	901	901	901
g. Current amortization	90	90	90	90	90	90	90	90	90	90
h. Project amortization	-	-	-	-	-	-	73	72	70	68
i. Supplies	6,048	6,000	5,598	5,566	5,757	5,755	5,799	5,964	6,234	6,551
j. Other expenses:										
Insurance	860	874	873	893	921	930	941	956	978	1,007
Utilities	644	681	621	652	704	704	703	709	732	763
Physician professional fees	468	664	743	749	903	1,432	1,889	1,627	1,376	1,026
Contracted services	4,906	5,183	5,212	5,760	5,754	5,656	5,565	5,610	5,746	5,940
Rent	930	1,109	1,200	1,210	1,228	1,177	1,174	1,200	1,227	1,258
Other	718	895	810	1,169	1,224	1,225	1,095	1,104	1,130	1,169
k. Total operating expenses	$ 37,713	$ 38,480	$ 38,806	$ 38,932	$ 39,727	$ 40,066	$ 42,292	$ 42,998	$ 44,250	$ 45,540
3. Income										
a. Income from operations	$ 396	$ 969	$ 1,102	$ 575	$ 1,140	$ 1,513	$ 584	$ 1,370	$ 1,650	$ 1,879
b. Nonoperating income/expense:										
Interest income	5	4	1	1	10	17	23	28	35	43
Loss on debt extinguishment	-	-	-	-	-	-	-	-	-	-
c. Subtotal	401	973	1,103	576	1,150	1,530	607	1,398	1,685	1,922
d. Income Taxes	-	-	-	-	-	-	-	-	-	-
e. Net Income (Loss)	$ 401	$ 973	$ 1,103	$ 576	$ 1,150	$ 1,530	$ 607	$ 1,398	$ 1,685	$ 1,922

(Continued)

ATTACHMENT 7

Fort Washington Medical Center, Inc.

Financial and Compliance Report
December 31, 2013

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Independent Auditor's Report

To the Board of Directors
Fort Washington Medical Center, Inc.
Fort Washington, Maryland

Report on the Financial Statements

We have audited the accompanying financial statements of Fort Washington Medical Center, Inc. (the Hospital) which comprise the balance sheets as of December 31, 2013 and 2012, and the related statements of operations, changes in net assets and cash flows for the years then ended and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Member of the RSM International network of independent accounting, tax and consulting firms.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Fort Washington Medical Center, Inc. as of December 31, 2013 and 2012, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our reports dated April 3, 2014, and May 9, 2013, on our consideration of the Hospital's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of these reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of the audit performed in accordance with *Government Auditing Standards* in considering the Hospital's internal control over financial reporting and compliance.

Other Matters

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying schedule of expenditures of federal awards (page 19) is presented for purposes of additional analysis as required by the U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal awards is fairly stated in all material respects in relation to the financial statements as a whole.

The accompanying supplemental information on page 18 marked unaudited is also presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and related directly to the underlying accounting and other records used to prepare the financial statements. The information on page 18 marked unaudited has not been subjected to the auditing procedures applied in the audit of the financial statements, and accordingly, we do not express an opinion or provide any assurance on it.

McGladrey LLP

Baltimore, Maryland
April 3, 2014

Fort Washington Medical Center, Inc.

Balance Sheets
December 31, 2013 and 2012

	2013	2012
Assets		
Current Assets		
Cash and cash equivalents	$ 1,061,622	$ 1,950,937
Patient accounts receivable, net of uncollectible accounts (2013 – $2,304,568; 2012 – $2,836,820)	5,243,940	6,743,932
Inventory, prepaid expenses, and other current assets	2,151,236	1,935,472
Incentive payments receivable	915,710	-
Net due from affiliates	1,798,158	1,475,017
Total current assets	11,170,666	12,105,358
Property and Equipment, net	6,894,643	6,800,759
Assets Limited as to Use	1,631,655	1,453,983
Deferred Financing Costs, net of accumulated amortization (2013 – $793,317; 2012 – $702,969)	1,299,629	1,389,977
	$ 20,996,593	$ 21,750,077
Liabilities and Net Assets		
Current Liabilities		
Accounts payable, accrued expenses and other	$ 7,068,904	$ 7,854,760
Advances from third-party payors	915,452	845,952
Short-term financing	456,254	450,369
Current portion of capital lease obligations	91,076	87,688
Current portion of long-term debt	403,483	339,183
Total current liabilities	8,935,169	9,577,952
Obligations under Capital Leases, less current portion	184,515	275,590
Long-Term Debt, less current portion	8,280,193	8,875,861
Total liabilities	17,399,877	18,729,403
Commitments and Contingencies (Notes 8 and 10)		
Net Assets		
Unrestricted	3,489,716	2,913,674
Temporarily restricted	107,000	107,000
Total net assets	3,596,716	3,020,674
	$ 20,996,593	$ 21,750,077

See Notes to Financial Statements.

Fort Washington Medical Center, Inc.

Statements of Operations
Years Ended December 31, 2013 and 2012

	2013	2012
Unrestricted Revenue, Gains and Other Support		
Net patient service revenue	$ 39,599,750	$ 40,205,041
Provision for bad debt	(1,850,854)	(2,099,182)
Net patient service revenue less provision for bad debt	37,748,896	38,105,859
Other operating revenue, gains, and support	1,758,315	1,801,611
Total unrestricted revenue, gains, and other support	39,507,211	39,907,470
Expenses		
Salaries and benefits	21,573,556	22,348,086
Supplies and services	16,544,519	15,757,295
Depreciation and amortization	813,842	700,898
Total expenses	38,931,917	38,806,279
Income from operations	575,294	1,101,191
Other Income		
Interest income	748	808
Total other income	748	808
Excess of revenue over expenses	$ 576,042	$ 1,101,999

See Notes to Financial Statements.

Fort Washington Medical Center, Inc.

Statements of Changes in Net Assets
Years Ended December 31, 2013 And 2012

	2013	2012
Unrestricted Net Assets		
Excess of revenue over expenses	$ 576,042	$ 1,101,999
Increase in unrestricted net assets	576,042	1,101,999
Temporarily Restricted Net Assets		
Restricted contributions	-	-
Increase in temporarily restricted net assets	-	-
Increase in net assets	576,042	1,101,999
Net Assets		
Beginning of year	3,020,674	1,918,675
End of year	$ 3,596,716	$ 3,020,674

See Notes to Financial Statements.

Fort Washington Medical Center, Inc.

Statements of Cash Flows
Years Ended December 31, 2013 and 2012

	2013	2012
Cash Flows from Operating Activities		
Change in net assets	$ 576,042	$ 1,101,999
Adjustments to reconcile change in net assets to net cash and cash equivalents provided by operating activities:		
Depreciation and amortization	801,129	791,247
Decrease in allowance for uncollectible accounts	(532,252)	(418,914)
Amortization of mortgage discount	12,713	12,714
Changes in assets and liabilities:		
(Increase) decrease in:		
Patient accounts receivable	2,032,244	29,117
Inventory, prepaid expenses and other current assets	(215,764)	(2,426)
Incentive payments receivable	(915,710)	-
Net due from affiliates	(323,141)	(285,373)
Increase (decrease) in:		
Accounts payable, accrued expenses, and other	(785,856)	556,183
Advances from third-party payers	69,500	(127,176)
Net cash and cash equivalents provided by operating activities	718,905	1,657,371
Cash Flows from Investing Activities		
Acquisition of property and equipment	(804,665)	(818,228)
Increase in assets limited as to use	(177,672)	(170,672)
Net cash and cash equivalents used in investing activities	(982,337)	(988,900)
Cash Flows from Financing Activities		
Principal payments on long-term debt	(70,833)	(332,663)
Payment of deferred financing costs and debt discount	(473,248)	-
Proceeds from short-term financing	585,348	687,495
Principal payments on short-term financing	(579,463)	(645,028)
Principal payments on capital lease obligations	(87,687)	(84,425)
Net cash and cash equivalents used in financing activities	(625,883)	(374,621)
Net (decrease) increase in cash and cash equivalents	(889,315)	293,850
Cash and Cash Equivalents		
Beginning	1,950,937	1,657,087
Ending	$ 1,061,622	$ 1,950,937
Supplemental Disclosure of Cash Flow Information		
Cash paid for interest	$ 556,462	$ 600,422

Note 1. Nature of Activities and Significant Accounting Policies

Nature of Activities: Fort Washington Medical Center, Inc. (the Hospital), located in Fort Washington, Maryland, is a licensed 31-bed acute care general hospital. The Hospital provides inpatient and outpatient services primarily for residents of Prince George's County, Maryland and the surrounding areas. Admitting physicians are practitioners who practice primarily in the local area. The Hospital was incorporated in Maryland in 1989 and is organized as a not-for-profit corporation. The Hospital is wholly owned by Nexus Health, Inc. (Nexus), formerly known as The Greater Southeast Community Hospital Foundation, Inc.

A summary of the Hospital's significant accounting policies follows:

Basis of Accounting: The accompanying financial statements are presented in accordance with the accrual basis of accounting, whereby revenue is recognized when earned and expenses are recognized when incurred.

Basis of Presentation: The financial statement presentation follows the recommendations of the Not-for-Profit Entities Topic of the Financial Accounting Standards Board (FASB) Accounting Standards Codification (the Codification) and the *AICPA Audit and Accounting Guide for Health Care Entities*. Under this guidance, the Hospital is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted, temporarily restricted, and permanently restricted net assets:

> *Unrestricted net assets* represent contributions, gifts, and grants which have no donor-imposed restrictions or which arise as a result of operations.
>
> *Temporarily restricted net assets* represent contributions, gift, and grants which have donor-imposed limitations on their use for a specified time period or purpose.
>
> *Permanently restricted net assets* represent contributions, gifts and grants that have been restricted by donors to be maintained by the Hospital in perpetuity. The Hospital has no permanently restricted net assets at December 31, 2013 and 2012.

Management Estimates and Assumptions: The presentation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Net Patient Service Revenue and Patient Accounts Receivable: The Hospital reports net patient service revenue at the estimated net realizable amounts from patients, third-party payors, and others as services are rendered. Allowances for the excess of charges over anticipated patient or third-party payer payments and net uncollectible self-pay amounts are included in the determination of net patient service revenue as reported in the statements of operations.

Note 1. Nature of Activities and Significant Accounting Policies (Continued)

Patient accounts receivable arise from health care services provided primarily to residents of Maryland. The principal payors for these services are the patients, insurance companies (including CareFirst) and Medicare and certain Medicaid programs. Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Hospital analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Hospital analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Hospital records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Hospital grants credit to patients, substantially all of whom are local residents. The Hospital generally does not require collateral or other security in extending credit; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits receivable under their health insurance programs, plans, or policies.

The Maryland Health Services Cost Review Commission (HSCRC) regulates the Hospital's rates for all of its inpatient and outpatient services. As part of the regulatory process, the HSCRC approves unit rates and charges per case amounts, and the Hospital is required to charge within certain limits related to these approved amounts. The HSCRC charge per case methodology recognizes case mix changes. Annual compliance periods begin on July 1 and end on June 30. Variances (overcharges and undercharges), as well as penalties and interest incurred, during a rate year are generally accounted for in the following rate year's approved unit rates and charge per case. The Hospital received a 1.03% unit rate and charge per case increase effective July 1, 2012. This 1.03% included reconciliation of variances for the compliance period ended December 31, 2012. The Hospital received a 1.65% unit rate and charge per case increase effective July 1, 2013. This 1.65% included reconciliation of variances for the compliance period ended December 31, 2013.

Excess of Revenue Over Expenses: The statements of operations include the excess of revenue over expenses. Changes in unrestricted net assets which are excluded from the excess of revenue over expenses, consistent with industry practice, include unrealized gains and losses on investments other than trading securities, permanent transfers of assets to and from affiliates for other than goods and services, debt repayments and contributions of (and assets released from donor restrictions related to) long-lived assets.

Charity Care: The Hospital follows the disclosure guidance contained in FASB's Accounting Standards Update (ASU) No. 2010-23, *Health Care Entities (Topic 954): Measuring Charity Care for Disclosure – a consensus of the FASB Emerging Issues Task Force*. This ASU requires that the measurement of charity care by a health care entity for disclosure purposes be based on the direct and indirect costs of providing the charity care, and that the Hospital provide disclosure regarding the method used to identify or determine such costs. The measurement and disclosure requirements in this were required to be applied to all periods presented in the financial statements. (See Note 12 for further information.)

Note 1. Nature of Activities and Significant Accounting Policies (Continued)

Cash and Cash Equivalents: Cash and cash equivalents consist principally of bank deposits, money market accounts, and repurchase agreements, except for assets limited as to use, that are readily convertible into cash with an original maturity of three months or less. Periodically during the year, the Hospital's cash balances may exceed federally insured limits. The Hospital has not experienced any losses in such accounts. Management does not believe the Hospital is exposed to any significant financial risk.

Inventory: Inventories are stated at the lower of cost or market. The weighted average cost method is used to determine the cost value of inventories.

Property and Equipment: Property and equipment are recorded on the basis of cost, except for donated items, which are recorded at fair market value at the date of the donation. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated economic life of the equipment. Expenditures, which materially increase values, change capacities, or extend economic lives, are capitalized. The cost of property and equipment and the related accumulated depreciation are removed from the accounts in the year assets are sold or retired, and any profit or loss on disposition is credited or charged to other gains or losses, as appropriate. Depreciation expense is computed utilizing the straight-line method over the following estimated economic lives of the assets.

	Years
Building and land improvements	10 – 40
Fixed equipment	10 – 15
Movable equipment	3 – 5

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support, and are excluded from the excess of revenue over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as temporarily restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Mortgage Discounts and Issuance Costs: Deferred financing costs relate to the 2004 mortgage note, which was refinanced during the 2013, and are being amortized on a method approximating the interest method over the life of the related debt. The amortization for deferred financing costs was $90,348 and $90,349 for each of the years ended December 31, 2013 and 2012, respectively. Amortization expense related to the mortgage discount was $12,713 and $12,714 for years ended December 31, 2013 and 2012, respectively. These amounts are recorded as interest expense included in supplies and services expense in the statements of operations.

Assets Limited as to Use: Assets limited as to use are comprised of cash and cash equivalents held by a trustee in accordance with the Hospital's mortgage loan and of amounts limited by donor restrictions.

Advances From Third-Party Payors: The Hospital will occasionally receive cash advances from various third party payors. These amounts have been reported in the accompanying balance sheets as a current liability.

Note 1. Nature of Activities and Significant Accounting Policies (Continued)

Income Taxes: The Hospital is generally exempt from federal income taxes under the provisions of Section 501(c)(3) of the Internal Revenue Code (IRC). Income that is not related to exempt purposes, less applicable deductions, is subject to federal and state corporate income taxes. The Hospital had no net unrelated business income for the years ended December 31, 2013 and 2012.

The Hospital has adopted the accounting standard on accounting for uncertainty in income taxes, which addresses the determination of whether tax benefits claimed or expected to be claimed on a tax return should be recorded in the financial statements. Under this policy, the Hospital may recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position would be sustained on examination by taxing authorities, based on the technical merits of the position. Management has evaluated the Hospital's tax positions and has concluded that the Hospital has taken no uncertain tax positions that require adjustment to the financial statements to comply with provisions of this guidance.

Generally, the Hospital is no longer subject to income tax examinations by the U.S. federal, state or local tax authorities for years before December 31, 2010.

Subsequent Events: The Hospital evaluated subsequent events through April 3, 2014, which is the date the financial statements were available to be issued.

Note 2. Patient Revenue and Accounts Receivable

At December 31, 2013 and 2012, the Hospital had gross patient accounts receivable from third-party payors and others as follows:

	Percentage	
	2013	2012
CareFirst	**15.1**	15.8
Worker's Compensation	**0.9**	1.1
Medicaid	**6.6**	6.4
Managed Care and Commercial	**33.2**	28.6
Medicare	**25.4**	32.2
Self-pay	**18.8**	15.9
	100.0	100.0

Note 2. Patient Revenue and Accounts Receivable (Continued)

Gross patient service revenue, by payer class, consisted of the following for the years ended December 31, 2013 and 2012:

	Percentage	
	2013	2012
CareFirst	**21.2**	20.5
Worker's Compensation	**0.5**	0.5
Medicaid	**6.0**	7.0
Managed Care and Commercial	**30.5**	29.4
Medicare	**34.7**	34.9
Self-pay	**7.1**	7.7
	100.0	100.0

Gross patient revenue consisted of the following split between inpatient and outpatient services for the years ended December 31, 2013 and 2012:

	2013	2012
Inpatient services	**$ 18,365,698**	$ 15,964,050
Outpatient services	**27,875,414**	30,319,035
	$ 46,241,112	$ 46,283,085

Note 3. Related Party Transactions

As a wholly-owned subsidiary of Nexus, the Hospital is affiliated with Nexus's other subsidiaries, which include Carolyn Boone Lewis Health Care Center (the Center) and Nexus Consulting, Inc. The composition of net due from affiliates as of December 31, 2013 and 2012, is as follows:

	2013	2012
Carolyn Boone Lewis Health Care Center	**$ 1,792,050**	$ 1,468,909
Nexus Consulting, Inc.	**6,108**	6,108
	$ 1,798,158	$ 1,475,017

The Hospital allocates certain joint costs to the Center, such as certain compensation, insurance, and information technology costs. The Hospital has occasionally advanced funded certain accounts payable disbursements to the Center. The Hospital also allocated a charge to the Center annually for management services in the amount of $356,004 for each of the years ended December 31, 2013 and 2012, and the Hospital is allocated a $120,000 charge annually from the Center for contracted dietary services.

Note 4. Property and Equipment

Property and equipment consists of the following at December 31, 2013 and 2012:

	2013	2012
Land and land improvements	$ 874,369	$ 874,369
Building	8,881,193	8,873,194
Equipment	11,109,172	10,639,442
Leased equipment	1,834,965	1,834,965
	22,699,699	22,221,970
Less accumulated depreciation		
Building, land improvements and equipment	16,742,733	16,167,815
Leased equipment	1,536,160	1,400,296
	18,278,893	17,568,111
	4,420,806	4,653,859
Construction in progress	2,473,837	2,146,900
	$ 6,894,643	$ 6,800,759

Depreciation expense reported in the accompanying statements of operations includes amortization expense of $135,865 related to leased equipment for each of the years ended December 31, 2013 and 2012.

Note 5. Assets Limited as to Use

Assets limited as to use consisted of the following as of December 31, 2013 and 2012:

	2013	2012
Mortgage reserve fund	$ 1,524,655	$ 1,346,983
Donor restricted cash	61,000	61,000
Pledges receivable	46,000	46,000
	$ 1,631,655	$ 1,453,983

In 2008, the Hospital commenced a capital campaign and contributions from the campaign will be used to fund major renovation and construction projects. Gross pledges receivable were $326,000, less an allowance of $280,000, as of both December 31, 2013 and 2012.

The payment terms of the pledges receivable as of December 31, 2013, are as follows:

Year Ending December 31,	
2014	$ 326,000
Less allowance for uncollectible accounts	(280,000)
	$ 46,000

Note 6. Short-Term Financing and Term Loan

Short-Term Financing: The Hospital borrowed funds to finance its annual insurance premium payments. Interest payable on these amounts is included in current liabilities as accrued expenses. Payments are made monthly and the total balance is due within one year. Interest expense was $7,617 in 2013 and $4,533 in 2012 at a rate of approximately 2.60% per annum. The outstanding balance of this financing was $456,254 and $450,369 as of December 31, 2013 and 2012, respectively.

Commercial Bank Loan: In January 2008, the Hospital obtained a loan in the amount of $250,000 from a commercial bank. The loan was funded by the transfer of existing balances from the Hospital's line of credit. The term of the loan is 75 months, and the loan bears interest based on *The Wall Street Journal* prime rate plus 2% per annum (effective interest rate at 12/31/2013, 5.25%).The Hospital is required to make interest-only payments monthly and quarterly principal payments of $10,000 with the remaining unpaid principal and interest due on April 16, 2014. The loan is guaranteed by Nexus, which has pledged 100% of the stock it owns in the Hospital as security for the loan. The loan contains restrictive covenants. The remaining principal balance as of December 31, 2013, is $9,094 and is included in the current portion of the long-term debt on the accompanying balance sheet.

Note 7. Mortgage Loan

On December 23, 2004, the Hospital entered into an $11,055,000 taxable mortgage loan insured by the United States Department of Housing and Urban Development (HUD) through its Federal Housing Administration (FHA). The loan provided for the satisfaction of the Hospital's previous bond obligation, and for construction, new equipment, and financing costs.

During the year ended December 31, 2013, the loan was refinanced through the same lender to lower the interest from 6.125% to 3.95% per annum, payable in monthly installments. The term of the loan was not changed and the last payment is due in 2030. Fees in the amount of $473,248 paid to the lender were recorded as additional discount on the loan in accordance with accounting standards applicable to debt modifications.

As of December 31, 2013 and 2012, the outstanding balance on the loan was $8,683,676 and $9,165,919, respectively. The loan is subject to restrictive covenants, including restrictions on additional long-term borrowings and prepayment of the outstanding obligation. Under the terms of the HUD-insured mortgage loan, the Hospital is required to maintain certain deposits with a trustee. Such deposits are included in assets limited as to use. The loan is secured by the Hospital premises, and all the assets and cash flows contained therein.

Scheduled principal repayments of the mortgage are due in future years as follows:

Years Ending December 31,	
2014	$ 394,298
2015	410,321
2016	426,754
2017	443,941
2018	461,775
Thereafter	7,226,867
	9,363,956
Less mortgage discount	(689,374)
	$ 8,674,582

Interest expense on all financing arrangements was $557,096 and $610,181 for the years ended December 31, 2013 and 2012, respectively.

Note 8. Leases

The Hospital leases medical and office equipment under eight leases requiring monthly payments ranging from approximately $140 to $10,750, and the term of these leases expire through 2018.

The Hospital also leases facility and office space under three leases, and guarantees the rental payments for its corporate headquarters office lease, under the terms of which the Hospital and Center are proportionally allocated all related rent expense through its management fee arrangement with Nexus (see Note 3). The corporate headquarters office lease is subject to annual escalations. Monthly rental payments range from approximately $1,350 to $14,000, and the term of these leases expire through 2018.

In addition, the Hospital leases other facility space and equipment under cancelable and non-cancelable operating leases with terms of one year or less.

Rental expense associated with the Hospital's operating leases for the years ended December 31, 2013 and 2012, was $1,209,573 and $1,200,387, respectively.

The Hospital has a capital lease arrangement for medical equipment for use in operations. The lease term is five years, expiring in November 2016, and bears interest at an annual rate of 3.8%, payable monthly. Interest expense related to this lease for the years ended December 31, 2013 and 2012, was $15,406 and $15,542, respectively, and is reported as a component of supplies and services expense in the accompanying statements of operations.

The aggregate future minimum rentals, as of December 31, 2013, under the operating and capital leases are as follows:

Years Ending December 31,	Operating	Capital
2014	$ 367,724	$ 99,967
2015	236,114	99,967
2016	77,348	91,637
2017	53,694	-
2018	49,332	-
Total	$ 784,212	291,571
Less amount representing interest		(15,980)
Present value of future minimum lease payments		275,591
Less current portion of obligation under capital leases		(91,076)
Obligations under capital leases – excluding current portion		$ 184,515

Note 9. Employee Benefit Plans

Pension: Employees of the Hospital and an affiliate participated in a noncontributory Defined Contribution Plan and currently participate in an Employee Thrift Plan that covers substantially all Hospital employees. Participant benefits became fully vested upon completion of five years of credited service or attainment of their normal retirement age. The Plan Administrator amended the Defined Contribution Plan to vest participants in 100% of their account balances as of December 8, 2000, with notice to participants as required by Section 204(h) of the Employee Retirement Income Security Act of 1974, as amended. The Board of Directors of the Hospital voted to terminate the Defined Contribution Plan effective June 30, 2004, after which time no further contributions were made.

Note 9. Employee Benefit Plans (Continued)

Contributions to the Employee Thrift Plan are based on a match of up to 3% of compensation and participants are immediately vested in those amounts. The Employee Thrift Plan was amended to provide for a discretionary contribution at the option of management. Pension expense for the Employee Thrift Plan was $440,511 and $431,030 for the Hospital for the years ended December 31, 2013 and 2012, respectively. In 2013, management elected not to fund the discretionary contribution previously accrued for plan year 2012, resulting in a reduction of pension expense in the amount of $194,830. In 2012, management elected not to fund the discretionary contribution previously accrued for plan year 2011, resulting in a reduction of pension expense in the amount of $184,076. Management accrued a discretionary contribution for plan year 2013.

Note 10. Commitments and Contingencies

Insurance: The Hospital currently maintains professional liability insurance coverage on a claims-made basis and general liability insurance coverage on an occurrence basis. The limits for professional liability insurance are $1,000,000 for each covered person and a $3,000,000 total limit. The limits for general liability are $1,000,000 per each occurrence, $3,000,000 general aggregate, $3,000,000 products/completed operations, $50,000 fire damage and $1,000,000 personal/advertising injury. The coverages are subject to a deductible of $50,000 for each incident and $150,000 in the aggregate. In addition, the Hospital maintains an excess liability insurance policy with a limit of $10,000,000 for each incident and $10,000,000 in the aggregate. The charge to operating expenses for insurance coverage for the years ended December 31, 2013 and 2012, was $892,853 and $873,450, respectively.

The Hospital is involved in litigation arising in the ordinary course of the Hospital's business. Based on the advice of counsel, management does not believe that, individually or in the aggregate, any such claims, investigations and lawsuits will have a material adverse effect on the Hospital's results of operations, cash flows or financial position.

Claims alleging malpractice have been asserted against the Hospital and are currently in various stages of litigation. Management and the Hospital's legal counsel intend to vigorously defend against these claims. It is the opinion of management that the commercial insurance in force is adequate to provide for potential losses resulting from any pending or threatened litigation as of December 31, 2013 and 2012.

Note 11. Certain Risks and Uncertainties

The Hospital's ability to maintain and/or increase future revenue could be adversely affected by (1) the HSCRC's changes to rate setting methodology or predicted results and related rate setting modifications that it considers necessary to effectively regulate Maryland hospitals' rates; (2) the growth of managed care organizations promoting alternative methods for health care delivery and payment of services such as discounted fee-for-service networks and capitated fee arrangements (the rate setting process in the State of Maryland prohibits hospitals from entering into discounted fee arrangements; however, managed care contracts may provide for exclusive service arrangements); (3) proposed and/or future changes in the laws, rules, regulations, and policies relating to the definition, activities, and/or taxation of not-for-profit tax-exempt entities; (4) the enactment into law of all or any part of the current budget resolutions under consideration by Congress related to Medicare and Medicaid reimbursement methodology and/or further reductions in payments to hospitals and other health care providers; (5) the future of Maryland's certificate of need program, where future deregulation could result in the entrance of new competitors, or future additional regulation may eliminate the Hospital's ability to expand new services; and (6) the ultimate impact of the federal Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act of 2010.

Note 11. Certain Risks and Uncertainties (Continued)

In January 2014, the Centers for Medicare & Medicaid Services (CMS) and the State of Maryland jointly announced a new initiative to modernize Maryland's unique all-payer rate-setting system for hospital services aimed at improving patient health and reducing costs. This initiative will replace Maryland's 36-year-old Medicare waiver to allow the state to adopt new policies that reduce per capita hospital expenditures and improve health outcomes as encouraged by the Affordable Care Act. Under the new model, Maryland hospitals will commit to achieving significant quality improvements, including reductions in Maryland hospitals' 30-day hospital readmissions rate and hospital acquired conditions rate. Maryland will limit all-payer annual per capita hospital growth, including inpatient and outpatient care, to 3.58%, below historical trends. Maryland will also limit annual Medicare per capita hospital cost growth to a rate lower than the national annual per capita growth rate per year for 2015 – 2018. The new model will allow Maryland to set global budgets and other alternative approaches to payment that reward systems of care that provide improved outcomes at lower cost. Management is currently assessing the impact of this new model on its operations and financial reporting.

The health care industry is subject to numerous laws and regulations of federal, state and local governments. Compliance with these laws and regulations, particularly those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Violation of these laws and regulations could result in the imposition of fined and penalties, as well as repayments of previously billed and collected revenue from patient services.

Note 12. Charity Care

In the ordinary course of business, the Hospital renders services to patients who are financially unable to pay for medical care. The Hospital provides care to these patients who meet certain criteria under its charity care policy without charge or at amounts less than the established rates. The Hospital provides care to all patients regardless of ability to pay. It is the policy of the Hospital to provide financial assistance (charity care) based on inability to pay or high medical expenses for patients who meet specified financial criteria and request such assistance. The Hospital communicates the availability of financial assistance on its website and in Hospital publications, as well as on posted notices in admitting, registration, patient accounts, emergency, and administration departments. Financial assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. A determination of financial assistance is re-evaluated every six months, as necessary. The Hospital's financial assistance policy is re-evaluated every calendar year, at a minimum, and the related poverty table is updated annually. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as a component of net patient service revenue or patient accounts receivable.

The Hospital maintains records to identify and monitor the level of charity care it provides. Charity care is measured based on the Hospital's estimated direct and indirect costs of providing charity care services. That estimate is made by calculating a ratio of cost to gross charges, applied to the uncompensated charges associated with providing charity care to patients. The ratio of cost to gross charges was 0.83 for each of the years ended December 31, 2013 and 2012.

The following information measures the level of charity care provided during the years ended December 31, 2013 and 2012:

	2013	2012
Cost of charity care provided	$ 1,660,480	$ 1,497,088

Note 13. Functional Expenses

The Hospital provides health care services to the community, including general inpatient and outpatient medical, surgical and rehabilitation services. Expenses related to providing these services were as follows for the years ended December 31, 2013 and 2012:

	2013	2012
Health care services (direct)	$ 29,321,904	$ 29,593,632
General and administrative (supportive)	11,104,738	11,153,967
Fundraising	356,129	157,862
	$ 40,782,771	$ 40,905,461

General and administrative expense includes provision for bad debt expense of $1,850,854 and $2,099,182 for the years ended December 31, 2013 and 2012, respectively.

Note 14. Management Services Agreement

On September 1, 2013, the Hospital entered into management services agreement with University of Maryland Medical System Corporation (UMMS) whereby the Hospital's current Chief Executive Officer (CEO) and Chief Financial Officer (CFO) became direct employees of UMMS, and UMMS was tasked with providing management supervision for the operation and business development of the Hospital. The CEO and CFO report directly to the Board of Directors of the Hospital and are responsible for supervising the day-to-day operation, management, administrative supervision, and maintenance of the facility on behalf of the Hospital. The agreement is for the period of nine months where, if not terminated by any party, will continue on month-to-months basis thereafter. Under the terms of the agreement, the Hospital reimburses UMMS semi-monthly for salaries, employment taxes and one half of the benefits paid out to the CEO and CFO. All other additional services provided to the Hospital by UMMS are on a flat rate fee and must be approved by the Hospital's Board of Directors. The total amount paid to UMMS by the Hospital during the year ended December 31, 2013 was $168,237.

Fort Washington Medical Center, Inc.

Other Statistical Information (Unaudited)
Years Ended December 31, 2013 and 2012

	2013	2012
Inpatient days	8,248	8,093
Admissions	2,306	2,185
Average length of stay	3.58	3.70
Inpatient surgical procedures	628	699
Ambulatory surgery visits	2,131	2,381
Radiology services	25,699	29,759
Laboratory services	3,219	3,219
Emergency services	43,881	45,715
Observation services	1,730	1,550
Total outpatient visits	74,529	80,243

Fort Washington Medical Center, Inc.

Schedule of Expenditures of Federal Awards
Year Ended December 31, 2013

Federal Grantor/Pass-Through Grantor Program or Cluster Title	Federal CFDA Number	Pass-Through Entity Indentifying Number	Federal Expenditures
Major Program			
U.S. Department of Housing and Urban Development:			
Section 242 Mortgage Insured Loan	14.128	N/A	$ 9,363,956
Total balance			$ 9,363,956

See Notes to Schedule of Expenditures of Federal Awards.

Fort Washington Medical Center, Inc.

Notes to Schedule of Expenditures of Federal Awards

Note 1. Basis of Presentation

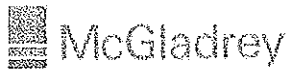
The accompanying schedule of expenditures of federal awards includes the federal grant activity of Fort Washington Medical Center, Inc. and is presented on the accrual basis of accounting. The information in this schedule is presented in accordance with the requirements of OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Therefore, some amounts presented in this schedule may differ from amounts presented in, or used in, the preparation of the basic financial statements.

Note 2. Composition of Balance

Section 242 Mortgage Insured Loan amount represents the balance of the loan outstanding as of December 31, 2013. During the year ended December 31, 2013, the loan was refinanced through the same lender to lower the interest from 6.125% to 3.95% per annum, payable in monthly installments. The term of the loan was not changed and the last payment is due in 2030. The loan is subject to restrictive covenants, including restrictions on additional long-term borrowings and prepayment of the outstanding obligation. Under the terms of the HUD-insured mortgage loan, the Hospital is required to maintain certain deposits with a trustee. The loan is secured by the Fort Washington Medical Center, Inc. premises, and all the assets and cash flows contained therein.

Scheduled principal repayments of the mortgage are due in future years as follows:

Years Ending December 31,	
2014	$ 394,298
2015	410,321
2016	426,754
2017	443,941
2018	461,775
Thereafter	7,226,867
	9,363,956
Less mortgage discount	(689,374)
	$ 8,674,582



Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

To the Board of Directors
Fort Washington Medical Center, Inc.
Fort Washington, Maryland

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Fort Washington Medical Center, Inc. (the Hospital), which comprise the balance sheets as of December 31, 2013, and the related statements of operations, changes in net assets, and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated April 3, 2014.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Hospital's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control. Accordingly, we do not express an opinion on the effectiveness of the Hospital's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Hospital's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards*.

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Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Hospital's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Hospital's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

McGladrey LLP

Baltimore, Maryland
April 3, 2014

Independent Auditor's Report on Compliance for Each Major Federal Program; Report on Internal Control Over Compliance; and Report on the Schedule of Expenditures Federal Awards Required by OMB Circular A-133

To the Board of Directors
Fort Washington Medical Center, Inc.
Fort Washington, Maryland

Report on Compliance for Each Major Federal Program

We have audited Fort Washington Medical Center, Inc.'s (the Hospital) compliance with the types of compliance requirements described in the OMB Circular A-133 *Compliance Supplement* that could have a direct and material effect on the Hospital's major federal programs for the year ended December 31, 2013. The Hospital's major federal program is identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its federal program.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for the Hospital's major federal program based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the Hospital's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for the major federal program. However, our audit does not provide a legal determination of the Hospital's compliance.

Opinion on Each Major Federal Program

In our opinion, the Hospital complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on the major federal program for the year ended December 31, 2013.

Member of the BDO International network of independent accounting, tax and consulting firms.

Report on Internal Control Over Compliance

Management of the Hospital is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the Hospital's internal control over compliance with the types of requirements that could have a direct and material effect on the major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for the major federal program and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Hospital's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of OMB Circular A-133. Accordingly, this report is not suitable for any other purpose.

McGladrey LLP

Baltimore, Maryland
April 3, 2014

Fort Washington Medical Center, Inc.

Schedule of Findings and Questioned Costs
Year Ended December 31, 2013

Section I. Summary of Independent Auditor's Results

Financial Statements

Type of auditor's report issued:	Unmodified		
Internal control over financial reporting:			
* Material weakness(es) identified?	___ Yes	X No	
* Significant deficiency(ies) identified that are not considered to be material weakness(es)?	___ Yes	X None Reported	
Noncompliance material to financial statements noted?	___ Yes	X No	

Federal Awards

Internal control over major programs:			
* Material weakness(es) identified?	___ Yes	X No	
* Significant deficiency(ies) identified that are not considered to be material weakness(es)?	___ Yes	X None Reported	
Type of auditor's report issued on compliance for major programs:	Unmodified		
Any audit findings disclosed that are required to be reported in accordance with Section 510(a) of Circular A-133?	___ Yes	X No	

Identification of major programs:

CFDA Numbers	Name Of Federal Program Or Cluster
14.128	U.S. Department of Housing and Urban Development: Section 242 Mortgage Insured Loan

Dollar threshold to distinguish between Type A and Type B programs:	$300,000	
Auditee qualified as low-risk auditee?	X Yes	___ No

(Continued)

Section II. **Findings Relating to the Financial Statement Audit as Required to be Reported in Accordance with *Government Auditing Standards* Generally Accepted in the United States of America**

A. **Significant Deficiencies or Material Weakness in Internal Control**

None Reported

B. **Compliance Findings**

None Reported

Section III. **Findings and Questioned Costs for Federal Awards**

A. **Significant Deficiencies or Material Weakness in Internal Control**

None Reported

B. **Compliance Findings**

None Reported

Fort Washington Medical Center, Inc.

Summary Schedule of Prior Audit Findings
Year Ended December 31, 2013

There were no prior audit findings reported.