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December 22, 2015

Via Hand Delivery and Email
Kevin McDonald, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

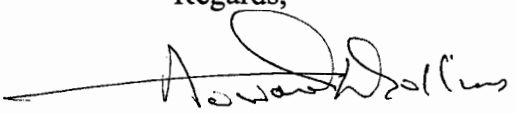
Re: Prince George's Post-Acute, LLC
Docket No. No. 13-16-2347
Request For Project Change After Certification

Dear Mr. McDonald:

On behalf of Prince George's Post-Acute, LLC, we are hereby submitting a Request for Project Change After Certification. For your convenience, six (6) copies of the Request are being submitted. A PDF copy of this submission and two full size copies of the drawings are being sent to you as well.

If there are any questions about the attached submission, or if any further discussion is needed, please let me know.

Regards,



Howard L. Sollins

HLS/tjr
Enclosures
cc: Ms. Ruby Potter, MHCC
Pamela Brown-Creekmur, Health Officer, Prince George's County
Gary L. Attman, President, FutureCare Health and Management
Les Goldschmidt, FutureCare Health and Management
Mr. Andrew L. Solberg
John J. Eller, Esquire

IN THE MATTER OF	*	BEFORE THE
PRINCE GEORGE'S POST ACUTE, LLC	*	MARYLAND HEALTH
Docket No. 13-16-2347	*	CARE COMMISSION

* * * * * * * * * * * * *

REQUEST FOR PROJECT CHANGE AFTER CERTIFICATION

Prince George's Post Acute, LLC ("PGPA"), by its undersigned counsel, asks the Maryland Health Care Commission (the "Commission") to approve a project change to this certificate of need ("CON").

On April 17, 2014, the Commission issued a CON authorizing PGPA to construct a two story 150 bed comprehensive care facility ("CCF") to be located on Brightseat Road, in Landover, MD in Prince George's County. Since then, substantial progress has been made and costs incurred, including the acquisition of the underlying real estate, securing the requisite land use approvals and engaging architects, construction manager and other consultants to evaluate and improve the design of the project.

The proposed CCF will offer essential post-acute services including: rehabilitation services including physical, speech and occupational therapy, post-operative care, infusion therapy, tube feedings, wound care, dialysis, pain management, diabetic management, dementia care, palliative care, respiratory/ventilator care, and a gero-psychiatric program. In addition, the CCF will offer a program entitled LYFE Today, which will offer an individualized program that is based on an individual's previous lifestyle, preferences, and current level of ability.

PGPA desires to make this facility a state of the art setting providing optimal care. As an affiliate of FutureCare Health and Management Corporation PGPA continues to evaluate, refine and improve its plans for this facility taking into account the evolution and direction of post-acute services in Maryland. Increased capital costs are projected that will not result in rate increases, and it is PGPA that will bear all of the additional costs to make this the best possible facility. The projected short term cost increases will yield long term efficiencies in the delivery of services.

This has led to a determination that this new facility should have a design that takes into account the effects and expected increase in short stay residents including rehabilitation needs that require greater space and equipment, higher acuity clinical needs to avoid hospitalizations and rehospitalizations, smaller nursing units to enable more immediate and direct care and varying room configurations that match the

different types of residents. The Medicaid Memorandum of Understanding is unaffected. Additional secure courtyards have been added that will enhance the holistic, healing experience. Also, the facility will provide functional space for onsite physicians and nurse practitioners and other health care practitioners ensuring that this medical support is readily available. Any increased costs to be incurred in the updated design of the facility will not result in higher rates.

Preserving the option of using HUD financing would result in increased costs at the outset but will provide long term, stable financing at a beneficial rate. As described in more detail below, these proposed changes will maximize the benefit of this CCF in the health care delivery system as a whole. The increase in capital costs reflect additional square footage and clinical and programmatic enhancements that PGPA is committed to providing (and funding) to benefit residents.

Attached is a copy of the corrected, original CON (Exhibit 1).[1] The approved Capital Costs in the initial CON were $18,506,675. The approved Total Project Cost in the original CON was $19,070,505. This Modification request seeks an increase to $26,273,741 for the Capital Costs and $27,929,096 for the Total Project Costs. Related design changes are reflected in the attached drawings.

Basis for Changed Elements

Upon consideration of trends and factors affecting the delivery of post-acute care, including developments in the delivery of service by skilled nursing facilities since the original PGPA application in early calendar year 2014, an updated design layout was developed for this project. While all of the design changes are fully compatible with the CON approval to build a 150 bed nursing center that has all beds dually certified and in the same address location as the award, the applicant wishes to share with the Commission the reasons why design alterations were advisable to accommodate the needs of the residents, staff and community at large. The trends and factors that were the impetus behind these changes include:

- Global budget creation under the new waiver agreement for hospitals by the Maryland Health Services Cost Review Commission which accelerates an emphasis on appropriate care rendered in settings outside of the high cost treatment environment in hospitals to mitigate the risk of rehospitalization.
- A movement in the federal Centers for Medicare and Medicaid Services survey process towards measuring and monitoring quality of life equal to the factors of quality of care.

[1] As part of its efforts to be diligent in its compliance with CON requirements, the applicant identified an error in the performance requirement in the original CON document it received and called it to the Staff's attention, resulting in the Staff issuing a corrected CON albeit with a shorter performance requirement.

- A greater movement toward managed care and new models of payment for Medicare and Medicaid services. This includes the growing adoption of health care networks driven to creating efficiencies necessary to operate in a bundled payment, accountable care organization, and value-based reimbursement post-acute environment.

- Rapid movement in the FutureCare Health and Management-affiliated facilities towards electronic medical record and incorporation of its use in unit design layout(s).

The structural, programmatic, and design changes to the PGPA project will position the CCF to reflect these current and anticipated changes in the post-acute environment. Most importantly, none of the changes outlined alter or diminish the commitments that were made in the original CON. Indeed, the changes seek to support the original programmatic concepts by adding refinement and definition to the approved project.

DISTRIBUTION OF BEDS

1) The number of short-term units has been increased from the original design of one 44 bed unit to two units, each with a forty bed complement, for a total of 80 beds. The increase in short-term beds is reflective of the fact that most residents entering FutureCare Health and Management nursing centers now spend short durations in length of stay. In fact, in recent tracking of admissions into all thirteen FutureCare facilities from the period January 1, 2015 thru July 31, 2015, 59.13% of admissions were discharged within the first 30 days. At the end of fifty days post admission 75.06% were discharged, and at the end of 100 day(s) 86.02% of admits no longer reside in the facility. Stated another way, only 13.98% of residents admitted from a hospital remain in the facility after 100 days (see table A). The fact that so few residents remain in the nursing facility setting post the one-hundred day mark, makes it appropriate to create a second short term unit within the bed mix.

   The improved design also has four nursing units, instead of the originally proposed three, allowing for smaller units with closer observation of the residents within each unit. The four nursing unit design allows for the two upper level unit(s) to monitor 40 residents each rather than the originally proposed 44 and 53 bed unit(s). The two terrace level nursing units in the updated design monitor 24 and 46 residents, while under the original design there was a single unit monitoring 53 residents. The creation of four nursing units will enhance resident care, by allowing staff to monitor fewer residents on each unit. The number of residents on each unit decreases by four on the short term unit and seven on the long term unit. Benefits that derive include increased staffing ratio(s) and hours per resident day throughout the facility.

   Other resident care advantages as a result of the design change include:

a) matching care needs of the resident to closer proximity of the space they will most frequently access, i.e. short term rehab to the gym, and long term ESRD residents to the dialysis center

b) less need for elevator traffic

c) placement of support spaces so as to diminish sight and sound disturbances

d) allowing more convenient access to designed courtyards for residents who are more likely to have limited physical ability to get outside of the facility

e) allowing for the spatial and other needs of the respiratory/ventilator unit

2) The number of private rooms in the original design stood at 80 beds and the newer model totals 82 private rooms. The difference in the number of private rooms between the two models in total is insignificant to the overall project; however, the placement of the private rooms as regards location distribution is improved. Residents in short term stay areas (the upper two units) generally seek privacy and are likely to experience more visitors and fewer feelings of loneliness and isolation. In long term bed areas, while each person will have individual preferences, many residents benefit from the companionship and bonding with a roommate.

3) Bariatric Beds in the original model nurnbered 8, evenly distributed between short term and long term stay units. In the improved design, the number has increased to 12, to reflect the creation of a designated respiratory/ventilator unit. These types of residents, along with dialysis residents, often have a difficult time expelling fluids from their systems, resulting in the likelihood of increased body weight. The improved design places all of the additional bariatric beds in the designated respiratory care unit. Attached as Exhibit 2 is a December 14, 2015 article from the *New York Times*, highlighting the serious problems in the availability of skilled nursing facilities equipped to handle bariatric residents, with associated problems in securing a safe and effective discharge of such residents to an appropriate post-acute setting.

RESIDENT ROOM SIZES

Private Resident Rooms, in both the short and long term units have been increased by approximately eight square feet each. The increased room size is of benefit to the aesthetics and quality of life issues, as it translates to a more open space. While the original design exceeded the required minimum room sizes, we believe that the increased size will benefit residents, visitors and staff.

Another element in accounting for the increased room size is that today's CCFs need to provide more procedures, treatments, and monitoring to mitigate the need for the use of hospitals or other off site locations for services. Examples of procedures that now take place at bedside in CCFs are EKG's, central and intravenous lines placement, swallowing functional stimulation, and procedures that historically were scheduled at hospitals on either an inpatient or an outpatient basis. CCFs are moving in the direction

of accommodating onsite sleep studies and blood transfusions, all of which require equipment at the bedside or in a designated treatment area. PGPA envisions that it will be a leader in moving toward advanced treatment capabilities in the center partly because it is being designed to accommodate these in-house procedures.

Semi-private room sizes have also increased, in ranges from 8 square feet to 28 square feet. This enhances the space available to each resident in this setting. There are three different models of "standard" semi-private rooms and two different models of bariatric semi-private rooms in the improved design that will allow for some choice in accommodation by residents where practical and also situating a resident in a space that best matches the care the resident needs. For example, a resident who is a fall risk might benefit from a room layout that puts the bed proximate to the door so staff can monitor easier. On the other hand, a resident who is being escorted to the bathroom every two hours as a result of bowel and bladder training might be located in a layout more proximate to the bathroom to cut down distance and time to toileting.

The respiratory/ventilator unit rooms have increased in size to accommodate the equipment needs of these residents. Equipment such as ventilators, associated alarms, medical supplies, bedside respiratory equipment and medications require more square footage. Frequently these residents require larger beds, and so even traditional beds are expandable from 35 to 48 inches in width. The additional staffing of respiratory therapists and the need for more frequent rounding by physicians, nurse practitioners and specialists, i.e. pulmonologists, ENT, infection control practitioners, all require a greater presence of trained staff in the room. Expanded space in the room is a necessity for delivering needed, highest acuity, quality care in an orderly fashion.

NURSING UNITS

PGPA will incorporate a fully Electronic Medical Record (EMR) that will allow for point of service charting, greater record sharing among health care providers, and ease of retrieval of medical history of the resident. To better achieve these outcomes, computer friendly "pods" which are modular and built for computer layout will replace the nursing station. A quiet area for charting will also be part of the design and allow greater access for charting by those directly rendering clinical assessments and treatments. While these features did not necessarily add square footage, they do enhance the ability of busy health care staff to work more efficiently and thus spend enhanced time providing care versus charting.

Furthermore, another design enhancement is an increased number of storage closets and alcoves along the corridor halls. The creation of these spaces eliminates clutter and, therefore, allows for greater safety of residents. Residents have greater access to handrails; tripping hazards are reduced; and visual sightlines for staff and residents are all improved upon proper storage of the multitude of equipment and supply carts typical in operating a nursing facility.

TREATMENT SPACES

1) Rehabilitation Services Center

The Rehab Center has been changed from 2,438 square feet to 4,319 square feet. The increase represents an additional 1,881 square feet in size. This increase is mitigated by the elimination of the aqua pool which was previously allocated 2,131 square feet. The aqua pool has been replaced with an alternate approach using weightless environment equipment described below. The change was prompted by the fact that, given the anticipated in-patient census of residents requiring speech, occupational or physical therapy, there needed to be more floor space in the gym.

One of the primary reasons for the idea of an aqua pool was to better serve those residents who would excel in a buoyant environment that the aqua pool promotes through displacement of weight. To still maintain this goal of providing therapy needs to those who would benefit in a weightless environment, PGPA is planning the installation of an overhead weightless system in identified areas of the rehab gym. This modality, much like the aqua pool, will allow a broader range of residents to be treated sooner in their recovery stay.

The treatment space will be located on the upper level where short term stay residents will be located. This will allow room to gym travel time to be reduced by eliminating elevator waiting time. While the gym is not for the exclusive use of any particular type of resident, its proximity to short term residents who are most likely to use the gym is a plus.

2) Physical Therapy Suite

On the Terrace in the lower level, a separate Physical Therapy Suite has been planned of an additional 697 square feet. This Rehab area will be primarily utilized by long term care residents to maintain restorative nursing function and assist any long-term resident to regain activities of daily living. As noted in the Treatment Space narrative above, this additional Terrace level therapy space has the added advantage of cutting down travel time by eliminating the need for elevator travel. Often, residents in the long term care beds have lower functional levels and compromised energy reserves which diminish their ability to tolerate long therapy sessions. The ability to deliver their care in a defined area with therapists accustomed and familiar with this population, will promote their recovery and highest level of function. The goals and baseline of this population are frequently different from those of the short term residents with a focus on return to the outside community.

3) Respiratory Unit

PGPA plans to have such a special care unit with 24 beds with a focus on residents with a respiratory/ventilator and tracheostomy care, which is a service that is compatible with a CCF license. FutureCare Health and Management has significant experience with respiratory programs within its affiliated CCFs. FutureCare currently operates three respiratory/ventilator units and two pulmonary rehab units. The addition of a PGPA designated 24 bed respiratory/ventilator unit, will bring the total portfolio to

four respiratory/ventilator sites, servicing system wide a potential of 157 respiratory compromised residents. The average occupancy of these respiratory/ventilator units is 91.28%. There are frequent occasions where units are filled, resulting in additional, avoidable, expensive days in the hospital or resident placement outside the resident's geographic area of choice.

Respiratory Units Occupancy %				
	Pineview	Homewood	Irvington	Total
Units' Beds	52	31	50	133
2014	90.75%	90.40%	88.71%	89.90%
2015 (through 11/30)	92.81%	89.14%	91.01%	91.28%

For example, the respiratory/ventilator unit at FutureCare Pineview (also in Prince George's county) has, on average, 48.3 of its 52 beds filled and there are many days when it is completely full.

The PGPA respiratory unit will be on the same floor as the planned dialysis center, enabling the admission of residents with the need for both services. FutureCare's Pineview facility already offers this model. The placement of the dialysis center proximate to the respiratory unit allows ease of transport for individuals who are ventilator dependent with tracheostomies and enhances safety by having respiratory therapists on-site at the dialysis center. The co-location of dialysis and ventilator services provides an important benefit to the healthcare delivery system as this population is among the most difficult for hospitals to discharge to an appropriate setting.

4) Medical Practitioner Office

The trend in nursing facilities is one of increasing complexity of residents receiving care. The practice of assessing, testing, and treating residents in-house as well as coordination with the continuum of care in the community are primary weapons in reducing re-hospitalizations. The FutureCare model has been to recruit in-house clinical resources to help foster these goals. Thus, FutureCare has an affiliate providing physicians and nurse practitioners and contracts with a broad range of consultants to diagnose and treat residents in-house (although each resident is free to use an outside physician, nurse practitioner, or physician assistant). Examples of FutureCare resources include the employment or contracting of internists, pulmonologists, infection control practitioners, physiatrists, nephrologists, nurse practitioners, and other specialists. These specialists need to have their own space to conduct resident exams and meet with residents and families in private. The addition of a medical office space and an exam room is crucial to meeting the goals of delivering the services needed to manage complex medical problems on-site.

In addition, FutureCare anticipates that PGPA will be adding telemedicine as part of its clinical assessment capabilities and is working with the University of Maryland School of Medicine on this program with the goal of reducing re-hospitalizations and

achieving better resident outcomes. This process will also require space for remote physician evaluations via a secure portal.

5) Dialysis Center

The dialysis space has been increased in size as a result of regulatory requirements. There has been a realization that the initial square footage projections in the preliminary stage were insufficient to support areas necessary for a nine chair dialysis center. Additional space was needed for the water treatment room, an employee break room, and additional storage for linen, janitorial supplies and mobility equipment.

ACTIVITY SPACES

As work began moving from preliminary design to conceptual and schematic review of PGPA, alterations were made that not only were meant to improve quality of care, but also quality of life considerations. Therefore, additions were made to allow for choice(s) of dining space and style, formal (dining room) or informal (café areas). A common space meeting for residents and families was added in the front Lobby area. Most importantly, additional common spaces were planned so that each unit has an area where residents/visitors can meet, thereby encouraging residents to socialize outside their rooms.

Because future residents of nursing homes will expect to be able to stay connected through the internet and 24/7 news connection, a Library/Media room was conceived. The room will act as a gathering place for residents to converse, discuss and keep up with intellectual, cultural, and social interests that they participated in prior to their admission.

The project's initial design included a Courtyard. However, a modification to the original proposal is the creation of an overhead deck for the top floor where residents can directly access the outside from the upper level. Placing that deck in the middle of the building allowed for the creation of two distinct courtyards on the lower level. Many of the common usage rooms, such as Beauty Salon, Physical Therapy Room, Lounge, and Family Dining are laid out to enable residents to enjoy views of the courtyard and obtain direct access while still being secure.

SUPPORT SPACES

During the building's design concept phase, it was determined that PGPA will need additional office space to support the staff professionals employed in its operation. We have already touched on the trend for more healthcare professionals to be present and a greater need of collateral allied health care professionals to reach objectives and goals. In addition to new space for physician office and charting areas, there was increased footage added to offices for Human Resources, Social Work, Admissions, and Staffing Office(s) areas to support some growth in future personnel.

Meeting Space was enhanced in the design phase through addition of a large Conference Room capable of holding 30 occupants. As the nursing home transitions to a place of greater complexity and community involvement, there will be an increased need for education of staff. The Conference Room, equipped with videoconferencing, will allow for staff to attend educational sessions on-site that will enhance their skill set and allow a space for Resident and Family Councils to have input in the operations of the facility. The space can also serve as a meeting area for outside community groups that may become stakeholders in the functioning of the facility, e.g., a Better Breathers Club. These community groups already are active in an existing number of FutureCare facilities.

The improved design increased the size of General Storage and Central Supply in recognition that the lack of storage spaces that is typical in most nursing centers leads to clutter on the direct care units. As CCFs take on more complex treatment space for a variety of equipment must be accommodated. The ability to have this equipment onsite, and not in a storage area outside the confines of the building, will promote more timely and efficient care delivery. Additionally, it will lead to a safer work place environment helping to prevent falls and other accidents through improper storage.

Capital Costs

The capital costs are increasing from $18,506,675 (as approved) to $26,273,741. There are several reasons for this increase.

1. In the original CON, PGPA relied on the consultant estimates that have not proved to be accurate. The approved project was $40.95 below the $178.73 MVS benchmark for Good Quality Class D facilities. PGPA has changed cost estimators.

2. For the reasons stated above, PGPA has increased the number of square feet from 87,700 to 93,490.

3. PGPA wishes to preserve the option of using HUD funding for this project. HUD requires that PGPA utilize all union labor. This has a significant impact on Costs. PGPA anticipates an added cost of (5%), which adds almost a million dollars to the cost of this project:

Building	$15,452,559
Site preparation	$2,114,706
Architect/engineering fees	$883,202
Total	$18,450,467
% Increase Due to Union Labor	5%
Amount of Increase Due to Union Labor	$922,523.33

By using HUD financing, PGPA would have an annual debt service that will be fixed at a lower rate than conventional financing. In addition, the lower rate will be locked in for 40 years with a longer amortization, which would be much more stable for

the facility. Attached is a December 17, 2015 letter from Capital Funding Group expressing confidence that a HUD application would be approved. This will be better than the alternatives that PGPA previously considered. Exhibit 3. A typical commercial loan would either be at a floating rate or locked for up to 10 years, normally less.

4. Upon more detailed review of the current site by a civil engineer significant slopes and clearing of existing forestation are identified as needed.

    a. Sloped Site

        i. Increased rough grading costs.

        ii. Additional cut and backfill on the site.

        iii. Added retaining walls.

    b. Other Site Cost Increases

        i. Site deforestation costs.

        ii. Parking requirements, both by code and occupancy, are increased with the increased building size

        iii. Increases in building size and parking requirements lead to additional costs in the following site improvement categories:

            1. Storm drains and SWM

            2. Sidewalks, curbs and gutter

            3. Landscaping

No payor will be affected by these capital cost increases. The owners are contributing an additional $3.5 million in the project. Medicare and Medicaid reimbursement, by far the largest payers for CCF services, are set using rates that are not based on these increased project costs. The same is true for other payers, including private payers and managed care.

PGPA submitted its CON application on August 2, 2013. The Commission approved the application on April 17, 2014. The approved Current Capital Costs in the approved project budget were $17,997,895 ($17,505,402+$492,493 in Capitalized Interest), excluding inflation.

Applying the inflation index which the Commission requires applicants to use once an application is approved would add 3.3768% inflation. In performing this calculation, PGPA based its calculations on the process outlined in the document on the Commission's website: "Determining the Threshold for Required Approval of Changes in Certificate of Need Approved Capital Cost" was used. See, the examples under http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_cap_cost_index_1st_qtr_2015.pdf

Filing Date		8/2/2013				
Modification Date		12/15/2015				
Step 1		2014.3	%MOVAVG	1.4	1.014	*A*
Step 2		2015.3	%MOVAVG	1.5	1.015	*B*
Step 3		2015.3	CIS Proxy	1.129		*C*
		2015.4	CIS Proxy	1.134		*D*
		D/C			1.004429	*E*
		*A * B * E*			**1.033768**	

Applying 3.3768% to the approved Capital Costs results in allowable capital costs of $18,605,649. ($17,997,895 x 1.033768 = $18,605,649)

With these cost increases, the comparison to the Marshall Valuation Service benchmark that the Commission uses as a measure of reasonableness is as follows. (A full MVS analysis is attached as Exhibit 4.)

III. Comparison

A. Adjusted Project Cost/Sq. Ft.	$186.94
B. Marshall ValuationService Benchmark	$179.77
	$7.17
	3.99%

II. THE PROPOSED PROJECT MODIFICATION IS APPROVABLE

The Commission's regulations at COMAR 10.24.01.17A require notification of any proposed project changes. Certain types of proposed project changes are impermissible, including the following (§.17C):

1. Changes in the fundamental nature of a facility or the services to be provided in the facility from those that were approved by the Commission;

2. Increases in the total licensed bed capacity or medical service categories from those approved;

3. Any change that requires an extension of time to meet the applicable performance requirements specified under Regulation .12 of this chapter, except as permitted under Regulation .12E of this chapter.

The proposed changes identified in this filing do not change the fundamental nature of the project; will not result in an increase in the total licensed bed capacity as previously approved; and will not require any extension of time beyond what is permitted under Regulation .12E to meet applicable performance requirements.

Though all project changes require notification to the Commission, only the following types of changes to a project require formal Commission approval (§.17B):

1. Before making a significant change in physical plant design;

2. Before incurring capital cost increases that exceed the approved capital cost inflated by an amount determined by applying the Building Cost Index published in Health Care Cost Review from the application submission date to the date of the filing of a request for approval of a project change;

3. When total projected operating expenses or revenue increases exceed the projected expenses or revenues in the approved Certificate of Need Application, inflated by 10 percent per year;

4. Before changing the financial mechanisms of the project;

5. Before changing the location or address of the project.

With respect to §.17B(1), while the design is changing, there will not be any *significant* changes in physical plant design. The approved project was for a two story 150 bed facility, and the modified project is the same. Exhibit 5 Includes Revised Project Drawings. Exhibit 6 includes a Revised Chart 1.

Capital costs will increase, hence §.17B(2) is applicable. Exhibit 7 includes a Revised Project Budget. Exhibit 4 includes a revised MVS Analysis.

Since revenues and expenses will increase above those projected in the approved CON inflated by 10 percent per year, §.17B(3) is applicable. Exhibit 8 includes both a Revised Table 2 STATISTICAL PROJECTIONS and a Revised Table 3 REVENUES AND EXPENSES - ENTIRE FACILITY. Exhibit 9 includes a Revised Table 4 REVENUES AND EXPENSES - (for first full year at full utilization). Exhibit 10 includes a Revised Table 6 MANPOWER INFORMATION. Exhibit 11 includes a Revised Table 7 NURSING STAFFING PATTERN.

Regarding §17B(4), the financing mechanisms for the project identified in the CON application was commercial financing but the plan is now to preserve the option to use HUD financing.

The location or address of the project will not change, hence §.17B(5) is not applicable.

CONCLUSION

PGPA's project design will be vastly improved over the one which was approved originally. The modifications are all permissible.

For all of the reasons set forth above, PGPA respectfully requests that the Commission approve the proposed changes described above.

Respectfully submitted,

Howard L. Sollins
John J. Eller
Ober|Kaler
100 Light Street
Baltimore, MD 21202

Counsel, Prince George's Post Acute

EXHIBITS

1. Original, Corrected Certificate of Need
2. December 14, 2015 Article from the *New York Times*
3. December 17, 2015 letter from Capital Funding Group
4. MVS Analysis
5. Revised Project Drawings
6. Revised Chart 1
7. Revised Project Budget
8. Revised Table 2 STATISTICAL PROJECTIONS and Revised Table 3 REVENUES AND EXPENSES - ENTIRE FACILITY
9. Revised Table 4 REVENUES AND EXPENSES - (for first full year at full utilization)
10. Revised Table 6 MANPOWER INFORMATION
11. Revised Table 7 NURSING STAFFING PATTERN
12. Affirmations

Exhibit 1

Original, Corrected Certificate of Need

MARYLAND HEALTH CARE COMMISSION

Corrected Certificate of Need

TO: Gary L. Attman, President
FutureCare Health & Management Corp.
8028 Ritchie Highway, Suite 118
Pasadena, Maryland 21122

April 17, 2014

RE: Prince George's Post Acute
Construction of a two-story,
150-bed Comprehensive Care Facility

13-16-2347
(Docket No.)

PROJECT DESCRIPTION

This Certificate of Need ("CON") authorizes Prince George's Post Acute, LLC, ("PGPA") to establish a two-story, 150 bed comprehensive care facility on Lots 4 and 9, Brightseat Road in Landover, Prince George's County.

The total approved project cost is $19,070,505, consisting of $14,387,419 for construction, $3,117,983 for other capital costs, $508,780 for inflation allowance, $492,492 for capitalized interest expense, and $563,830 for financial and other cash requirement. PGPA expects to finance this project with $1,970,505 in cash contributions from the owners, with the remaining $17.1 million financed through a mortgage loan from a commercial lending institution.

ORDER

The Maryland Health Care Commission considered the Staff Report and Recommendation and, based on the Staff's analysis and the record in this review, ordered, on April 17, 2014, that a Certificate of Need be issued for the project, with the following two conditions:

> **At the time of first use review, Prince George's Post Acute shall provide the Commission with a modified Memorandum of Understanding with the Maryland Medical Assistance Program agreeing to maintain the minimum proportion of Medicaid patient days required by Nursing Home Standard COMAR 10.24.08.05A(2).**
>
> **Prior to first use review, FutureCare Health and Management Corporation shall provide the Commission with information demonstrating that PGPA has established collaborative relationships with other types of long term care providers in Prince George's County to assure that each resident has access to the entire long term care continuum, including, as appropriate, formal transfer and referral agreements.**

PERFORMANCE REQUIREMENTS

In accordance with COMAR 10.24.01.12C(3)(c), the project is subject to the following performance requirements:

1. Obligation of not less than 51 percent of the approved capital expenditure, as documented by a binding construction contract within 18 months of the date of this Certificate of Need;

2. Initiation of construction no later than four months after the effective date of the binding construction contract; and

3. Documentation that the approved project has been completed, has been licensed, and has met all legal requirements and is providing the approved services no later than 18 months after the effective date of the binding construction contract.

CHANGES TO THE APPROVED PROJECT

Before making any changes to the facts in the CON application and other information provided to the Commission, PGPA must notify the Commission in writing and receive Commission approval of each proposed change, including the obligation of any funds above those approved by the Commission in this CON, in accordance with COMAR 10.24.01.17. Pursuant to COMAR 10.24.01.17B(2), the project cannot incur capital cost increases that exceed the approved capital cost inflated by an amount determined by applying the applicable Building Cost Index published on a quarterly basis by Global Insight in Health-Care Cost Review unless it obtains a modification of this CON from the Commission. Instructions for determining the threshold that necessitates Commission review and approval of changes to the capital cost approved in this CON are located on the Commission's website at: http://mhcc.maryland.gov/certificateofneed/mdreginflation.pdf.

DESIGN APPROVAL AND FACILITIES LICENSURE BY DHMH

This CON does not constitute a license or replace any approvals required by the Office of Health Care Quality ("OHCQ") or others within the Department of Health and Mental Hygiene ("DHMH") to construct and operate a new health care facility or to operate new or renovated space within an existing facility. An applicant must provide DHMH with all information it requires for plan approval, facility licensure, and the placement into operation of a new facility or new space within a facility, including information pertaining to project design and specifications.

QUARTERLY STATUS REPORTS

PGPA must submit quarterly status reports to the Commission, on a quarterly basis, beginning on July 17, 2014 and continuing through the completion of the project.

REQUEST FOR FIRST USE REVIEW

PGPA must request a first use review from the Commission, specifying the anticipated date of first use. Such request must be in writing, not less than 60 days but not more than 120 days before the first use of its 150 bed comprehensive care facility. The Commission will review the request in consultation with the Office of Health Care Quality, as provided in COMAR 10.24.01.18, to determine whether the project conforms to this Certificate of Need. First use approval does not constitute a license or replace any approvals required by OHCQ or others within DHMH to add space to an existing health care facility, or use renovated space within an existing facility. Therefore, PGPA should assure that OHCQ is notified of the imminent completion of the project and should arrange for completion of any inspections and or approvals required by OHCQ in a timely manner. First use approval remains in effect for 90 days. If first use of the additional beds does not occur within 90 days of approval, PGPA shall reapply for first use approval.

ACKNOWLEDGEMENT OF RECEIPT OF CERTIFICATE OF NEED

Acknowledgement of your receipt of this Certificate of Need, stating acceptance of its terms and conditions, is required within thirty (30) days of your receipt of this CON.

MARYLAND HEALTH CARE COMMISSION

Ben Steffen

Ben Steffen
Executive Director

cc: Dr. Patricia Tomsko Nay, Office of Health Care Quality, DHMH
Margaret A. Heald, Office of Health Care Quality, DHMH
Mark Leeds, Office of Health Services, DHMH
Susan Panek, Office of Health Services, DHMH
Pamela Creekmur, Prince George's County Health Department

Exhibit 2

December 14, 2015 Article from the *New York Times*

The New York Times http://nyti.ms/1Z8cTFT

HEALTH

Rising Obesity Rates Put Strain on Nursing Homes

By SARAH VARNEY DEC. 14, 2015

RED BAY, Ala. — At 72, her gray hair closely shorn, her days occupied by sewing and television, Wanda Chism seems every bit a typical nursing home patient — but for her size.

Ms. Chism is severely obese, unable to leave her bed without a mechanical lift and a team of nurses. She has not walked in years. Her life is circumscribed by the walls of her room.

Obesity is redrawing the common imagery of old age: The slight nursing home resident is giving way to the obese senior, hampered by diabetes, disability and other weight-related ailments. Facilities that have long cared for older adults are increasingly overwhelmed — and unprepared — to care for this new group of morbidly heavy patients.

"The population is shifting faster than the ability of nursing homes to deal with them," said Cheryl Phillips, a senior vice president at LeadingAge, an association of nonprofit providers of services for older adults. "We don't have adequate staff. We don't have adequate equipment. We don't have adequate knowledge."

The percentage of those entering American nursing homes who are moderate and severely obese — with a body mass index of 35 or greater — has risen sharply, to nearly 25 percent in 2010 from 14.7 percent in 2000, according to a recent study, and many signs suggest the upward trend is continuing.

But as demand from severely obese patients surges, nursing home administrators say they cannot afford to care for them, because Medicaid, which covers more than 60 percent of all nursing home residents, does not reimburse them for the specialized equipment required: motorized lifts; larger wheelchairs, bedside commodes and shower chairs; and longer intramuscular needles and blood pressure cuffs. The devices are expensive: $10,000 for a mechanical lift, for instance, and $5,000 for an extra-wide bed.

"It's really not a moneymaker," said Aundrea Fuller, an owner of Generations of Red Bay, the private, for-profit facility that cares for Ms. Chism in a specially outfitted wing that can accommodate 10 obese patients. Ms. Fuller's decision to open the unit, which frequently has a waiting list, fulfills her personal mission to aid obese people, who are often ostracized and forgotten. But it makes little business sense.

"You've got to do it because you have a heart for it," she said.

There is no national census of available beds in American nursing homes for those weighing more than 350 pounds, the maximum weight a standard hospital bed can handle. But industry groups and researchers say facilities rarely accept more than a few markedly obese patients.

Genesis HealthCare, one of the nation's largest nursing-home chains, recently closed its much lauded bariatric care program. Nursing experts considered it a model for safe handling of obese patients.

"One or two places that have tried to do it recognize the economics just don't work," said Dr. David Gifford, the senior vice president of quality and regulatory affairs at the American Health Care Association, an industry trade group.

As a result, nursing homes across the country are routinely declining referrals from hospitals seeking to transfer obese patients, creating dilemmas for hospital staff members tasked with safely discharging those ready to leave.

The problem is especially acute in the South, where obesity rates first skyrocketed decades ago and extreme obesity — a 40 B.M.I. and above — continues to rise.

"This is definitely not my grandmother's elderly population," said Julie Locher, a medical sociologist at the University of Alabama at Birmingham. "This is a totally different cohort that is aging now."

In neighboring Mississippi, where 29 percent of people 65 and over are obese, nursing homes that accept heavy residents are few and far between, said Sandra Terra, an administrator at the University of Mississippi Medical Center in Jackson. Ninety percent of the nursing facilities to which her hospital routinely discharges patients "won't have anything to do with" obese patients, she said.

The delays are exasperating and commonplace. "It's not uncommon to make 30 or 40 referrals to finally find a placement," said Barbara Miller, the director of case management at the University of Arkansas for Medical Sciences, an academic health center with a hospital and clinics in Little Rock.

Whether these routine denials violate anti-discrimination laws is unclear, especially because the degree to which obesity is a legally protected disability remains unsettled. Industry specialists argue the law is unambiguous.

"Nursing homes aren't required, like emergency rooms, to admit patients, so they have a lot of latitude," said David Grabowski, a professor of health care policy at Harvard Medical School.

But some experts argue that severely obese patients with significant physical impairments could challenge their denials.

"That's what the Americans With Disabilities Act is meant to protect against," said Eric Carlson, a lawyer for Justice in Aging, a legal advocacy group.

Legal experts say the question is far from settled, but in at least one instance, a severely obese patient who was denied admission to a nursing home filed a discrimination complaint through the federal Office for Civil Rights. To resolve the issue, the nursing home, the GlenShire Nursing and Rehabilitation Center in Illinois, admitted the patient and provided an extra-wide dialysis chair.

The reluctance to accept hospital referrals, especially when physical therapy or wound care is needed, comes down to practical matters: How many staff members

will it take to turn the patient? Where is the wound? How long will physical therapy take?

"We ask them, 'What is the barrier?,'" said Akofa Bonsi-Wallace, the former director of discharge planning at the University of Alabama at Birmingham hospital, who often reached out to nursing homes in Georgia, Florida and Tennessee. "Most of the time it's staffing. We've heard, 'I already have a morbidly obese patient, and they are eating away at my staffing hours.'"

At the Generations of Red Bay facility, nurses reposition obese residents like Ms. Chism, who are unable to move on their own, every few hours to avoid dangerous pressure ulcers. Daily personal needs require monumental coordination. One nurse can help a resident of normal weight dress and sit in a chair within 15 minutes, said Kathy McCurry, head treatment nurse. "With a bariatric patient, that takes an hour with two certified nursing assistants."

There are other reasons nursing homes are wary, including the inability to transport such patients to the emergency room, the possibility of staff injuries and higher workers' compensation costs, and the infeasibility of remodeling older buildings with wider door frames and special plumbing to accommodate sturdier toilets.

The paucity of available beds has meant heavy patients can languish in hospitals, at great expense to Medicare, private insurance companies and the hospitals.

"We've had patients in the hospital for several months," said Dr. Lynn Crawford, the medical director of the University of Alabama at Birmingham Hospital-Highlands geriatrics unit — an observation echoed by other hospitals and national industry groups.

Martin Bayne, 65, who has Parkinson's disease and weighs 370 pounds, found himself stuck in a hospital in Pennsylvania after episodes of congestive heart failure and the flu. "It was hell for me," he said, lamenting the helplessness and humiliation he felt awaiting placement in a skilled nursing facility.

"There's a terrible feeling that goes along with knowing that you're not wanted," said Mr. Bayne, an advocate and blogger on issues of aging. He now lives in a personal care home in Center Valley, Pa.

Patients can end up in nursing homes hours away, and across state lines, from their families, compounding a difficult period of their lives. "They are already ill and feeling compromised," Ms. Terra, of the University of Mississippi Medical Center, said. "But at some point, we have to say: 'It has to do with your weight. I can't find a place for you to go.'"

By 2040, more than 82 million people will be 65 and older, twice as many as in 2000. Adult obesity has continued to increase — 38 percent of Americans 60 and older are obese — and one in 20 adults is considered extremely obese.

As tens of millions of these obese Americans age, Dr. Crawford said, "it's going to be exponentially worse."

Nursing home administrators say they also have to accommodate a number of younger obese patients with serious health problems who are unable to live on their own. Lee Nalls, 28, slouched in a wheelchair in his room in the bariatric wing at Generations of Red Bay. A diabetic who has been severely obese since childhood, Mr. Nalls had suffered a stroke that left his right side paralyzed. Through physical therapy, he said, he is hoping to recover and have "a life outside of here."

Hospitals have become increasingly inventive, with some offering donations of specialized beds, mattresses and lifts to nursing homes considering admission of an obese patient. "We step in to try to help with that transition," Ms. Bonsi-Wallace said.

The prospect of losing weight is neither realistic nor advisable for these patients, doctors say.

"The expectation has been that we're going to get them back up on their feet and get them home again," said Ms. Phillips of LeadingAge. "But there is a group of them that is not going to happen. And losing weight at this point in their life is not a viable option."

Indeed, weight loss can be dangerous for obese patients who, despite their size, lose muscle mass and can become frail, placing them at risk for fractures.

For Wanda Chism, her golden years have played out far differently than she imagined. "I always pictured my retirement: I wanted a tricycle and be on my way."

Instead, she seems resigned that she will be in her small room and oversize bed at the obesity wing at Generations of Red Bay until the end.

She surveyed the odds and ends of fabric spilling out of her plastic sewing bins and the call buzzer and TV remote she uses to summon the outside world.

"It's home," she said, nodding. "It's home."

This article was produced in collaboration with Kaiser Health News, an editorially independent program of the Kaiser Family Foundation.

A version of this article appears in print on December 15, 2015, on page D1 of the New York edition with the headline: Scaling Up.

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Exhibit 3

December 17, 2015 letter from Capital Funding Group

CAPITAL FUNDING, LLC

December 17, 2015

Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

RE: Prince George's Post Acute, LLC Certificate of Need Application, Docket No. 13-16-2347

Dear Mr. McDonald,

I am writing in regard to the above referenced Certificate of Need application. My company works with companies such as FutureCare in obtaining HUD financing for capital projects. I have been working with FutureCare on the financing of this project. Though HUD, through their underwriting will ultimately determine the final loan amount, we are confident that the applicant's HUD financing application for approximately $22,400,000 will be approved.

Sincerely,

Erik Howard
Managing Director – Healthcare Real Estate Finance

1422 Clarkview Road, Baltimore, MD 21209 T. 410-342-3155 F. 410-342-7101 www.capfundinc.com

Exhibit 4

MVS Analysis

The following compares the project costs to the Marshall Valuation Service ("MVS") benchmark.

I. Marshall Valuation Service Calculation

Type		Convalescent Hospital	
Construction Quality/Class		D/Good	
Stories		2	
Perimeter		1,847	
Height of Ceiling		11.13	
Square Feet		93,490	
f.1	Average floor Area	46,745	
A. Base Costs			
	Basic Structure	$177.28	11/15
	Elimination of HVAC cost for adjustment	0	
	HVAC Add-on for Mild Climate	0	
	HVAC Add-on for Extreme Climate	0	
Total Base Cost		$177.28	
B. Additions			
	Elevator (If not in base)	$5.46	
	Other	$0.00	
Subtotal		$5.46	
Total		$182.74	
C. Multipliers			
Perimeter Multiplier		0.948400615	
	Product	$173.31	
Height Multiplier (plus/minus from 12')		0.979944807	
	Product	$169.83	
Multi-story Multiplier (0.5%/story above 3)		1	
	Product	$169.83	
D. Sprinklers			
	Sprinkler Amount	2.97	
Subtotal		$172.80	

E. Update/Location Multipliers		
Update Multiplier	1.01	12/15
Product	$174.53	
Location Multiplier	1.03	10/15
Product	$179.77	
Final Square Foot Cost Benchmark	**$179.77**	

II. Cost of New Construction

A. Base Calculations	Actual	Per Sq. Foot
New Construction	$15,452,559	$165.29
Fixed Equipment	In Building	
Site Preparation	$2,114,706	$22.62
Architectual Fees	$883,202	$9.45
Capitalized Construction Interest + Loan Placement Fee	$1,777,343	$19.01
Permits	$275,000	$2.94
Subtotal	$20,502,810	$219.30

However, this project includes a considerable amount of costs for facets of the project that would not be included in the MVS average, such as demolition, canopies, etc. Each of these is listed below:

B. Extraordinary Cost Adjustments

	Project Costs	Associated A&E Fees	Associated Cap Interest	Total
Storm Drains	$250,000	$12,569		**$262,569**
Rough Grading	$350,000	$17,596		**$367,596**
Demolition/Deforestation	$58,000	$2,916		**$60,916**
Sediment & Erosion Control	$80,000	$4,022		**$84,022**
Site Improvements	$66,000	$3,318		**$69,318**
Landscaping	$96,030	$4,828		**$100,858**
Roads	$489,500	$24,610		**$514,110**
Lighting	$255,404	$12,841		**$268,244**
Utilities	$100,000	$5,028		**$105,028**
Jurisdictional Hook-up Fees	$100,000	$5,028		**$105,028**
Signs	$5,900	$297	$560	**$6,757**
Canopy	$75,000	$3,771	$7,119	**$85,889**
Premium for All Union Labor	$105,735	$5,316		**$111,051**

Premium for All Union Labor	$772,628	$38,844	$73,335	**$884,807**
Total Cost Adjustments	$2,804,197	$140,982	$81,013	**$3,026,193**
Per Square Foot				**$32.37**
C. Adjusted Project Cost	$17,476,617			
Per square foot	$186.94			

These costs should fairly be eliminated from the costs that are compared to the MVS Estimate in order to obtain and "apples to apples" comparison. Eliminating all of the extraordinary costs reduces the project costs that should be compared to the MVS benchmark to $186.94.

III. Comparison

A. Adjusted Project Cost/Sq. Ft.	$186.94
B. Marshall ValuationService Benchmark	$179.77
	$7.17
	3.99%

One can see that PGPA estimates that the costs in the apples to apples comparison to the MVS estimate are approximately 4% above the MVS benchmark.

Exhibit 5

Revised Project Drawings

1 LOWER LEVEL PLAN

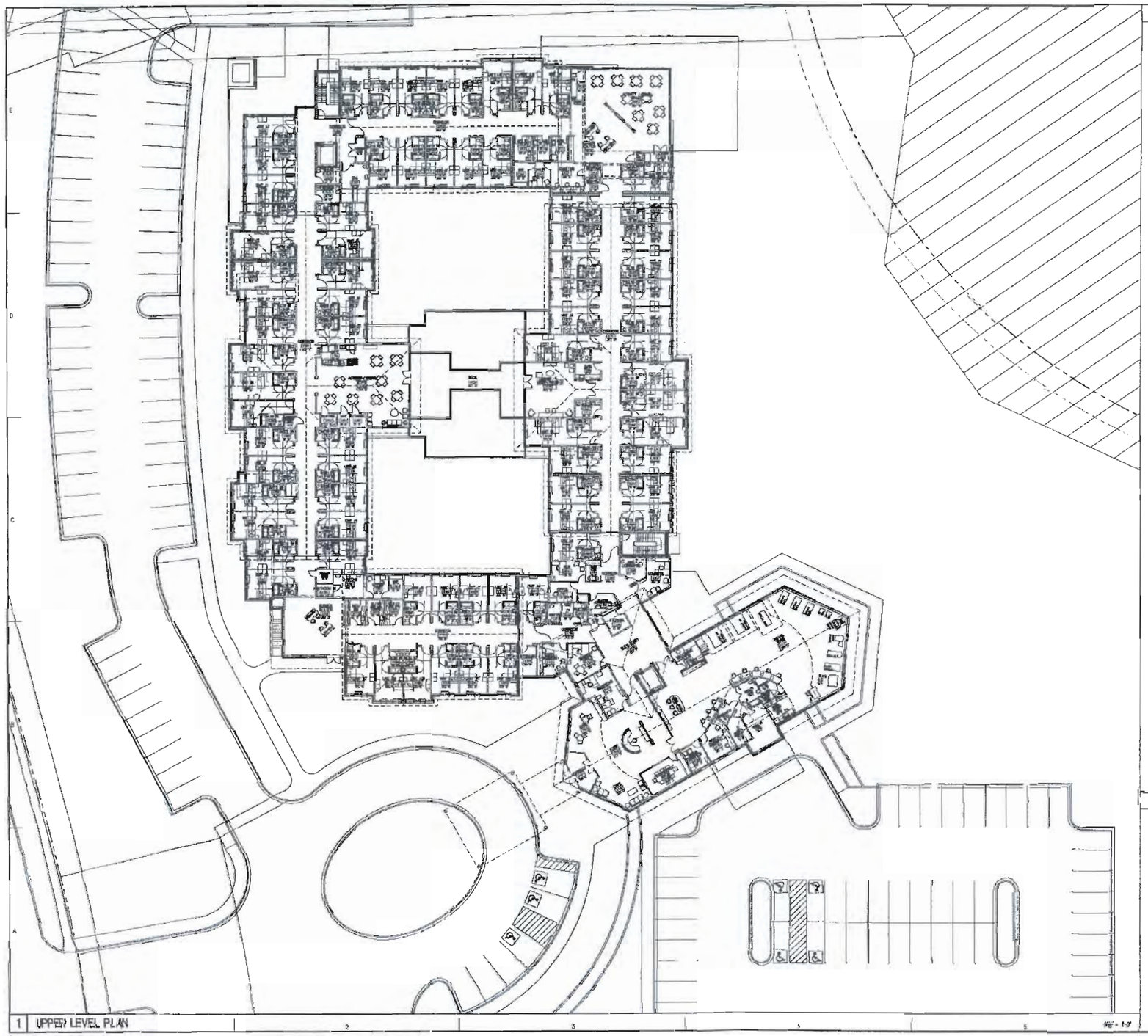
GENERAL NOTES

KEY

FUTURECARE PGPA
BRIGHTSEAT ROAD
PRINCE GEORGE'S COUNTY LANDOVER, MARYLAND 20785

LOWER LEVEL PLAN

A101



1 UPPER LEVEL PLAN

GENERAL NOTES

KEY

FUTURECARE PGPA
BRIGHTSEAT ROAD
PRINCE GEORGE'S COUNTY LANDOVER, MARYLAND 20785

UPPER LEVEL PLAN

A102

2 NORTH ELEVATION

1/8" = 1'-0"

1 WEST ELEVATION

1/8" = 1'-0"

MATERIAL KEY LIST

KEY

FUTURECARE PGPA
BRIGHTSEAT ROAD
PRINCE GEORGE'S COUNTY LANDOVER, MARYLAND 20785

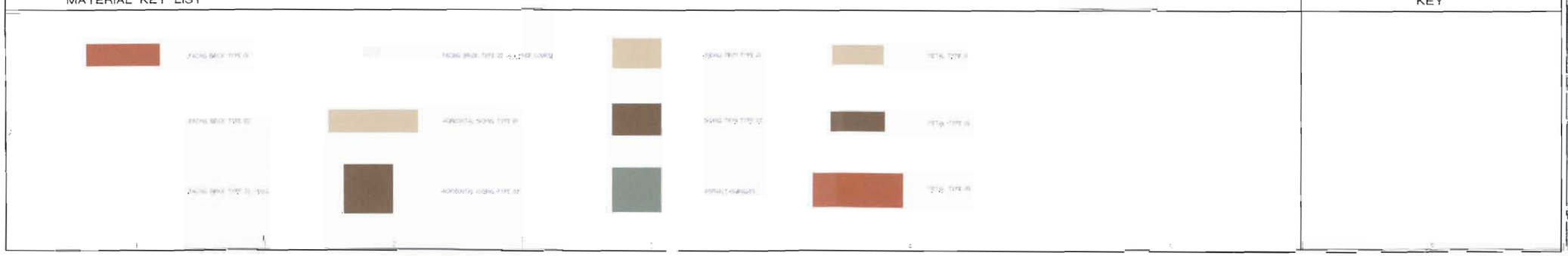
BUILDING ELEVATIONS

A201-C

2 EAST ELEVATION

2 SOUTH ELEVATION

MATERIAL KEY LIST



KEY

KANN PARTNERS

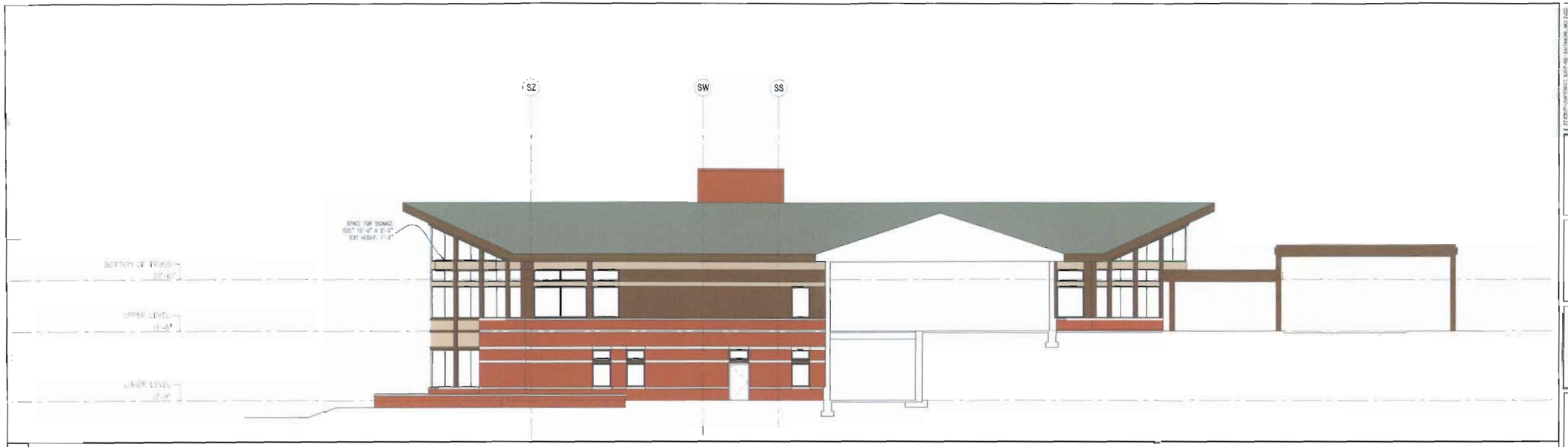
FUTURECARE PGPA

BRIGHTSEAT ROAD

PRINCE GEORGE'S COUNTY LANDOVER, MARYLAND 20785

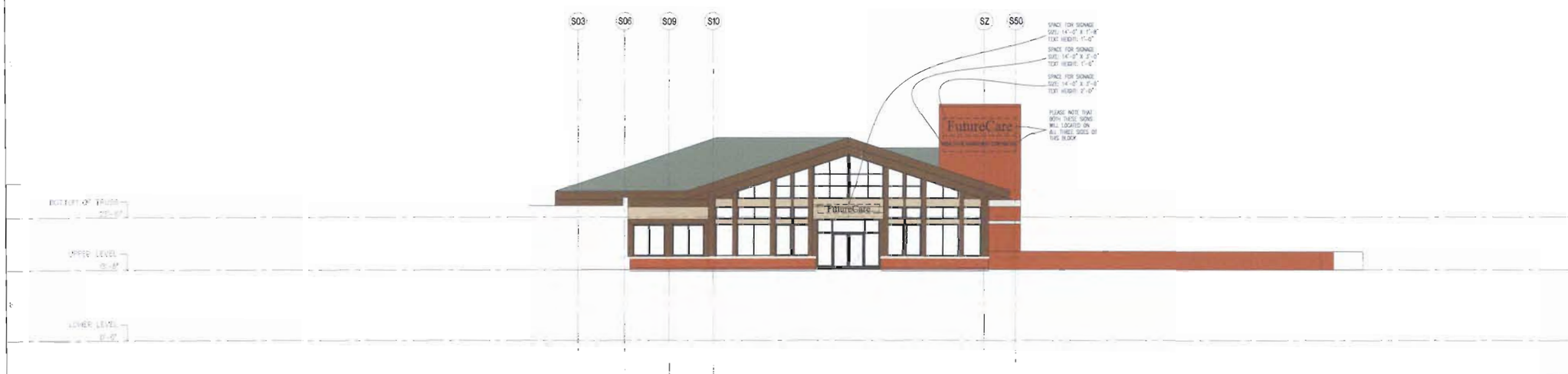
BUILDING ELEVATIONS

A202-C



2 NORTHWEST ELEVATION

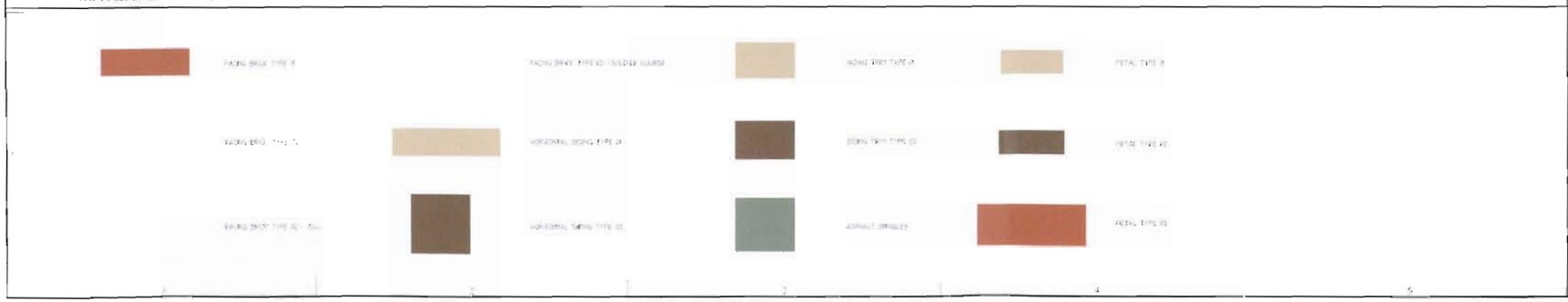
1/8" = 1'-0"



1 SOUTHWEST ELEVATION

1/8" = 1'-0"

MATERIAL KEY LIST



KEY

KANN PARTNERS

FUTURECARE PGPA

BRIGHTSEAT ROAD

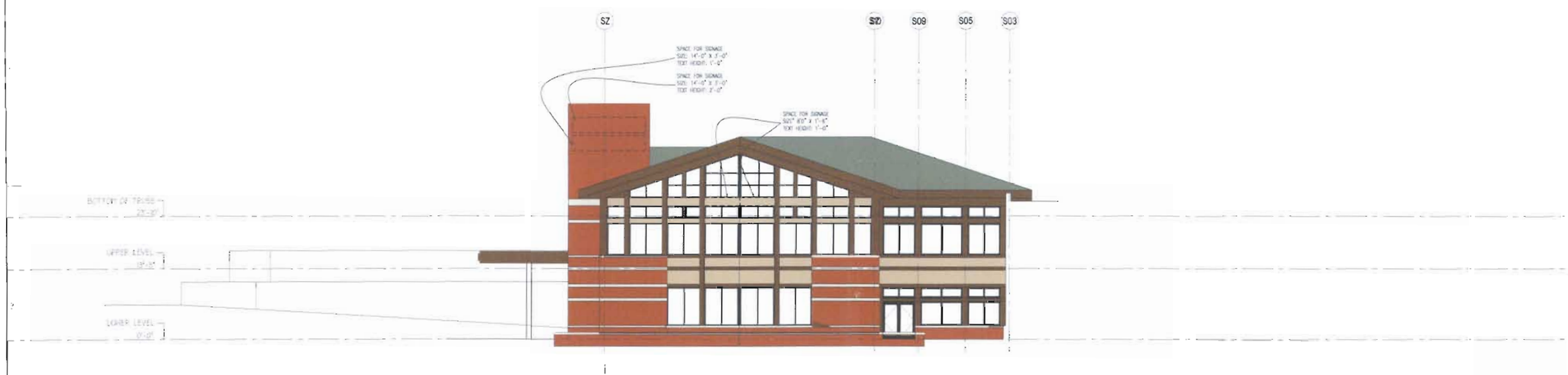
PRINCE GEORGE'S COUNTY LANDOVER, MARYLAND 20785

BUILDING ELEVATIONS

A203-C

2 SOUTHEAST ELEVATION

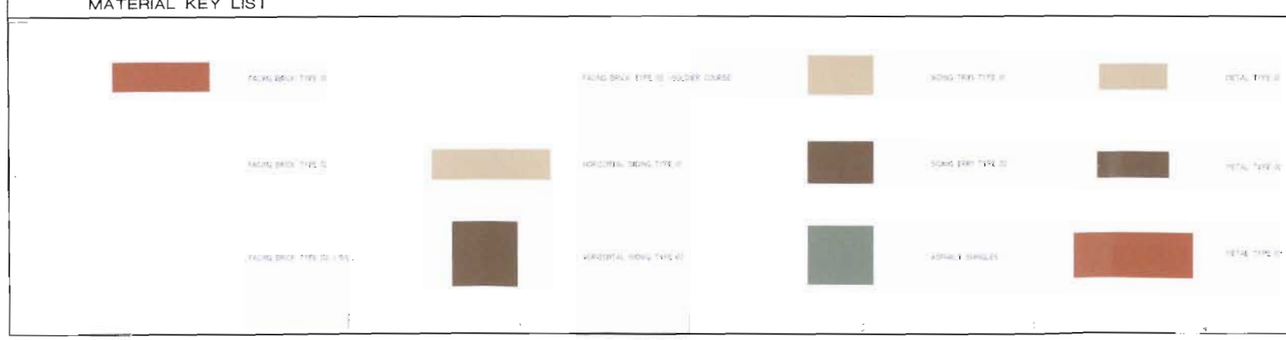
1/8" = 1'-0"



1 NORTHEAST ELEVATION

1/8" = 1'-0"

MATERIAL KEY LIST



KEY

KANN PARTNERS

P 410-234-0900
P 410-539-4921
WWW.KANNPARTNERS.COM

FUTURECARE PGPA

BRIGHTSEAT ROAD

PRINCE GEORGE'S COUNTY LANDOVER, MARYLAND 20785

BUILDING ELEVATIONS

A204-C

2 COURTYARD - WEST ELEVATION -

1/8" = 1'-0"

1 COURTYARD - EAST ELEVATION -

1/8" = 1'-0"

MATERIAL KEY LIST

KEY

KANN PARTNERS

FUTURECARE PGPA

BRIGHTSEAT ROAD

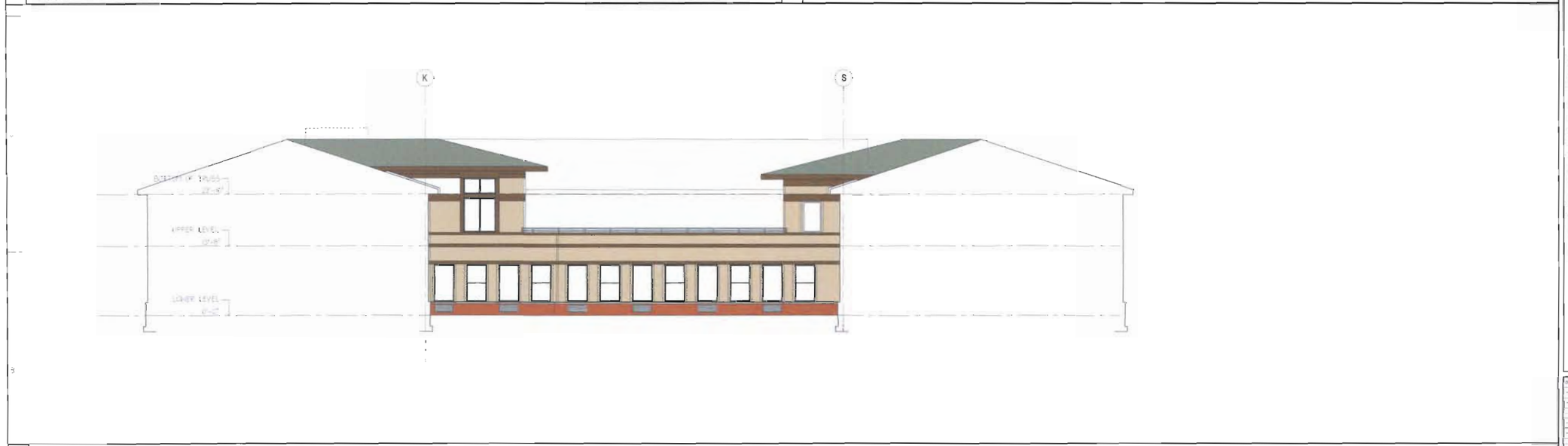
PRINCE GEORGE'S COUNTY LANDOVER, MARYLAND 20785

BUILDING ELEVATIONS

A205 -C

2 COURTYARD - NORTH ELEVATION - 1/8" = 1'-0"

3 COURTYARD - SOUTH ELEVATION - 1/8" = 1'-0"



1 COURTYARD - SOUTH NORTH ELEVATION SIM - 1/8" = 1'-0"

MATERIAL KEY LIST

KEY

KANN PARTNERS

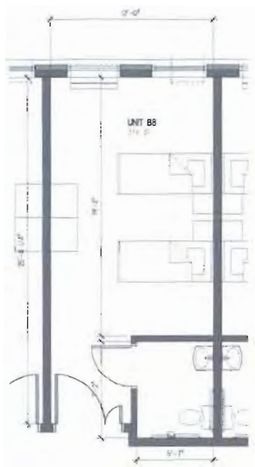
FUTURECARE PGPA

BRIGHTSEAT ROAD

PRINCE GEORGE'S COUNTY LANDOVER, MARYLAND 20785

BUILDING ELEVATIONS

A206 -C



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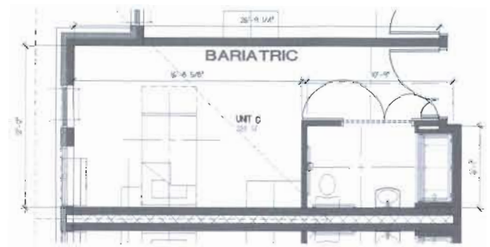
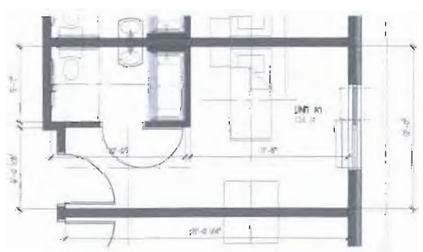


6 UNIT C1 (SIMILAR C2) 1/4" = 1'-0"

3 UNIT D2 (SIMILAR D1) 1/4" = 1'-0"



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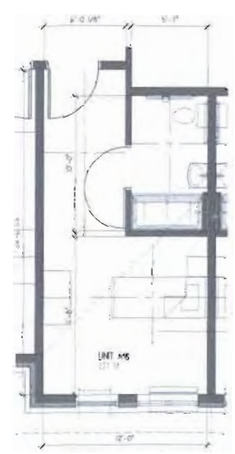


1 UNIT A15 (SIMILAR A8) 1/4" = 1'-0"

NOTE:
SIMILAR UNITS LISTED ON THIS DRAWING HAVE MINOR DIMENSION VARIATIONS.

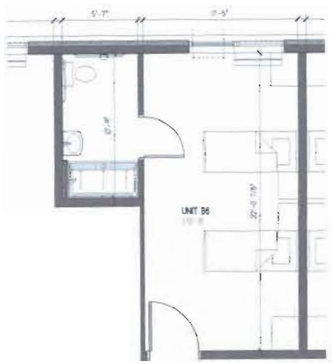
2 UNIT B2 (SIMILAR B4) 1/4" = 1'-0"

KANN PARTNERS

FUTURECARE PGPA
BRIGHTSEAT ROAD
PRINCE GEORGE'S COUNTY LANDOVER, MARYLAND 20785

ENLARGED UNIT PLANS

A421



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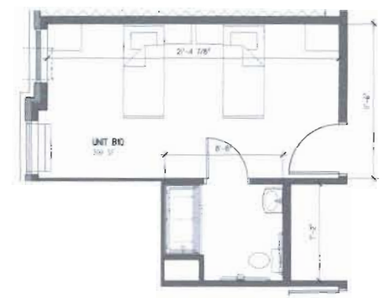

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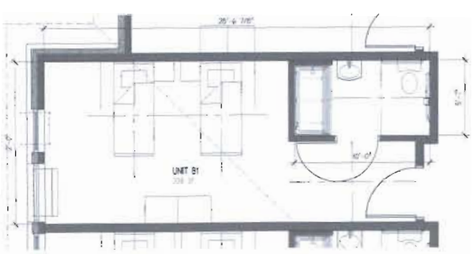

1 UNIT B1 1/4" = 1'-0"

2 UNIT B3 1/4" = 1'-0"

3 UNIT B5 1/4" = 1'-0"

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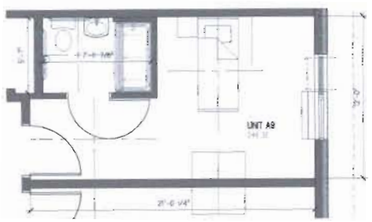
BRIGHTSEAT ROAD
PRINCE GEORGE'S COUNTY LANDOVER, MARYLAND 20785

ENLARGED UNIT PLANS

A422



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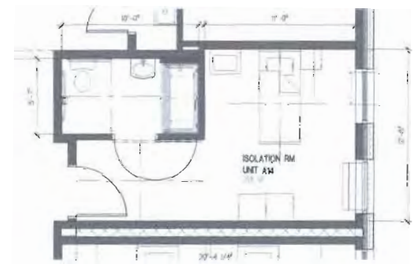

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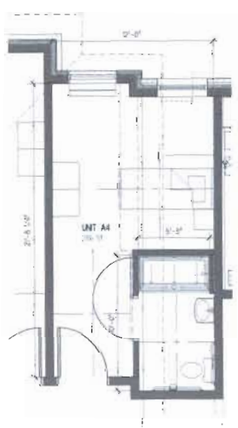
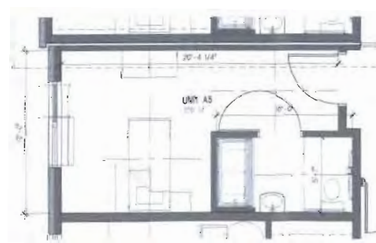
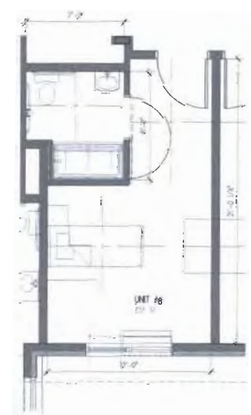
7 UNIT D3 1/4" = 1'-0"



1 UNIT A4 (SIMILAR A2, A10, A3) 1/4" = 1'-0"



2 UNIT A5 1/4" = 1'-0"



3 UNIT A8 1/4" = 1'-0"

NOTE:
SIMILAR UNITS LISTED ON THIS DRAWING
HAVE MINOR DIMENSION VARIATIONS.

KAMN PARTNERS

FUTURECARE PGPA
BRIGHTSEAT ROAD
PRINCE GEORGE'S COUNTY LANDOVER, MARYLAND 20785

ENLARGED UNIT PLANS

A423

Exhibit 6

Revised Chart 1

Chart 1. Project Construction Characteristics and Costs		
Base Building Characteristics	Complete if Applicable	
	New Construction	Renovation
Class of Construction		
Class A		
Class B		
Class C		
Class D	X	
Type of Construction/Renovation		
Low		
Average		
Good	X	
Excellent		
Number of Stories	2	
Total Square Footage	93,490	
Basement		
First Floor	46,190	
Second Floor	47,300	
Third Floor		
Fourth Floor		
Perimeter in Linear Feet		
Basement		
First Floor	1808' - 7"	
Second Floor	1885' - 9"	
Third Floor		
Fourth Floor		
Wall Height (floor to eaves)		
Basement		
First Floor	13' - 8"	
Second Floor	10' - 2" (14'-2" in Lobby/Rehab)	
Third Floor		
Fourth Floor		
Elevators		
Type *Passenger* *Freight*		
Number 2 0		
Sprinklers (Wet or Dry System)	Wet	
Type of HVAC System	Through-wall PTACs in Resident Rooms; split systems in all other areas.	
Type of Exterior Walls	Steel studs with exterior brick veneer and siding.	

Exhibit 7

Revised Table 2: Project Budget

				Approved	Modification Request
1.	**Capital Costs:**				
	a.	**New Construction**			
		(1)	Building	$10,407,176	$15,452,559
		(2)	Fixed equip. (not in above)	$0	$0
		(3)	Land purchase	$2,250,000	$2,250,000
		(4)	Site preparation	$772,655	$2,114,706
		(5)	Architect/engineering fees	$782,588	$883,202
		(6)	Permits (building, utilities, etc.)	$175,000	$275,000
		Total New Construction		**$14,387,419**	**$20,975,467**
	b.	**Renovations**			
		(1)	Building		
		(2)	Fixed equip. (not in above)		
		(3)	Architect/engineering fees		
		(4)	Permits (building, utilities, etc.)		
		Total Renovaton		**$0**	**$0**
	c.	**Other Capital Costs**			
		(1)	Movable equipment	$2,000,000	$2,319,707
		(2)	Other (Real Estate Taxes, Project Management Consultant, MIP, and Other)		$394,075
		(3)	Contingencies	$1,117,983	$1,000,000
		Total Other Capital Cost		**$3,117,983**	**$3,713,782**
		(1)	Capitalized Construction. Interest	$492,493	$1,045,436
		Total Current Capital Costs		**$17,997,895**	**$25,734,685**
	d.	**Non-Current Capital Costs**			
			Estimated Inflation	$508,780	$539,056
		Total Proposed Capital Costs		**$18,506,675**	**$26,273,741**
	2.				
		a.	Loan Placement Fees	$503,830	$1,108,355
		b.	Legal fees (CON related)	$40,000	$85,000
		c.	Legal fees (Other)		$65,000
		d.	Consultant Fees		
			CON Application Assistance	$20,000	$75,000
			Other (interior Design Consultant)		$52,000
			Total Financing Costs	**$563,830**	**$1,385,355**
	3.	Working Capital Startup Costs			$270,000
		TOTAL USES OF FUNDS (1 - 3)		**$19,070,505**	**$27,929,096**
	B.	**Sources of Funds for Project:**			
		1	Cash	$1,970,505	$5,529,096
		2	Pledges: Gross		
			less allowance for uncollectable		
		3	Gifts, bequests		
		4	Interest income		
		5	Authorized bonds		
		6	Mortgage	$17,100,000	$22,400,000
		7	Working capital loan		
		8	Grants or Appropriation:		
			(a) Federal		
			(b) State		
			(c) Local		
		9	Other (specify)		
		TOTAL SOURCES OF FUNDS (1 - 9)		$19,070,505	$27,929,096

Exhibit 8

Revised Table 2 STATISTICAL PROJECTIONS and
Revised Table 3 REVENUES AND EXPENSES - ENTIRE FACILITY

Prince George's Post Acute, LLC

Revised TABLE 2: STATISTICAL PROJECTIONS - PROPOSED BUDGET

12/21/2015

	Projected Years (ending with first full year at full utilization) 1 CY 20X1	2 CY 20X2	3 CY 20X3
Admissions			
a. ECF			
b. Comprehensive	468	842	840
c. Assisted Living			
d. Respite Care *			
e. Adult Day Care			
f. Other (Specify)			
g. TOTAL	468	842	840
Patient Days			
a. ECF			
b. Comprehensive	21,834	49,105	50,005
c. Assisted Living			
d. Respite Care *			
e. Adult Day Care			
f. Other (Specify)			
g. TOTAL	21,834	49,105	50,005
Occupancy Percentage			
a. ECF			
b. Comprehensive	72.75%	89.69%	91.33%
c. Assisted Living			
d. Respite Care *			
e. Adult Day Care			
f. Other (Specify)			
g. TOTAL	72.75%	89.69%	91.33%
Number of Licensed Beds			
a. ECF			
b. Comprehensive	82.22	150	150
c. Assisted Living			
d. Respite Care *			
e. Adult Day Care			
f. Other (Specify)			
g. TOTAL	82.22	150	150

	Licensed Beds:
January - April	40
May - August	80
September - December	126
	Available Days
January - April	4,800
May - August	9,840
September - December	15,372
	30,012
Average number licensed beds	82.22

* Respite care admissions, patient days, and number of beds should not be reported under "comprehensive" or "assisted living" categories.

Prince George's Post Acute, LLC

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED BUDGET

12/15/2015

Supplemental Information:

Admissions Details	1 CY 20X1	2 CY 20X2	3 CY 20X3
Private	6	2	2
Medicare	340	667	676
Medicaid - MD	69	47	33
Managed Care	29	99	102
Hospice	9	12	12
CIGNA/Healthspring	15	15	15
Totals	468	842	840

Prince George's Post Acute, LLC

Revised Table 3: REVENUES AND EXPENSES - ENTIRE FACILITY

12/21/2015

	Two Most Actual Ended Recent Years		Current Year Projected	1	2	3
CY or FY (Circle)	PY 20XX	PY 20XX	CY 20XX	CY 20X1	CY 20X2	CY 20X3
1. **Revenue**						
a. Inpatient Services				9,025,320	21,718,390	22,639,797
b. Outpatient Services				-	-	-
c. Gross Patient Services Revenues	-	-	-	9,025,320	21,718,390	22,639,797
d. Allowance for Bad Debt				(168,511)	(404,056)	(421,129)
e. Contractual Allowance & Adjustments						
f. Charity Care						
g. Net Patient Services Revenue	-	-	-	8,856,809	21,314,334	22,218,668
Other Operating Revenues						
Miscellaneous Revenue				83,536	122,522	123,854
h. Total Other Operating Revenue	-	-	-	83,536	122,522	123,854
i. Net Operating Revenues	-	-	-	8,940,345	21,436,856	22,342,522
Expenses						
a. Salaries, Wages and Professional Fees (inc. benefits)				5,062,899	9,983,024	10,366,732
b. Contractual Services				1,408,809	2,722,116	2,738,332
c. Interest on Current Debt				-	-	-
d. Interest on Project Debt				-	-	-
e. Current Depreciation				-	-	-
f. Project Depreciation				-	-	-
g. Current Amortization				-	-	-
h. Project Amortization				-	-	-
i. Supplies				311,571	747,084	775,383
j. Other Expenses				-	-	-
Pharmacy				547,196	1,173,391	1,191,478
Management Fee				480,000	1,528,800	1,593,000
Other Administration				343,571	479,917	483,463
Food				156,987	353,066	359,537
Utilities				151,140	267,628	272,535
Taxes/Property/Insurance				530,996	960,687	976,505
Rental of Facility				1,513,382	1,511,812	1,510,160
Equipment Rental/Repairs & Maint				106,826	281,055	304,236
Lab, Xray, Ambulance Services				140,512	288,393	291,729
j. Total Other Expenses	-	-	-	3,970,610	6,844,749	6,982,643
k. Total Operating Expenses	-	-	-	10,753,889	20,296,973	20,863,090
3. **Income (Loss)**						
a. Income from Operation	-	-	-	(1,813,543)	1,139,884	1,479,433
b. Non-Operating Income						
c. Subtotal	-	-	-	(1,813,543)	1,139,884	1,479,433
d. Income Taxes						
e. Net Income (Loss)	-	-	-	(1,813,543)	1,139,884	1,479,433

Prince George's Post Acute, LLC
Revised Table 3: REVENUES AND EXPENSES - ENTIRE FACILITY
12/21/2015

CY or FY (Circle)	Two Most Actual Ended Recent Years PY 20XX	PY 20XX	Current Year Projected CY 20XX	1 CY 20X1	2 CY 20X2	3 CY 20X3
4. **Patient Mix**						
A. Percent of Net Patient Revenue						
1) Medicare				55.30%	46.64%	45.32%
2) Medicaid				31.23%	42.71%	44.28%
3) Commercial Insurance				5.87%	5.89%	5.82%
4) Self-Pay				4.48%	2.13%	2.04%
5) Part B therapy, Other Patient Revenues				3.13%	2.64%	2.54%
6) Total				100.00%	100.00%	100.00%
B. Percent of Patient Days by Payer Source						
1) Medicare				42.78%	38.16%	37.96%
2) Medicaid				45.07%	52.36%	52.55%
3) Commercial Insurance				5.02%	5.76%	5.84%
4) Self-Pay				5.86%	2.97%	2.92%
5) Hospice				1.26%	0.74%	0.73%
Total				100.00%	100.00%	100.00%

From Table 5:

c. Medicaid Analysis	Patient Days	Patient Days	Patient Days
a. Light			
b. Moderate			
c. Heavy			
d. Heavy Special - ALL MEDICAID DAYS	9,841	25,712	26,280
e. Total	9,841	25,712	26,280
c. Medicaid Analysis	Daily Rate	Daily Rate	Daily Rate
a. Light			
b. Moderate			
c. Heavy			
d. Heavy Special - ALL MEDICAID DAYS	287.41	362.15	382.99
e. Additional Services	1.62	0.62	0.61

Please note: Classification of Medicaid Days has changed.

Exhibit 9

Revised Table 4 REVENUES AND EXPENSES - (for first full year at full utilization)

Prince George's Post Acute, LLC
Revised TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT
12/21/2015

		1	2	3
	CY or FY (circle)	CY 20X1	CY 20X2	CY 20X3
1.	**Revenue**			
	a. Inpatient Services	9,025,320	21,718,390	22,639,797
	b. Outpatient Services	-	-	-
	c. Gross Patient Services Revenues	9,025,320	21,718,390	22,639,797
	d. Allowance for Bad Debt	(168,511)	(404,056)	(421,129)
	e. Contractual Allowance & Adjustments			
	f. Charity Care			
	g. Net Patient Services Revenue	8,856,809	21,314,334	22,218,668
	h. Other Operating Revenues			
	Miscellaneous Revenue	83,536	122,522	123,854
	Total Other Operating Revenue	83,536	122,522	123,854
	i. Net Operating Revenues	8,940,345	21,436,856	22,342,522
2,	**Expenses**			
	a. Salaries, Wages and Professional Fees (inc. benefits)	5,062,899	9,983,024	10,366,732
	b. Contractual Services	1,408,809	2,722,116	2,738,332
	c. Interest on Current Debt	-	-	-
	d. Interest on Project Debt	-	-	-
	e. Current Depreciation	-	-	-
	f. Project Depreciation	-	-	-
	g. Current Amortization	-	-	-
	h. Project Amortization	-	-	-
	i. Supplies	311,571	747,084	775,383
	j. Other Expenses	-	-	-
	Pharmacy	547,196	1,173,391	1,191,478
	Management Fee	480,000	1,528,800	1,593,000
	Other Administration	343,571	479,917	483,463
	Food	156,987	353,066	359,537
	Utilities	151,140	267,628	272,535
	Taxes/Property/Insurance	530,996	960,687	976,505
	Rental of Facility	1,513,382	1,511,812	1,510,160
	Equipment Rental/Repairs & Maint	106,826	281,055	304,236
	Lab, Xray, Ambulance Services	140,512	288,393	291,729
	j. Total Other Expenses	3,970,610	6,844,749	6,982,643
	k. Total Operating Expenses	10,753,889	20,296,973	20,863,090

Prince George's Post Acute, LLC
Revised TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT
12/21/2015

3. **Income**			
a. Income from Operation	(1,813,543)	1,139,884	1,479,433
b. Non-Operating Income			
c. Income	(1,813,543)	1,139,884	1,479,433
d. Income Taxes			
e. Net Income (Loss)	(1,813,543)	1,139,884	1,479,433
4. **Patient Mix**			
A. Percent of Net Patient Revenue			
1) Medicare	55.30%	46.64%	45.32%
2) Medicaid	31.23%	42.71%	44.28%
3) Commercial Insurance	5.87%	5.89%	5.82%
4) Self-Pay	4.48%	2.13%	2.04%
5) Part B therapy, Other Patient Revenues	3.13%	2.64%	2.54%
6) Total	100.00%	100.00%	100.00%
B. Percent of Patient Days by Payer Source			
1) Medicare	42.78%	38.16%	37.96%
2) Medicaid	45.07%	52.36%	52.55%
3) Commercial Insurance	5.02%	5.76%	5.84%
4) Self-Pay	5.86%	2.97%	2.92%
5) Hospice	1.26%	0.74%	0.73%
6) Total	100.00%	100.00%	100.00%

From Table 5:

c. Medicaid Analysis	Patient Days	Patient Days	Patient Days
a. Light			
b. Moderate			
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d. Heavy Special - ALL MEDICAID DAYS	9,841	25,712	26,280
e. Total	9,841	25,712	26,280
c. Medicaid Analysis	Daily Rate	Daily Rate	Daily Rate
a. Light			
b. Moderate			
c. Heavy			
d. Heavy Special - ALL MEDICAID DAYS	287.41	362.15	382.99
e. Additional Services	1.62	0.62	0.61

Please note: Classification of Medicaid Days has changed.

Prince George's Post Acute, LLC
Revised TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT
12/21/2015

SUPPLEMENTAL INFORMATION - Other Administration

ADVERTISING -HELP WANTED	7,502
AUTO	1,999
BANK CHARGES	14,001
DATA PROCESSING	33,005
DUES & SUBSCRIPTIONS	24,006
INSURANCE-NON PROPERTY	126,236
OFFICE SUPPLIES	42,507
ACCOUNTING	19,200
LEGAL & CONSULTING	44,703
LICENSES & PERMITS	4,499
TELEPHONE	29,002
EDUCATION & TRAINING EXPENSE	4,800
MEETINGS & SEMINARS	1,200
INTEREST-WORKING CAPITAL	60,003
ADVERTISING-MEDIA	6,000
PRINTING & VIDEO PRODUCTION	3,864
MEETINGS WITH REFERRAL SOURCES	1,536
PROMOTIONAL GIFTS	2,400
COMMUNITY RELATIONS	2,400
CONTRIBUTIONS	600
AMORTIZATION OF STARTUP COSTS	54,000
Total Other Administration	483,463

SUPPLEMENTAL INFORMATION - Supplies

MEDICAL SUPPLIES	353,038
ENTERAL SUPPLIES	22,503
OXYGEN SUPPLIES	32,508
VENT/TRACH SUPPLIES	43,800
VENT OXYGEN	23,702
ACTIVITY SUPPLIES	20,003
PATIENT PERSONAL CARE SUPPLIES	55,008
DIETARY SUPPLIES	54,008
LAUNDRY SUPPLIES	21,499
LINEN PURCHASES	23,503
DIAPERS & DISPOSABLES	51,501
HOUSEKEEPING SUPPLIES	59,507
THERAPY SUPPLIES	10,800
MEDICAL RECORDS SUPPLIES	4,003
Total Supplies	775,383

Prince George's Post Acute, LLC
Revised TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT
12/21/2015

SUPPLEMENTAL INFORMATION - Contractual Services

ADMINISTRATOR	205,256
AGENCY NURSING	63,540
SOCIAL SERVICE	3,000
NURSE PRACTITIONER	219,600
RESPIRATORY AGENCY	76,371
MEDICAL DIRECTOR	48,000
PSYCHOGERIATRIC CONSULTANT	2,700
MEDICAL RECORDS	600
DENTIST	9,600
BARBER AND BEAUTY	20,003
PHARMACY CONSULTANT	9,900
PHYSICAL THERAPY	915,096
OCCUPATIONAL THERAPY	686,321
SPEECH THERAPY	478,345
Total Contractual Services	2,738,332

SUPPLEMENTAL INFORMATION - Pharmacy

OVER THE COUNTER DRUGS	35,004
PRESCRIPTIONS MEDICARE	688,216
PRESCRIPTIONS MANAGED CARE	183,960
PRESCRIPTIONS MEDICAID	48,000
I.V THERAPY EXPENSE	236,298
Total Pharmacy	1,191,478

SUPPLEMENTAL INFORMATION - Miscellaneous Revenue

BARBER AND BEAUTY	24,002
DIALYSIS SPACE RENTAL	48,000
VENDING MACHINES	3,600
EMPLOYEE AND GUEST MEALS	31,800
CABLE TV SERVICE	12,252
VACCINES	4,200
Total Miscellaneous Revenue	123,854

Exhibit 10

Revised Table 6 MANPOWER INFORMATION

Prince George's Post Acute, LLC
Revised TABLE 6: MANPOWER INFORMATION
12/21/2015

	Position	Current No FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	Total Cost
Administration						
	Administrator				contractual	205,256
	Admissions		0.00	32.30	employee	61,632
	Clerical		0.00	13.27	employee	25,322
	Quality Assurance		0.00	41.28	employee	78,763
	Reception		0.00	14.33	employee	65,762
	Business Office		0.00	25.52	employee	191,129
	Medical Records		0.00	18.79	employee	34,761
	Inservice Training		0.00	41.32	employee	39,332
Direct Care						
	DON		0.00	68.01	employee	129,772
	RN		0.00	38.41	employee	1,570,364
	LPN		0.00	30.57	employee	1,045,694
	CNA		0.00	15.97	employee	1,713,399
	Restorative Aide		0.00	16.15	employee	97,014
	Unit Manager		0.00	40.25	employee	307,121
	Shift Supervisor		0.00	38.98	employee	260,270
	Unit Secretaries		0.00	18.98	employee	108,689
	MDS Coordinator		0.00	45.13	employee	271,115
	Vent Director		0.00	38.54	employee	73,532
	Vent RRT's		0.00	34.26	employee	830,206
	Pharmacy				contractual	9,900
	Agency				contractual	63,540
	Physical Therapy				contractual	915,096
	Occupational Therapy				contractual	686,321
	Speech Therapy				contractual	478,345
	Respiratory Therapy				contractual	76,371
Support						
	Activities		0.00	16.26	employee	118,269
	Dietary		0.00	17.00	employee	502,224
	Laundry		0.00	12.47	employee	95,612
	Housekeeping		0.00	13.29	employee	264,675
	Maintenance		0.00	19.39	employee	109,781
	Social Service		0.00	29.04	employee	226,067
	Social Service				contractual	3,000
	Medical Director				contractual	48,000
	Nurse Practitioner				contractual	219,600
	Psychogeriatric				contractual	2,700
	Dentist				contractual	9,600
	Barber and Beauty				contractual	20,003
TOTAL			-			10,958,236

Total Salaries and Employee Benefits	10,366,732	Employee Benefits	2,146,228
Total Contractual	2,737,732		
	13,104,464	Total	13,104,464

Total Employee Benefits	2,146,228
Total Salaries	8,220,505
	26.1%

Prince George's Post Acute, LLC

Revised TABLE 6: MANPOWER INFORMATION SUPPLEMENTAL INFORMATION

12/21/2015

Employee Benefits	
FICA Taxes	653,277
FUI Taxes	13,310
SUI Taxes	88,533
Workman's Compensation	157,308
Employee Group Health Ins.	389,793
Employee Life Insurance	3,072
Employee Expense	36,000
401K Expense	18,996
Tuition Reimbursement	3,756
Drug Screens/Other Expenses	11,556
Background Checks	2,100
Vacation	340,659
Holiday	146,494
Sick	180,852
Personal	94,536
Other	6,006
	2,146,248

Estimated based upon normal operating policies of other FutureCare facilities.

Exhibit 11

Revised Table 7 NURSING STAFFING PATTERN

Prince George's Post Acute, LLC

Revised TABLE 7: NURSING STAFFING PATTERN

12/21/2015

	TOTAL FACILITY			TOTAL FACILITY		
	Weekday			Weekend/Holiday		
	D	E	N	D	E	N
Staff Category						
DON	1	-	-	-	-	-
RN	5	5	4	5	5	4
LPN	4	4	3	4	4	3
CNA	16	14	10	16	14	10
RESTORATIVE AIDE	3	-	-	-	-	-
UNIT MANAGER	4	-	-	-	-	-
SHIFT SUPERVISOR	-	1	1	1	1	1
UNIT SECRETARIES	3	-	-	-	-	-
MDS COORDINATOR	3	-	-	-	-	-
WOUND/SKIN SPECIALIST	1					
WEIGHT COORDINATOR	1					
QUALITY ASSURANCE	1					
INSERVICE	0.5					

Key: D - Day Shift
E - Evening Shift
N - Night Shift

	UNIT 1 (included above in Total Facility)			UNIT 1 (included above in Total Facility)		
	Weekday			Weekend/Holiday		
	D	E	N	D	E	N
Staff Category						
DON						
RN	2	2	2	2	2	2
LPN						
CNA	4	3	2	4	3	2
RESTORATIVE AIDE						
UNIT MANAGER	1					
SHIFT SUPERVISOR						
UNIT SECRETARIES						
MDS COORDINATOR						

Prince George's Post Acute, LLC

Revised TABLE 7: NURSING STAFFING PATTERN

12/21/2015

	UNIT 2 (included above in Total Facility)			UNIT 2 (included above in Total Facility)		
	Weekday			Weekend/Holiday		
Staff Category	D	E	N	D	E	N
DON						
RN		1			1	
LPN	2	2	2	2	2	2
CNA	4	3	3	4	3	3
RESTORATIVE AIDE						
UNIT MANAGER	1					
SHIFT SUPERVISOR						
UNIT SECRETARIES						
MDS COORDINATOR						

	UNIT 3 (included above in Total Facility)			UNIT 3 (included above in Total Facility)		
	Weekday			Weekend/Holiday		
Staff Category	D	E	N	D	E	N
DON						
RN	2	1	1	2	1	1
LPN	1	1	0.5	1	1	0.5
CNA	4	4	3	4	4	3
RESTORATIVE AIDE						
UNIT MANAGER	1					
SHIFT SUPERVISOR						
UNIT SECRETARIES						
MDS COORDINATOR						

	UNIT 4 (included above in Total Facility)			UNIT 4 (included above in Total Facility)		
	Weekday			Weekend/Holiday		
Staff Category	D	E	N	D	E	N
DON						
RN	1	1	1	1	1	1
LPN	1	1	0.5	1	1	0.5
CNA	4	4	2	4	4	2
RESTORATIVE AIDE						
UNIT MANAGER	1					
SHIFT SUPERVISOR						
UNIT SECRETARIES						
MDS COORDINATOR						

Prince George's Post Acute, LLC

Revised TABLE 7: NURSING STAFFING PATTERN

12/21/2015

	NOT UNIT SPECIFIC (included above in Total Facility)			NOT UNIT SPECIFIC (included above in Total Facility)		
	Weekday			Weekend/Holiday		
	D	E	N	D	E	N
Staff Category						
DON	1					
RN						
LPN						
CNA						
RESTORATIVE AIDE	3					
UNIT MANAGER						
SHIFT SUPERVISOR		1	1	1	1	1
UNIT SECRETARIES	3					
MDS COORDINATOR	3					
WOUND/SKIN SPECIALIST	1					
WEIGHT COORDINATOR	1					
QUALITY ASSURANCE	1					
INSERVICE ADON	0.5					

Exhibit 12

Affirmations

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

Signature _____ Date 11/17/2015

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

Leslie D. Goldschmidt
Signature

12/16/15
Date

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

Signature

12/17/15
Date