DOCTORS COMMUNITY HOSPITAL

APPLICATION FOR CERTIFICATE OF NEED

BEHAVIORAL HEALTH PROGRAM: 16-Bed INPATIENT UNIT

OCTOBER 7, 2016

DOCTORS COMMUNITY HOSPITAL

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For internal staff use

MARYLAND HEALTH CARE COMMISSION

_____

MATTER/DOCKET NO.

_____

DATE DOCKETED

HOSPITAL
APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **Doctors Community Hospital**

Address:

8118 Good Luck Road	**Lanham**	**20706**	**Prince George's**
Street	City	Zip	County

Name of Owner (if differs from applicant):

2. OWNER

Name of owner: **Doctors Community Hospital**

3. APPLICANT. ***If the application has co-applicants, provide the detail regarding each co-applicant in sections 3, 4, and 5 as an attachment.***

Legal Name of Project Applicant
Doctors Community Hospital

Address:

8118 Good Luck Road	**Lanham**	**20706**	**Maryland**	**Prince George's**
Street	City	Zip	State	County

Telephone: **301-552-8118**

Name of Owner/Chief Executive: **Phillip B. Down**

4. Name of Licensee or Proposed Licensee**, if different from applicant:**
N/A

5. LEGAL STRUCTURE OF APPLICANT **(and LICENSEE, if different from applicant).**

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	XX	
	(2) For-profit	☐	
	(3) Close	☐	State & date of incorporation Maryland; 1989
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited liability partnership	☐	
	Limited liability limited partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☐	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	XX	

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: Phillip B. Down

Mailing Address:

8118 Good Luck Road	**Lanham**	**20706**	**MD**
Street	City	Zip	State

Telephone: **301-552-8085**

E-mail Address (required): **pdown@dchweb.org**

Fax: **301-552-3355**

B. Additional or alternate contact:

Name and Title: Peter P. Parvis

Mailing Address:

1 West Pa. Ave., Suite 900	**Towson**	**21204**	**MD**
Street	City	Zip	State

Telephone: **410-821-6565**
E-mail Address (required): **pparvis@milesstockbridge.com**
Fax: **410-823-8123**

7. TYPE OF PROJECT

The following list includes all project categories that require a CON under Maryland law. Please mark all that apply.

If approved, this CON would result in:

(1) A new health care facility built, developed, or established ☐
(2) An existing health care facility moved to another site ☐
(3) A change in the bed capacity of a health care facility X ☐
(4) A change in the type or scope of any health care service offered by a health care facility X ☐
(5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf

8. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is; why you need/want to do it; and what it will cost. A one-page response will suffice. Please include:

(1) Brief description of the project – what the applicant proposes to do;
(2) Rationale for the project – the need and/or business case for the proposed project;
(3) Cost – the total cost of implementing the proposed project; and
(4) Master Facility Plans – how the proposed project fits in long term plans.

Doctors Community Hospital ("DCH") seeks approval for: 1) the establishment of a Behavioral Health Program ("BHP") for adults, including a 16-bed acute inpatient hospital psychiatric unit; and 2) capital expenditures related to the renovation of the former Magnolia Gardens Nursing Home, a two story building located on the DCH campus to house the BHP. The main objectives of the project are to address the needs of the adult residents of Prince George's County and neighboring communities for inpatient and outpatient mental health and substance abuse treatment services.

In taking the initiative to address these community health care needs, DCH is establishing its BHP and making the needed investments to improve its physical plant on its current site, DCH will add beds to its license and incur capital expenditures in excess of the statutory threshold for CON review, and incur operating expenses related to the initiation of a new health care services. DCH reserves the right to seek from the Health Services Cost Review Commission future additional rate charging authority to help fund this project,

and therefore, is not taking the “pledge” as set forth at COMAR 10.24.01.03 J.36 Therefore, a CON is required for the capital expenditures associated with this project, totaling $7.5 Million.

B. Comprehensive Project Description: The description must include details, as applicable, regarding:

(1) Construction, renovation, and demolition plans;
(2) Changes in square footage of departments and units;
(3) Physical plant or location changes;
(4) Changes to affected services following completion of the project; and
(5) If the project is a multi-phase project, describe the work that will be done in each phase. If the phases will be constructed under more than one construction contract, describe the phases and work that will be done under each contract.

See Exhibit 1. Complete Project Description

Complete the DEPARTMENTAL GROSS SQUARE FEET WORKSHEET (Table B) in the CON TABLE PACKAGE for the departments and functional areas to be affected.

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

Complete the Bed Capacity (Table A) worksheet in the CON Table Package if the proposed project impacts any nursing units.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: 28 acres

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

Anticipated Dates	Action

C. Form of Site Control (Respond to the one that applies. If more than one, explain.):

(1) Owned by: Doctors Community Hospital
Please provide a copy of the deed.

(2) Options to purchase held by: N/A
Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: N/A
Please provide a copy of the land lease as an attachment.

(4) Option to lease held by: N/A
Please provide a copy of the option to lease as an attachment.

(5) Other: N/A
Explain and provide legal documents as an attachment.

11. PROJECT SCHEDULE

In completing this section, please note applicable performance requirement time frames set forth at COMAR 10.24.01.12B & C. Ensure that the information presented in the following table reflects information presented in Application Item 7 (Project Description).

	Proposed Project Timeline	
Single Phase Project		
Obligation of 51% of capital expenditure from CON approval date	2	months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	1	months
Completion of project from capital obligation or purchase order, as applicable	12	months
Multi-Phase Project for an existing health care facility (Add rows as needed under this section)		
One Construction Contract		
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.		
Initiation of Construction within 4 months of the effective date of the binding construction contract.		
Completion of 1st Phase of Construction (Demolition) within 24 months of the effective date of the binding construction contract		
Fill out the following section for each phase. (Add rows as needed)		
Completion of 2nd phase (Construction of New Tower) within 24 months of completion of each previous phase		
Completion of 3rd phase (Renovations) within 24 months of completion		
Multiple Construction Contracts for an existing health care facility (Add rows as needed under this section)		
Obligation of not less than 51% of capital expenditure for the 1st Phase within 12 months of the CON approval date		months
Initiation of Construction on Phase 1 within 4 months of the effective date of the binding construction contract for Phase 1		months
Completion of Phase 1 within 24 months of the effective date of the binding construction contract.		months
To Be Completed for each subsequent Phase of Construction		
Obligation of not less than 51% of each subsequent phase of construction within 12 months after completion of immediately preceding phase		months
Initiation of Construction on each phase within 4 months of the effective date of binding construction contract for that phase		months
Completion of each phase within 24 months of the effective date of binding construction contract for that phase		months

12. PROJECT DRAWINGS

A project involving new construction and/or renovations must include scalable schematic drawings of the facility at least a 1/16” scale. Drawings should be completely legible and include dates.

Project drawings must include the following before (existing) and after (proposed) components, as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, room sizes, number of beds, location of bathrooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as “shell space”.

B. For a project involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. For a project involving site work schematic drawings showing entrances, roads, parking, sidewalks and other significant site structures before and after the proposed project.

D. Exterior elevation drawings and stacking diagrams that show the location and relationship of functions for each floor affected.

See Exhibit 2. Project Drawings

13. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete the Construction Characteristics (Table C) and Onsite and Offsite Costs (Table D) worksheets in the CON Table Package.

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project, and the steps necessary to obtain utilities. Please either provide documentation that adequate utilities are available or explain the plan(s) and anticipated timeframe(s) to obtain them.

All needed utilities are in place on the existing DCH campus to support the project.

PART II - PROJECT BUDGET

Complete the Project Budget (Table E) worksheet in the CON Table Package.

Note: Applicant must include a list of all assumptions and specify what is included in all costs, as well the source of cost estimates and the manner in which all cost estimates are derived.

Applicant Response:

DCH has relied upon the expertise of CR Goodman & Associates with the preparation of the Project Drawings and Construction Budget for this Application. CR Goodman has extensive experience in the budgeting, design, and construction of a variety of health care facilities, especially in Maryland.

The Project Cost Estimates include six categories for which the following assumptions were applied:

Category	Cost	Assumptions (% of Current Project Costs)
Pre-Construction Costs	**$50,000**	**.68%**
Construction Costs	**$5,883,000**	**80.9%**
Equipment and Furnishings	**$500,000**	**6.8%**
Consultants	**$70,000**	**1.0%**
Inspections/Permits	**$90,000**	**1.2%**
Contingencies	**$674,000**	**9.3%**
TOTAL Current Project Costs	***$7,267,000***	***100%***
Escalation	**$211,000**	
TOTAL Project Costs (Escalated)	***$7,478,000***	

Source: CR Goodman & Associates

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.

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

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

To respond adequately to this criterion, the applicant must address each applicable standard from each chapter of the State Health Plan that governs the services being proposed or affected, and provide a direct, concise response explaining the project's consistency with each standard. In cases where demonstrating compliance with a standard requires the provision of specific documentation, documentation must be included as a part of the application.

Every acute care hospital applicant must address the standards in **COMAR 10.24.10: Acute Care Hospital Services**. A Microsoft Word version is available for the applicant's convenience on the Commission's website. Use of the *CON Project Review Checklist for Acute Care Hospitals General Standards* is encouraged. This document can be provided by staff.

Other State Health Plan chapters that may apply to a project proposed by an acute care hospital are listed in the table below. A pre-application conference will be scheduled by Commission Staff to cover this and other topics. It is highly advisable to discuss with Staff which State Health Plan chapters and standards will apply to a proposed project before application submission. Applicants are encouraged to contact Staff with any questions regarding an application.

Copies of all applicable State Health Plan chapters are available from the Commission and are available on the Commission's web site here:
http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp

10.24. 07	**State Health Plan: an overview** ○ **Psychiatric services** ○ **EMS**
10.24. 09	**Specialized Health Care Services - Acute Inpatient Rehab Services**
10.24. 11	**General Surgical Services**
10.24. 12	**Inpatient Obstetrical Services**
10.24. 14	**Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services**
10.24. 15	**Organ Transplant Services**
10.24. 17	**Cardiac Surgery and Percutaneous Coronary Artery Intervention Services**
10.24. 18	**Neonatal Intensive Care Services**
Capital Projects Exceeding the CON Threshold for Capital Expenditures	**Hospital Capital Projects Exceeding the CON Threshold for Capital Expenditures** Hospital projects that require CON review because the capital expenditure exceeds the CON threshold for capital expenditures but do not involve changes in bed capacity, the addition of new services, and otherwise have no elements that are categorically regulated should address all applicable standards in **COMAR 10.24.10: Acute Care Hospital Services** in their CON application. Applicants should consult with staff in a pre-application conference about any other SHP chapters containing standards that should be addressed, based on the nature of the project.

COMAR 10.24.10 ACUTE CARE CHAPTER
COMAR 10.24.10.04A. 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.

Standard .04A (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.

Applicant Response:

The Hospital has reviewed the State Health Plan requirements for maintaining a representative list of services and charges, procedures for promptly responding to individual requests for current charges for specific services/procedures, and for staff training to ensure that inquiries regarding charges for its services are appropriately handled, and is preparing a policy to assure compliance.

The DCH Patient Handbook provides notice to the patient of the availability of patient charges. Upon request, information concerning charges for and the range and types of services provided is made available to the public. DCH also provides charge estimates and details on an individual request basis. DCH does not have a list of services and charges as a handout. Information is made available to patients in advance of services being rendered or if the patient has questions after receiving a statement. Patients may contact the Financial Counseling office Monday - Friday from 8:30 a.m. - 4:00 p.m. for charge estimates or the Patient Financial Services Customer Service office Monday - Friday from 8:30 a.m. - 4:00 p.m. for a copy of their detailed bill

Standard .04A(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.

Applicant Response:

(a) See Exhibit 3 for DCH Policy

(b) **DCH's level of charity care does not fall within the bottom quartile of all hospitals. To the contrary, for FY 2014, the most recent Health Service Cost Review Commission Community Benefit Report shows that DCH provided total Community Benefits as 10.54% of its Total Operating Expenses, and is appropriate to the needs of its service area population. This compares favorably with the Statewide average of 10.47%.**

A copy of the Hospital's charity care policy has been published in The Gazette, Prince George's County Edition and on the Hospital's website. Financial assistance (charity care) applications will be provided to any person requesting financial help or claiming an inability to pay a bill. Financial assistance is offered to qualified applicants before, during, or after services are rendered. All applicants for financial assistance will be directed to the Patient Financial Services Department, whereby the Hospital maintains a staff of easily accessible financial counselors and social workers who proactively assess potential patients and assist eligible patients on an individual basis in the process of procuring financial assistance to pay for needed healthcare services upon admission and/or discharge. Applicants will be notified of their probable eligibility within 2 business days of their initial request, however, it should be noted that this process does not affect the delivery of services and that acute, emergent and labor/delivery services are provided regardless of the status of a patient's charity care application.

A copy of the Charity Care Policy also is posted in the admission office, patient financial services and the DCH Emergency Department.

Standard .04A (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.

Applicant Response:

DCH complies with all applicable federal, state and local health and safety regulations. DCH 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.

DCH has reviewed the measure values for the Quality Measures included in the most recent update of the Maryland Hospital Performance Guide. None of the measure values fell within the bottom quartile of all hospitals' reported performance measured for any Quality Measures, nor have any fallen below a 90% level of compliance with the Quality Measure. To the contrary, DCH excels in the regulatory required process and outcomes measures, meeting or exceeding the 95th percentile. As further examples: DCH has demonstrated sustained reductions in Maryland Hospital Acquired Conditions significantly over the last 2 report years decreasing patient harm by 32%. DCH has consistently outperformed the State in readmission reduction maintaining all cause readmissions below the HSCRC

expected rates. DCH has maintained a position in the top 10% statewide for readmission reduction. CMH has also maintained mortality rates below the HSCRC expected rates ranking in one of the highest survival rates in the State.

COMAR 10.24.10 ACUTE CARE CHAPTER

COMAR 10.24.10.04 B. PROJECT REVIEW STANDARDS

Standard .04B(1) – Geographic Accessibility

A new acute 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.

Applicant Response:

The proposed project does not involve a new hospital or an existing hospital being relocated to a new site. Also, all of the identified services are already within 30 minutes under normal driving conditions for 90% of the residents of Doctors Community Hospital's service area. This Standard is not applicable.

Standard .04B(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.

(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.

Applicant Response:

DCH is not proposing to add MSGA beds as part of this project. Therefore, this standard does not apply.

Standard .04B(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.

Applicant Response:

This standard is inapplicable because the Project does not involve establishment of a new pediatric service.

Standard .04B(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.**

Applicant Response:

The Applicant notes neither section (a) nor (b) is applicable to this Project. The charge per case methodology is not applicable to hospitals operating under the Global Budgeted Revenue system. The proposed project to be undertaken by DCH will not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The financial assumptions supporting TABLE G. assume a rate increase related to the costs of the proposed project.

The proposed Project is to establish and operate a 16-bed adult inpatient psychiatric unit as one component of a comprehensive Behavioral Health Program ("BHP") at DCH and to renovate an existing building on the DCH campus to house this unit.

The project does not eliminate any services. The proposed Project will improve access for indigent and or uninsured patients living in the proposed service area of the DCH BHP.

Standard .04B (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 introductions of a single new service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for the 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 is 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 operating 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 with a Priority Funding Area.

Applicant Response:

DCH is proposing the establishment of a new hospital service for the care and treatment of mental illness and substance abuse. Currently, the capacity to provide mental health and substance abuse services in the service area of DCH is not sufficient to meet the need for the sixteen inpatient beds for adults proposed in this application.

The principal need identified by the leadership of DCH that the project seeks to address is an insufficient number of available beds at DCH for the care of future adult, psychiatric and substance abuse inpatients in the current hospital facility, and a lack of an organized, robust outpatient network of outpatient services. Because DCH does not have sufficient available beds and suitable space in its current facility to provide for a dedicated 16-bed inpatient psychiatric unit and for supporting and providing outpatient services for the treatment of mental disorders and substance abuse on its campus, residents of the DCH service area must obtain care at other Maryland hospitals and at other service providers, some of which are located outside Prince Georges County, or in the District of Columbia. For patients at DCH who need these services, they are referred and transferred to other acute care general hospitals and mental health care service providers for lack of available treatment capacity on the DCH campus.

The first alternative considered and rejected by DCH was to find available space within its current facilities on the campus for the BHP, including the proposed 16-bed inpatient unit. Currently, DCH staffs and operates 190 Medical Surgical beds on its campus and has no available space for an inpatient psych unit.

For a complete breakdown of the current inventory of patient beds and rooms at DCH, see TABLE A.

To address the need for the patient rooms and beds required to implement the BHP at DCH, three proposed alternative projects were evaluated for cost-effectiveness.

First, DCH considered the renovation and re-use of existing patient rooms and Medical/Surgical beds in the main DCH hospital building for the project. This alternative was rejected because the space and bed requirements for developing and operating a 16-bed inpatient adult psychiatric unit would have required taking an entire floor of the Hospital out of service that is currently providing Medical/Surgical services. Given the continuing demand for and utilization of these beds and services, converting an entire floor for an inpatient psychiatric unit was not a practical or cost-effective alternative. In addition, the renovation activity needed to prepare the existing space in the Hospital for the unit would have been highly disruptive to the ongoing operation of the hospital for medical/surgical services.

Second, DCH considered building a new private freestanding psychiatric hospital on its own campus apart from the campus of DCH. A review of available land in Prince George's County on which to build such a hospital indicated that the current 28-acre hospital campus, and the availability of the former Magnolia Hall Nursing Home for renovation and re-use on the Hospital campus, was a superior location, and would allow better integration of DCH's BHP with the existing medical and hospital resources there, including the DCH Emergency Department.

Finally, we considered and selected the proposed project as the most cost-effective alternative. This project was selected because it could be implemented relatively quickly in comparison to new construction, would increase the available square footage of the DCH campus at a reasonable cost, would maintain necessary access to existing hospital ancillary and support services, would immediately address the recognized deficiencies of the current available inpatient adult mental health and substance abuse services in the DCH service area, and could be

implemented without a significant increase in patient rates or charges. Most importantly, the selected alternative provides an opportunity to expand the service offerings of DCH to the residents of its service area, and address their needs for mental health and substance abuse services in a familiar location.

For these reasons, we believe the proposed project is the most cost-effective alternative for achieving DCH's objective, and therefore meets the standard.

Standard .04B (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.**

Applicant Response:

The purpose of the proposed project is to increase the availability and accessibility of behavioral health and substance abuse services to the residents of the DCH service area in a hospital setting. Currently, the utilization of inpatient hospital services for the treatment of psychiatric disorders and substance abuse by Prince George's county residents is lower than the utilization of these same services by the Maryland adult population as a whole. Our view is that this "gap" in utilization is a measure of unmet need in Prince George's County. By increasing the availability and accessibility of these services, we fully expect the utilization of the proposed 16-bed inpatient unit at DCH will increase the discharge rate of adult residents of Prince George's county for these services, and therefore shrink the gap between what is needed and what has actually been provided to these residents in the past.

The need for inpatient mental health and substance abuse treatment services is addressed through the utilization of 16 beds to be located in a vacant nursing home facility on the Hospital campus which will undergo significant renovations. The need to provide a dedicated space for inpatient beds at DCH has emerged as a planning priority as the reconfiguration of inpatient services was being considered and proposed in Prince George's County, beginning in 2012. This available space was created for this Project by the construction and operation of Doctors Community Rehabilitation and Patient Care Center in August, 2015. This Project continues the redevelopment of the DCH campus as a site for cost-effective and accessible inpatient and outpatient hospital services in Prince George's County.

In order to provide a sufficient number of rooms and beds for adults needing inpatient hospital mental health and substance abuse services, DCH conducted a two needs analyses. First, DCH reviewed its own data to measure the numbers and types of patients served at DCH that could benefit from the proposed BHP. Currently, patients with mental health disorders and substance abuse treatment needs present in the DCH Emergency Department. For adult patients who require immediate admission to an inpatient psychiatric unit, obtaining referrals to an existing hospital unit that is willing and able to take a new patient has become increasingly difficult. This frequently results in patients "boarding" in the DCH Emergency Department, many of whom are in crisis, and cannot be safely discharged into the community.

Second, DCH reviewed the most current data to determine the existing numbers of hospital discharges and patient days of care provided to residents of Prince George's County in 2014, the most recent Calendar Year for which data is available for both Maryland and District of Columbia hospitals.

These data show that 4,832 residents of Prince George's County age 19+ were discharged from a Maryland or District of Columbia hospital for inpatient mental health and substance abuse services in CY 2014, as shown below:

District of Columbia Hospital	Discharges	Average LOS	Patient Days
George Washington University	67	5.2	348
Howard University Hospital	40	4.5	181
MedStar Georgetown University Hospital	42	6.8	287
MedStar National Rehabilitation Hospital	1	6.0	6
MedStar Washington Hospital Center	152	7.4	1,130
Providence Hospital	66	5.7	374
Sibley Memorial Hospital	36	10.5	379
United Medical Center	94	6.0	560
Grand Total	**498**	**6.6**	**3,265**

Source: District of Columbia Hospital Database.

Maryland Hospitals	Discharges	Average LOS	Patient Days
ANNE ARUNDEL MED. CTR.	37	6.5	241

BALTIMORE WASHINGTON MEDICAL CENTER	19	5.4	102
BON SECOURS HOSPITAL	35	3.7	131
CALVERT MEMORIAL HOSPITAL	33	4.5	149
CARROLL CTY. GENERAL HOSPITAL	6	4.5	27
CIVISTA MEDICAL CENTER	7	6.0	42
DOCTORS COMMUNITY HOSPITAL	**18**	**3.9**	**71**
DORCHESTER GENERAL HOSPITAL	3	6.0	18
FORT WASHINGTON MEDICAL CTR.	21	3.9	82
FRANKLIN SQUARE HOSPITAL	34	6.1	208
FREDERICK MEMORIAL HOSPITAL	6	7.7	46
GOOD SAMARITAN HOSPITAL	1	26.0	26
HARFORD MEMORIAL HOSPITAL	3	5.3	16
HOLY CROSS GERMANTOWN HOSPITAL	3	3.0	9
HOLY CROSS HOSPITAL	97	4.8	465
HOWARD CTY. GENERAL HOSPITAL	56	4.6	255
JOHNS HOPKINS BAYVIEW MED. CTR.	27	5.0	136
JOHNS HOPKINS HOSPITAL	46	20.1	926
JOHNS HOPKINS ONCOLOGY CENTER	1	14.0	14
LAUREL REGIONAL HOSPITAL	471	3.8	1,800
MARYLAND GENERAL HOSPITAL	30	6.0	180
MERCY MEDICAL CENTER	8	3.0	24
MERITUS MEDICAL CENTER	1	2.0	2
MONTGOMERY GENERAL HOSPITAL	127	3.5	442
NORTHWEST HOSPITAL CENTER	6	4.8	29
PRINCE GEORGES HOSP. CTR.	1,283	6.2	7,947
SAINT JOSEPH HOSPITAL	6	10.5	63
SHADY GROVE HOSPITAL	3	5.0	15
SINAI HOSPITAL	5	12.6	63
SOUTHERN MARYLAND HOSPITAL	853	4.6	3,934
ST. AGNES HEATHCARE	1	13.0	13
ST. MARY'S HOSPITAL	29	4.1	119
SUBURBAN HOSPITAL	161	4.2	676
U OF MD HOSPITAL	70	11.7	816
UMD (SHOCK TRAUMA)	1	0.0	0
UNION MEMORIAL HOSPITAL	9	4.9	44
WASH. ADVENTIST HOSPITAL	816	6.0	4,899
WESTERN MARYLAND REGIONAL MED CTR	1	4.0	4
Grand Total	**4,334**	**5.5**	**24,034**

Source: Maryland Hospital Discharge Data Abstract.

These data reveal that only 54% of adult residents of Prince George's County were discharged from an inpatient psychiatric unit located in a Prince George's County acute care hospital. The other 46% migrated to hospital located outside the County.

This outmigration also represents an unmet need for the proposed DCH 16-bed unit, which will provide a fourth site for obtaining inpatient psychiatric and substance abuse treatment services in the County. Having an additional location by definition will improve accessibility for Prince George's County residents, by reducing travel time and expense to obtain needed care in other jurisdictions.

A second review of more recent discharge data was conducted to demonstrate the need for the proposed DCH unit. This review compared the discharges reported by Prince George's County residents age 15+ to the discharges reported by all residents of the State of Maryland in FY 2016. As shown above, because of the lack of local bed capacity in hospitals in Prince George's County, slightly less than half of all adult inpatient psychiatric care in CY 2014 was provided in a hospital located outside the County or outside the State. We examined the more recent Maryland hospital discharge data to determine if the shortage of available beds in the County resulted in less overall utilization by Prince George's County residents than the utilization reported by residents of other Maryland jurisdictions. That is, that the hospital discharge rate of adults for inpatient psychiatric and substance abuse care was lower than expected among Prince George's County residents than residents of the State of Maryland as a whole.

The data indicated that Prince George's County adult residents were discharged less frequently from an acute care general hospital for psychiatric or substance abuse treatments than adult residents of the State of Maryland as a whole. In FY 2016, all Maryland acute hospitals reported discharging 3,429 adult patients (age 15+) who were residents of Prince George's County, and 37,969 patients (age 15+) who were Maryland residents of all jurisdictions. On a per capita basis, the Maryland hospital discharge rate for Prince George's county residents was 4.74 discharges per thousand residents, in comparison to 7.71 discharges per thousand State of Maryland residents of the same age cohort, almost double the difference in actual utilization.[1] In our view, this difference is not the result of a lower

1 **Had the discharges reported by District of Columbia hospitals in CY 2014 by Prince George's County residents been added to the total number of patients discharged only from Maryland**

prevalence of mental illness or substance abuse in Prince George's county relative to the adult population of State of Maryland, or more effective and efficient systems of care for the treatment of these conditions. Rather this difference is the result of an insufficient number of available and staffed beds located in acute care general hospitals in Prince George's County to treat local adult residents where they live and work.

DCH's conclusion is that the difference in discharge rates is one measure of unmet need in the adult population of Prince George's County for inpatient behavioral healthcare and the beds needed to provide that care. Had the actual utilization of these services by adult residents of Prince George's County reached the rate reported by all adult residents of the State of Maryland, we would have seen 5,751 discharges among Prince George's county adults, not 3,538 discharges, a difference of 2,213 discharges. (If we add the approximately 587 District of Columbia hospital discharges to the 3,538 discharges reported by Maryland hospitals, the difference between actual and expected utilization shrinks to 1,626 discharges not provided to Prince George's Count adult residents, but were provided to the equivalent adult State of Maryland population as a whole.)

At an average length of stay of 6 days, filling this "gap" between the actual utilization of services and the expected, or needed, utilization of service, this difference would have resulted in 9,756 additional days of needed inpatient hospital care for adult residents of Prince George's County in FY 2016 in Maryland hospitals, or care for 27 patients per day, every day, for that entire year. We then projected the increase in the size of the gap through FY 2021, assuming that the discharge rates for this adult population would remain constant, and the adult population of Prince George's County grows as projected below.

	FY 2016	FY 2021

hospitals in FY 2016, the Prince George's county resident discharge rate would have increased to approximately 5.53 discharges per thousand residents, indicating a smaller "gap" between the Statewide discharge rate and the Prince George's County discharge rate.

DC Hospital Discharges (Estimated from CY 2014)	A	587	639
Maryland Hospital Discharges	B	3,538	3,732
TOTAL	C=A+B	4,125	4,371
PG County Discharge Rate (MD Hospitals ONLY)	D=B/G	4.74	4.74
Statewide Use Rate (MD Hospitals only)	E	7.71	7.71
PG County Discharge Rate (with DC Discharges)	F=C/G*1000	5.53	5.56
PG County Adult Population	G	745,769	786,560
PG Discharges assuming Statewide Use Rate of Maryland Hospitals and PG's Population	H=E/1000*G	5,751	6,066
Unmet Need (Difference between Actual Discharges of PG County residents and Number of Discharges at Statewide Use Rate)	I=H-C	1,626	1,695

Source: Maryland Discharge Data Abstract, FY 2016; DC Discharge Database, CY 2014; Claritas Population Estimates and Projections.

It is this gap, this need for additional inpatient hospital days of care for over 1,600 patients per year that was not provided for Prince George's county residents, that is at the heart of the project to establish a 16-bed inpatient psychiatric unit at DCH as soon as possible. The future utilization of this 24/7/365 day inpatient unit by Prince George's County residents will help bridge some of the gap between the actual services provided and amount of service that is actually needed.

As shown on TABLE I., DCH projects that it will discharge 900 adult patients from the proposed unit in FY 2021, the second full year of operation of the proposed 16-bed unit, addressing approximately 56% of the current and future unmet need.

Standard .04B(7) – Construction Cost of Hospital Space.

> **(a) The cost per square foot of hospital construction projects shall be no greater than the cost of good quality Class A hospital construction given in the Marshall and Swift Valuation (MVS) Quarterly, updated to the nearest quarter using the Marshall and Swift update multipliers, and adjusted as shown in the Marshall and Swift guide as necessary for terrain of the site, number of levels, geographic locality, and other listed factors.**
>
> **(b) Each Certificate of Need applicant proposing costs per square**

foot above the limitations set forth in the Marshall and Swift Guide must demonstrate that the higher costs are reasonable.

(c) If the projected cost per square foot exceeds the MVS benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the proposed construction cost that exceeds the MVS benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

Applicant Response:

The renovations to be undertaken on the DCH campus will involve an existing building that once housed the Magnolia Gardens Nursing Home and is estimated to cost approximately $7.5 Million. The current renovation costs proposed to prepare the building for the proposed inpatient unit, and provide shell space for outpatient behavioral health services are estimated to be approximately $5.5 Million, not including architectural fees, equipment and furnishings and other capital costs. This estimate is divided into two parts. First, is the cost of renovating the entire 2 story building for hospital service re-use and to provide shell space for future fit-outs. This cost is estimated to be $2.6 Million for core and shell renovations of 32,935 BGSF, and $2.9 Million for fit-out renovations to 29,378 BGSF. The total renovation costs are less than $200 per BGSF.

On a square footage basis, these renovation construction costs estimates are well below the costs of new hospital construction estimated by the Marshall and Swift Valuation (MVS) Quarterly. For example, the MVS standards estimated for recently approved new construction projects for Maryland hospitals has been well over $300 per BGSF.

Because the estimated costs per square foot for renovation proposed for the project are below the limitations set forth in the MVS Guide, the Project is consistent with this Standard.

Standard .04B(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 nonhospital 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.**

Applicant Response:

This standard is inapplicable because the Project does not involve the construction of non-Hospital space.

Standard .04B(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.

Applicant Response:

The space planned for the psychiatric nursing unit to be addressed in this project is less than 500 square feet per bed. Therefore, the project is consistent with the Standard.

Standard .04B(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.

Applicant Response:

DCH is not a high-charge hospital, and therefore, does not need to agree to a rate reduction agreement with the Health Services Cost Review Commission.

Standard .04B(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.

Applicant Response:

DCH is currently an efficient hospital and will remain an efficient hospital following completion of the project. To the extent possible, the planning and design of the project in a renovated building previously designed and operated as a nursing home took potential efficiency improvements into account, but these cannot be quantified in a manner that would clearly demonstrate significant cost savings, when the operational and capital costs of the additional square footage, personnel and other needed resources proposed for the BHP is taken into account as well.

Because DCH will become a larger hospital, with additional available square footage in its physical plant for patient care, DCH's operational expenses will increase with respect to heating and cooling, maintenance, housekeeping, and other "overhead" expenses. Additional FTEs will be added to the hospital's existing employees increasing hospital costs and requiring additional revenues as shown on TABLE L. WORKFORCE,

At the same time, the inability to provide a BHP on the existing DCH campus, including additional patient rooms for the 16 beds for adults, demonstrate a lack of alternatives for efficiently providing needed the inpatient care days being proposed. As a result of these deficiencies, the hospital cannot address patient needs efficiently and must "board" mentally ill patients awaiting transfers to other facilities, depend on consultation services obtained from an out-of-County hospital, manage transfers and admissions to other hospitals and service providers of adult patients who require inpatient services, and increase the rate of re-admissions for lack of continuity of care. All of these limitations at DCH add to the costs of care.

In our view, incurring the additional expenses associated with supporting the increased number of patients who will benefit from the proposed BHP on the DCH campus, will be balanced with the possible improvements in operational efficiency and improvements in the overall patient care experience at DCH.

Standard 04B(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.

Applicant Response:

The design of the proposed 16-bed adult inpatient psychiatric unit will incorporate design features that will assure a safe treatment environment.

Standard .04B(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;

(iii) 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.

Applicant Response:

(a) The following assumptions have been used to develop the financial projections shown in TABLES J. and K. which projects a break even operation:

Table J. New Service or Facility – Uninflated

FY 2021 Patient Revenue: $7,778,700

FY 2021 Adjustments to Revenue: $1,224,176

FY 2021 Net Patient Services Revenue: $6,534,524

FY 2021 Expenses: $6,534,524

Table K. New Service or Facility – Inflated

FY 2021 Patient Revenue: $8,094,546

FY 2021 Adjustments to Revenue: $1,294,695

FY 2021 Net Patient Services Revenue: $6,799,852

FY 2021 Expenses: $6,799,852

(b)

(i) As discussed under Standard .04B (6) – Burden of Proof Regarding Need, the utilization projections for the proposed 16-bed adult unit assume that there is an unmet need in Prince George's County, and that a portion of this unmet need will be met in the proposed unit.

(ii) Revenue estimates are based on current allowable charge levels and incorporate the current reimbursement methodologies employed by the HSCRC.

(iii) Staffing and overall expense projections are based on current expenditure levels but take into account projected changes in utilization and the necessary increases that are responsive to the additional square footage of the facility, and the operation

of the proposed inpatient unit.

(iv) As shown on TABLES J. and K., the Project will break even through FY 2021, following the completion of the Project.

Standard .04B(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 *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.

Applicant Response:

This standard is inapplicable because the Project does not involve a new or expanded emergency department.

Standard .04B(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

(b) 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.

Applicant Response:

This standard is inapplicable because the Project does not involve an expanded emergency department.

Standard .04B(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 Services Cost Review Commission.

Applicant Response:

This standard is not applicable because the Project does not involve the creation of additional shell space at DCH other than the core and shell renovations of the existing, vacant 2-story nursing home building that is currently neither part of the Hospital, nor is included in this application. All of the finished, fit-out space on the second floor of the building will be dedicated to the 16-bed inpatient unit described in this application.

Availability

AP 1a. The projected maximum need for child, adolescent, and adult acute psychiatric beds is calculated using the Commission's statewide child, adolescent, and adult acute psychiatric bed need projection methodologies specified in this section of the State Health Plan. Applicants for Certificates of Need must state how many child, adolescent and adult acute psychiatric beds they are applying for in each of the following categories: net acute psychiatric bed need, and/or state hospital conversion bed need.

Applicant Response:

There is no published bed need projection in effect for child, adolescent and adult psychiatric beds, and the need projection methodology of the State Health Plan is recognized as obsolete. For this reason, DCH has prepared a needs assessment for its proposed 16-bed adult unit based on its review of utilization data of Maryland and District of Columbia hospitals by residents of Prince George's County in comparison to the overall utilization of Maryland acute care general hospitals by Maryland residents for these beds and services. This needs assessment shows a gap in utilization between expected and actual utilization, an unmet need, that DCH proposes to address. In addition, the needs assessment includes reducing the "outmigration" to out-of-County Maryland and District of Columbia hospitals by residents of Prince George's County for adult inpatient psychiatric services. The projected discharges and patient days for the proposed 16-bed unit are expected to result in an occupancy rate in excess of 80% in its second full year of operation, and have no measurable impact on the utilization of the three adult inpatient psychiatric units in Prince George's County located at Prince George's Hospital Center, Laurel Regional Hospital, or MEDSTAR Southern Maryland Hospital Center. The size of the unmet need should result in no reductions in the actual utilization of these units as a result of the operation of the proposed DCH unit.

Therefore, the projected use of the proposed adult inpatient unit at DCH will be comprised of: 1) Prince George's County adult residents whose needs are not being addressed to the same extent as the adult Maryland population treated in

Maryland acute care hospital, and 2) Prince George's County residents whose needs have historically been addressed in Maryland hospitals located outside Prince George's County and in District of Columbia hospitals. Under both considerations, there is a demonstrated need for the proposed unit at DCH to improve the availability of and accessibility of needed services in the County.

AP 1b. A Certificate of Need applicant must document that it has complied with any delicensing requirements in the State Health Plan or in the Hospital Capacity Plan before its application will be considered.

Applicant Response:

This standard does not apply because there are no delicensing requirements in effect.

AP 1c. The Commission will not docket a Certificate of Need application for the "state hospital conversion bed need" as defined, unless the applicant documents written agreements with the Mental Hygiene Administration. The written agreements between the applicant and the Mental Hygiene Administration will specify:

- **(i) the applicant's agreement to screen, evaluate, diagnose and treat patients who would otherwise be admitted to state psychiatric hospitals. These patients will include: the uninsured and underinsured, involuntary, Medicaid and Medicare recipients:**
- **(ii) that an equal or greater number of operating beds in state facilities which would have served acute psychiatric patients residing in the jurisdiction of the applicant hospital will be closed and delicensed, when the beds for the former state patients become operational;**
- **(iii) that all patients seeking admission to the applicant's facility will be admitted to the applicant's facility and not be transferred to the state**

hospital unless the applicant documents that the patient cannot be treated in its facility; and

(iv) that the applicant and the Mental Hygiene Administration (MHA) will be responsible for assuring financial viability of the services, including payment of bed debt by DHMH as specified in the written agreement between MHA and the applicant.

Applicant Response:

This standard is not applicable because this project does not involve the addition of hospital conversion beds.

AP 1d. Preference will be given to Certificate of Need applicants applying for the "net adjusted acute psychiatric bed need," as defined, who sign a written agreement with the Mental Health Administration as described in part (i) and (iii) of Standard AP 1c.

Applicant Response:

This standard does not apply to this project because this application is not being reviewed comparatively with another application.

AP 2a. All acute general hospitals with psychiatric units must have written procedures for providing psychiatric emergency treatment 24 hours a day, 7 days a week with no special limitation for weekends or late night shifts.*

Applicant Response:

DCH will develop written procedures for providing psychiatric emergency treatment 24 hours a day, 7 days a week with no exceptions.

AP 2b. Any acute general hospital containing an identifiable psychiatric unit must be an emergency facility, designated by the DHMH to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition.*

Applicant Response:

DCH's adult inpatient psychiatric unit will be an emergency facility designated by the DHMH to perform evaluations as specified in the standard. The unit will not be locked for the treatment of involuntary patients.

AP 2c. Acute general hospitals with psychiatric units must have emergency holding bed capabilities and a seclusion room.

Applicant Response:

DCH will have emergency holding bed capabilities and a seclusion room.

AP 3a. Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include: chemotherapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.

Applicant Response:

DCH's acute adult inpatient services will include services required by this standard.

AP 3b. In addition to the services mandated in standard 3a., inpatient child and adolescent acute psychiatric services must be provided by a multidisciplinary treatment team which provides services that address daily living skills,

psychoeducational and/or vocational development, opportunity to develop interpersonal skills within a group setting, restoration of family functioning and other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family. Applicants for a Certificate of Need for child and/or adolescent acute psychiatric beds must document that they will provide a separate physical environment consistent with the treatment needs of each age group.

Applicant Response:

In addition to the proposed 16-bed acute psychiatric unit for adults addressed in this application at this time, in the future, DCH intends to provide adult and adolescent psychiatric services on an outpatient basis. These may include a Psychiatric Day Hospital Program or related Outpatient Clinical Programs, or both, to be located on the DCH campus, and within the same building in which the inpatient adult unit will be located. The specific details regarding the outpatient programs' physical design, needed physical plant renovations, staffing and clinical and financial plan for those intended outpatient services currently are being formulated.

A full description of DCH plan for providing outpatient behavioral health services may be provided as a supplement to this application at a later date if Commission approval is required prior to implementation.

AP 3c. All acute general hospitals must provide psychiatric consultation services directly or through contractual arrangements.

Applicant Response:

DCH will provide psychiatric consultation services as a component of its proposed 16-bed adult inpatient psychiatric unit.

AP 4a. A Certificate of Need for child, adolescent or adult acute psychiatric beds shall be issued separately for each age category. Conversion of psychiatric beds from one of these services to another shall require a separate Certificate of Need.

Applicant Response:

This standard is not applicable because the proposed project for an adult inpatient psychiatric unit does not include child or adolescent services.

AP 4b. Certificate of Need applicants proposing to provide two or more specific acute psychiatric services must provide that physical separations and clinical/programmatic distinctions are made between patient groups.

Applicant Response:

This standard is not applicable because the proposed project only includes the development and operation of a 16-bed acute psychiatric unit for adults.

Accessibility

AP 5. Once a patient has requested admission to an acute psychiatric inpatient facility, the follow services must be made available:

- **(i) intake screening and admission;**
- **(ii) arrangements for transfer to a more appropriate facility for care if medically indicated;**
- **(iii) necessary evaluation to define the patient's psychiatric problem and/or**
- **(iv) emergency treatment.**

Applicant Response:

DCH will make available all of the services required by this standard as applicable to the operation of an inpatient acute psychiatric unit for adults.

AP 6. All hospitals providing care in designated psychiatric units must have separate written quality assurance programs, program evaluations and treatment protocols for special populations including: children, adolescents, patients with secondary diagnosis of substance use, and geriatric patients either through direct treatment or referral.

Applicant Response:

DCH does not intend to provide inpatient psychiatric services in separate designated units for special populations. The existing quality assurance programs of DCH, program evaluations and treatment protocols in effect at the Hospital and applicable to the existing services provided there, will be expanded to include those pertinent to the proposed inpatient unit.

AP 7. An acute general or private psychiatric hospital applying for a Certificate of Need for new or expanded acute psychiatric services may not deny admission to a designated unit solely on the basis of the patient's legal status rather than clinical criteria.

Applicant Response:

DCH does not propose to accept adult patients who are admitted as involuntary patients on Certificates and the proposed unit will not be locked.

AP 8. All acute general hospitals and private freestanding psychiatric hospitals must provide a percentage of uncompensated care for acute psychiatric patients which is equal to the average level of uncompensated care provided by all acute general hospitals located in the health service area where the hospital is located,

based on data available from the Health Services Cost Review Commission for the most recent 12-month period.

Applicant Response:

DCH will provide a percentage of uncompensated care for adult psychiatric patients tied to the percentage of additional gross patient revenue approved for this new service by the Health Services Cost Review Commission (HSCRC). We anticipate that the percentage approved for the proposed unit will be consistent with the average level of uncompensated care of all acute hospitals in Prince George's County which provide similar services.

AP 9. If there are no child acute psychiatric beds available within a 45 minute travel time under normal road conditions, then an acute child psychiatric patient may be admitted, if appropriate, to a general pediatric bed. These hospitals must develop appropriate treatment protocols to ensure a therapeutically safe environment for those child psychiatric patients treated in general pediatric beds.

Applicant Response:

This standard does not apply to this project because the proposed inpatient unit is for adults, and will not admit children or adolescents.

Cost

AP 10. Expansion of existing adult acute psychiatric bed capacity will not be approve in any hospital that has a psychiatric unit that does not meet the following occupancy standards for two consecutive years prior to formal submission of the application.

Psychiatric Bed Range (PBR)	**Occupancy Standards**

PBR <20	**80%**
20≤PBR<40	**85%**
PBR≥40	**90%**

Applicant Response:

This standard does not apply because the proposed project is not an expansion of an existing adult acute psychiatric unit.

AP 11. Private psychiatric hospitals applying for a Certificate of Need for acute psychiatric beds must document that the age-adjusted average total cost for an acute (<30 days) psychiatric admission is no more that the age-adjusted average cost per acute psychiatric in acute psychiatric units in the local health planning area.

Applicant Response:

The standard does not apply because DCH is applying to develop and operate a 16-bed acute psychiatric unit to be located in a general acute care hospital.

Quality

AP 12a. Acute inpatient psychiatric services must be under the clinical supervision of a qualified psychiatrist.

Applicant Response:

The inpatient psychiatric services at DCH will be under the clinical supervision of a qualified psychiatrist who will serve as its Medical Director.

AP 12b. Staffing of acute psychiatric programs should include therapies for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment. Staffing should cover a seven day per week treatment program.

Applicant Response:

The staffing plan for the DCH inpatient unit is shown on TABLE L., which includes all of the regular and contracted employees for the unit, that will be open and available seven days per week and on weekends. After care coordinators will assure that patients without a private therapist will facilitate referrals and further treatment. Group and individual therapy will be provided seven days per week.

AP 12 c. Child and/or adolescent acute psychiatric units must include staff who have experience and training in child and/or adolescent acute psychiatric care, respectively.

Applicant Response:

This standard does not apply to this project because the proposed adult unit does not include child or adolescent beds.

Continuity

AP 13. Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long term care, aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.

Applicant Response:

DCH will develop written policies governing discharge planning and referrals between its program for adult inpatient psychiatric treatment and a full range of other services, including inpatient, outpatient, long term care, aftercare treatment programs, and alternative treatment programs. The continuum of care envisioned at DCH may include the outpatient services to be provided on-site for adults and adolescents currently under review. Other services needed by DCH's patients may be made available through referrals.

Acceptability

AP 14. Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following:

(i) the local and state mental health advisory council(s);

(ii) the local community mental health center(s);

(iii) the Department of Health and Mental Hygiene; and

(iv) the city/county mental health department(s).

Letters from other consumer organizations are encouraged.

Applicant Response:

Letters of acknowledgement and support will be provided to the Commission under separate cover.

COMAR 10.24.01.08G(3)(b). Need.

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.

INSTRUCTIONS: Please identify the need that will be addressed by the proposed project, quantifying the need, to the extent possible, for each facility and service capacity proposed for development, relocation, or renovation in the project. The analysis of need for the project should be population-based, applying utilization rates based on historic trends and expected future changes to those trends. This need analysis should be aimed at demonstrating needs of the population served or to be served by the hospital. The existing and/or intended service area population of the applicant should be clearly defined.

Fully address the way in which the proposed project is consistent with each applicable need standard or need projection methodology in the State Health Plan.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population of the hospital. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified. Fully explain all assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), the relevant population considered in the analysis, and the service capacity of buildings and equipment included in the project, with information that supports the validity of these assumptions.

Explain how the applicant considered the unmet needs of the population to be served in arriving at a determination that the proposed project is needed. Detail the applicant's consideration of the provision of services in non-hospital settings and/or through population-based health activities in determining the need for the project.

Complete the Statistical Projections (Tables F and I, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package.

Applicant Response:

As described in the response to Standard .04B (6) – Burden of Proof Regarding Need, DCH considered the data on the utilization of Maryland and District of Columbia hospitals for adult inpatient psychiatric and substance abuse services, and identified a "gap" between the number of discharges by Prince George's County residents and residents of the State of Maryland as a whole for the services to be provided. This gap between need and historic utilization is the source unmet

need for the services DCH proposes to provide in this project, a 16-bed inpatient psychiatric unit to be located in renovated space in a building on the DCH campus.

To reach the conclusion the unit will address an unmet need in the adult population of Prince George's County, DCH analyzed the Maryland Hospital Discharge Datebase as well as the DC Hospital Database for the Prince George's County adult residents who would be served by the proposed unit beginning in FY 2019. Over 1,600 additional discharges would have taken place had additional hospital inpatient beds been available and those beds were utilized at the actual Statewide rate. DCH proposes to meet some of this estimated unmet need on its Lanham campus.

The location of the proposed unit was selected to maximize patient availability and accessibility at the least cost by locating the proposed unit on the campus of DCH in vacant building suitable for renovations. Alternative sites for locating the unit were considered unavailable, more costly, and more disruptive than the site chosen.

DCH participates in numerous projects to improve community health, including non-hospital population health initiatives, and believes that the development and operation of the proposed hospital unit is entirely consistent and complementary to those initiatives.

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

The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the proposed project. The applicant should identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including:

a) the alternative of the services being provided through existing facilities;

b) or through population-health initiatives that would avoid or lessen hospital admissions.

Describe the hospital's population health initiatives and explain how the projections and proposed capacities take these initiatives into account.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development costs to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective method to reach stated goal(s) and objective(s) or the most effective solution to the identified problem(s) for the level of costs required to implement the project, when compared to the effectiveness and costs of alternatives, including the alternative of providing the service through existing facilities, including outpatient facilities or population-based planning activities or resources that may lessen hospital admissions, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Applicant Response:

Please refer to the response to Standard .04B (5) – Cost-Effectiveness.

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

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- Complete applicable Revenues & Expenses (Tables G, H, J and K as applicable), and the Work Force information (Table L) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable.

- Describe and document relevant community support for the proposed project.

- Identify the performance requirements applicable to the proposed project and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, contracting and obtaining and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame.

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies.

Applicant Response:

CMH intends to fund this project by incurring additional debt, and with a rate increase. The Project Budget is found at TABLE E. in the CON Table Package. DCH's most recent audited financial statements (FY 2016) show that CMH had $39.3 million in cash and cash equivalents, and $16 Million in short term investments. This results in $55 million in cash and investments were available to help fund this project. See Exhibit 4.

Letters of Support for the Project will be submitted under separate cover.

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

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

INSTRUCTIONS: List all of the Certificates of Need that have been issued to the applicant or related entities, affiliates, or subsidiaries since 2000, including their terms and conditions, and any changes to approved CONs that were approved. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

Applicant Response:

There has been one other CON-approved project. at DCH since 2000, Docket # 15-16-2163, which was approved by the Commission in November, 2007. The project was implemented as approved.

COMAR 10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System.

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project[2];

b) On access to health care services for the service area population that will be served by the project. (state and support the assumptions used in this analysis of the impact on access);

c) On costs to the health care delivery system.

If the applicant is an existing hospital, provide a summary description of the impact of the proposed project on costs and charges of the applicant hospital, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

Applicant Response:

Because DCH's proposed project is designed to address unmet needs for services among Prince George's County residents, there should be no impact on the volumes of any other existing Maryland hospital providers. In calculating future volume projections, DCH assumed that the current utilization of the three adult inpatient psychiatric units in Prince George's County would remain unchanged as a result of the development of its proposed 16-bed unit.

DCH's proposed project includes the renovation of existing space in a vacant nursing home building located on its Lanham, Maryland campus to provide a cost-effective location for this needed 16-bed unit. The utilization of this additional unit

[2] **Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, the relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions.**

in the County will have a positive impact on the health status of hundreds of Prince George's County residents annually.

In our view, the overall access to health care services for the service area population will improve as a result of the planned utilization of the proposed new service and unit at DCH.

The availability of the additional bed capacity at DCH will likely reduce the number of times the Hospital's ED will need to "hold" a mentally ill adult patient awaiting admission to an available bed, or transfer to another hospital that has an available bed.

DCH has assumed an increase in patient charges in Table G. beginning in FY 2019 related to the proposed project.

Finally, DCH believes that there is a long-term cost saving to the proposed project insofar as the efficient use of renovated existing space has been programmed into the project, which will provide DCH with the long-term flexibility to meet future patient needs for Medical/Surgical services, without incurring the high costs of additional new hospital construction for Behavioral Health services.

Given the market environment in which DCH operates, the ability to make use of an existing vacant nursing home building as a platform for a modest bed and service addition increases its operational flexibility.

EXHIBITS

Exhibit #	Title
1	Complete Project Description
2	Project Drawings
3	DCH Policies
4	FY 2016 Audited Financial Statements

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.

   Phillip B. Down, President and CEO, Doctors Community Hospital, 1990 – present.

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

   Phil Down is the only member of the Executive Staff that have been previously involved in the management of another health care facility.

   Philip Down: Howard County General Hospital, Columbia, MD 1978-1986
   North Shore Children's Hospital, Salem, Mass. 1973-1978
   St. Elizabeth's Hospital of Boston, Boston, Mass. 1973-1978

   DCH is a co-owner of Magnolia Gardens Limited Liability Company which is the owner of Magnolia Gardens, a comprehensive care facility located on the campus of DCH.

3. In the last 5 years, has the Maryland license or certification of the applicant facility, or the license or certification from any state or the District of Columbia of any of the facilities listed in response to Question 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) ? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant(s), 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. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) ever received inquiries from a federal or any state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with Maryland, another state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

   NO

5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, 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 as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

   NO

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

_____

Signature of Owner or Authorized Agent of the Applicant

_____

Print name and title

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTION: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count, before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. See additional instruction in the column to the right of the table.

NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, other than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, 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 no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients) the physical capacity of such rooms should be counted as they are currently used.

Before the Project							After Project Completion						Additional Instruction
Hospital Service	Location (Floor/Wing)*	Licensed Beds: July 1, 2016	Based on Physical Capacity: Room Count Private	Semi-Private	Total Rooms	Bed Count Physical Capacity	Hospital Service	Location (Floor/Wing)*	Based on Physical Capacity: Room Count Private	Semi-Private	Total Rooms	Bed Count Physical Capacity	
ACUTE CARE							ACUTE CARE						
General Medical/Surgical*	3rd Floor		21	2	23	25	General Medical/Surgical*	3rd Floor	21	2	23	25	
	3rd Floor		29		29	29		3rd Floor	29		29	29	
	4th Floor		24	2	26	28		4th Floor	24	2	26	28	
	4th Floor		29		29	29		4th Floor	29		29	29	
	5th Floor		26	2	28	30		5th Floor	26	2	28	30	
	5th Floor		29		29	29		5th Floor	29		29	29	
SUBTOTAL Gen. Med/Surg*		166	158	6	164	170	SUBTOTAL Gen. Med/Surg*		158	6	164	170	*Calculate the sum of all General Medical/Surgical rows*
ICU/CCU	2nd Floor	24	24		24	24	ICU/CCU		24		24	24	
Other *(Specify/add rows as needed)*					0	0					0	0	
TOTAL MSGA		190	182		188	194	TOTAL MSGA		182		188	194	*Calculate the sum of Med/Surg Subtotal, ICU/CCU, and other physical capacity*
Obstetrics					0	0	Obstetrics				0	0	
Pediatrics					0	0	Pediatrics				0	0	
Psychiatric					0	0	Psychiatric		16		16	16	
TOTAL ACUTE		190	182	0	188	194	TOTAL ACUTE		198	0	204	210	*Ensure that Total includes Total MSGA and Obstetrics, Pediatrics, and Psych rows*
NON-ACUTE CARE							NON-ACUTE CARE						
Dedicated Observation**					0	0	Dedicated Observation**				0	0	
Rehabilitation					0	0	Rehabilitation				0	0	
Comprehensive Care					0	0	Comprehensive Care				0	0	
Other *(Specify/add rows as needed)*					0	0	Other *(Specify/add rows as needed)*				0	0	
TOTAL NON-ACUTE		0					TOTAL NON-ACUTE						*Calculate the sum of all Non-Acute Care rows*
HOSPITAL TOTAL		190	182	0	188	194	HOSPITAL TOTAL		198	0	204	210	*Ensure that Hospital Total includes Total Acute and Total Non-acute rows*

* Include beds dedicated to gynecology and addictions, if unit(s) is separate for acute psychiatric unit

** Include services included in the reporting of the "Observation Center". Service furnished by the hospital on the hospital's promise, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient; Must be ordered and documented in writing, given by a medical practitioner.

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

INSTRUCTION: Add or delete rows if necessary. See additional instruction in the column to the right of the table.

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
					0
16-bed Inpatient Unit			11,461		11,461
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
Total					

TABLE C. CONSTRUCTION CHARACTERISTICS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☐	☑
Class B	☐	☐
Class C	☐	☐
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☐	☑
Excellent	☐	☐
Number of Stories		

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement		
First Floor		
Second Floor		11,461
Third Floor		
Fourth Floor		
Average Square Feet		
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Total Linear Feet		
Average Linear Feet		
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Average Wall Height		
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		
Freight		
Sprinklers	**Square Feet Covered**	
Wet System		
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project		
Type of Exterior Walls for proposed project		

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table D for each structure.

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation		N/A
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs		
Site Demolition Costs		
Storm Drains		
Rough Grading		
Hillside Foundation		
Paving		
Exterior Signs		
Landscaping		
Walls		
Yard Lighting		
Other *(Specify/add rows if needed)*		
Subtotal On-Site excluded from Marshall Valuation Costs		$0
OFFSITE COSTS		
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs		
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	$0	$0
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	$0	$0

*The combined total site and offsite cost included and excluded from Marshall Valuation Service should typically equal the estimated site preparation cost reported in Application Part II, Project Budget (see Table E. Project Budget). If these numbers are not equal, please reconcile the numbers in an explanation in an attachment to the application.

TABLE E. PROJECT BUDGET

INSTRUCTION: Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application. See additional instruction in the column to the right of the table.

NOTE: Inflation should only be included in the inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.a as a use of funds and on line B.8 as a source of funds.

	Hospital Building	Other Structure	Total	Additional instruction for cost categories
A. USE OF FUNDS				
1. CAPITAL COSTS				
a. Land Purchase			$0	
b. New Construction				
(1) Building			$0	
(2) Fixed Equipment			$0	*These costs should be consistent with the Marshall Valuation Service definition of Group 1 equipment: Permanent equipment, installed on or attached to the building, part of a general contract, and included in calculator costs.*
(3) Site and Infrastructure	$55,000		$55,000	
(4) Architect/Engineering Fees			$0	
(5) Permits (Building, Utilities, Etc.)			$0	
SUBTOTAL	$55,000	$0	$55,000	*Ensure that SUBTOTAL includes all categories under 1.b.*
c. Renovations				
(1) Building	$5,279,673		$5,279,673	
(2) Fixed Equipment (not included in construction)	$0		$0	
(3) Architect/Engineering Fees	$549,086		$549,086	
(4) Permits (Building, Utilities, Etc.)	$40,000		$40,000	
Inspections	$50,000		$50,000	
SUBTOTAL	$5,918,759	$0	$5,918,759	*Ensure that SUBTOTAL includes all categories under 1.c.*
d. Other Capital Costs				
(1) Movable Equipment	$431,740		$431,740	
(2) Contingency Allowance	$673,495		$673,495	
(3) Gross interest during construction period			$0	
(4) Other: IT and Low Voltage Systems	$250,000		$250,000	
SUBTOTAL	$1,355,235		$1,355,235	*Calculate sum of all categories under 1.d.*
TOTAL CURRENT CAPITAL COSTS	$7,328,994	$0	$7,328,994	*Ensure that TOTAL CURRENT CAPITAL COSTS includes all SUBTOTALS above*
e. Inflation Allowance	$211,187		$211,187	*Inflation should only be included in this category*
TOTAL CAPITAL COSTS	$7,540,181	$0	$7,540,181	*Ensure that TOTAL CAPITAL COSTS includes TOTAL CURRENT CAPITAL COSTS and Inflation Allowance*
2. Financing Cost and Other Cash Requirements				
a. Loan Placement Fees			$0	
b. Bond Discount			$0	
c. Legal Fees	$25,000		$25,000	
d. Non-Legal Consultant Fees	$45,000		$45,000	
e. Liquidation of Existing Debt			$0	
f. Debt Service Reserve Fund			$0	
g. Other: Pre-Construction Management Costs	$50,000		$50,000	
SUBTOTAL	$120,000		$120,000	*Calculate sum of all categories under 2.*
3. Working Capital Startup Costs	$801,749		$801,749	*Start up costs are costs incurred before opening a facility or new service that under generally accepted accounting principles are not chargeable as operating expense or maintenance.*
TOTAL USES OF FUNDS	$8,461,929	$0	$8,461,929	*Ensure that TOTAL USES OF FUNDS includes TOTAL CAPITAL COSTS, SUBTOTAL under A.2., and Working Capital Startup Costs*
B. Sources of Funds				
1. Cash			$0	
2. Philanthropy (to date and expected)			$0	*Identify and explain the sources, plans, and the hospital's experience regarding fundraising goals under the response to the Viability standard in Section XX of the CON application.*
3. Authorized Bonds			$0	
4. Interest Income from bond proceeds listed in #3			$0	
5. Mortgage	$8,495,181		$8,495,181	
6. Working Capital Loans			$0	
7. Grants or Appropriations				
a. Federal			$0	
b. State			$0	
c. Local			$0	
8. Other *(Specify/add rows if needed)*			$0	*Include the value of any donated land for the project in this category*
TOTAL SOURCES OF FUNDS	$8,495,181		$8,495,181	*Calculate sum of all categories under B; Note that TOTAL SOURCES OF FUNDS should match TOTAL USES OF FUNDS*
Annual Lease Costs (if applicable)				
1. Land			$0	
2. Building			$0	
3. Major Movable Equipment			$0	
4. Minor Movable Equipment			$0	
5. Other *(Specify/add rows if needed)*			$0	

Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
FY	2016	2016	2017	2018	2019	2020	2021			
1. DISCHARGES										
a. General Medical/Surgical*	8,731	9,827	9,827	9,827	9,827	9,827	9,827			
b. ICU/CCU	1,417	1,335	1,335	1,335	1,335	1,335	1,335			
Total MSGA	10,148	11,162	11,162	11,162	11,162	11,162	11,162			0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric					300	750	900			
Total Acute	10,148	11,162	11,162	11,162	11,462	11,912	12,062			0
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL DISCHARGES	10,148	11,162	11,162	11,162	11,462	11,912	12,062			0
2. PATIENT DAYS										
a. General Medical/Surgical*	37,855	45,473	45,473	45,473	45,473	45,473	45,473			
b. ICU/CCU	5,528	6,164	6,164	6,164	6,164	6,164	6,164			
Total MSGA	43,383	51,637	51,637	51,637	51,637	51,637	51,637			0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric					1,800	4,500	5,400			
Total Acute	43,383	51,637	51,637	51,637	53,437	56,137	57,037			0
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	43,383	51,637	51,637	51,637	53,437	56,137	57,037			0
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	4.3	4.6	4.6	4.6	4.6	4.6	4.6			
b. ICU/CCU	3.9	4.6	4.6	4.6	4.6	4.6	4.6			
Total MSGA	4.3	4.6	4.6	4.6	4.6	4.6	4.6			
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric					6.0	6.0	6.0			
Total Acute	4.3	4.6	4.6	4.6	4.7	4.7	4.7			
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL AVERAGE LENGTH OF STAY	4.3	4.6	4.6	4.6	4.7	4.7	4.7			
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*	164	164	164	164	164	164	164			
b. ICU/CCU	26	26	26	26	26	26	26			
Total MSGA	190	190	190	190	190	190	190			
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric	0	0	0	0	16	16	16			
Total Acute	190	190	190	190	206	206	206			0
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL LICENSED BEDS	190	190	190	190	206	206	206	0	0	0
5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 365 days per year.*										
a. General Medical/Surgical*	63.2%	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%			
b. ICU/CCU	58.3%	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%			
Total MSGA	62.6%	74.5%	74.5%	74.5%	74.5%	74.5%	74.5%			
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric					30.8%	77.1%	92.5%			
Total Acute	62.6%	74.5%	74.5%	74.5%	71.1%	74.7%	75.9%			
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL OCCUPANCY %	62.6%	74.5%	74.5%	74.5%	71.1%	74.7%	75.9%			
6. OUTPATIENT VISITS										
a. Emergency Department	56,964	58,088	58,088	58,088	58,088	58,088	58,088			
b. Same-day Surgery	6,004	6,336	6,336	6,336	6,336	6,336	6,336			
e. Other (Specify/add rows of needed)										
TOTAL OUTPATIENT VISITS	62,968	64,424	64,424	64,424	64,424	64,424	64,424			
7. OBSERVATIONS**										
a. Number of Patients	5,815	6,001	6,001	6,001	6,001	6,001	6,001			
b. Hours	132,947	115,339	115,339	115,339	115,339	115,339	115,339			

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses shoul with the projections in Table F and with the costs of Manpower listed in Table L, Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In a the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the source operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full oc columns if needed in order to document that the hospital will generate excess total expenses consistent with the Financial Feasibility standard.				
FY	2015	2016	2017	2018	2019	2020	2021	
1. REVENUE								
a. Inpatient Services	$ 127,952,893	$ 137,455,812	$ 138,446,751	$ 138,446,751	$ 141,039,651	$ 144,929,001	$ 146,225,451	
b. Outpatient Services	$ 94,780,280	$ 93,979,082	$ 91,177,089	$ 91,177,089	$ 91,177,089	$ 91,177,089	$ 91,177,089	
Gross Patient Service Revenues	*$ 222,733,173*	*$ 231,434,894*	*$ 229,623,840*	*$ 229,623,840*	*$ 232,216,740*	##########	##########	
c. Allowance For Bad Debt	$ 5,527,304	$ 5,001,963	$ 5,830,807	$ 5,830,807	$ 5,830,807	$ 5,830,807	$ 5,830,807	
d. Contractual Allowance	$ 22,620,577	$ 19,948,789	$ 16,858,764	$ 16,858,764	$ 17,301,850	$ 17,803,406	$ 17,881,020	
e. Charity Care	$ 10,947,887	$ 12,200,283	$ 12,361,309	$ 12,361,309	$ 12,361,309	$ 12,361,309	$ 12,361,309	
f. GBR Adjustment	$ -	$ -	$ -	$ -	$ -	$ -	$ 221,920	
Net Patient Services Revenue	*$ 183,637,405*	*$ 194,283,859*	*$ 194,572,960*	*$ 194,572,960*	*$ 196,722,774*	##########	##########	
f. Other Operating Revenues (Specify/add rows if needed)	$ 7,124,007	$ 7,117,037	$ 6,220,960	$ 6,220,960	$ 6,220,960	$ 6,220,960	$ 6,220,960	
NET OPERATING REVENUE	*$ 190,761,412*	*$ 201,400,896*	*$ 200,793,920*	*$ 200,793,920*	*$ 202,943,734*	##########	##########	
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 91,713,164	$ 99,280,899	$ 104,640,469	$ 104,640,469	$ 106,355,471	$ 108,219,234	$ 108,653,288	
b. Contractual Services	$ 9,361,702	$ 9,436,624	$ 9,251,247	$ 9,251,247	$ 9,582,247	$ 9,913,247	$ 9,913,247	
c. Interest on Current Debt	$ 7,788,812	$ 7,459,872	$ 6,122,580	$ 6,122,580	$ 6,122,580	$ 6,122,580	$ 6,122,580	
d. Interest on Project Debt				$ -	$ 210,909	$ 417,107	$ 410,559	
e. Current Depreciation	$ 8,154,835	$ 8,598,399	$ 8,211,946	$ 8,211,946	$ 8,211,946	$ 8,211,946	$ 8,211,946	
f. Project Depreciation				$ -	$ 171,903	$ 343,807	$ 343,807	
g. Current Amortization	*$ 149,133*	*$ 144,974*	*$ 140,314*	$ 140,314	$ 140,314	$ 140,314	$ 140,314	
h. Project Amortization				$ -	$ -	$ -	$ -	
i. Supplies	$ 25,095,074	$ 28,024,369	$ 27,772,741	$ 27,772,741	$ 27,772,741	$ 27,772,741	$ 27,772,741	
j. Drugs	$ 6,392,443	$ 7,412,793	$ 6,691,039	$ 6,691,039	$ 6,762,439	$ 6,844,039	$ 6,874,639	
k. Other Expenses (Specify/add rows if needed)	$ 28,272,720	$ 28,971,415	$ 26,795,250	$ 26,795,250	$ 27,286,760	$ 27,640,865	$ 27,716,990	
TOTAL OPERATING EXPENSES	*$ 176,927,883*	*$ 189,329,345*	*$ 189,625,586*	*$ 189,625,586*	*$ 192,617,311*	*$ 195,625,880*	*$ 196,160,111*	*$ -*
3. INCOME								
a. Income From Operation	*$ 13,833,529*	*$ 12,071,551*	*$ 11,168,334*	*$ 11,168,334*	*$ 10,326,423*	*$ 10,705,648*	*$ 11,168,334*	*$ -*
b. Non-Operating Income	$ 534,008	$ (4,122,560)	$ 1,649,670	$ 1,649,670	$ 1,649,670	$ 1,649,670	$ 1,649,670	
SUBTOTAL	*$ 14,367,537*	*$ 7,948,991*	*$ 12,818,004*	*$ 12,818,004*	*$ 11,976,093*	*$ 12,355,318*	*$ 12,818,004*	
c. Income Taxes								
NET INCOME (LOSS)	*$ 14,367,537*	*$ 7,948,991*	*$ 12,818,004*	*$ 12,818,004*	*$ 11,976,093*	*$ 12,355,318*	*$ 12,818,004*	
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	40.2%	41.0%	41.0%	41.0%	41.0%	41.0%	41.0%	
2) Medicaid	5.1%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	
3) Blue Cross	17.1%	17.8%	17.8%	17.8%	17.8%	17.8%	17.8%	
4) Commercial Insurance	16.0%	15.2%	15.2%	15.2%	15.2%	15.2%	15.2%	
5) Self-pay	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	
6) Other	14.3%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	
TOTAL	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	
b. Percent of Equivalent Inpatient Days								
1) Medicare	31.4%	32.5%	32.5%	32.5%	32.5%	32.5%	32.5%	
2) Medicaid	4.1%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	
3) Blue Cross	20.7%	20.6%	20.6%	20.6%	20.6%	20.6%	20.6%	
4) Commercial Insurance	18.2%	16.9%	16.9%	16.9%	16.9%	16.9%	16.9%	
5) Self-pay	6.9%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	
6) Other	18.6%	19.1%	19.1%	19.1%	19.1%	19.1%	19.1%	
TOTAL	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent w
Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and s
Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion an needed in order to document that the hospital will generate excess rever with the Financial Feasibility standard			
FY	2015	2016	2017	2018	2019	2020	2021
1. REVENUE							
a. Inpatient Services	$ 127,952,893	$ 137,455,812	$ 138,446,751	$ 139,831,219	$ 143,874,548	$ 149,320,495	$ 152,162,791
b. Outpatient Services	$ 94,780,280	$ 93,979,082	$ 91,177,089	$ 92,088,860	$ 93,009,748	$ 93,939,846	$ 94,879,244
Gross Patient Service Revenues	*$ 222,733,173*	*$ 231,434,894*	*$ 229,623,840*	*$ 231,920,078*	*$ 236,884,296*	*$ 243,260,341*	*$ 247,042,035*
c. Allowance For Bad Debt	$ 5,527,304	$ 5,001,963	$ 5,830,807	$ 5,889,115	$ 5,948,006	$ 6,007,486	$ 6,067,561
d. Contractual Allowance	$ 22,620,577	$ 19,948,789	$ 16,858,764	$ 17,027,352	$ 17,649,617	$ 18,342,867	$ 18,607,061
e. Charity Care	$ 10,947,887	$ 12,200,283	$ 12,361,309	$ 12,484,922	$ 12,609,771	$ 12,735,869	$ 12,863,228
f. GBR Adjustment	$ -	$ -	$ -	$ -	$ -	$ -	$ 230,931
Net Patient Services Revenue	*$ 183,637,405*	*$ 194,283,859*	*$ 194,572,960*	*$ 196,518,690*	*$ 200,676,902*	*$ 206,174,118*	*$ 209,273,255*
g. Other Operating Revenues (Specify/add rows if needed)	$ 7,124,007	$ 7,117,037	$ 6,220,960	$ 6,283,170	$ 6,346,001	$ 6,409,461	$ 6,473,556
NET OPERATING REVENUE	*$ 190,761,412*	*$ 201,400,896*	*$ 200,793,920*	*$ 202,801,859*	*$ 207,022,903*	*$ 212,583,580*	*$ 215,746,811*
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 91,713,164	$ 99,280,899	$ 104,640,469	$ 105,686,874	$ 108,493,216	$ 111,498,385	$ 113,065,047
b. Contractual Services	$ 9,361,702	$ 9,436,624	$ 9,251,247	$ 9,343,759	$ 9,774,850	$ 10,213,628	$ 10,315,765
c. Interest on Current Debt	$ 7,788,812	$ 7,459,872	$ 6,122,580	$ 6,183,806	$ 6,245,644	$ 6,308,100	$ 6,371,181
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ 215,148	$ 429,746	$ 427,229
e. Current Depreciation	$ 8,154,835	$ 8,598,399	$ 8,211,946	$ 8,294,065	$ 8,377,006	$ 8,460,776	$ 8,545,384
f. Project Depreciation	$ -	$ -	$ -	$ -	$ 175,359	$ 354,225	$ 357,767
g. Current Amortization	$ 149,133	$ 144,974	$ 140,314	$ 141,717	$ 143,134	$ 144,566	$ 146,011
h. Project Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -
i. Supplies	$ 25,095,074	$ 28,024,369	$ 27,772,741	$ 28,050,468	$ 28,330,973	$ 28,614,283	$ 28,900,426
j. Drugs	$ 6,392,443	$ 7,412,793	$ 6,691,039	$ 6,757,949	$ 6,898,364	$ 7,051,420	$ 7,153,777
k. Other Expenses (Specify/add rows if needed)	$ 28,272,720	$ 28,971,415	$ 26,795,250	$ 27,063,203	$ 27,835,224	$ 28,478,411	$ 28,842,411
TOTAL OPERATING EXPENSES	*$ 176,927,883*	*$ 189,329,345*	*$ 189,625,586*	*$ 191,521,842*	*$ 196,488,919*	*$ 201,553,540*	*$ 204,124,998*
3. INCOME							
a. Income From Operation	*$ 13,833,529*	*$ 12,071,551*	*$ 11,168,334*	*$ 11,280,017*	*$ 10,533,984*	*$ 11,030,040*	*$ 11,621,813*
b. Non-Operating Income	$ 534,008	$ (4,122,560)	$ 1,649,670	$ 1,666,167	$ 1,682,828	$ 1,699,657	$ 1,716,653
SUBTOTAL	*$ 14,367,537*	*$ 7,948,991*	*$ 12,818,004*	*$ 12,946,184*	*$ 12,216,813*	*$ 12,729,696*	*$ 13,338,466*
c. Income Taxes							
NET INCOME (LOSS)	*$ 14,367,537*	*$ 7,948,991*	*$ 12,818,004*	*$ 12,946,184*	*$ 12,216,813*	*$ 12,729,696*	*$ 13,338,466*
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	40.2%	41.0%	41.0%	41.0%	41.0%	41.0%	41.0%
2) Medicaid	5.1%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
3) Blue Cross	17.1%	17.8%	17.8%	17.8%	17.8%	17.8%	17.8%
4) Commercial Insurance	16.0%	15.2%	15.2%	15.2%	15.2%	15.2%	15.2%
5) Self-pay	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%
6) Other	14.3%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%
TOTAL	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	31.4%	32.5%	32.5%	32.5%	32.5%	32.5%	32.5%
2) Medicaid	4.1%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
3) Blue Cross	20.7%	20.6%	20.6%	20.6%	20.6%	20.6%	20.6%
4) Commercial Insurance	18.2%	16.9%	16.9%	16.9%	16.9%	16.9%	16.9%
5) Self-pay	6.9%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%
6) Other	18.6%	19.1%	19.1%	19.1%	19.1%	19.1%	19.1%
TOTAL	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
FY	2019	2020	2021				
1. DISCHARGES							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	0	0	0	0	0	0	0
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	300	750	900				
Total Acute	300	750	900	0	0	0	0
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL DISCHARGES	300	750	900	0	0	0	0
2. PATIENT DAYS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	0	0	0	0	0	0	0
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	1,800	4,500	5,400				
Total Acute	1800	4500	5400	0	0	0	0
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL PATIENT DAYS	1,800	4,500	5,400	0	0	0	0
3. AVERAGE LENGTH OF STAY							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	6.0	6.0	6.0				
Total Acute	6.0	6.0	6.0				
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL AVERAGE LENGTH OF STAY	6.0	6.0	6.0				
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	0	0	0	0	0	0	0
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	16	16	16				
Total Acute	16	16	16	0	0	0	0
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL LICENSED BEDS							
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	30.8%	77.1%	92.5%				
Total Acute	30.8%	77.1%	92.5%				
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL OCCUPANCY %	#DIV/0!	#DIV/0!	#DIV/0!				
6. OUTPATIENT VISITS							
a. Emergency Department							
b. Same-day Surgery							
c. Laboratory							
d. Imaging							
e. Other (Specify/add rows of needed)							
TOTAL OUTPATIENT VISITS	0	0	0	0	0	0	0
7. OBSERVATIONS**							
a. Number of Patients							
b. Hours							

*Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION. After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L, Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.					Additional Instruction
FY	2019	2020	2021			*Indicate CY or FY*
1. REVENUE						
a. Inpatient Services	$ 2,592,900	$ 6,482,250	$ 7,778,700			
b. Outpatient Services						
Gross Patient Service Revenues	*$ 2,592,900*	*$ 6,482,250*	*$ 7,778,700*	*$ -*	*$ -*	*Ensure that Gross Patient Service Revenue includes 1 a-b.*
c. Allowance For Bad Debt						
d. Contractual Allowance	$ 443,086	$ 944,642	$ 1,022,256			
e. Charity Care						
f. GBR Adjustment	$ -	$ -	$ 221,920			
Net Patient Services Revenue	*$ 2,149,814*	*$ 5,537,608*	*$ 6,534,524*	*$ -*	*$ -*	*Ensure that Net Patient Services Revenue includes Gross Patients Service Revenue minus 1 c-e.*
g. Other Operating Revenues (Specify)						
NET OPERATING REVENUE	*$ 2,149,814*	*$ 5,537,608*	*$ 6,534,524*	*$ -*	*$ -*	*Ensure that Net Operating Revenue reflects the sum of Net Patient Services Revenue and all Other Operating Revenue rows.*
2. EXPENSES						
a. Salaries & Wages (including benefits)	$ 1,715,002	$ 3,578,765	$ 4,012,819			
b. Contractual Services	$ 331,000	$ 662,000	$ 662,000			
c. Interest on Current Debt						
d. Interest on Project Debt	$ 210,909	$ 417,107	$ 410,559			
e. Current Depreciation						
f. Project Depreciation	$ 171,903	$ 343,807	$ 343,807			
g. Current Amortization						
h. Project Amortization						
i. Supplies						
j. Drugs	$ 71,400	$ 153,000	$ 183,600			
k. Other Expenses (Specify)	$ 491,510	$ 845,615	$ 921,740			
TOTAL OPERATING EXPENSES	*$ 2,991,725*	*$ 6,000,294*	*$ 6,534,525*	*$ -*	*$ -*	*Ensure that Total Operating Expenses includes any added Other rows.*
3. INCOME						
a. Income From Operation	*$ (841,911)*	*$ (462,686)*	*$ (0)*	*$ -*	*$ -*	*Ensure that Income from Operation includes Net Operating Revenue minus Total Operating Expenses.*
b. Non-Operating Income						
SUBTOTAL	*$ (841,911)*	*$ (462,686)*	*$ (0)*	*$ -*	*$ -*	*Ensure that Subtotal includes 3 a-b.*
c. Income Taxes						
NET INCOME (LOSS)	*$ (841,911)*	*$ (462,686)*	*$ (0)*	*$ -*	*$ -*	*Ensure that the Net Income (Loss) includes Subtotal and Income Taxes.*
4. PATIENT MIX						
a. Percent of Total Revenue						
1) Medicare	28.9%	28.9%	28.9%			
2) Medicaid	47.3%	47.3%	47.3%			
3) Blue Cross	6.5%	6.5%	6.5%			
4) Commercial Insurance	10.0%	10.0%	10.0%			
5) Self-pay	5.8%	5.8%	5.8%			
6) Other	1.4%	1.4%	1.4%			
TOTAL	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*Ensure that 4a captures 100% of patients*
b. Percent of Equivalent Inpatient Days						
Total MSGA						
1) Medicare	29.8%	29.8%	29.8%			
2) Medicaid	47.0%	47.0%	47.0%			
3) Blue Cross	6.5%	6.5%	6.5%			
4) Commercial Insurance	9.6%	9.6%	9.6%			
5) Self-pay	5.7%	5.7%	5.7%			
6) Other	1.3%	1.3%	1.3%			
TOTAL	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*Ensure that 4b captures 100% of patients*

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Projected years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard

Indicate CY or FY	2019	2020	2021	0	0
1. REVENUE					
a. Inpatient Services	$ 2,645,017	$ 6,678,669	$ 8,094,546	$ -	$ -
b. Outpatient Services	$ -	$ -	$ -	$ -	$ -
Gross Patient Service Revenues	***$ 2,645,017***	***$ 6,678,669***	***$ 8,094,546***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ -	$ -	$ -	$ -	$ -
d. Contractual Allowance	$ 451,992	$ 973,266	$ 1,063,764	$ -	$ -
e. Charity Care	$ -	$ -	$ -	$ -	$ -
f. GBR Adjustment	$ -	$ -	$ 230,931	$ -	$ -
Net Patient Services Revenue	***$ 2,193,025***	***$ 5,705,403***	***$ 6,799,852***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)	$ -	$ -	$ -	$ -	$ -
NET OPERATING REVENUE	***$ 2,193,025***	***$ 5,705,403***	***$ 6,799,852***	***$ -***	***$ -***
2. EXPENSES					
a. Salaries & Wages (including benefits)	$ 1,749,474	$ 3,687,205	$ 4,175,756	$ -	$ -
b. Contractual Services	$ 337,653	$ 682,059	$ 688,880	$ -	$ -
c. Interest on Current Debt	$ -	$ -	$ -	$ -	$ -
d. Interest on Project Debt	$ 215,148	$ 429,746	$ 427,229	$ -	$ -
e. Current Depreciation	$ -	$ -	$ -	$ -	$ -
f. Project Depreciation	$ 175,359	$ 354,225	$ 357,767	$ -	$ -
g. Current Amortization	$ -	$ -	$ -	$ -	$ -
h. Project Amortization	$ -	$ -	$ -	$ -	$ -
i. Supplies	$ -	$ -	$ -	$ -	$ -
j. Drugs	$ 72,835	$ 157,636	$ 191,055	$ -	$ -
k. Other Expenses (Specify)	$ 501,389	$ 871,238	$ 959,166	$ -	$ -
TOTAL OPERATING EXPENSES	***$ 3,051,858***	***$ 6,182,109***	***$ 6,799,853***	***$ -***	***$ -***
3. INCOME					
a. Income From Operation	***$ (858,833)***	***$ (476,706)***	***$ (0)***	***$ -***	***$ -***
b. Non-Operating Income					
SUBTOTAL	***$ (858,833)***	***$ (476,706)***	***$ (0)***	***$ -***	***$ -***
c. Income Taxes					
NET INCOME (LOSS)	***$ (858,833)***	***$ (476,706)***	***$ (0)***	***$ -***	***$ -***
4. PATIENT MIX					
a. Percent of Total Revenue					
1) Medicare	28.9%	28.9%	28.9%	0.0%	0.0%
2) Medicaid	47.3%	47.3%	47.3%	0.0%	0.0%
3) Blue Cross	6.5%	6.5%	6.5%	0.0%	0.0%
4) Commercial Insurance	10.0%	10.0%	10.0%	0.0%	0.0%
5) Self-pay	5.8%	5.8%	5.8%	0.0%	0.0%
6) Other	1.4%	1.4%	1.4%	0.0%	0.0%
TOTAL	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*
b. Percent of Equivalent Inpatient Days					
1) Medicare	29.8%	29.8%	29.8%	0.0%	0.0%
2) Medicaid	47.0%	47.0%	47.0%	0.0%	0.0%
3) Blue Cross	6.5%	6.5%	6.5%	0.0%	0.0%
4) Commercial Insurance	9.6%	9.6%	9.6%	0.0%	0.0%
5) Self-pay	5.7%	5.7%	5.7%	0.0%	0.0%
6) Other	1.3%	1.3%	1.3%	0.0%	0.0%
TOTAL	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*

TABLE L. WORK FORCE INFORMATION

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables G and J. See additional instruction in the column to the right of the table.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *		
Job Category	Current Year FTEs	Average Salary per FTE	Current Year Total Cost	FTEs	Average Salary per FTE	Total Cost *(should be consistent with projections in Table J)*	FTEs	Average Salary per FTE	Total Cost	FTEs	Total Cost *(should be consistent with projections in Table G)*	*Additional Instruction*
1. Regular Employees												
Administration (List general categories, add rows if needed)												
Management	25.4	$155,587	$3,955,552			$0			$0	25.4	$3,955,552	
Finance	62.8	$51,378	$3,224,064	2.00	51,792	103,584			$0	64.8	$3,327,648	
Medical Records	14.3	$56,712	$811,683	1.0	$109,824	$109,824			$0	15.3	$921,507	
Administrative - Other	53.1	$67,944	$3,610,304	5.7	$68,321	$390,749			$0	59.8	$4,001,053	
Total Administration	155.6	$74,549	$11,601,602	9.7	$62,284	$604,157			$0	165.3	$12,205,759	*Calculate the sum of Administration*
Direct Care Staff (List general categories, add rows if needed)												
House Officers	8.1	$121,904	$984,482			$0			$0	8.1	$984,482	
Nursing	493.9	$72,584	$35,849,215	31.90	79,207	2,526,701			$0	525.8	$38,375,916	
Allied	340.4	$75,709	$25,767,922	3.60	69,264	249,350			$0	344.0	$26,017,273	
Social Services	3.7	$70,490	$261,622	1.60	74,880	119,808			$0	5.3	$381,430	
Total Direct Care	846.0	$74,303	$62,863,242	37.10	$76,815	$2,895,859			$0	883.1	$65,759,102	*Calculate the sum of Direct Care*
Support Staff (List general categories, add rows if needed)												
Food & Nutrition	52.6	$37,274	$1,959,914	2.40	26,208	62,899			$0	55.0	$2,022,813	
IT	26.9	$77,737	$2,088,884	1.00	44,304	44,304			$0	27.9	$2,133,188	
Operations - EVS	54.8	$32,178	$1,762,808	4.50	34,944	157,248			$0	59.3	$1,920,056	
Operations - Plant	13.6	$70,722	$963,988	1.00	57,408	57,408						
Operations - Security	5.6	$50,130	$282,395	4.50	42,432	190,944						
Operations - Other	15.0	$52,156	$784,575	0.00	$0	$0			$0	15.04	$784,575	
Total Support	168.5	$46,552	$7,842,564	13.40	$42,432	$512,803			$0	181.04	$8,355,367	*Calculate the sum of Administration Support Staff*
REGULAR EMPLOYEES TOTAL	1,170	$70,336	$82,307,408	60.20	$66,677	$4,012,819			$0	1,230.1	$86,320,228	*Calculate the sum of Administration, Direct Care, and Support Staff*
2. Contractual Employees												
Administration (List general categories, add rows if needed)												
Medical Director			$0	0.16	$312,000	$50,000			$0	0.16	$50,000	
			$0			$0			$0	0.00	$0	
			$0			$0			$0	0.00	$0	
			$0			$0			$0	0.00	$0	
Total Administration			$0			$0			$0	0.00	$0	*Calculate the sum of Administration*
Direct Care Staff (List general categories, add rows if needed)												
Psychiatrist			$0	2.0	$278,681	$557,362			$0	2.00	$557,362	
			$0			$0			$0	0.00	$0	
			$0			$0			$0	0.0	$0	
			$0			$0			$0	0.0	$0	
Total Direct Care Staff			$0			$0			$0	0.0	$0	*Calculate the sum of Direct Care*
Support Staff (List general categories, add rows if needed)												
			$0			$0			$0	0.0	$0	
			$0			$0			$0	0.0	$0	
			$0			$0			$0	0.0	$0	
			$0			$0			$0	0.0	$0	
Total Support Staff			$0			$0			$0	0.0	$0	*Calculate the sum of Administration Support Staff*
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0	*Calculate the sum of Administration, Direct Care, and Support Staff*
Benefits *(State method of calculating benefits below) :*												
												Include the method of calculating benefits in green field at far left
TOTAL COST	1,170.2		$82,307,408	60.2		$4,012,819	0.0		$0		$86,320,228	*Ensure that the sums and Total Cost of Regular Employees Total and Contractual Employee are correct*

PROJECT DESCRIPTION

Doctors Community Hospital proposes to renovate an existing building located on its Lanham campus for the purpose of initiating a Behavioral Health Program. This Program is envisioned to provide needed inpatient and outpatient hospital services to the underserved residents of Prince George's County. The renovation plans include the complete replacement of the interior of a 2-story building that once operated as the Magnolia Gardens Nursing Home. The location of the building will permit the full integration of the behavioral health services to be provided there, as it is immediately adjacent to the Emergency Department of the Hospital, a principal source of future patient referrals. The second floor of the building will be renovated and "fit-out" to house a 16-bed acute psychiatric unit for adults. The "fit-out" renovation plans for the first floor of the building are in the process of being developed. The first floor is considered a potential location for creating a robust and comprehensive hospital outpatient behavioral health service for both adults and adolescents. For purposes of this Application, the first floor of the building will remain as shelled space when the building renovations are completed and the inpatient unit becomes available for occupancy.

The proposed 16-bed unit will increase the square footage of the Hospital, and establish a new Hospital Department. The project is anticipated to be completed in a single phase. The renovation plan is intended to be implemented under one construction contract.

1 A103 New Work Plan - 2nd Floor
SCALE: 1/8" = 1'-0"

CRGoodmanAssociates
ARCHITECTURE ■ INTERIOR DESIGN ■ PLANNING
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SEAL

I CERTIFY THAT THESE DOCUMENTS WERE PREPARED OR APPROVED BY ME, AND THAT I AM A DULY LICENSED ARCHITECT UNDER THE LAWS OF THE STATE OF MARYLAND, LICENSE NUMBER: _____ EXPIRATION DATE: _____
STATE OF MARYLAND LICENSE NUMBER: 14696

CONSULTANTS

ISSUE	DATE	NUMBER

CLIENT

PROJECT TITLE
DOCTORS COMMUNITY HOSPITAL

DATE 09-07-16

CRGA PROJECT NUMBER 15.148.A

DRAWING TITLE
PROPOSED 2ND FLOOR

DRAWING NUMBER
A103

DOCTORS COMMUNITY HOSPITAL

HOSPITAL POLICY/PROCEDURE

TABLE OF CONTENTS

Exhibits

DOCTORS COMMUNITY HOSPITAL

HOSPITAL POLICY/PROCEDURE

SUBJECT: **Pre-Registration / Insurance Verification & Collection**

POLICY NUMBER: 010

DATE: October 1, 1995, Revised December 2010

Prepared by Patient Financial Services

Philip B. Down, President
Approved by

PURPOSE

The purpose of this policy is to:

1. Establish standards whereby all information that is required to bill a patient is obtained prior to service.
2. Determine and comply with all of the limitations and requirements of the patient's insurance coverage.
3. Determine the patient's liability.
4. Assist the patient in resolving any financial or insurance issues prior to service.

POLICY

Pre-registration will be performed to ensure that a patient and/or responsible party are aware of the financial obligation required for payment of service to be rendered by the hospital. Whenever possible, appointments and scheduled surgeries will be pre-registered to obtain demographic, insurance and financial information required for billing patients, their guarantors and/or third party payers.

Payment requirement instructions will be given to the patient during the appointment or pre-registration process.

PROCEDURE

Third Party Insurance

All third-party coverage will be verified to the fullest extent possible prior to service. Patient insurance is verified through an electronic eligibility system to ensure coverage and accurate registration data.

Patient authorization will be sought from Physician Offices for payers who require clinical approval; Other authorization requirements will be conducted by Patient Services Coordinators by entering data on line with the payer system or by phone contact.

Patients will be contacted to pay any patient liability amount based upon insurance contracted coverage information. Effort will be made to collect patient liability prior to the date of the scheduled service event.

Self-Pay

When the Case is scheduled, staff will determine amount to request as deposit based upon the average cost from financial history using the CPT codes of previous surgeries to find cases and then by review of the dollars charged for recent cases that match that surgical CPT code.

Upon completion of average CPT cost analysis, self-pay patients are contacted prior to date of scheduled case and pre-registered. An attempt to collect the expected amount of the surgery as a deposit is discussed with patients. Patients are also instructed that this average deposit does not include professional charges such as, physician and anesthesiology fees. Patients are advised that any additional hospital charges will be billed and are payable in full within 30 days of receipt of bill. Patients, who fail to resolve their balances within 30 days, are referred to an outside billing agent for collection of the debt at the earliest possible date.

Deposit payments can be accepted by cash, check or on-line credit card through Secure Net, which is a secure internet web site purchased through the hospital's banking agent.

If a patient indicates that deposit payment will not be made, the Patient Services Coordinator will contact the physician's office to determine if the elective surgical case can be postponed until funds are available.

If the surgeon indicates the case is urgent and the patient must have the surgery, then the patient is advised of the hospital's Financial Assistance Program and encouraged to apply (see Hospital Financial Assistance Policy No. 050). Regardless of patient's eligibility for the Financial Assistance Program, the surgical procedure will continue if the physician determines the immediate need to proceed with the surgery.

DOCTORS COMMUNITY HOSPITAL

HOSPITAL POLICY/PROCEDURE

SUBJECT: Registration

POLICY NUMBER: 020

DATE: October 1, 1995
Revised May 2010

Prepared by Patient Financial Services

Philip B. Down, President
Approved by

PAGE: 1 of 2

PURPOSE

The purpose of this policy is to establish a standard that will ensure that essential information is gathered for the billing and collection process. Registration staff must be familiar with and have access to documents that outline billing and payment requirements of third-party and other responsible payers.

POLICY

Patients will be registered in a timely, efficient and accurate manner in the hospital's information system. Service will not be refused to any patient requiring emergency treatment.

PROCEDURE

Patients will be registered when:

There is a reservation order or prescription order from a physician's office for inpatient, emergency services, diagnostic and therapeutic services. Phone orders are accepted for direct admissions from the doctor's office.

All patients who have a full registration process will have insurance data verified real time against insurance eligibility software.

Emergency Patients: A short form registration is completed by entering the patient's name, date of birth and chief complaint in the hospital's computer system in order to assign the patient with a system control number. Patient's insurance is not sought during a short form registration process under EMTALA regulations.

After the patient's medical screening, clinical staff will alert registration staff either verbally or through electronic method that the patient has completed medical screening or is eligible for full registration to include patient demographic and financial information.

All patient types of registration

After a complete registration has occurred, patients are given the following documents and patient or responsible party signatures are required as listed below:

HIPPA FORMS (all patients)
Important Message from Medicare (Medicare patients only)
Consent Form (all patients).
Maryland Insurance Commissioner form (inpatients only)

At conclusion of pre-registration of an ER patient and full registration of all others, a patient arm bracelet will be placed on the patient's arm after verifying with the patient that the information is correct.

Patient Liability Collection

Patient's co-payments and accounts receivable patient liability unpaid balances are requested at time of service. (See Hospital Credit and Collection Policy 030)

All signature documents obtained during registration as well as license, patient identification and insurance card will be scanned and stored in the accounts receivable system attached to the individual patient control number.

Doctors Community Hospital
Hospital Policy/Procedure

Subject: Credit and Collection Policy

Policy Number: 030

Prepared by: _____
Patient Financial Services Department

Date: October 1, 1995
Last Revised Date: November 2010

Philip B. Down, President
Approved by: _____

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

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

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

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

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

Self-pay and residual self-pay balances are outsourced to a contracted agent who sends statements and letters seeking collection of hospital debt. The billing agent is directed to seek full payment at the earliest possible date and can accept monthly payment arrangements until the account is paid in full. The agent's collection activity will include statements, letters and phone calls generally at 30 day intervals. Collection efforts may be more or less frequently depending upon patient responses and other circumstances. All letters have been reviewed and approved by the hospital's Director of Patient Financial Services.

Sale of Debts

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

Bad Debt

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

Agency Bad Debt Write–Off

Prior to bad debt write off, patients may receive statements, phone calls and or letters generally within 30 day intervals. For some situations, efforts may be more or less frequently. When statements, letters and phone calls have not been successful for debt collection, accounts will transition to bad debt status initiating new collection letters and calls by the billing/collection agent.

The hospital usually processes bad debt write off of accounts at 120 days or greater depending upon length of time for insurance to pay. A bad debt report is automatically generated by the hospital's computer system based on the hospital write-off age in accounts receivable parameters. Accounts which qualify for write-off are transferred to the bad debt file and reported to the collection agency at least once a month. However, since the billing/collection agency is performing the collection activity, an account may be listed as open in the agent's active non bad debt billing system because payments are active or the account is pending other information. The collection notes for patient liability are retained in the billing/collection agent's computer system and not the hospital's system. Collection action notes are randomly selected and audited at least annually to validate the follow-up criteria is met as established by the hospital.

The hospital's billing/collection agent has been directed not to move an account to bad debt status in their file or notify a patient that they have been placed in bad debt until 120 days from discharge has occurred, which should provide sufficient time for ongoing collection efforts to collect hospital debts. An exception would be if the patient has delinquent history for other debts for the hospital and has not been responsive or has broken prior payment agreements for other accounts recently classified as bad debts.

The billing/collection agent makes recommendations for write off of account balances for reasons such as, timely filing for insurance, patient bankruptcy, deceased and no estate and Financial Assistance. In such cases, no additional collection effort is made by the hospital or agents.

Recoveries from Bad Debt

Payments for accounts written off to bad debt are booked as recoveries to bad debt and are netted against the individual patient's bad debt account balance. Collection fees are booked as collection expense in the General Ledger and the agent is paid on a contingency fee.

Credit Bureau Reporting

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

does not report accounts to the credit bureau when legal placement is made in order to ensure that the same debt is not reported twice to the credit bureau.

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

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

Judgments and Liens
The hospital will not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill. If a hospital holds a lien on a patient's primary residence, the hospital will maintain its position as a secured creditor with respect to other creditors to whom the patient may owe a debt. Garnishment of wages will occur when the hospital was awarded a judgment and the court judgment is beyond the patient appeal time. Garnishment of wages is not sought unless the patient ignores the debt or fails to make payment as agreed.

Vacate Judgment
The hospital or its agent will notify the court to vacate judgment when patients qualify for Financial Assistance. (See Financial Assistance Policy number 050).

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

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

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

DOCTORS COMMUNITY HOSPITAL
HOSPITAL POLICY/PROCEDURE

SUBJECT: **Billing** **POLICY NUMBER: 040**

Prepared by: Patient Financial Services **DATE: May 2010**

Phillip B. Down, President
Approved by: **Page: 1 of 2**

PURPOSE

To ensure that claims are billed accurately and at the earliest possible date from discharge of service.

POLICY

Claims are downloaded in UB print image format from the hospital's information system to an electronic billing system each business day. The electronic billing system converts hospital print images to HIPAA 837 transaction format. All claims process through an electronic edit system using software edits as developed by individual payers to ensure correct data and payer compliance is met.

The basic steps of the billing process are as follows:

1. Claim Submission

a. Claims download from the hospital's information system by print image to the electronic billing system.
b. The electronic billing system processes claims through an edit scrubber and hi-lights by each billing field revealing any conflicts or missing data.
c. Billing staff make corrections as instructed in the edit pop up rule for claim correction.
d. All claims including corrected claims are batched and sent daily to the Electronic Clearing house for adjudication.

2. Claim Verification

a. Daily, the billing staff access a report using the electronic billing system of previous claims billed to determine claims that are approved by the payer, and claims that deny.
b. Denied claims are reviewed for reasons for denial and billing corrections and Re-submission is made.

Billing Notes

Each work day, billing information is scripted from the electronic billing system to the hospital's information accounts receivable system listing date of billing, biller's name, and amount of claim.

Billing Reports

Activity reports are reviewed at least weekly by the Patient Accounts Manager to determine the following:

1. Reasons for payer errors
2. Edit failures
3. Percentage of clean claims (no errors)
4. Time from system download to billed date
5. Time from patient discharge to billed date

Doctors Community Hospital
Hospital Policy/Procedure

SUBJECT: Financial Assistance Policy

Policy Number 050

Prepared by: Patient Financial Services

Date: May 5, 2003

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

Philip B. Down, President
Approved by

PURPOSE

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

POLICY

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

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

1. Published notices of available Financial Assistance are printed in local newspapers annually,
2. Signs are posted at emergency registration, outpatient registration and the hospital's business office in patient waiting areas,
3. Financial policy brochures written in English and Spanish, specifying who to call for Financial Assistance, medical assistance and billing questions, is available in patient lobby waiting areas of the hospital,
4. Financial policy brochures are provided to every inpatient at time of admission. The information is a hand-out as part of the Hospital's admission package,
5. Financial policy is provided to every inpatient with their initial summary bill,
6. Financial policy is provided to every patient upon patient request by the Business Office,

7. An overview of Financial Assistance is provided to all hospital employees as part of the annual employee orientation in order to provide direction or assistance to patients.

Eligibility Criteria

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

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

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

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

Other Eligibility Consideration:

Self-pay patients enrolled in certain means-tested programs will qualify as presumptive Financial Assistance eligibility for free care by submitting proof of enrollment in a social service program within 30 days of request for free care. No application by the patient or family household will be required as long as there is documentation for the means test program. If the patient fails to summit the means-tested documentation within 30 days, upon patient request an additional 30 days will be granted for documentation. Programs that should be considered for presumptive assistance are as follows:

1. Household with children in the free or reduced lunch program,
2. Supplemental Nutritional Assistance Program (SNAP),
3. Low income household energy assistance program,
4. Primary Adult Care Program,
5. Women, Infants and Children program (WIC),

In addition to programs listed in means-test for presumptive charity, the hospital will consider all accounts as free care without patient application or further proof when such patients' insurance eligibility through the hospital eligibility verification system indicate that the patient qualifies for a program such as pharmacy only, physician care only, partial coverage for care provided in the emergency room by Medicaid MCO's and other state programs. Financial Assistance will be granted as free care, when the patient is eligibility for assistance programs, where there is no medical insurance coverage, such as spin down amounts not covered by Medical Assistance. The hospital may apply discretion and approve patients beyond the 12 month medical bill period when the patient's health status is severe or other financial circumstances prevent payment from the patient.

Ineligible Patients

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

1. Patients who have health insurance and services are payable by other third-party insurance,
2. Patients who refuse to complete the hospital's Financial Screening Application, when presumptive free care is not warranted,

3 A non U S citizen who traveled to the US primarily for the purpose of receiving medical services at no cost,

4. Patients whose credit bureau report validates the patient's application was false or misleading,
5. Patients who fail to provide supporting information to validate information contained on the Financial Assistant Application,
6. Patients whose monetary assets exceed $10,000 excluding up to $150,000 in a primary residence and retirement benefits where the IRS has granted preferential treatment.

Application Requests

Self pay patients are requested to complete an application when they apply for Financial Assistance unless they qualify for presumptive financial assistance and in such case, no application is required. A Financial Screening Application (see Exhibit A) is given to the patient when one of the following situations occurs:

1. Patient requests Financial Assistance,
2. Patient or family member expresses inability to pay for medical debts,
3. Other hospital departments staff request Financial Assistance for the patient,
4. Medicaid Advocates or Collection Agents request Financial Assistance Application.

Application Process

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

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

Approval Process

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

Denial Process

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

Patient Refund

If it is determined that the patient qualifies for Financial Assistance for the period of time for the debt, the hospital will refund to the patient any payment amounts exceeding $25.00 within a 2 year period from the date of service he/she was found to be eligible for Financial Assistance or meets the presumptive means test. An exception will be if the patient did not cooperate in providing the data for the financial assistance application and in such cases the refund period will be limited to 30 days from the patient's request for Financial Assistance.

DOCTORS COMMUNITY HOSPTIAL

HOSPITAL POLICY/PROCEDURE

SUBJECT: Cashier and Cash Application **POLICY NUMBER 060**

DATE: May 2010

Policy Prepared by: Patient Financial Service

Philip B. Down, President

Approved by

PURPOSE

The purpose of this policy is to establish a payment process that ensures that payments are applied to the proper patient's account and to establish an acceptable manner for applying payments that are not specifically directed.

POLICY

Accounts receivable payments and remittances are received by lockbox, US mail, electronic payment processing system, counter window payments, department accounts receivable collection payments and miscellaneous non-accounts receivable payments. All payments received are rung in a cash register and Meditech system cash batches are reconciled to monies received. Cash and Checks are deposited within 24 hours of receipt on each working day. A general accounting reconciliation report is completed daily, listing deposits, credit card payments, miscellaneous account payments, accounts receivable lockbox payments and money received from the bank's electronic funds transactions.

PROCEDURE

Accounts Receivable Posting Processes

Checks and payment posting is completed by the following methods

Electronic Posting

Upon receipt of check by mail, lockbox or EFT method, electronic remittances which match monies received is downloaded and posted to the hospital's cash batch system applying payments directly to individual patient accounts. At the end of the electronic posting, from the electronic system report section, a reconciliation report is retrieved and compared to the hospital computer system batch report to ensure all payments posted match the total of the check received. Corrections may be necessary to correct accounts that did not electronically post or for any contractual allowances that posted incorrectly.

United States Mail
Checks received from US mail are applied to patient accounts in a manual posting batch. A batch report is retrieved at the end of posting. Checks are totaled to the batch report total to ensure all accounts receivable posting is correct.

Lockbox
Delivery is made daily by courier, which includes copies of checks and remittance advices. When remittances are also listed on the electronic posting system, batches are downloaded for accounts receivable posting and posted under the section listed as Electronic Posting. Other payments are batched and posted directly into the hospital accounts receivable batch system applying payments to each patient account. Batch reconciliation reports are retrieved and compared to the total of checks in the batch.

Counter Payments
Payments are accepted at the Cashier's window for patient accounts receivable payments and miscellaneous general ledger accounts by cash, checks and credit card payments.

Credit Card Processing – Patients who wish to pay by credit card are entered into the Bank of America Secure Net On-Line System. A credit card reconciliation report is retrieved by the Cash Posting staff in the Cashier Office. Payments received are posted to the patient's account in the Accounts Receivable Batch System and batch reports are reconciled to the bank reconciliation report from the Secure Net System.

Cash Register
All monies received in the Cashier office are rung into the cash register and a register total is printed at the end of the business day.

Bank Deposits
Bank deposits are completed daily for all methods of cash received and are reconciled to type of receipts as printed on the daily cash ring out report from the cash register.

Unapplied Cash
In the event a payment lacks identification and payee can not be reached, the payment is applied to an unapplied account by insurance type. The amount of unapplied cash is posted to the final daily Cash Reconciliation Report which is sent to General Accounting.

Cash application staff, as soon as possible, makes an effort to contact the payee by phone or letter for additional information. Once the correct information is received, payment is retracted from the unapplied account and posted to the correct patient account by date of payment received.

Reconciliation Process
Every accounts receivable batch is affixed with a batch ticket listing the amount of the batch, the batch number, the date of payment, the date of posting, interest and any amount short or under listed as credit/no check. All batch tickets are separated by lock box batches, electronic funds and counter mail. Batch tickets are totaled and reconciled to other summary totals such as, electronic funds report and bank lock box total summary report to ensure every payment was posted correctly to the detail patient account record. All batches reconciled from sub reports are recorded on the Cash Reconciliation Report. The data on the report includes:

Miscellaneous payments listed by G.L. Account number (receipts are attached for each sub account)

Hospital Cash from the deposit ticket (attach deposit ticket)
A register card of total dollars processed (attach register card)
Amount of credit card transactions (attach Secure Net Report)
Money received from Dietary Department (attach dietary receipts)
Lock box total (attach Bank Lock Box Summary Amount)
Electronic Funds (attach copy of Bank Report of electronic funds)

The Cash Reconciliation reports along with attachments are delivered to the General Accounting Office daily for the proof of cash reconciliation process.

DOCTORS COMMUNITY HOSPITAL

HOSPITAL POLICY/PROCEDURE

SUBJECT: Denial Processing & Tracking **POLICY NUMBER: 070**

DATE: October 1, 1995
Prepared by Patient Financial Services **Revised June 2010:**

Philip B. Down, President
Approved by **PAGE: 1 of 2**

PURPOSE

To establish a standard and process to ensure correct payments are made based upon patient's contract coverage and need for care. Notification of denied claims are receivedby payers from the following sources, mail correspondence, electronic 835 remittances, paper remittances received from the lock box of US mail. Denials are researched and appeals are performed to recover denied amounts. Denials are listed in a denial spreadsheet to track reasons, payers, doctors and service lines, change of denial status and recoveries and percent of denials to total revenue.

POLICY

Denial Notification - Upon remittance denial notification, staff reviews denials to determine reasons and change collector code in the hospital system to an internal denial collector code for tracking purposes.

When the denial is an error of the payer or the payer reason is to request additional information, staff retains the claim by building a case in their automated follow-up system for denial resolution.

Staff contacts the payer by phone to resolve the denial reason. Medical records are sent when requested by the payer.

Write off Approval
Denials are written off, when it is determined that in-house staff can not overturn the denial. The denial is written off using the adjustment code, which best describes the denial reason provided by the payer.

Manager Approval
When follow-up staff has exhausted their internal ability to seek payment from the payer, a denial approval form is created and given to Management for write off approval. The manager performs the following actions:

1. Manager determines reason for write off.

2. Analyzes causes for denial to determine if revised procedures would prevent future denials.

3. Approves and initiates write off action when approved.

Denial Coordinator Approval – Denials due to medical necessity issues are reviewed by denial coordinator and written off upon referral to physician for appeal. Accounts are coded with collector code for follow-up and on-going audit of management staff.

Nurse contractor
Decision for write off for Maryland Medicaid is noted on the 3808 Medical Necessity form by the State review contractor. The appropriateness of write off is reviewed by the hospital's contracted Nurse Auditor. Upon nursing approval, the Medicaid Biller initiates the write off and forwards the write off information to the denial coordinator for physician appeal.

Appeals – The following types of denial reasons are outsourced for appeal: Medical Necessity, facility did not authorize, no concurrent review, lower level of care needed.

1. Inpatient, outpatient surgery or other high dollar outpatient accounts are referred to a physician to appeal
2. Outpatient accounts where the denial appears to be final are outsourced to a denial company for appeal.

The denial coordinator performs the initial process for denial tracking by changing the collector code so the denial activity can be tracked and follow-up performed for any amount not denied in the accounts receivable follow-up system. The medical records are retrieved from the on-line system and sent to the outsourced agent for appeal. A Medicaid ad hoc denial history form is completed and forwarded to the Project Manager for entry into the denial log. (Note: An automated denial posting and tracking system which is interfaced to the hospital computer system is under construction)

When denials are overturned and payment is received, the initial write off is reversed. The denial coordinator sends notification of the recovery to the Project Manager to post the recovery in the denial log.

When it is determined that the denial after appeal will not be overturned, the case on the denial log is posted as case closed.

DOCTORS COMMUNITY HOSPITAL

HOSPITAL POLICY/PROCEDURE

SUBJECT: Credit Balance/ Refunds

POLICY NUMBER: 080

DATE: October 1, 1995
REVISED: June 2010

Prepared by Patient Financial Services

Philip B. Down, President
Approved by

PAGE: 1 of 2

PURPOSE

The purpose of this policy is to ensure that an overpayment on a patient's account is refunded to the appropriate payee in a timely manner for overpayments greater than the small balance write off of $14.99.

POLICY

Insurance overpayments: The hospital allows third-party payers contract agents to work in the Business Office to review credit balances. The contracted agent reviews all remittance schedules to determine reason and correct amount of overpayments for each account.

When the overpayment is a discount error or some other reason not classified as a true overpayment, a refund adjustment sheet is sent to the hospital's Patient Account Manager to correct the account.

Overpayments resulting in a refund to the payer are referred to the Patient Account Manager for refund approval by the contracted refund agent of the payer. Upon management signature, most refunds are settled by requesting the payer to do a payment retraction on the next remittance advice.

Payers who do not routinely do refund retractions are sent a refund check for the overpayment.

The refund adjustment is posted to the detail patient account and an invoice is sent to General Accounting to process the refund check to the payer.

Self-Pay overpayments
Credit balance reports are reviewed for self-pay overpayments by hospital staff for research and process of self-pay refunds. Some refunds are initiated by patient requests by phone or letter.

Self-pay invoices are pulled to determine the payee and transactions which created the overpayment. The patient's name is checked in the accounts receivable and bad debt file to ensure there are no other outstanding balances due from the patient. When the patient owes other accounts, the credit balance is transferred to the debit balance but only when such off-set is for the same patient who owes the hospital a patient liability.

Overpayments are refunded to the patient by applying a refund adjustment and sending a refund processing form to General Accounting to initiate the refund check.

If a patient refund check is returned, accounts receivable staff attempts to locate the patient. If a new address is found the refund check is mailed to the new address and the account is changed to show the new address and change is recorded under computer system notes.

If a patient refund check is returned but no new address can be found or returned after a second attempt to refund, the check is sent to General Accounting to be mailed to the State of Maryland as "unclaimed funds". A notation is made on the patient detail account that the check was sent to Accounting.

Exhibit A (1)

DOCTORS COMMUNITY HOSPITAL
sion for caring.

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

Financial Screening Form

Please Print Legibly

Patient Name _____ SS # _____ - _____ - _____

Patient Address _____

City _____ State _____ Zip Code _____

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

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

Spouse Address *(if different from Patient)* _____

City _____ State _____ Zip Code _____

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

LIST ALL CHILDREN UNDER 21 YEARS OF AGE

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

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

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

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

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

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

Responsible Party Name _____ SS # _____ - _____ - _____

Address _____

City _____ State _____ Zip Code _____

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

EMPLOYMENT INFORMATION

Place of Employment _____

Address _____

City _____ State _____ Zip Code _____

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

INSURANCE INFORMATION

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

If YES, Name of Company _____ Policy # _____

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

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

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

Exhibit A (2)

Please provide proof of income and expenses with this application:

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

MONTHLY INCOME

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

OTHER MONEY RECEIVED

Alimony		
Child Support		
Other		
TOTAL		

OTHER ASSETS

Name of Bank (Checking) _____

Account # _____

Name of Bank (Savings) _____

Account # _____

Name of Bank (Checking) _____

Account # _____

Name of Credit Union _____

Account # _____

Other Bank Account(s) _____

_____

Do you own stocks? ..... ☐ Yes ☐ No
Do you own bonds? ..... ☐ Yes ☐ No
Do you own property? ..... ☐ Yes ☐ No

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

Applicant Signature _____

Date of Application _____

MONTHLY EXPENSES

Rent / Mortgage _____

To Whom Paid _____

Telephone No. ( ) _____ - _____ Ext. _____

Auto Payment _____

Year _____ Make _____ Model _____

Financed By _____

Phone No. ( ) _____ - _____ Ext. _____

Electricity _____

Gas Utility _____

Telephone _____

Alimony _____

Child Support _____

Credit Cards *(See Below)* _____

Medical / Dental *(See Below)* _____

TOTAL _____

DOCUMENT CREDIT CARDS & MEDICAL / DENTAL

List Credit Cards

Account # _____

Account # _____

Account # _____

List Medical / Dental

_____ _____

_____ _____

_____ _____

Other Expenses

_____

_____

_____

_____

_____

_____

_____

_____

Exhibit B

Dear Patient:

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

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

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

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

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

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

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

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

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

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

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

Exhibit C

DOCTORS COMMUNITY HOSPITAL
8118 GOODLUCK ROAD
LANHAM, MARYLAND 20706

[DATE]

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

RE: [ACCOUNT #]
[PATIENT NAME]

Dear [GUARANTOR NAME]:

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

ACCOUNT #	AMOUNT APPROVED	REMAINING BALANCE PAYABLE BY PATIENT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Yours truly,

Leslie Meade
Collections Team Leader

Exhibit D

Dear Patient:

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

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

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

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

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

_____ Other reason (s) _____

_____

_____

_____

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

Thank you,

Leslie Meade, Team Leader
Patient Accounts Coordinator

Doctors Community Hospital and Subsidiaries

Consolidated Financial Statements and Other Financial Information

Years Ended June 30, 2016 and 2015

DIXON HUGHES GOODMAN LLP

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DIXON HUGHES GOODMAN LLP

Independent Auditors' Report

The Board of Directors
Doctors Community Hospital and Subsidiaries
Lanham, Maryland

We have audited the accompanying consolidated financial statements of Doctors Community Hospital and Subsidiaries (the "Hospital"), which comprise the consolidated balance sheets as of June 30, 2016 and 2015, and the related consolidated statements of operations and other changes in unrestricted net assets, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated 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 consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated 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 consolidated 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 consolidated financial statements.

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Doctors Community Hospital and Subsidiaries as of June 30, 2016 and 2015, and the results of its operations and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter – New Accounting Pronouncement

As discussed in Note 14 to the consolidated financial statements, during the year ended June 30, 2016, the Hospital implemented new accounting guidance for accounting for debt issuance cost and reporting that requires retroactive adjustments to amounts previously reported as of and for the year ended June 30, 2015. Our opinion is not modified with respect to this matter.

DIXON HUGHES GOODMAN LLP

Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the basic consolidated financial statements as a whole. The consolidating information presented in the supplemental schedules is presented for purposes of additional analysis rather than to present the financial position and results of operations of the individual organizations, and is not a required part of the basic consolidated financial statements. Such information is the responsibility of management, was derived from, and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Dixon Hughes Goodman LLP

Tysons, Virginia
September 29, 2016

Doctors Community Hospital and Subsidiaries
Consolidated Balance Sheets

ASSETS	June 30 2016	2015
CURRENT ASSETS		
Cash and cash equivalents	$ 39,302,838	$ 32,178,431
Assets whose use is limited for debt service	1,998,377	7,033,280
Patient accounts receivable, less uncollectible accounts of $9,871,656 and $9,342,967	22,357,343	20,786,249
Other amounts receivable	3,315,836	3,742,775
Inventories	4,095,155	3,833,507
Prepaid expenses	3,003,939	3,238,192
TOTAL CURRENT ASSETS	74,073,488	70,812,434
INVESTMENTS		
Marketable securities	15,946,559	15,628,089
Joint ventures and equity investments	6,236,780	5,599,073
	22,183,339	21,227,162
ASSETS WHOSE USE IS LIMITED		
Investments held by trustee or authority, less current portion	10,972,491	11,635,652
LAND, BUILDINGS, AND EQUIPMENT	115,687,985	119,276,741
GOODWILL	3,046,972	2,948,390
OTHER ASSETS	21,578,882	24,790,507
TOTAL ASSETS	$ 247,543,157	$ 250,690,886

See the accompanying notes to the consolidated financial statements.

LIABILITIES	June 30 2016	2015
CURRENT LIABILITIES		
Accounts payable and accrued expenses	$ 16,586,341	$ 15,925,026
Salaries, wages, and related items	13,346,381	11,872,519
Advances from third party payers	8,716,556	7,338,584
Interest payable to bondholders	1,973,835	3,865,670
Current portion of long-term obligations	4,134,850	4,234,699
TOTAL CURRENT LIABILITIES	44,757,963	43,236,498
NONCURRENT LIABILITIES		
Deferred compensation and accrued claims	12,125,342	14,526,429
Pension obligation	7,685,080	5,395,509
Long-term obligations, net of current portion	134,932,271	137,760,728
TOTAL LIABILITIES	199,500,656	200,919,164
NET ASSETS		
Unrestricted	45,236,896	46,623,446
Noncontrolling interest	1,870,306	1,741,446
TOTAL UNRESTRICTED NET ASSETS	47,107,202	48,364,892
Temporarily restricted	935,299	1,406,830
TOTAL NET ASSETS	48,042,501	49,771,722
TOTAL LIABILITIES AND NET ASSETS	$ 247,543,157	$ 250,690,886

See the accompanying notes to the consolidated financial statements.

Doctors Community Hospital and Subsidiaries
Consolidated Statements of Operations and
Other Changes in Unrestricted Net Assets

	Year Ended June 30	
	2016	**2015**
REVENUE		
Patient service revenue, net of contractual allowances and discounts	$ 225,614,450	$ 213,507,894
Provision for bad debts	(5,113,446)	(5,816,788)
Net patient service revenue less provision for bad debts	220,501,004	207,691,106
Other operating revenue	4,214,577	4,905,703
Contributions	298,129	257,676
Net assets released from restrictions used for operations	1,189,083	1,091,808
TOTAL OPERATING REVENUE	226,202,793	213,946,293
EXPENSES		
Salaries and wages	99,149,648	91,768,948
Employee benefits	16,119,335	16,024,273
Purchased services	32,364,329	33,327,158
Supplies	36,225,202	32,369,269
Other expenses	19,923,517	17,258,006
Depreciation	9,469,597	9,079,652
Amortization	144,974	149,133
Fundraising	4,702	10,649
Interest	7,482,069	7,839,825
TOTAL EXPENSES	220,883,373	207,826,913
INCOME FROM OPERATIONS	5,319,420	6,119,380
NONOPERATING GAINS (LOSSES)		
Loss on sale of property	(17,578)	(165,201)
Extinguishment of debt	(4,558,885)	0
Unrealized loss on trading securities	(53,422)	(172,894)
Gain(Loss) in joint ventures	708,268	(684,592)
EXCESS OF REVENUE OVER EXPENSES	1,397,803	5,096,693
Subsidiary distributions to noncontrolling interest-holders	(141,560)	(1,283,094)
Net assets released from restrictions for capital acquisitions	122,125	-
Pension - related changes other than net periodic pension cost	(2,636,058)	(389,744)
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	$ (1,257,690)	$ 3,423,855

See the accompanying notes to the consolidated financial statements.

Doctors Community Hospital and Subsidiaries
Consolidated Statements of Changes in Net Assets

	Year Ended June 30, 2016			Year Ended June 30, 2015		
	Total	Controlling Interests	Noncontrolling Interests	Total	Controlling Interests	Noncontrolling Interests
UNRESTRICTED NET ASSETS						
Excess of revenue over expenses (expenses over revenue)	$ 1,397,803	$ 1,127,383	$ 270,420	$ 5,096,693	$ 3,996,960	$ 1,099,733
Net assets released from restrictions for capital expenditures	122,125	122,125	0	0	0	0
Dividends paid to noncontrolling interest-holders	(141,560)	0	(141,560)	(1,283,094)	0	(1,283,094)
Pension - related changes other than net periodic pension cost	(2,636,058)	(2,636,058)	0	(389,744)	(389,744)	0
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS AND NONCONTROLLING INTERESTS	(1,257,690)	(1,386,550)	128,860	3,423,855	3,607,216	(183,361)
TEMPORARILY RESTRICTED NET ASSETS						
Restricted contributions	839,677	839,677	0	841,649	841,649	0
Net assets released from restrictions for capital expenditures	(122,125)	(122,125)	0	0	0	0
Net assets released from restrictions for operations	(1,189,083)	(1,189,083)	0	(1,091,811)	(1,091,811)	0
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	(471,531)	(471,531)	0	(250,162)	(250,162)	0
INCREASE (DECREASE) IN NET ASSETS	(1,729,221)	(1,858,081)	128,860	3,173,693	3,357,054	(183,361)
NET ASSETS, BEGINNING OF YEAR	49,771,722	48,030,276	1,741,446	46,598,029	44,673,222	1,924,807
NET ASSETS, END OF YEAR	$ 48,042,501	$ 46,172,195	$ 1,870,306	$ 49,771,722	$ 48,030,276	$ 1,741,446

See the accompanying notes to the consolidated financial statements.

Doctors Community Hospital and Subsidiaries
Consolidated Statements of Cash Flows

	Year Ended June 30	
OPERATING ACTIVITIES AND OTHER GAINS	**2016**	**2015**
Increase (Decrease) in net assets	$ (1,729,221)	$ 3,173,693
Adjustments to reconcile increase (decrease) in net assets to net cash and cash equivalents provided by operating activities		
Restricted contributions received	(839,677)	(841,649)
Depreciation	9,469,597	9,079,652
Provision for bad debts	5,113,446	5,816,788
Unrealized loss on investments	53,422	172,894
Loss on sale of property	17,578	165,201
Realized loss on sale of investments	32,871	111,275
Amortization on bond issue	144,974	149,133
Extinguishment of debt	4,558,885	0
(Increase) Decrease in joint ventures and equity investments	(708,207)	684,592
Increase (Decrease) in:		
Accounts payable and accrued expenses	661,315	981,213
Accrued salaries, wages, and related items	1,473,862	462,497
Advances from third party payers	1,377,972	(496,305)
Pension obligation	2,289,571	(169,153)
Interest payable	(1,891,835)	(177,711)
Other liabilities	(2,401,087)	1,566,575
Decrease (Increase) in:		
Net patient accounts receivable	(6,684,540)	(1,285,668)
Other receivables	426,939	651,861
Inventories	(261,648)	(275,459)
Prepaid expenses and other assets	3,445,878	(2,559,618)
NET CASH AND CASH EQUIVALENTS PROVIDED BY OPERATING ACTIVITIES AND OTHER GAINS	14,550,095	17,209,811
INVESTING ACTIVITIES		
Net sales of trading investments, including assets whose use is limited	734,416	7,336,379
Increase in goodwill	(98,582)	0
Proceeds from sale on property	84,916	87,100
Distributions from (contributions to) joint ventures	70,500	(1,981,720)
Purchase of property, plant and equipment	(5,983,335)	(12,131,110)
NET CASH AND CASH EQUIVALENTS USED IN INVESTING ACTIVITIES	(5,192,085)	(6,689,351)

(Continued)

	Year Ended June 30	
FINANCING ACTIVITIES	**2016**	**2015**
Principal payments on debt	$ (75,608,666)	$ (5,043,674)
Proceeds from new debt	73,445,000	0
Cost of debt issuance	(909,613)	0
Restricted contributions received	839,677	841,649
NET CASH AND CASH EQUIVALENTS USED IN FINANCING ACTIVITIES	(2,233,602)	(4,202,025)
NET INCREASE IN CASH AND CASH EQUIVALENTS	7,124,408	6,318,435
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	32,178,431	25,859,996
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 39,302,839	$ 32,178,431

See the accompanying notes to the consolidated financial statements.

Notes to the Consolidated Financial Statements

1. Organization and Summary of Significant Accounting Principles

Organization

Doctors Community Hospital (the Hospital) is a not-for-profit, non-stock corporation that operates an acute care general hospital facility licensed for 163 beds. The Hospital serves the health care needs of the residents of Prince George's County, the District of Columbia, and the greater Washington, D.C. metropolitan area. The Hospital has five wholly owned/controlled subsidiaries: Doctors Community Hospital Foundation, Inc. (the Foundation), Doctors Community Health Ventures, Inc. (Health Ventures), Doctors Community Sleep Center, LLC (the Sleep Center), Doctors Community Healthcare Programs (CHP), and Spine Team of Maryland, LLC (STM).

The Foundation was incorporated in Maryland in 1990 as a not-for-profit, non-stock corporation established to raise and invest funds to support or benefit the operations of the Hospital. The Foundation's bylaws provide that all funds raised, except those required for the operation of the Foundation, be distributed to or be held for the benefit of the Hospital. Under the Foundation's bylaws, a majority of its directors must be directors of Doctors Community Hospital, appointed by its President. The Foundation's bylaws also provide the Hospital with the authority to direct its activities, management, and policies.

Health Ventures is incorporated under the laws of Maryland as a for-profit, stock corporation. Doctors Community Hospital owns 100% of its stock. Health Ventures invests in for-profit businesses consistent with the mission and strategic plan of Doctors Community Hospital. Health Ventures consolidates two LLCs: Metropolitan Medical Specialist, LLC (MMS) and Doctors Community Management Services, LLC. (MSO) and has investment in three other companies: Magnolia Gardens LLC (Magnolia Gardens), Diagnostic Imaging Center, LLC (DI), Mid-Atlantic Urology, Inc. (MAUI).

The Hospital owned a 60% interest in Doctors Community Hospital Sleep Center, LLC (the Sleep Center) through May 2015, at which time the Hospital acquired the full 100% interest in the Sleep Center, which continues as a limited liability company formed in Maryland for the purpose of providing diagnostic sleep services for residents of Prince Georges County and surrounding areas. The Sleep Center operates of a 10-bed sleep lab located on the Hospital's campus and provides outpatient sleep studies.

Doctors Community Healthcare Programs (CHP) consists of two wholly owned/controlled entities: Doctors Community Hospital Clinics (CLINICS) and Capital Orthopedics Specialists, LLC (COS). CLINICS is a limited liability company formed in Maryland for the purpose of providing outpatient medical care for the residents of Prince Georges County and surrounding areas. CLINICS include a cardiology outpatient program and mobile van that travels the county. COS is a limited liability company formed in Maryland for the purpose of providing surgical services for the residents of Prince Georges County and surrounding areas.

The Hospital owns a 60% interest in Doctors Regional Cancer Center, LLC (DRCC). DRCC is a limited liability company formed in June 2007 by Maryland Regional Cancer Care, LLC (MRCC) for the purpose of providing outpatient cancer treatment services to the residents of central Maryland. The Hospital owns 100% interest in Spine Team Maryland, LLC (STM) for the purpose of providing outpatient ear, nose and throat services to the residents of Prince Georges County and surrounding areas. The Hospital owns 61% interest in the Southern Maryland Integrated Healthcare, LLC (ACO). The ACO is a limited liability company formed in Maryland for the purpose of providing a Medicare Shared Savings Program (MSSP) among primary care providers serving the residents of Prince Georges County and surrounding areas.

Principles of consolidation

The consolidated financial statements include the accounts of the Hospital, Health Ventures, the Foundation, DRCC, the Sleep Center, ACO, and CHP (collectively, the Company). All intercompany accounts and

transactions have been eliminated in consolidation. The consolidated financial statements include non-controlling interest held by third parties in less than wholly owned subsidiaries.

Use of estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and cash equivalents

The Company has cash holdings in commercial banks routinely exceeding the Federal Deposit Insurance Corporation maximum insurance limit of $250,000. Cash and cash equivalents are reported at cost which approximates market value.

Investments

Marketable securities, including assets whose use is limited, consists of investments in equity and debt securities and are carried at fair value. All such investments are classified as trading. Assets whose use is limited that are required to meet current liabilities of the Hospital have been classified as current assets.

Unrestricted investment income, including realized gains and losses on the sale of trading securities, is reported as other operating revenue. The cost of securities sold is based on the specific-identification method. Unrealized gains and losses on trading securities are included in non-operating gains (losses) in the accompanying consolidated statements of operations and other changes in unrestricted net assets.

Patient revenue and accounts receivable

Net patient service revenue and net patient accounts receivable are reported at estimated net realizable amounts from patients, third party payers, and others for services rendered. Discounts ranging from 2.25% to 8% of Hospital charges are given to Medicare, Medicaid, and certain approved commercial health insurance providers and health maintenance organizations. In addition, these payers routinely review patient billings and deny payments for certain charges that they deem medically unnecessary or performed without appropriate pre-authorization. Discounts and denials are recorded as reductions of net patient service revenue. Accounts receivable from these third-party payers have been adjusted to reflect the difference in charges and estimated reimbursable amounts. Gross patient revenue was comprised of the following for the years ended June 30:

	2016	**2015**
Medicare	**43%**	42%
Medicaid	**19%**	20%
Blue Cross Blue Shield	**18%**	17%
Other third-party payers	**17%**	18%
Self-pay patients	**3%**	3%
	100%	100%

The Company bills third party payers directly for services provided. Insurance coverage and credit information are obtained from patients upon admission when available. No collateral is obtained for patient accounts receivable. Patient accounts receivable deemed to be uncollectible by management have been written off. An allowance for doubtful accounts is recorded based on historical trends for patient accounts receivable that are anticipated to become uncollectible in future periods.

Gross patient accounts receivable were comprised of the following for the years ended June 30:

	2016	2015
Medicare	**29%**	27%
Medicaid	**25%**	27%
Blue Cross Blue Shield	**12%**	11%
Other third-party payers	**21%**	23%
Self-pay patients	**13%**	12%
	100%	100%

Patient service revenue, net of contractual allowances and discounts and after the provision for bad debts, is described in the table below for fiscal years 2016 and 2015. Amounts classified as self-pay do not include coinsurance and deductibles related to third party payers.

	2016	2015
Gross patient revenue:		
Third party payers	**$ 265,468,414**	$ 252,541,142
Self-pay	**8,210,363**	7,564,746
Total gross patient revenue	**273,678,777**	260,105,888
Deductions:		
Discounts and allowances	**(35,863,545)**	(35,645,311)
Charity care	**(12,200,782)**	(10,952,683)
Net patient service revenue	**225,614,450**	213,507,894
Less: provisions for bad debts	**(5,113,446)**	(5,816,788)
Net patient service revenue	**$ 220,501,004**	$ 207,691,106

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Company believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on the consolidated financial statements. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs.

Inventories

Inventories consist of supplies and drugs and are carried at the lower of cost or market using the average-cost method.

Land, buildings, and equipment

Land, buildings, and equipment are recorded at cost. Depreciation is recorded over the estimated useful lives of the assets using the straight-line method. Maintenance and repairs are charged to expense as incurred. The straight-line method is used to amortize the cost of equipment under capital leases over the estimated useful lives of the equipment or the term of the lease, whichever is appropriate.

Restricted net assets

Temporarily restricted net assets are those whose use by the Hospital and the Foundation has been limited by donors to a specific time period or purpose. As of June 30, 2016 and 2015, the Company had no permanently restricted net assets. Temporarily restricted net assets are available to fund various health care services and other community benefits provided by the Hospital. The Company's policy is to treat restricted contributions recorded and released in the same fiscal year as unrestricted contributions.

Excess of Revenue over Expenses

The consolidated statements of operations and other changes in unrestricted net assets include the excess of revenue over expenses (the "performance indicator"). Changes in unrestricted net assets, which are excluded from the excess of revenue over expenses, consistent with industry practice, include contributions received and used for additions of long-lived assets, distributions to non-controlling interest-holders, and changes in the pension obligation other than net periodic pension cost.

Charity care

A patient is classified as a charity recipient by reference to certain established policies of the Hospital. These policies define charity services as those services for which no payment is anticipated. In assessing a patient's ability to pay, the Hospital utilizes the generally recognized poverty income levels in the local community, but also includes certain cases where incurred charges are significant when compared to income.

Under current accounting standards, the Company is required to report the cost of providing charity care. The cost of charity care provided by the Company totaled $12,200,782 and $10,952,683 for the years ended June 30, 2016 and 2015, respectively. Rates charged by the Hospital for regulated services are determined based on assessment of direct and indirect cost calculated pursuant to the methodology established by the Maryland Health Services Cost Review Commission ("HSCRC" – see Note 10), and therefore the cost of charity services noted above for the Hospital are equivalent to its established rates for those services. For any charity services rendered by the Company other than from the Hospital, the cost of charity care is calculated by applying the estimated total cost-to-charge ratio for the non-Hospital services to the total amount of charges for services provided to patients benefitting from the charity care policies of the Company's non-Hospital affiliates. These charges are excluded from consolidated net patient service revenue.

The Hospital receives a payment from the HSCRC with respect to an Uncompensated Care Fund ("UCC") established for rate-regulated hospitals in Maryland. The UCC is intended to provide Maryland hospitals with funds to support the provision of uncompensated care at those hospitals. The Hospital received $3,978,562 for 2016 and $5,222,691 for 2015 in UCC payments. All hospitals contribute to the Health Care Coverage Fund (HCCF) that supports the expansion of Medicaid eligibility and support the Medicaid program. The Hospital contributed $2,275,444 for 2016 and $2,258,604 for 2015 to the HCCF.

Contributions and pledges

Unconditional promises to give cash and other assets to the Hospital and the Foundation are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received or when the conditions for receiving the donation have been satisfied. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. Contributions restricted by donors for additions to the Hospital's operating property are transferred from temporarily restricted net assets to unrestricted net assets when the expenditure is made. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and statements of changes in net assets as net assets released from restriction.

The Hospital and Foundation write off any grants and pledges receivable that are considered uncollectible; accordingly, there is no allowance for doubtful accounts recorded for these grants and pledges. Grants and pledges receivable have not been discounted because management considers the effect to be immaterial. The

balance of pledges receivable was $306,283 and $346,355 at June 30, 2016 and 2015, respectively, and is included in other amounts receivable in the accompanying consolidated balance sheets.

Other operating revenues

The Hospital met compliance requirements to receive incentive payments for upgrading and implementing certified electronic health record systems and becoming a meaningful user under the provisions of the American Recovery and Reinvestment Act of 2009. The Hospital recognized $74,301 and $740,178 of meaningful use incentives during the years ended June 30, 2016 and 2015, respectively, and reported these amounts as other operating revenue in the accompanying statements of operations and other changes in unrestricted net assets. The portion of the meaningful use incentive that was not yet received is $190,105 and $584,585 as of June 30, 2016 and 2015, respectively, and is recorded as other amounts receivable in the accompanying consolidated balance sheets.

Advertising Costs

The Hospital expenses advertising costs as they are incurred. Advertising expense was $1,384,178 and $975,695 for the fiscal years June 30, 2016 and 2015, respectively, and is reported as other expense in the accompanying consolidated statements of operations and other changes in unrestricted net assets.

Functional expenses

The Company's consolidated operating expenses by functional classification are as follows for the years ended June 30:

	2016	2015
Health care services	**$ 158,743,151**	$ 149,326,739
Management and general	**61,733,447**	58,071,509
Fundraising	**406,775**	428,665
	$ 220,883,373	$ 207,826,913

Fair value of financial instruments

The following methods and assumptions were used by the Company to estimate the fair value of financial instruments:

- **Cash and cash equivalents, patient accounts receivable, other amounts receivable, notes receivable, accounts payable and accrued expenses, employee compensation and related payroll taxes, and advances from third-party payers***:* The carrying amount reported in the balance sheets for each of these assets and liabilities approximates their fair value.
- **Marketable securities and assets limited as to use***:* Fair values are based on quoted market prices of individual securities or investments if available, or are estimated using quoted market prices for similar securities (see *Note 2*)
- **Long-term debt***:* Fair values of the Hospital's fixed-rate debt are based on current traded values.

Income taxes

The Hospital and the Foundation are exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code as public charities. Both entities are entitled to rely on this determination as long as there are no substantial changes in their character, purposes, or methods of operation. Management has concluded that there have been no such changes, and therefore the Hospital and Foundation's status as public charities exempt from federal income taxation remain in effect.

The state in which the Hospital and the Foundation operate also provides a general exemption from state income taxation for organizations that are exempt from federal income taxation. However, both entities are subject to federal and state income taxation at corporate tax rates on unrelated business income. Exemption from other state and local taxes, such as real and personal property taxes is separately determined. The Hospital and the Foundation had no unrecognized tax benefits or such amounts were immaterial during the periods presented. For tax periods with respect to which no unrelated business income was recognized, no tax return was required. Although informational returns were filed for the Hospital and the Foundation, no tax returns were filed during 2016 and 2015.

Health Ventures is subject to corporate income tax, and incurred an income tax liability of $0 for each year ended June 30, 2016 and 2015.

DRCC is a Maryland limited liability company that has not elected to be taxed as a corporation under current Treasury regulations. DRCC is owned by more than one member. As such, DRCC is subject to the partnership tax rules under Subchapter K of the Internal Revenue Code of 1986 (IRC), as amended. Under these rules DRCC is not subject to federal or state income tax, but must file annual information returns indicating their gross and taxable income to determine the tax results to their members.

The Sleep Center and CHP are Maryland limited liability companies that have not elected to be taxed as corporations under current treasury regulations. Sleep Center and CHP are wholly owned by the Hospital. As such, the Sleep Center and CHP are considered “disregarded entities” under current IRC regulations.

Goodwill

Goodwill represents the excess of cost over the fair value of assets acquired. Management evaluates goodwill for impairment on an annual basis. Management reviewed the carrying value reported for goodwill in the accompanying consolidated balance sheets for impairment and believes there is no significant impairment of goodwill as of June 30, 2016 and 2015 (see *Note 12*).

Subsequent Events

Subsequent events have been evaluated by management through September 29, 2016 which is the date the consolidated financial statements were available to be issued.

The Hospital is preparing to advance refund $68,690,000 of Series 2010 Bonds with a 5.75% coupon interest rate. In the current interest rate environment, it is possible for the Hospital to advance refund these Series 2010 Bonds with proceeds from a new bond issuance for a debt service savings of $7.3 million. The advance refunding is scheduled to close in December 2016, and the anticipated extinguishment of debt loss is estimated to be $14 million.

2. Investments

The following is a summary of investment securities held by the Company as of June 30:

	2016	2015
Marketable securities:		
Cash and cash equivalents		
Money market and CD funds	$ **8,443,568**	$ 8,738,762
Equity		
Stocks and mutual funds	**7,502,991**	6,889,327
	$ 15,946,559	$ 15,628,089
Assets whose use is limited:		
Cash and cash equivalents		
Money market funds	**$ 197,585**	$ 6,070,379
Fixed maturity		
U.S. government agency bonds/notes	**12,773,283**	12,598,553
	$ 12,970,868	$ 18,668,932

Assets whose use is limited are held in the following funds:

	2016	2015
Funds held by Trustee or Authority:		
Debt service reserve fund	**$ 12,970,868**	$ 18,668,932
Less assets required for current obligations	**(1,998,377)**	(7,033,280)
	$ 10,972,491	$ 11,635,652

Investment return is summarized as follows:

	2016		
	Other Operating Revenue	Non-Operating Gains (Losses)	Total
Interest and dividend income	**$ 262,450**	**$ 0**	**$ 262,450**
Net realized loss	**(32,871)**	**0**	**(32,871)**
Net unrealized loss	**0**	**(53,422)**	**(53,422)**
Investment fees	**(27,911)**	**0**	**(27,911)**
	$ 201,668	**$ (53,422)**	**$ 148,246**

	2015		
	Other Operating Revenue	Non-Operating Gains (Losses)	Total
Interest and dividend income	$ 431,512	$ 0	$ 431,512
Net realized loss	(111,275)	0	(111,275)
Net unrealized loss	0	(172,894)	(172,894)
Investment fees	(28,720)	0	(28,720)
	$ 291,517	$ (172,894)	$ 118,623

Current accounting standards define fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date, and establish a three-level hierarchy for fair value measurements based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels of inputs that may be used to measure fair value are as follows:

Level 1: Quoted prices in active markets for identical assets or liabilities.

Level 2: Observable inputs other than Level 1 prices such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3: Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities. Level 3 assets and liabilities include financial instruments whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques, as well as instruments for which the determination of fair value requires significant management judgment or estimation.

The following discussion describes the valuation methodologies used for the Company's financial assets and liabilities measured at fair value. The techniques utilized in estimating the fair values are affected by the assumptions used, including discount rates, and estimates of the amount and timing of future cash flows. Care should be exercised in deriving conclusions about the Company's business, its value, or financial position based on the fair value information of financial assets and liabilities presented below.

Fair value estimates are made at a specific point in time, based on available market information and judgments about the financial asset or liability, including estimates of the timing, amount of expected future cash flows, and the credit standing of the issuer. In some cases, the fair value estimates cannot be substantiated by comparison to independent markets. In addition, the disclosed fair value may not be realized in the immediate settlement of the financial asset or liability. Furthermore, the disclosed fair values do not reflect any premium or discount that could result from offering for sale at one time an entire holding of a particular financial asset or liability. Potential taxes and other expenses that would be incurred in an actual sale or settlement are not reflected in the amounts disclosed.

Fair values of the Company's investments in mutual funds classified at Level 1 are based on quoted market prices. Fair values for the Company's fixed maturity securities (corporate debt and federal government obligations) are based on prices provided by its investment managers and its custodian bank. Both the investment managers and the custodian bank use a variety of pricing sources to determine market valuations. Each designate specific pricing services or indexes for each sector of the market based upon the provider's experience. The Company's federal government obligations and government backed securities portfolio is highly liquid, which allows for a high percentage of the portfolio to be priced through pricing services.

The following table presents the Company's fair value hierarchy for financial instruments measured at fair value on a recurring basis as of June 30, 2016.

	Level 1	Level 2	Level 3	Total Fair Value
Cash and cash equivalents:				
Money market funds	$ 0	$ 8,641,153	$ 0	$ 8,641,153
Fixed income:				
U.S. government agency bonds/notes	0	12,773,283	0	12,773,283
Equity securities:				
Hospital information services	544,667	0	0	554,667
Mutual funds:				
Short term bond	269,260	0	0	269,260
Intermediate government	225,802	0	0	225,802
Merger arbitrage	5,105,170	0	0	5,105,170
World bond	381,701	0	0	381,701
Floating rate bonds	438,631	0	0	438,631
High-yield bond	256,467	0	0	256,467
Intermediate-term bond	280,551	0	0	280,551
Equity large bond	496,482	0	0	496,482
Long/short equity	251,484	0	0	251,484
Moderate allocation	510,146	0	0	510,146
Mid-cap growth	448,108	0	0	448,108
Real estate	228,250	0	0	228,250
Foreign large blend	992,245	0	0	992,245
Large blend	136,096	0	0	136,096
Diversified emerging markets	263,931	0	0	263,931
Large growth	138,226	0	0	138,226
Small growth	270,290	0	0	270,290
Total assets	$ 11,237,507	$ 21,414,436	$ 0	$ 32,651,943

The total investments of $32,654,019 includes deposits in transit of $2,076 plus financial instruments of $32,651,943. The above table includes financial instruments of $3,736,592 included in other assets on the consolidated balance sheets for deferred compensation and other arrangements.

The following table presents the Company's fair value hierarchy for financial instruments measured at fair value on a recurring basis as of June 30, 2015:

	Level 1	Level 2	Level 3	Total Fair Value
Cash and cash equivalents:				
Money market funds	$ 0	$ 14,210,052	$ 0	$14,210,052
Fixed income:				
U.S. government agency bonds/notes	0	12,598,553	0	23,598,553
Equity securities:				
Hospital information services	599,089	0	0	599,089
Mutual funds:				
Short term bond	298,399	0	0	298,399
Intermediate government	248,578	0	0	248,578
Merger arbitrage	4,981,376	0	0	4,981,376
World bond	355,610	0	0	355,610
Floating rate bonds	434,013	0	0	434,013
High-yield bond	247,207	0	0	247,207
Intermediate-term bond	257,027	0	0	257,027
Equity large bond	525,663	0	0	525,663
Long/short equity	250,806	0	0	250,806
Moderate allocation	540,383	0	0	540,383
Mid-cap growth	486,740	0	0	486,740
Real estate	179,066	0	0	179,066
Foreign large blend	1,147,666	0	0	1,147,666
Large blend	146,773	0	0	146,773
Diversified emerging markets	278,875	0	0	278,875
Large growth	154,254	0	0	154,254
Small growth	322,149	0	0	322,149
Total assets	$ 11,453,674	$ 26,808,605	$ 0	$ 38,262,279

The total investments of $38,264,353 includes deposits in transit of $2,076 plus financial instruments of $38,262,279. The above table includes financial instruments of $3,967,332 included in other assets on the consolidated balance sheets for deferred compensation and other arrangements.

There were no significant transfers between fair value hierarchy levels for the years ended June 30, 2016 and 2015.

3. Joint Ventures and Equity Investments

Health Ventures invests in corporations and other forms of business consistent with the mission and strategic plan of the Company. Health Ventures' unconsolidated investments are carried at cost or at equity depending on the percentage of ownership and control. Health Venture's investment in Magnolia Gardens L.L.C. is not consolidated with the financial statements of the Company because Health Ventures does not control the investee. The investment income of these joint ventures and equity investments is reported in non-operating gains/losses in the accompanying consolidated statements of operations and other changes in unrestricted net assets. These investments, which are reported as noncurrent assets in the accompanying consolidated statements, are summarized as follows as of June 30:

Name	Percent Ownership	Accounting Method	Carrying Value 2016	2015
Magnolia Gardens LLC	51%	Equity	**$ 5,721,987**	$ 5,166,072
Metropolitan Ambulatory Urological Institute, LLC	32%	Equity	**110,264**	114,275
Diagnostic Imaging, LLC	50%	Equity	**404,529**	318,726
			$ 6,236,780	$ 5,599,073

4. Related Party Transactions

The Hospital has income guarantee agreements with certain physicians. These advances are held as promissory notes and are often forgiven based on the established terms of these notes, such as maintaining an active practice in the Hospital's community.

The Hospital advanced funds to Health Ventures in its establishment of Metropolitan Medical Group, LLC (MMS). Since MMS is wholly owned by Health Ventures, the amounts loaned to MMS have been eliminated in consolidation.

A member of the board of directors maintains a business that had transactions with the Hospital that amounted to $428,945 and $468,143 for the years ended June 30, 2016 and 2015, respectively. The Medical Director of Radiology for the Hospital is an investor in Diagnostic Imaging, LLC, which is an unconsolidated subsidiary of Health Ventures.

5. Land, Buildings, and Equipment

Land, buildings, and equipment are summarized as follows:

	Useful Life	June 30 2016	2015
Land improvements	2-40 Years	**$ 4,448,553**	$ 3,817,933
Buildings	4-40 Years	**136,915,272**	135,847,156
Leasehold improvements	4-40 Years	**2,136,878**	2,684,726
Furniture and equipment	2-20 Years	**89,912,146**	81,920,471
Equipment under capital lease obligations	2-20 Years	**5,377,761**	10,399,215
		238,790,610	234,669,501
Less accumulated depreciation		**129,775,636**	121,891,291
		109,014,974	112,778,210
Construction in progress		**534,540**	360,060
Land		**6,138,471**	6,138,471
		$115,687,985	$119,276,741

Accumulated depreciation includes accumulated amortization of capital leased equipment in the amount of $3,383,379 and $5,219,931 as of June 30, 2016 and 2015, respectively. Depreciation expense related to capital leased equipment was $973,804 and $1,058,203 for fiscal year 2016 and 2015, respectively.

6. Long-Term Debt

Long-term indebtedness as of June 30, consisted of the following:

	2016	2015
Maryland Health and Higher Education Facilities Authority Revenue Bonds, Series 2007A:		
5.00% term bonds due July 1, 2020	$ **0**	$ 19,200,000
5.00% term bonds due July 1, 2027	**0**	30,795,000
5.00% term bonds due July 1, 2029	**0**	10,915,000
Maryland Health and Higher Education Facilities Authority Revenue Bonds, Series 2016 Note 2.180% term bonds due October 1, 2024	**41,500,000**	0
Maryland Health and Higher Education Facilities Authority Revenue Bonds, Series 2016 Bond 2016A – Tax Exempt Private Placement 2007 Refunding 2.567% term bonds due July 1, 2030.	**16,795,000**	0
Series 2016A – Tax Exempt Private Placement 2010 Partial Refunding 2.567% term bonds due July 1, 2030	**15,150,000**	0
Maryland Health and Higher Education Facilities Authority Revenue Bonds, Series 2010:		
5.30% term bonds due July 1, 2025	**0**	4,720,000
5.625% term bonds due July 1, 2030	**445,000**	9,095,000
5.75% term bonds due July 1, 2038	**68,245,000**	68,245,000
Capital Orthopedics promissory note	**0**	53,912
Capital leases	**167,820**	1,198,605
	142,302,820	144,222,517
Current portion of long-term debt	**(4,134,850)**	(4,234,699)
Deferred financing costs, net of accumulated amortization	**(1,856,333)**	(1,858,085)
Original issue premium, net of accumulated amortization	**0**	1,317,602
Original issue discount, net of accumulated amortization	**(1,379,366)**	(1,686,607)
	$ 134,932,271	$ 137,760,728

The fair value of the Company's long-term debt, based on quoted market prices, was $76,883,851 for the Series 2010 Bonds at June 30, 2016. The fair value of the Company's long-term debt, based on quoted market prices was $136,021,517 for the Series 2007A Bonds and Series 2010 Bonds at June 30, 2015.

Financing costs incurred in issuing the Maryland Health and Higher Educational Facilities Authority (the Authority or MHHEFA) Revenue Bonds have been capitalized by the Hospital. These costs are being amortized over the life of the related bond issue using the bonds-outstanding method, which approximates the interest method. Deferred financing costs are presented as a direct deduction of long-term debt and are amortized using the straight-line method over the term of the related financing.

Deferred financing costs and accumulated amortization, which are included in long-term debt in the accompanying consolidated balance sheets, are as follows:

	2016	2015
Deferred financing costs	**$ 2,184,564**	$ 3,008,043
Accumulated amortization	**(328,231)**	(1,149,958)
	$ 1,856,333	$ 1,858,085

The aggregate maturities of long-term debt, including sinking fund principal requirements during the next five fiscal years, are as follows:

2017	$ 4,134,850
2018	4,662,970
2019	4,690,000
2020	4,405,000
2021	4,945,000
2022 and after	119,465,000
	$ 142,302,820

Total interest paid for the years ended June 30, 2016 and 2015 was $9,329,764 and $7,828,518, respectively.

Revenue bonds

On June 28, 2016 MHHEFA issued $73,445,000 principal amount of Revenue Bond, Series 2016A and Series 2016B. The proceeds of this issue were used to retire the Series 2007A Bonds and Series 2010 Bonds (partial) in order to take advantage of lower interest rates with an estimated net present value savings of $7.3 million.

On May 15, 2010, MHHEFA issued $82,670,000 principal amount of Revenue Bonds, Series 2010 (Series 2010 Bonds). The proceeds of this issue were used to retire the Revenue Bonds, Series 2008 and to finance the costs of renovation and equipment purchases. In June 28, 2016, the Hospital partially refunded this bond with a remaining balance of $68,690,000.

On January 4, 2007, MHHEFA issued $77,685,000 principal amount of Revenue Bonds, Series 2007A (Series 2007 Bonds). The proceeds of this issue were used to retire certain existing bonds, pooled loans, and to finance the costs of renovation and equipment purchases. In June 28, 2016, the Hospital refunded this bond.

The Obligated Group for Maryland Health and Higher Educational Facilities Authority (the Authority or MHHEFA) bond issuances includes the Hospital, Foundation, Sleep Center, CHP, and Health Ventures excluding the MAUI, Magnolia Gardens, DI LLC, ACO, and STM. The Series 2010 Bonds and the Series 2016 Bonds are secured by the revenue and accounts receivables of the Obligated Group, and certain other property secured by a Deed of Trust. The Obligated Group is required to maintain certain compliance ratios and covenants as defined under the bond documents. In the opinion of the management, the Hospital has complied with the required covenants for 2016 and 2015.

Other debt

During 2008, DRCC obtained a $4,000,000 revolving line of credit from a commercial lender to finance the acquisition of certain medical equipment. The line of credit was converted to a capital lease during 2009. The outstanding principal balance was $167,820 and $981,508 on June 30, 2016 and 2015, respectively. Beginning in October 2009, monthly payments of principal and interest at 6.8% per annum become due. Aggregate future principal payments as of June 30, 2016 are as follows:

2017	$ 104,850
2018	62,970
	$ 167,820

In July 2012, DRCC refinanced the capital lease. The refinanced balance was $2,711,191 at an interest rate of 3.6%. Other debt includes the Hospital's obligations under various other capital leases (see *Note 8*).

In September 2013, the Hospital acquired an orthopedic practice. The payment for the practice included a down payment and 23 monthly payments. The amount paid during the year ended June 30, 2016 was $53,912 which fully paid this obligation.

7. Medical Malpractice and Workers' Compensation Insurance

From October 18, 2001 to October 31, 2004, the Hospital maintained occurrence-based professional liability insurance with a per-claim limit of $8,000,000 and aggregate annual limit of $10,000,000 with a commercial carrier. The Hospital was liable for a deductible up to $250,000 for each occurrence up to a maximum of $750,000. Prior to October 18, 2001, the Hospital's policy had no deductible. Effective November 1, 2004, due to the commercial carrier discontinuing services in Maryland and rising insurance costs, the Hospital purchased coverage on a claims-made basis from Freestate Healthcare Insurance Company, Ltd., a group captive formed by several Maryland hospitals. The Hospital owns 20% interest in the captive that is accounted for using the cost method. The cost of $15,000 is recorded in other noncurrent assets in the accompanying consolidated balance sheets as of June 30, 2016 and 2015. Premiums are expensed as incurred and are established based on the Hospital's historical experience supplemented as necessary with industry experience. The total premium is allocated to each of the shareholders based on their experience. Retrospective premium assessments and credits are calculated based on the aggregate experience of all named insureds under the policy. Each named insured's assessment of credit is based on the percentage of their actual exposure to the actual exposure of all named insureds. In management's opinion, the assets of Freestate are sufficient to meet its obligations as of June 30, 2016. If the financial condition of Freestate were to materially deteriorate in the future, and Freestate was unable to pay its claim obligations, the responsibility to pay those claims would return to the member hospitals.

The captive is responsible for claims up to $1,000,000 for each and every loss event. Additional coverage has been purchased for all claims in excess of $1,000,000 to a limit of $6,000,000 effective March 1, 2006, and $10,000,000 effective March 1, 2012. The estimated unpaid loss liability reserved by the captive for the Hospital was $7,522,419 and $9,942,588 at June 30, 2016 and 2015, respectively. These amounts are included in long term liabilities and the related anticipated insurance recoveries were reported in noncurrent assets in the accompanying consolidated balance sheets. The liability for all claims incurred but not reported for the Hospital was $1,174,000 and $1,017,475 at June 30, 2016 and 2015, respectively. The discount rate for unpaid losses is 3.5% for years ending June 30, 2016 and 2015. The Hospital engages a consulting actuary to assist in the determination of all professional liability claims incurred but not reported.

The Hospital is self-insured against workers' compensation claims up to a per-claim limit of $500,000 with an annual limitation of approximately $1,000,000. A liability has been recorded for all known claims and an estimate for claims incurred but not reported in the amount of $753,924 and $647,283 at June 30, 2016 and 2015, respectively. These amounts are included in accounts payable and accrued expenses in the accompanying consolidated balance sheets.

8. Leases

The Company has operating leases covering various medical and other equipment and facilities. Generally, the leases carry renewal provisions and require the Hospital to pay maintenance costs.

The Hospital, COS, and DRCC have entered into capital leases for certain equipment. The cost of assets under capital leases is included in land, building, and equipment (see *Note 5*), and related capital lease obligations are included in long-term debt (see *Note 6*) in the accompanying consolidated balance sheets. Depreciation expense on these assets is included with depreciation expense in the consolidated statements of operations and other changes in unrestricted net assets.

Future minimum lease payments as of June 30, 2016 are as follows:

	Capital Leases	Leases Operating
2017	$ 104,850	$ 1,446,584
2018	62,970	1,239,495
2019	0	1,138,971
2020	0	1,152,701
2021	0	1,181,519
Total minimum lease payments	167,820	$ 6,159,270.
Current portion of capital leases	(104,850)	
Capital lease obligations, less current portion	$ 62,970	

Total rental expense reported in the accompanying consolidated statements of operations and other changes in unrestricted net assets for the years ended June 30, 2016 and 2015 was $3,310,658 and $4,095,228, respectively.

9. Retirement Plans

The Hospital has a 403b defined contribution plan (the "contribution plan") covering substantially all its employees. The contribution plan is employee and employer contributory. The Hospital contributed a match of $0.50 for every $1.00 of elective deferrals for a plan year for eligible employees up to 4% of base compensation. Defined contribution plan expense amounted to approximately $885,779 and $1,003,633 for 2016 and 2015, respectively.

The Hospital froze the defined benefit pension plan that it sponsors (the Plan) in 2011, which covered substantially all employees. The Plan curtailment was recognized in 2011. The decision to terminate the Plan has not been made by the board of directors. The benefits are based on years of service and employee compensation during years of employment. The Hospital's funding policy is to make sufficient contributions to the Plan to comply with the minimum funding provisions of the Employee Retirement Income Security Act of 1974 (ERISA). The

Hospital expects to contribute $639,415 to the Plan during 2017 to keep the funding levels at the ERISA requirements. The measurement date of the Plan is June 30.

The following table provides a reconciliation of the benefit obligation, Plan assets, and funded status of the Plan in the Company's consolidated financial statements based on actuarial valuations for the years ended June 30,:

	2016	2015
Accumulated Benefit Obligation	**$ 24,607,554**	$ 22,289,348
Change in Benefit Obligation		
Benefit Obligation at beginning of year	**$ 22,289,348**	$ 22,243,504
Interest cost	**836,850**	817,815
Actuarial loss/(gain)	**2,050,707**	(162,145)
Benefits paid	**(569,351)**	(609,826)
Benefit Obligation at End Of Year	$ **24,607,554**	$ 22,289,348
Change in Plan Assets		
Fair value of Plan assets at beginning of year	**$ 16,893,839**	$ 16,678,842
Actual return of Plan assets	**9,740**	103,482
Employer contributions	**588,246**	721,341
Benefits paid	**(569,351)**	(609,826)
Fair Value of Plan Assets at End of Year	**16,922,474**	16,893,839
Funded Status (Pension Obligation)	**$ (7,685,080)**	$ (5,395,509)
Components of Net Periodic Benefit Costs		
Interest cost	$ **836,850**	$ 817,815
Expected return on plan assets	**(1,050,025)**	(1,060,335)
Recognition of loss from change in measurement date	**454,934**	404,964
4Net Period Pension Cost	**$ 241,759**	$ 162,444

The total amount recognized in unrestricted net assets in the accompanying consolidated financial statements for 2016 and 2015 is as follows:

	2016	2015
Net loss	**$ 11,284,112**	$ 8,648,054

The Plan's assets are invested primarily in cash and cash equivalents and mutual funds as follows as of June 30:

	2016	2015
Equity funds	**35%**	35%
Bond funds	**65%**	65%
	100%	100%

Plan assets are invested to ensure that the Plan has the ability to pay all benefit and expense obligations when due, to maximize return within prudent levels of risk for pension assets, and to maintain a funding cushion for unexpected developments. The target weighted-average asset allocation of pension investments was 35% equities and 65% fixed maturity securities and cash as of June 30, 2016.

The Plan's estimated future benefit payments are as follows:

2017	$ 2,803,529
2018	1,259,497
2019	1,159,360
2020	1,277,953
2021	1,447,854
2022 – 2026	7,448,878
	$ 15,397,071

The weighted-average assumptions used to determine net periodic benefit cost and the projected benefit obligation for the years ended June 30 were as follows:

	2016	2015
Discount rate	**3.05%**	3.95%
Expected return on Plan assets	**6.50%**	6.50%

The following table presents the Company's fair value hierarchy for financial instruments measured at fair value on a recurring basis as of June 30, 2016:

	Level 1	Level 2	Level 3	Fair Value
Mutual Funds				
Diversified emerging mkts	**$ 430,111**	**$ 0**	**$ 0**	**$ 430,111**
Foreign large blend	**338,774**	**0**	**0**	**338,774**
Foreign small/mid growth	**84,381**	**0**	**0**	**84,381**
High yield bond	**1,750,749**	**0**	**0**	**1,750,749**
Inflation0protected bond	**1,690,450**	**0**	**0**	**1,690,646**
Intermediate government	**1,683,646**	**0**	**0**	**1,683,646**
Intermediate0term bond	**3,245,804**	**0**	**0**	**3,245,804**
Large growth	**1,334,578**	**0**	**0**	**1,334,578**
Large value	**1,221,831**	**0**	**0**	**1,221,831**
Mid0cap growth	**834,035**	**0**	**0**	**834,035**
Mid0cap value	**868,186**	**0**	**0**	**868,186**
Multisector bond	**2,567,892**	**0**	**0**	**2,567,892**
Small growth	**342,657**	**0**	**0**	**342,657**
Small value	**529,380**	**0**	**0**	**529,380**
Total assets	**$ 16,922,474**	**$ 0**	**$ 0**	**$ 16,922,474**

The following table presents the Company's fair value hierarchy for financial instruments measured at fair value on a recurring basis as of June 30, 2015:

	Level 1	Level 2	Level 3	Fair Value
Mutual Funds				
Diversified emerging mkts	$ 413,205	$ 0	$ 0	$ 413,205
Foreign large blend	338,540	0	0	338,540
Foreign small/mid growth	84,262	0	0	84,262
High yield bond	1,717,487	0	0	1,717,487
Inflation0protected bond	1,679,468	0	0	1,679,468
Intermediate government	1,697,867	0	0	1,697,867
Intermediate0term bond	3,291,058	0	0	3,291,058
Large growth	1,362,594	0	0	1,362,594
Large value	1,199,821	0	0	1,199,821
Mid0cap growth	841,159	0	0	841,159
Mid0cap value	841,330	0	0	814,330
Multisector bond	2,561,421	0	0	2,561,421
Small growth	349,438	0	0	349,438
Small value	516,189	0	0	516,189
Total assets	$ 16,893,839	$ 0	$ 0	$ 16,893,839

There were no significant transfers between fair value hierarchy levels for the years ended June 30, 2016 and 2015.

The Hospital has a deferred compensation plan that permits certain executives to defer receiving a portion of their compensation. The deferred amounts are included in other assets in the accompanying consolidated balance sheets. The associated liability of an equal amount is included in other liabilities in the accompanying consolidated balance sheets. The liability recorded regarding the deferred compensation was $3,428,923 and $3,566,366 as of June 30, 2016 and 2015, respectively. During 2016 and 2015, distributions of $24,760 and $112,723 were made to participants in the deferred compensation plan, respectively.

The Hospital is the beneficiary of split dollar life insurance policies in place for certain executives. Approximately $9,200,000 is included in other assets at June 30, 2016 and 2015, which is the amount that could be realized by the Hospital under the insurance contracts.

10. Maryland Health Services Cost Review Commission

Certain of the Hospital's charges are subject to review and approval by the Maryland Health Services Cost Review Commission (the Commission). Hospital management has filed the required forms with the Commission and believes the Hospital is in compliance with Commission requirements.

The current rate of reimbursement for principally all hospital inpatient and outpatient services to patients under the Medicare and Medicaid programs is based on an agreement between the Centers for Medicare and Medicaid Services and the Commission. This agreement is based upon a waiver from Medicare reimbursement principles under Section 1814(b) of the Social Security Act and will continue as long as all third-party payers elect to be reimbursed under this program, the rate of increase for costs per hospital services is below the national average, and other specific quality indicators are met. In January 2014, the State of Maryland and CMS agreed to implement a new waiver focused on population health, and the previous waiver was terminated.

Under the Commission's new reimbursement methodology, the Hospital entered into a global budget arrangement effective July 1, 2013, and a gross revenue target was established for the Hospital based on fiscal year 2013 charges adjusted for inflation and other statewide allocation adjustments. The actual revenue charged was compared to the revenue target, and to the extent that the actual charges exceeded or were less than the target, the overcharge or undercharge, plus applicable penalties reduced (in the case of overcharges) or increased (in the case of undercharges) the approved target for future rate years.

Management believes that a waiver program will remain in effect at least through June 2017. The Hospital overcharged its revenue target in June 30, 2016 and 2015 by $1,451,807 and $311,529, respectively. Overcharges and undercharges are recouped in succeeding years through the Commission's rate setting methodology.

The timing of the Commission's rate adjustments for the Hospital could result in an increase or reduction in rates due to the variances and penalties in a year subsequent to the year in which such items occur. The Hospital's policy is to accrue revenue based on actual charges for services to patients in the year in which the services to patients are performed and billed.

11. Contingencies

Litigation

There are several lawsuits pending in which the Hospital has been named as defendant. In the opinion of Hospital management, after consultation with legal counsel, the potential liability, in the event of adverse settlement, will not have a material impact on the Hospital's consolidated financial position.

Risk factors

The Company's ability to maintain and/or increase future revenues could be adversely affected by:

- 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);

- 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;

- 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;

- 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 Company's ability to expand new services; and

- The ultimate impact of the federal Patient Protection and Affordable Care Act and the Health Care Education Affordability Reconciliation Act of 2010.

The Joint Commission, a non-governmental privately owned entity, provides accreditation status to hospitals and other health care organizations in the United States. Such accreditation is based upon a number of requirements such as undergoing periodic surveys conducted by Joint Commission personnel. Certain managed care payers require hospitals to have appropriate Joint Commission accreditation in order to participate in those programs. In addition, the Center for Medicare and Medicaid Services (CMS), the agency with oversight of the Medicare and

Medicaid programs, provides "deemed status" for facilities having Joint Commission accreditation. By being Joint Commission accredited, facilities are "deemed" to be in compliance with the Medicare and Medicaid conditions of participation. Termination as a Medicare provider or exclusion from any or all of these programs/payers would have a materially negative impact on the future financial position, operating results and cash flows of the Hospital. In February 2016 the Hospital was surveyed by Joint Commission and received a full three-year Joint Commission accreditation through February 2019.

The Company invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in values of investment securities will occur in the near term, and such changes could materially affect the amounts reported as investments on the consolidated balance sheets.

12. Goodwill

The Company uses the acquisition method of accounting to record goodwill when purchasing physician practices and other similar entities. The table below presents goodwill that has been recorded as of June 30 for the following acquisitions:

	2016	2015
Cancer center, DRCC	**$ 1,062,531**	$ 1,062,531
Orthopedic practice	**376,316**	376,316
Nursing home	**766,285**	766,285
Cancer center, MRCC	**646,975**	646,975
Physician practices	**194,865**	77,340
STM practice	**0**	18,943
	$ 3,046,972	$ 2,948,390

13. Temporarily Restricted Net Assets

Temporarily restricted net assets are available as of June 30 for the following programs and projects:

	2016	2015
Nancy Heilman Scholarship Fund	**$ 1,479**	$ 1,479
Brian Efran Memorial Fund	**5,850**	5,850
Jane Schafer Scholarship Fund	**10,785**	10,785
Rehabilitation Services	**12,937**	12,937
Cardiac Rehab Services	**4,968**	8,544
Borden Breast Center	**20,000**	20,000
Women's Health	**57,494**	19,693
Surgical Services	**378,513**	369,213
Diabetes Center	**36,906**	50,575
Lymphedema Center	**7,826**	7,826
Smoking Grant	**24,230**	12,230
Community Outreach	**0**	244,693
Komen Grant	**21,868**	379,202
MHA HPP Disaster Grant	**13,708**	11,777
Health fair screening	**2,891**	1,416
So. Md. Transitional Care Partnership	**0**	170,000
DHMH Biosense Grant	**4,575**	4,575
Population Health Mobile Clinic	**331,269**	76,038
	$ 935,299	$ 1,406,833

14. Change in Method of Accounting for Debt Issuance Costs

In April 2015, the Financial Accounting Standards Board issued Accounting Standards Update No. 2015-03 *Interest-Imputation of Interest (Subtopic 835-30); Simplifying the Presentation of Debt Issuance Costs* ("ASU 2015-03"). The amendments in this update require that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts. The recognition and measurement for debt issuance costs were not affected by the amendments in ASU 2015-03.

Prior to the issuance of ASU 2015-03, the Hospital reported debt issuance costs as a deferred asset in the consolidated balance sheets. As a result of the retrospective application of the adoption of ASU 2015-03, the debt issuance costs as of June 30, 2015 have been reclassified and presented as a direct deduction to Long-Term Obligations, Net of Current Portion in the accompanying consolidated balance sheets consistent with the presentation as of June 30, 2016.

Supplementary Information

Doctors Community Hospital and Subsidiaries
Consolidating Balance Sheet
June 30, 2016

	Hospital, CHP	Foundation	Health Ventures	Sleep Center	Eliminations	Total Obligated Group	DRCC	Magnolia Gardens MAUI, DI	STM ACO	Eliminations	Total
ASSETS											
CURRENT ASSETS											
Cash and cash equivalents	$ 37,400,191	$ 304,171	$ 457,891	$ 1,119	$ 0	$ 38,163,372	$ 1,045,658	$ 0	$ 93,808	$ 0	$ 39,302,838
Assets limited to use for debt service	1,998,377	0	0	0	0	1,998,377	0	0	0	0	1,998,377
Patient accounts receivable, net of allowance	40,420,728	0	526,755	0	0	40,947,483	775,646	0	72,368	0	41,795,497
allowance for bad debts	(9,871,656)	0	0	0	0	(9,871,656)	0	0	0	0	(9,871,656)
allowance for contractuals	(9,566,498)	0	0	0	0	(9,566,498)	0	0	0	0	(9,566,498)
Other amounts receivable	2,479,796	452,898	218,492	0	0	3,151,186	83,292	0	81,358	0	3,315,836
Inventories	4,095,155	0	0	0	0	4,095,155	0	0	0	0	4,095,155
Prepaid expenses	2,900,573	12,663	(1,465)	0	0	2,911,771	80,774	0	11,394	0	3,003,939
TOTAL CURRENT ASSETS	69,856,666	769,732	1,201,673	1,119	0	71,829,190	1,985,370	0	258,928	0	74,073,488
INVESTMENTS											
Marketable securities	15,946,559	0	0	0	0	15,946,559	0	0	0	0	15,946,559
Investment in Doctors Regional Cancer Center	2,805,459	0	0	0	(2,805,459)	0	0	0	0	0	0
Investment in Sleep Services of America, Inc.	0	0	0	0	0	0	0	0	0	0	0
Joint ventures and equity investments	0	0	0	0	0	0	0	6,236,780	0	0	6,236,780
Due to DCH	44,344,120	0	0	2,456,741	(38,914,268)	7,886,593	0	0	0	(7,886,593)	0
	63,096,138	0	0	2,456,741	(41,719,727)	23,833,152	0	6,236,780	0	(7,886,593)	22,183,339
ASSETS WHOSE USE IS LIMITED											
Funds held by Trustee or Authority, less current portion	10,972,491	0	0	0	0	10,972,491	0	0	0	0	10,972,491
Land and land improvements	10,587,024	0	0	0	0	10,587,024	0	0	0	0	10,587,024
Building and fixed equipment	129,893,423	0	0	0	0	129,893,423	0	0	0	0	129,893,423
Medical office building	8,062,095	0	0	0	0	8,062,095	0	0	0	0	8,062,095
Major movable equipment	85,568,214	0	800,370	0	0	86,368,584	9,585,451	0	431,075	0	96,385,110
Construction in progress	531,352	0	0	0	0	531,352	0	0	0	0	531,352
Accumulated depreciation	(122,379,398)	0	(634,034)	0	0	(123,013,432)	(6,548,261)	0	(209,326)	0	(129,771,019)
Land, building, and equipment	112,262,710	0	166,336	0	0	112,429,046	3,037,190	0	221,749	0	115,687,985
GOODWILL	1,633,712	0	766,285	0	0	2,399,997	646,975	0	0	0	3,046,972
OTHER ASSETS	24,063,951	0	0	0	(2,485,069)	21,578,882	0	0	0	0	21,578,882
TOTAL ASSETS	$ 281,885,668	$ 769,732	$ 2,134,294	$ 2,457,860	$ (44,204,796)	$ 243,042,758	$ 5,669,535	$ 6,236,780	$ 480,677	$ (7,886,593)	$ 247,543,157

See independent auditors' report.

Doctors Community Hospital and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets
June 30, 2016

	Hospital, CHP	Foundation	Health Ventures	Sleep Center	Eliminations	Total Obligated Group	DRCC	Magnolia Gardens MAUI, DI	STM ACO	Eliminations	Total
LIABILITIES AND NET ASSETS											
CURRENT LIABILITIES											
Accounts payable and accrued expenses	$ 14,272,892	$ 143,877	$ 1,126,727	$ 72,792	$ 0	$ 15,616,288	$ 768,850	$ 0	$ 201,203	$ 0	$ 16,586,341
Due to DCH	16,184,808	(269,294)	724,415	0	(16,639,929)	(0)	57,101	0	7,829,492	(7,886,593)	(0)
Salaries, wages, and related items	13,117,281	0	229,100	0	0	13,346,381	0	0	0	0	13,346,381
Advances from third party payers	8,716,556	0	0	0	0	8,716,556	0	0	0	0	8,716,556
Interest payable to bondholders	1,973,835	0	0	0	0	1,973,835	0	0	0	0	1,973,835
Current portion of long-term obligation	4,030,000	0	0	0	0	4,030,000	104,850	0	0	0	4,134,850
TOTAL CURRENT LIABILITIES	58,295,372	(125,417)	2,080,242	72,792	(16,639,929)	43,683,060	930,801	0	8,030,695	(7,886,593)	44,757,963
NONCURRENT LIABILITIES											
Deferred compensation and IBNRs	12,125,342	0	0	0	0	12,125,342	0	0	0		12,125,342
Pension obligation	7,685,080	0	0	0	0	7,685,080	0	0	0		7,685,080
Long-term obligations, net of current portion	134,869,301	0	22,274,339	0	(22,274,339)	134,869,301	62,970	0	0	0	134,932,271
TOTAL LIABILITIES	212,975,095	(125,417)	24,354,581	72,792	(38,914,268)	198,362,783	993,771	0	8,030,695	(7,886,593)	199,500,656
NET ASSETS AND MEMBERS' EQUITY											
Unrestricted	68,870,423	0	0	2,385,068	(29,381,121)	41,874,370	0	0	(1,631,142)	4,993,668	45,236,896
Members' equity	0	0	(22,220,287)	0	22,220,287	0	4,675,764	6,236,780	(5,918,876)	(4,993,668)	0
Temporarily restricted	40,150	895,149	0	0	0	935,299	0	0	0	0	935,299
Non Controlling Interest	0	0	0	0	1,870,306	1,870,306	0	0	0	0	1,870,306
TOTAL NET ASSETS	68,910,573	895,149	(22,220,287)	2,385,068	(5,290,528)	44,679,975	4,675,764	6,236,780	(7,550,018)	0	48,042,501
TOTAL NET ASSETS AND LIABILITIES	$ 281,885,668	$ 769,732	$ 2,134,294	$ 2,457,860	$ (44,204,796)	$ 243,042,758	$ 5,669,535	$ 6,236,780	$ 480,677	$ (7,886,593)	$ 247,543,157

See independent auditors' report.

Doctors Community Hospital and Subsidiaries
Consolidating Statement of Operations
For the Year Ended June 30, 2016

	Hospital, CHP	Foundation	Health Ventures	Sleep Center	Eliminations	Total Obligated Group	DRCC	Magnolia Gardens MAUI, DI	STM ACO	Total
UNRESTRICTED NET ASSETS										
OPERATING REVENUE										
Inpatient revenue	$ 137,455,815	$ 0	$ 0	$ 0	$ 0	$ 137,455,815	$ 0	$ 0	$ 0	$ 137,455,815
Outpatient revenue	114,178,232	0	10,768,252	3,446,224	0	128,392,708	7,658,722	0	171,532	136,222,962
Contractuals	(43,966,528)	0	(4,097,799)	0	0	(48,064,327)	0	0	0	(48,064,327)
Net patient service revenue, net of contractual allowances and discounts	207,667,519	0	6,670,453	3,446,224	0	217,784,196	7,658,722	0	171,532	225,614,450
Less provision for bad debts	(5,017,271)	0	0	0	0	(5,017,271)	(96,175)	0	0	(5,113,446)
Net patient service revenue less provision for bad debt	202,650,248	-	6,670,453	3,446,224	-	212,766,925	7,562,547	-	171,532	220,501,004
Other operating revenue	6,458,898	15,610	69,681	(418)	(2,385,069)	4,158,702	14,298	0	41,577	4,214,577
Contributions	0	298,129	0	0	0	298,129	0	0	0	298,129
Net assets released from restrictions used for operations	1,189,083	0	0	0	0	1,189,083	0	0	0	1,189,083
TOTAL OPERATING REVENUE	210,298,229	313,739	6,740,134	3,445,806	(2,385,069)	218,412,839	7,576,845	0	213,109	226,202,793
EXPENSES										
Salaries and wages	89,946,134	266,453	8,700,503	32,100	0	98,945,190	0	0	204,458	99,149,648
Employee benefits	15,355,730	82,149	635,417	6,509	0	16,079,805	0	0	39,530	16,119,335
Purchased services	24,736,846	27,569	642,202	1,235,803	0	26,642,420	5,324,394	0	397,515	32,364,329
Supplies	35,764,009	16,566	337,445	24,219	0	36,142,239	81,900	0	1,063	36,225,202
Other expenses	16,729,497	9,336	1,262,461	14,559	0	18,015,853	864,413	0	1,043,251	19,923,517
Depreciation	8,772,704	0	74,628	1,550	0	8,848,882	601,136	0	19,579	9,469,597
Amortization	144,974	0	0	0	0	144,974	0	0	0	144,974
Fundraising	0	4,702	0	0	0	4,702	0	0	0	4,702
Interest	7,459,872	0	0	0	0	7,459,872	22,197	0	0	7,482,069
TOTAL EXPENSES	198,909,766	406,775	11,652,656	1,314,740	0	212,283,937	6,894,040	0	1,705,396	220,883,373
INCOME (LOSS) FROM OPERATIONS	11,388,463	(93,036)	(4,912,522)	2,131,066	(2,385,069)	6,128,902	682,805	0	(1,492,287)	5,319,420
NONOPERATING INCOME										
Loss on sale of property	1,365	0	0	0	0	1,365	0	0	(18,943)	(17,578)
Extinquishment of debt	(4,558,885)	0	0	0	0	(4,558,885)	0	0	0	(4,558,885)
Unrealized loss on trading securities	(53,422)	0	0	0	0	(53,422)	0	0	0	(53,422)
Equity (loss) in joint ventures	405,604	0	69,681	0	(405,604)	69,681	0	638,587	0	708,268
EXCESS OF REVENUE OVER EXPENSES (EXPENSES OVER REVENUE)	7,183,125	(93,036)	(4,842,841)	2,131,066	(2,790,673)	1,587,641	682,805	638,587	(1,511,230)	1,397,803
Net asset transfer	(93,035)	93,035	0	0	0	0	0	0	0	0
Dividends paid	0	0	0	(53,892)	212,332	158,440	(300,000)	0	0	(141,560)
Contributions	67,529	772,148	0	0	0	839,677	0	0	0	839,677
Net assets released from restrictions for use in operations	(592,933)	(596,150)	0	0	0	(1,189,083)	0	0	0	(1,189,083)
Net assets released from restrictions for capital acquisitions	0	(122,125)	0	0	0	(122,125)	0	0	0	(122,125)
Net assets released from restrictions for capital acquisitions	122,125	0	0	0	0	122,125	0	0	0	122,125
Pension - related changes other than net periodic pension cost	(2,636,058)	0	0	0	0	(2,636,058)	0	0	0	(2,636,058)
Increase (decrease) in net assets	4,050,753	53,872	(4,842,841)	2,077,174	(2,578,341)	(1,239,383)	382,805	638,587	(1,511,230)	(1,729,221)
Net assets, beginning of year	64,859,820	841,277	(17,307,765)	307,894	(2,712,187)	45,989,039	4,292,959	5,528,512	(6,038,788)	49,771,722
Net assets, end of year	$ 68,910,573	$ 895,149	$ (22,150,606)	$ 2,385,068	$ (5,290,528)	$ 44,749,656	$ 4,675,764	$ 6,167,099	$ (7,550,018)	$ 48,042,501

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