Application for Certificate of Need

MedStar Franklin Square Medical Center
Surgical Services Replacement Facility

August 5, 2016

TABLE OF CONTENTS
APPLICATION SECTIONS

TABLE OF CONTENTS
APPLICATION SECTIONS (con't)

TABLE OF CONTENTS
ATTACHMENTS

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: Franklin Square Hospital Center
d/b/a MedStar Franklin Square Medical Center

Address:	9000 Franklin Square Drive	Rosedale	21237	Baltimore
	Street	**City**	**Zip**	**County**

Name of Owner (if differs from applicant): MedStar Health, Inc.

2. OWNER

Name of owner: MedStar Health, Inc.

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

There are no co-applicants

Legal Name of Project Applicant

Franklin Square Hospital Center d/b/a MedStar Franklin Square Medical Center

Address:

9000 Franklin Square Drive	Rosedale	21237	Maryland	Baltimore
Street	**City**	**Zip**	**State**	**County**

Telephone: 443-777-7000

Name of Owner/Chief Executive: Samuel E. Moskowitz, FACHE

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from applicant:

Not Applicable

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).

See Attachment 1, MedStar Franklin Square Medical Center Organization Chart.

A.	Governmental	☐
B.	Corporation	☐
	(1) For-Profit	☐
	(2) Non-Profit	☒
	(3) Close	☐
C.	Partnership General Limited	☐
	Limited liability limited partnership	☐
	Other (Specify):	☐
D.	Limited Liability Company	☐
E.	Other (Specify):	☐
	To be formed:	☐
	Existing:	☒

State & date of incorporation: State of Maryland, 1898; amended State of Maryland, 1901

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

A Lead or primary contact:

Name and Title: Eric Slechter, Director, Planning, MedStar Health

Address:	9000 Franklin Square Drive	Rosedale	21237	Maryland
	Street	**City**	**Zip**	**State**

Telephone: 443-777-7525

E-mail Address: (Required) eric.slechter@medstar.net

Fax: 443-777-7904

B. Additional or alternate contacts:

Name and Title: Jennifer Wilkerson, Vice President, Planning, MedStar Health

Address:	5565 Sterrett Place	Columbia	21044	Marvland
	Street	**City**	**Zip**	**State**

Telephone: 410-772-6973

E-mail Address: (Required) jennifer.wilkerson@medstar.net

Fax: NA

Name and Title: Patricia Cameron, Senior Policy Analyst, MedStar Health

Address:	5565 Sterrett Place	Columbia	21044	Marvland
	Street	**City**	**Zip**	**State**

Telephone: 410-772-6689

E-mail Address: (Required) patricia.cameron@medstar.net

Fax: NA

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 ☐
(4) A change in the type or scope of any health care service offered by a health care facility ☐
(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.

RESPONSE:

See Attachment 2.

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.

RESPONSE:

See Attachment 3.

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

RESPONSE:

See Attachment 4.

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.

RESPONSE:

Table A is Not Applicable for this project.

The project does not impact any nursing units.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: **3.112** acres

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

RESPONSE:

MFSMC knows of no land use approvals for the site that have not been obtained.

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

RESPONSE:

(1) **Owned by:** HH MedStar Health, Inc.
Please provide a copy of the deed.

See Attachment 5.

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

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

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

(5) Other: NA
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 8 (Project Description).

	Proposed Project Timeline	
Single Phase Project		
Obligation of 51% of capital expenditure from CON approval date	18	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	25	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	NA	months
Initiation of Construction within 4 months of the effective date of the binding construction contract.	NA	months
Completion of 1st Phase of Construction within 24 months of the effective date of the binding construction contract	NA	months
Fill out the following section for each phase**.** (Add rows as needed)		
Completion of each subsequent phase within 24 months of completion of each previous phase	NA	months
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	NA	months
Initiation of Construction on Phase 1 within 4 months of the effective date of the binding construction contract for Phase 1	NA	months
Completion of Phase 1 within 24 months of the effective date of the binding construction contract.	NA	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	NA	months
Initiation of Construction on each phase within 4 months of the effective date of binding construction contract for that phase	NA	months
Completion of each phase within 24 months of the effective date of binding construction contract for that phase	NA	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.

RESPONSE:

See Attachment 6 and attached drawings separately enclosed.

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.

RESPONSE:

See Attachment 7-8.

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.

RESPONSE:

The major utilities (normal power, emergency power, chilled water and steam) for the site will come from the existing central utility plant on the campus. These utilities will be

connected underground crossing in front of the Emergency Department and into the new building's ground floor mechanical room. The ground floor mechanical room will house all necessary pumps, air handling units, etc. to service the new building.

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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.

RESPONSE:

See Attachment 9.

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PART III - 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.

   Response:

   Kenneth A. Samet, FACHE
   President and CEO
   MedStar Health, Inc.
   5565 Sterrett Place
   Columbia, Maryland 21044

   Samuel E. Moskowitz, FACHE
   President
   MedStar Franklin Square Medical Center 9000
   Franklin Square Drive
   Rosedale, Maryland 21237

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.

   Response:

   Samuel E. Moskowitz, FACHE
   Mercy Medical Center
   345 St. Paul Place
   Baltimore, Maryland 21202
   Executive Management

   2/1993 - 5/2012

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.

   Response:

   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.

Response:

The hospital's compliance with state and federal regulations and accreditation requirements is subject to periodic governmental inquiries, and the hospital has responded appropriately to any such inquiries. From time to time, the hospital may make a business decision to resolve a matter, but there is nothing material to the hospital or to this project, and the hospital has not been subject to any additional compliance terms or scrutiny as a result.

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).

Response:

No

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

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.

8-5-16
Date

Signature of Owner or Board-designated Official

President
Position/Title

Samuel E. Moskowitz, FACHE

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

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(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). <u>The State Health Plan</u>.

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. <u>In cases where demonstrating compliance with a standard requires the provision of specific documentation, documentation must be included as a part of the application.</u>

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.

10.24.01.08G(3)(b). <u>Need</u>.

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.

RESPONSE:

See response to **10.24.11.05 SURGERY Standards; B. Project Review Standards. 2. Need - Minimum Utilization for Establishment of a New or Replacement Facility** in Attachment 26. Given that the proposed project is a replacement of MFSMC's surgical services facility and does not represent a new service, it was determined in consultation with MHCC staff that Table I is Not Applicable. See Attachment 10 for Table F.

10.24.1.8 G(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.

RESPONSE:

In MFSMC's attached Comprehensive Project Description (Attachment 3), the hospital has demonstrated that the continued delivery of surgical services in the current outmoded facility is not feasible. In its planning process to identify the preferred solution to this current condition, hospital leadership, with the help of consulting partners, identified and evaluated two options: (1) Option 1: Renovation of existing OR facility; (2) Option 2: Replacement of existing OR facility with a new facility.

An in-depth analysis of these two options was performed comparing each option against the two project goals: (1) Design and renovate/construct a replacement facility for the hospital's antiquated ORs that brings the hospital into compliance with all appropriate standards for the delivery of surgical services; (2), Design and renovate/construct the facility at the most efficient project cost, in the shortest, most efficient period of time, and with the least disruption to the delivery of services during the renovation/construction period.

To summarize the results of the assessment, it was determined that Option 1 would not provide enough square footage to accommodate 14 ORs with 600 SF clear floor areas, nor would it provide floor to floor dimensions that comply with standards and industry norms (mitigating this deficiency would be cost prohibitive). Further, Option 1 would not facilitate the efficiency gains associated with consolidating the hospital's surgical services because the current building footprint cannot accommodate the 14 ORs in one location. It was also determined that Option 1 would be much less cost effective, would take over three times as long to complete, and would result in significant disruption to surgical services during the construction period.

Conversely, Option 2 will result in ORs that are fully in compliance with standards and industry norms, and will position the hospital to continue to provide, high quality, safe and technologically advanced surgical services to the communities it serves. It will accommodate the consolidation of the entire MFSMC surgical services delivery system, and so will enable the maximizing of expense reduction opportunities. Additionally, the project will be significantly less costly, will be completed much more quickly, and will result in no disruptions to the delivery of services during the project period. For these reasons, the proposed project represents the best, most cost efficient alternative.

See Attachment 27 for the comparison in tabular form.

10.24.1.8 G G(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 timeframes 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, inapplicable.

- 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 timeframe.

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

RESPONSE:

- See Attachment 11 for project financial assumptions and Attachments 12-13 for projected Revenues & Expenses (Tables G and H), and Attachment 14 - Workforce Information. Given that the proposed project is a replacement of MFSMC surgical services facility and does not represent a new or separate service, it was determined in consultation with MHCC staff that tables Table J and K are not applicable.

- Over the last 8-10 years, MedStar Health and MFSMC have significantly increased their focus on community support and philanthropy. In its most recent capital campaign, funding for the construction of a replacement Neonatal Intensive Care Unit (NICU), MFSMC exceeded its aggressive goal of $4M, raising $4.5M. In 2012, the hospital received the largest private donation in its history. MFSMC is aggressively engaging its community to develop support for the replacement of its surgical services facility, and is confident that, as was the case with its NICU campaign, it will exceed its goal in this endeavor.

- The performance requirements for this project can be found on page 6 above. The proposed funding plan and vehicles are straightforward; the project is a 24-25 month start to finish, single-phase project, and MFSMC does not anticipate any issues in

meeting its performance requirement in a timely manner.

It should be noted that a separate project related to the proposed project involves the vacating and demolition of the building currently occupying the site of the proposed project, the Eastern Family Resource Center (EFRC). Baltimore County, in partnership with MedStar Health, is constructing a replacement for the antiquated EFRC. Upon completion of the building, the County will move its services there and will vacate the current building. At this time, the building will be demolished and construction of MFSMC's surgical services replacement facility will begin. The new EFRC is projected to be completed, and the existing building will be vacated and demolished in the 4th quarter of CY2017. This time frame corresponds to the proposed project's performance requirements. See the project time line on p.17.

The practice of MedStar Health is to fund major facility projects with a combination of tax-exempt debt, cash, and philanthropy. In evaluating alternative funding approaches for the MedStar Franklin Square Medical Center Surgical Services Replacement Facility project, and giving consideration to other capital investments planned across MedStar in the next few years, we have decided to fund this project with approximately $40.0 million tax-exempt debt and $30.0 million cash and fund raising. The type of tax-exempt debt to be issued will be determined based on market conditions at the time of the financing. MedStar currently maintains the following credit ratings: Moody's Investors Service A2, Positive outlook; Fitch Ratings A Stable outlook; and Standard and Poor's A Positive outlook. Given MedStar's strong credit ratings and favorable ratings outlook, the Company is confident that financing can be obtained. In addition, MedStar currently holds approximately $1.7 billion unrestricted cash and investments, which supports the Company's ability to issue the additional debt and fund any necessary capital from current cash and investment balances.

- See Attachment 15 - MedStar Health audited financial statements for FY14 and FY15.

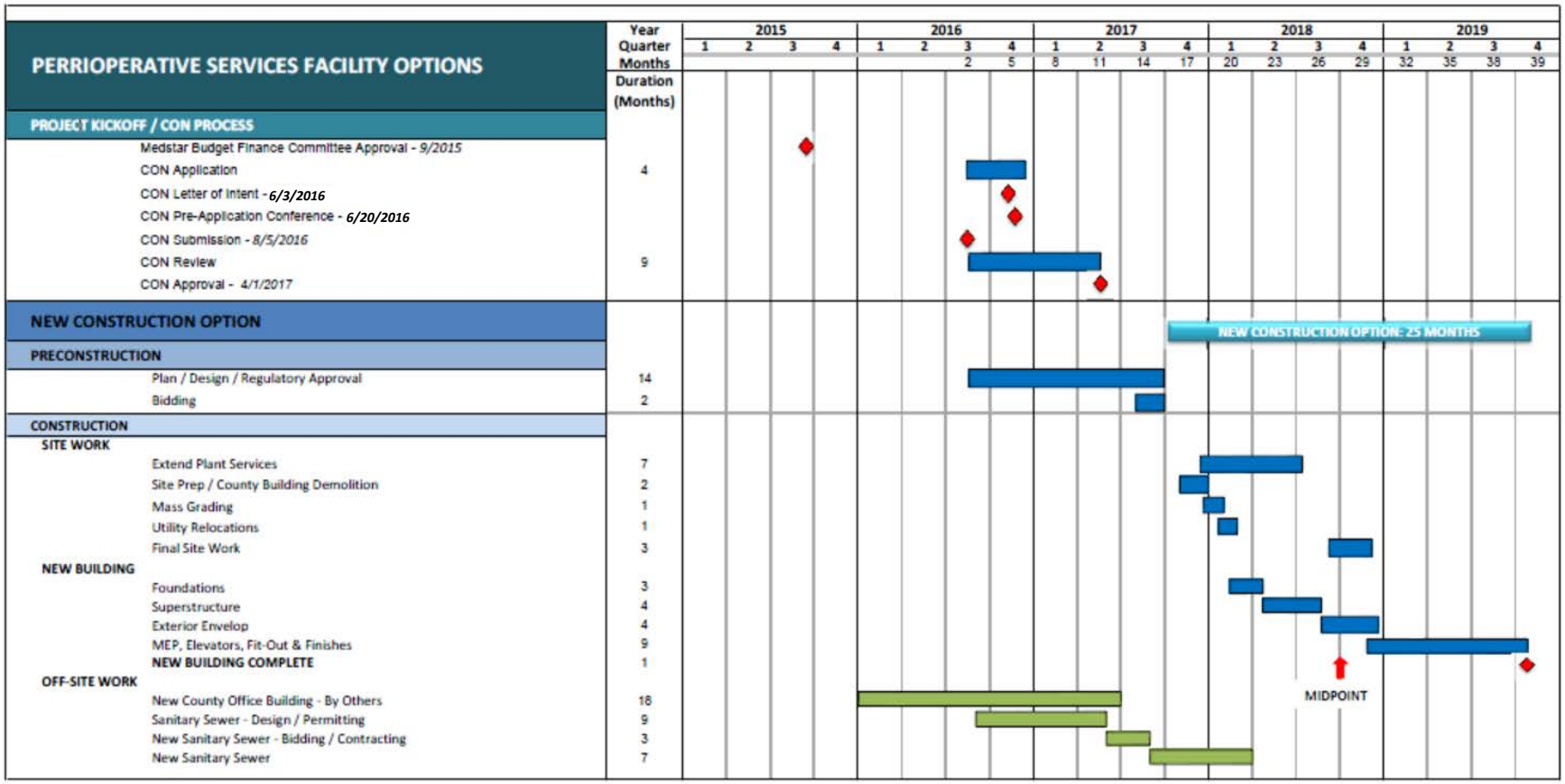
10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

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.

RESPONSE:

MFSMC has applied for one CON since 2000, Docket No. 05-03-2173. This CON was approved on July 26, 2007. A modification to the CON was filed by letter on January 26, 2007 (see Attachment 16 and 17). This project was implemented in compliance with the terms and conditions of the CON.


PERRIOPERATIVE SERVICES FACILITY OPTIONS
Year
Quarter
Months
Duration (Months)
2015
2016
2017
2018
2019
1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4
2 5 8 11 14 17 20 23 26 29 32 35 38 39
PROJECT KICKOFF / CON PROCESS
Medstar Budget Finance Committee Approval - 9/2015
CON Application 4
CON Letter of Intent - 6/3/2016
CON Pre-Application Conference - 6/20/2016
CON Submission - 8/5/2016
CON Review 9
CON Approval - 4/1/2017
NEW CONSTRUCTION OPTION
NEW CONSTRUCTION OPTION: 25 MONTHS
PRECONSTRUCTION
Plan / Design / Regulatory Approval 14
Bidding 2
CONSTRUCTION
SITE WORK
Extend Plant Services 7
Site Prep / County Building Demolition 2
Mass Grading 1
Utility Relocations 1
Final Site Work 3
NEW BUILDING
Foundations 3
Superstructure 4
Exterior Envelop 4
MEP, Elevators, Fit-Out & Finishes 9
NEW BUILDING COMPLETE 1
OFF-SITE WORK
New County Office Building - By Others 18
Sanitary Sewer - Design / Permitting 9
New Sanitary Sewer - Bidding / Contracting 3
New Sanitary Sewer 7
MIDPOINT

10.24.1.8 G(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[1];

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.

RESPONSE:

MFSMC's proposed projected is a replacement of its existing surgical services facility and a reduction in the number of ORs from the current sixteen to a post-project total of fourteen.

Because the hospital is not expanding its OR capacity and is designing its new OR facility to meet expected demand, it anticipates no impact on the volume of services provided by other existing health care providers, cost of those service, or access to those services in the health planning region.

The hospital has assumed in its projections of revenues and expenses (see Attachment 12-13: Table G, H) a rate assumption to offset the annual depreciation and interest expense resulting from the project.

10.24.10.04 Acute Care Hospital Review Standards

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

(1) Information Regarding Charges.

Information regarding hospital charges shall be available to the public.
After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

RESPONSE :

MFSMC complies with this Standard.

MFSMC's Financial Counseling Department and Finance Department provides information concerning charges upon request as well as information concerning the range and types of services provided to the public. Each request for information is addressed individually depending on the nature of the patient's inquiry. Charges for services at MFSMC comply with the rates approved by the Health Services Cost Review Commission.

The Hospital provides information regarding the range and types of services it provides in the following forms:

- MFSMC provides at the time of registration a pamphlet detailing the scope of services that the Hospital offers (See Attachment 18 – Patient Registration Pamphlet).

- MFSMC also provides information on the range of services it offers on its website at *http://www.medstarfranklinsquare.org/our-services/#q={}*

(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.

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.

RESPONSE:

MFSMC complies with this Standard.

MFSMC provides medical services to all patients regardless of their ability to pay. Please refer to MedStar Health's written policy Attachment 19 – MedStar Health Charity Care Policy for MFSMC's policy regarding the provision of complete and partial charity care for indigent and Medicaid patients and Attachment 20 – Federal Poverty Guidelines for MFSMC's determination of charity allowance based on the Federal Poverty Level standards.

MFSMC also posts formal notices in both English and Spanish at the Hospital's primary access points, including the main patient entrance, the Woman's Pavilion entrance, the ambulatory services entrance, the emergency department entrance and all admitting/ registration areas, that it complies with the Omnibus Budget Reconciliation Act of 1989 (OBRA) and affirms MFSMC's obligation and commitment to treat emergent and acute patients regardless of the patient's ability to pay. The hospital also provides a one page summary of its financial assistance policy to all patients who receive medical care. See Attachment 21 for a copy of the document.

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.

MFSMC makes a determination of eligibility for charity care within two (2) days of the patient's completion of an application form for such a determination. 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.

(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.

RESPONSE:

MFSMC Complies with this Standard:

MFSMC collects and reviews its quality performance data monthly to monitor and improve its performance. These measures include Serious Safety Events, Acute Care Core Measures, and Patient and Employee Safety Measures. See Attachment 22 for a fuller description of MFSMC's approach to Quality and Safety. MFSMC was granted accreditation by The Joint Commission on July 18, 2016. The hospital is in the process of submitting its application for renewal of its Maryland Licensure, which expires on August 10, 2016. See Attachments 23-24.

4. Transfer Agreements.

(a) Each ASF and hospital shall have written transfer and referral agreements with hospitals capable of managing cases that exceed the capabilities of the ASF or hospital.

(b) Written transfer agreements between hospitals shall comply with the Department of Health and Mental Hygiene regulations implementing the requirements of Health- General Article§19-308.2.

(c) Each ASF shall have procedures for emergency transfer to a hospital that meet or exceed the minimum requirements in COMAR10.05.05.09.

RESPONSE:

MFSMC complies with this Standard.

MFSMC provides a full range of inpatient and outpatient services and maximizes coordination of patient care services and healthcare providers across the continuum. The appropriate type and level of care are provided according to the patient's assessed bio-psycho-social needs. For patients needing care not provided by the Hospital or for patients needing post-acute care, transfer agreements are maintained with accredited providers of those services. See Attachment 25 – Transfer Agreement**,** for an example of the Hospital's transfer agreements.

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B. Project Review Standards

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

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

RESPONSE:

MFSMC complies with this Standard.

MFSMC's proposed project, the replacement and consolidation of the hospital's surgical service facility, will be located on the hospital campus immediately adjacent to the existing inpatient tower.

(2) Identification of Bed Need and Addition of Beds.
Only medical/surgical/gynecological/addictions ("MSGA") beds and pediatric beds identified as needed and/or currently licensed shall be developed at acute care general hospitals.

(a) Minimum and maximum need for MSGA and pediatric beds are determined using the need projection methodologies in Regulation .05 of this Chapter.

(b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients is included in the MSGA need projection.

(c) Additional MSGA or pediatric beds may be developed or put into operation only if:

(i) The proposed additional beds will not cause the total bed capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital made pursuant to Health-General §19-307.2; or

(ii) The proposed additional beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter; or

(iii) The proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection; or

(iv) The number of proposed additional MSGA or pediatric beds may be

derived through application of the projection methodology, assumptions, and targets contained in Regulation .05 of this Chapter, as applied to the service area of the hospital.

RESPONSE:

This Standard is Not Applicable.

MFSMC's project does not include a request for additional beds. This project has no impact on the hospital's inpatient bed need.

(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.

RESPONSE:

This Standard is Not Applicable.

MFSMC's project is not related to the establishment or expansion of a pediatric service.

(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.

RESPONSE:

MFSMC complies with this Standard.

(a) MFSMC has selected the most cost-effective alternative in the replacement of its outmoded surgical services facility (Attachment 27). It has demonstrated that its current facility is no longer able to support the delivery of high quality, safe, and technologically advanced surgical services to its community (Attachment 3). It has also demonstrated that its replacement facility will enable significant cost savings over the life of the building (Attachment 27). Because the hospital has demonstrated the need for the project and the cost-effectiveness of the project, hospital leadership believes the proposed project does not create an unwarranted adverse impact on hospital charges, but reflects a reasonable and necessary investment in the healthcare of the communities that MFSMC serves.

MFSMC plans to pursue a partial rate application or Global Budget Revenue modification with the HSCRC to fund at least the incremental depreciation and interest costs of the project. Based on CY 2015 HSCRC market shift data, MFSMC's average charge per ECMAD is 0.32% below its peer group and 9% below the Statewide average. Given Franklin Square's relative average charge per ECMAD and the funding mechanisms within the GBR system, MFSMC expects to demonstrate it can maintain a reasonable charge structure including funding for incremental capital expenditures. See table below.

ROC Peer Group 1	CY 2015 Charges	CY 2015 ECMADs	CY 2015 Charge per ECMAD	% Over / (Under) Peer Group Avg.	% Over / (Under) Statewide Avg.
UM Rehabilitation and Orthopaedic Institute	$99,524,402	6,365	$15,636	25.31%	14.31%
MedStar Good Samaritan Hospital	270,548,008	20,335	13,305	6.63%	(2.73%)
St. Agnes Hospital	372,843,970	29,246	12,748	2.17%	(6.80%)
Greater Baltimore Medical Center	367,179,426	29,501	12,446	(0.25%)	(9.00%)
MedStar Franklin Square Medical Center	458,629,208	36,875	12,437	(0.32%)	(9.07%)
UM Baltimore Washington Medical Center	375,277,805	30,946	12,127	(2.81%)	(11.34%)
Holy Cross Hospital	438,287,890	36,583	11,981	(3.98%)	(12.41%)
Suburban Hospital	259,335,545	21,861	11,863	(4.93%)	(13.27%)
Peer Group Total	**$2,641,626,254**	**211,713**	**$12,477**	**0.00%**	**(8.78%)**
Statewide Total [5]	***$13,266,251,182***	***969,902***	***$13,678***	***9.62%***	***0.00%***

Notes:
[1] Source: HSCRC Market Shift File
[2] Includes HSCRC PAU
[3] Excludes OP Oncology and Categoricals
[4] In-State Only
[5] Includes Acute Care Hospitals only

(b) The hospital has shown that the reduction in its inventory of ORs from sixteen to fourteen will not inappropriately diminish the availability or accessibility to care for the population in its primary service area, including access for the indigent and/or uninsured**.** See Attachment 26.

(5) Cost-Effectiveness.

A proposed hospital capital project should represent the most cost effective approach to meeting the needs that the project seeks to address.

(a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:

(i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;

(ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and

(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.

(b) An applicant proposing a project involving limited objectives, including, but not limited to, the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization, may address the cost-effectiveness of the project without undertaking the analysis outlined in (a) above, by demonstrating that there is only one practical approach to achieving the project's objectives.

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:

(i) That it has considered, at a minimum, the two alternative project sites located within a Priority Funding Area that provide the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);

(ii) That it has quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed project site;

(iii) That it has detailed the capital and operational costs associated with implementing the project at each alternative project site and at the proposed project site, with a full accounting of the cost associated with transportation system and other public utility infrastructure costs; and

(iv) That the proposed project site is superior, in terms of cost-effectiveness, to the alternative project sites located within a Priority Funding Area.

RESPONSE:

MFSMC complies with this Standard. Section (c) is Not Applicable.

MFSMC's project is the most cost-effective solution to the needed replacement of its outdated sixteen operating rooms.

(a) In its response to 10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives above and in its Attachment 27, MFSMC has demonstrated that the proposed project is the most cost-effective alternative to the replacement of its surgical services delivery system, and is effectively the only practical project alternative. Attachment 27 details the comparison and findings.

Because of the limited objective of MFSMC's project, the hospital believes that given the language of Section (b) "… an applicant proposing a project involving limited objectives, including, but not limited to a project limited to renovation of an existing facility for purposes of modernization…" pertains to its project. The hospital has nonetheless provided a reasonably comprehensive comparison of alternatives in Attachment 27 that is in keeping with Section (a).

(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.

RESPONSE:

MFSMC complies with this Standard.

See Attachment 26 in response to **10.24.11.05 SURGERY Standards, 2. Need**.

(7) Construction Cost of Hospital Space.

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

RESPONSE:

MFSMC complies with this Standard.

See Attachment 28, the project's Marshall & Swift Valuation.

(8) Construction Cost of Non-Hospital Space.

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

RESPONSE:

This Standard is Not Applicable.

MFSMC does not propose to construct any non-hospital space in its project

(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.

RESPONSE:

This Standard is Not Applicable.

MFSMC does not propose to construct any inpatient nursing units in its project

(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.

RESPONSE:

This Standard is Not Applicable.

(11) Efficiency.

A hospital shall be designed to operate efficiently. Hospitals proposing to replace or expand diagnostic or treatment facilities and services shall:

(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in which the planning and design of the project took efficiency improvements into account; and

(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or

(c) Demonstrate why improvements in operational efficiency cannot be achieved.

RESPONSE:

MFSMC complies with this Standard.

(a) The hospital is projecting three improvements in operational efficiency that will result from this project:

(1) A reduction in the hospital's OR inventory from 16 rooms to 14 rooms. This reduction facilitates a corresponding reduction in staff expenses, including physician (anesthesiology) and other support staff;

(2) Consolidation of the hospital's surgical services into one location climates the duplication of pre-operative, post-operative and administrative staff expenses;

(3) Improved design and layout of ORs improves work flow and increase staff and equipment sharing efficiencies.

The hospital estimates annual savings of $2.0M for the life of the project as a result of these efficiency improvements. See also Attachment 3, Attachment 11 (table, p.69) and Attachment 14.

(12). 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.

RESPONSE:

Patient safety played a central role in the planning and design of MFSMC's replacement surgical services facility. The proposed project integrates best practices in facility design for inpatient and outpatient surgical care, including patient and staff safety. The proposed operating rooms meet current best practices, with 12 general operating rooms having a minimum clear area of 600 SF and a hybrid operating room with a clear area of 800 square feet and a bronchoscopy operating rooms with a clear area of 700 SF as per the Facility Guidelines Institute (FGI) Guidelines for Design and Construction of Hospitals and Outpatient Facilities minimum area requirement. All rooms have a floor to floor height dimension of over 16 Ft., facility proper positive air flow over

patient for the length of the procedure. Further, these dimensions accommodate the advanced surgical technologies that promote high quality outcomes and patient safety as well as the number of clinicians often required in advanced surgery. The clear floor area contributes significantly to infection control as it eliminates in room "crowding" that increase the possibility of breakdown in sterile technique.

Each room has been designed with a standardized room layout with all equipment in the same location in every room. This design feature has been shown to reduce errors and improve safety in other industries, and MFSMC's design partners, as well as many others, believe it will have the same effect in health care.

Sterile and semi-sterile areas have been designed with access control features. Peripheral support areas of the surgical suite, including storage areas, equipment rooms, and scrub sink areas are located off a semi-restricted corridor. The clean core which directly connects to every operating room can only be accessed by authorized personnel and patients.

The Phase I post-anesthetic care unit and Phase II recovery areas also meet the clear area requirements as per the FGI Guidelines for Design and Construction of Hospitals and Outpatient Facilities minimum area requirement and have a separating wall to allow for more patient privacy and enhancing patient care and experience. The Phase I - post-anesthetic care unit meets the 1.5 post-anesthesia patient care stations per operating room as per the Facility Guidelines Institute (FGI) Guidelines for Design and Construction of Hospitals and Outpatient Facilities requirement.

(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.

RESPONSE:

MFSMC complies with this Standard.

MFSMC's proposed project is a replacement and consolidation of it existing surgical services delivery model into one new facility. It is neither the establishment of a new surgical service nor the expansion of an existing service. In fact, as noted elsewhere in this application, the project will result in a net reduction of two licensed ORs at MFSMC, from sixteen to fourteen. For the development of the forecasted profit and loss statements and volumes, historical trends of expenditures and utilization were used as a base. Inflationary factors from a five year forecast that was completed in early 2016 were used as a basis for the forecast years. See also comments on 10.24.9.1G(3)(d). Viability of the Proposal and the associated attachments and Tables G and H, Uninflated and Inflated Entity Revenue and Expenses.

(14) Emergency Department Treatment Capacity and Space.

(a) An applicant proposing a new or expanded emergency department shall classify service as low range or high range based on the parameters in the most recent edition of *Emergency Department Design: A Practical Guide to Planning for the Future* from the American College of Emergency Physicians. The number of emergency department treatment spaces and the departmental space proposed by the applicant shall be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians *Emergency Department Design: A Practical Guide to Planning for the Future*, given the classification of the emergency department as low or high range and the projected emergency department visit volume.

(b) In developing projections of emergency department visit volume, the applicant shall consider, at a minimum:

(i) The existing and projected primary service areas of the hospital, historic trends in emergency department utilization at the hospital, and the number of hospital emergency department service providers in the applicant hospital's primary service areas;

(ii) The number of uninsured, underinsured, indigent, and otherwise underserved patients in the applicant's primary service area and the impact of these patient groups on emergency department use;

(iii) Any demographic or health service utilization data and/or analyses that support the need for the proposed project;

(iv) The impact of efforts the applicant has made or will make to divert non-emergency cases from its emergency department to more appropriate primary care or urgent care settings; and

(v) Any other relevant information on the unmet need for emergency department or urgent care services in the service area.

RESPONSE:

This Standard is Not Applicable.

MFSMC's proposed project does not involve the construction of a new or expanded emergency department.

(15) Emergency Department Expansion.

A hospital proposing expansion of emergency department treatment capacity shall demonstrate that it has made appropriate efforts, consistent with federal and state law, to maximize effective use of existing capacity for emergent medical needs and has appropriately integrated emergency department planning with planning for bed capacity, and diagnostic and treatment service capacity. At a minimum:

(a) The applicant hospital must demonstrate that, in cooperation with its medical staff, it has attempted to reduce use of its emergency department for non-emergency medical care. This demonstration shall, at a minimum, address the feasibility of reducing or redirecting patients with non-emergent illnesses, injuries, and conditions, to lower cost alternative facilities or programs;

(b) The applicant hospital must demonstrate that it has effectively managed its existing emergency department treatment capacity to maximize use; and

(c) The applicant hospital must demonstrate that it has considered the need for bed and other facility and system capacity that will be affected by greater volumes of emergency department patients.

RESPONSE:

This Standard is Not Applicable.

MFSMC's proposed project does not involve the a expansion of emergency department capacity.

(16) Shell Space.

Unfinished hospital space for which there is no immediate need or use, known as "shell space," shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective. 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 considers the most likely use identified by the hospital for the unfinished space and the time frame projected for finishing the space. The applicant shall demonstrate that the hospital is likely to need the space for the most likely identified use in the projected time frame.

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.

The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Service Cost Review Commission.

RESPONSE:

This Standard is Not Applicable.

MFSMC's proposed project does not involve the construction of shelled space.

[1] **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**

10.24.11.05 SURGERY Standards

A. General Standards.

The following general standards encompass Commission expectations for the delivery of surgical services by all health care facilities in Maryland, as defined in Health General §19-114 (d). Each applicant that seeks a Certificate of Need for a project or an exemption from Certificate of Need review for a project covered by this Chapter shall address and document its compliance with each of the following general standards as part of its application.

1. Information Regarding Charges.

Information regarding charges for surgical services shall be available to the public. A hospital or an ambulatory surgical facility shall provide to the public, upon inquiry or as required by applicable regulations or law, information concerning charges for the full range of surgical services provided.

RESPONSE:

MFSMC complies with this Standard.

See response to **10.24.10.04 Acute Care Hospital Review Standards A(1)** above

2. Charity Care Policy

a) Each hospital and ambulatory surgical facility shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide ambulatory surgical services on a charitable basis to qualified indigent persons consistent with this policy. The policy shall have the following provisions:

(i) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the facility shall make a determination of probable eligibility.

(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the surgical facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's arrival for surgery, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

(iii) Criteria for Eligibility. Hospitals shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. ASFs, at a minimum, must include the following eligibility criteria in charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for

services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of ASFs described in these regulations.

(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.

(c) A proposal to establish or expand an ASF for which third party reimbursement is available, shall commit to provide charitable surgical services to indigent patients that are equivalent to at least the average amount of charity care provided by ASFs in the most recent year reported, measured as a percentage of total operating expenses. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If an existing ASF has not met the expected level of charity care for the two most recent years reported to MHCC, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the service area population.

(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a Certificate of Need for a surgical facility project, shall commit to provide charitable services to indigent patients. Charitable services may be surgical or non-surgical and may include charitable programs that subsidize health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by ASFs, measured as a percentage of total ASF expenses, in the most recent year reported. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service area, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the population in the proposed service area.

RESPONSE:

MFSMC complies with this Standard.

See response to **10.24.10.04 Acute Care Hospital Review Standards A(2)** above.

3. Quality of Care.

A facility providing surgical services shall provide high quality care.

(a) An existing hospital or ambulatory surgical facility shall document that it is licensed, in good standing, by the Maryland Department of Health and Mental Hygiene.

(b) A hospital shall document that it is accredited by the Joint Commission.

(c) An existing ambulatory surgical facility shall document that it is:

(i) In compliance with the conditions of participation of the Medicare and Medicaid programs; and

(ii) Accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, or another accreditation agency recognized by the Centers for Medicare and Medicaid as acceptable for obtaining Medicare certification.

(iii) A person proposing the development of an ambulatory surgical facility shall demonstrate that the proposed facility will:

(i) Meet or exceed the minimum requirements for licensure in Maryland in the areas of administration, personnel, surgical services provision, anesthesia services provision, emergency services, hospitalization, pharmaceutical services, laboratory and radiologic services, medical records, and physical environment.

(ii) Obtain accreditation by the Joint Commission, the Accreditation Association for Ambulatory Health Care, or the American Association for Accreditation of Ambulatory Surgery Facilities within two years of initiating service at the facility or voluntarily suspend operation of the facility.

RESPONSE:

MFSMC complies with this Standard.

See response to **10.24.10.04 Acute Care Hospital Review Standards A(3)** above.

4. Transfer Agreements.

(d) Each ASF and hospital shall have written transfer and referral agreements with hospitals capable of managing cases that exceed the capabilities of the ASF or hospital.

(e) Written transfer agreements between hospitals shall comply with the Department of Health and Mental Hygiene regulations implementing the requirements of Health- General Article §19-308.2.

(f) Each ASF shall have procedures for emergency transfer to a hospital that meet or exceed the minimum requirements in COMAR 10.05.05.09.

RESPONSE:

MFSMC complies with this Standard.

See response to 10.24.10.04 Acute Care Hospital Review Standards A(4) above.

B. Project Review Standards.

The standards in this section govern reviews of Certificate of Need applications and requests for exemption from Certificate of Need review involving surgical facilities and services. An applicant for a Certificate of Need or an exemption from Certificate of Need shall demonstrate consistency with all applicable review standards.

1. Service Area

An applicant proposing to establish a new hospital providing surgical services or a new ambulatory surgical facility shall identify its projected service area. An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall document its existing service area, based on the origin of patients served.

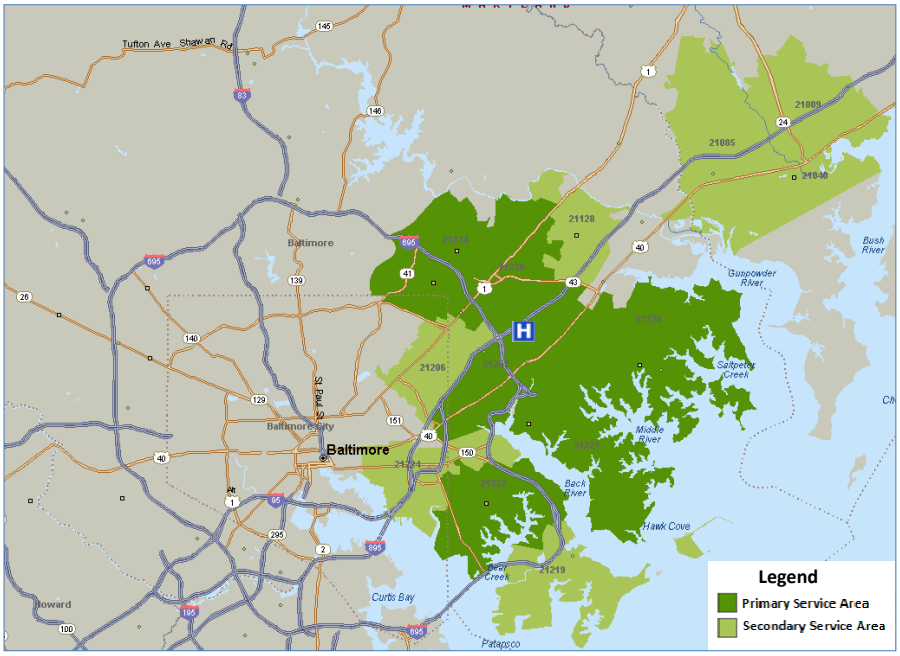
RESPONSE:

MFSMC is proposing to replace its existing surgical facilities. It is not proposing to establish a new hospital providing surgical services or a new ambulatory surgical facility.

MFSMC is located at 9000 Franklin Square Drive in Rosedale, Maryland. The hospital's service area includes eastern Baltimore City, eastern Baltimore County, and southern Harford County. The hospital's primary and secondary service areas include the following zips: 21221, 21220, 21222, 21237, 21234, 21236, 21206, 21224. 21219, 21040, 21128,

21085, 21009 (see map below). This geography represent MFSMC's Commission-defined Primary and Secondary Service Areas, the zip codes of origin of the top 80% of MFSMC discharges.

MFSMC Primary and Secondary Service Area



2. Need - Minimum Utilization for Establishment of a New or Replacement Facility.

An applicant proposing to establish or replace a hospital or ambulatory surgical facility shall demonstrate the need for the number of operating rooms proposed for the facility. This need demonstration shall utilize the operating room capacity assumptions and other guidance included in Regulation .06 of this Chapter. This needs assessment shall demonstrate that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility.

(a) An applicant proposing the establishment or replacement of a hospital shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for inpatient and outpatient surgical procedures by the new or replacement hospital's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed new or replacement hospital by surgical specialty or operating room category; and

(iii) In the case of a replacement hospital project involving relocation to a new site, an analysis of how surgical case volume is likely to change as a result of changes in the surgical practitioners using the hospital.

(b) An applicant proposing the establishment of a new ambulatory surgical facility shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for outpatient surgical

RESPONSE:

MFSMC complies with this Standard.

See Attachment 26 for MFSMC's Need analysis.

3. Need - Minimum Utilization for Expansion of An Existing Facility.

An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall:

(a) Demonstrate the need for each proposed additional operating room, utilizing the operating room capacity assumptions and other guidance included at Regulation .06 of this Chapter;

(b) Demonstrate that its existing operating rooms were utilized at optimal capacity in the most recent 12-month period for which data has been reported to the Health Services Cost Review Commission or to the Maryland Health Care Commission; and

(c) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the completion of the additional operating room capacity. The needs assessment shall include the following:

(i) Historic trends in the use of surgical facilities at the existing facility;

(ii) Operating room time required for surgical cases historically provided at the facility by surgical specialty or operating room category; and

(iii) Projected cases to be performed in each proposed additional operating room.

RESPONSE:

This Standard is Not Applicable

MFSMC is not proposing to expand its number of operating rooms.

4. Design Requirements.

Floor plans submitted by applicant must be consistent with the current FGI Guidelines.

(a) A hospital shall meet the requirements in Section 2.2 of the FGI Guidelines.

(b) An ASF shall meet the requirements in Section 3.7 of the FGI Guidelines.

(c) Design features of a hospital or ASF that are at variance with the current FGI Guidelines shall be justified. The Commission may consider the opinion of staff at the Facility Guidelines Institute, which publishes the FGI Guidelines, to help determine whether the proposed variance is acceptable.

RESPONSE:

MFSMC complies with this Standard.

All project building plans comply with the applicable FGI Guidelines sections.

5. Support Services

Each applicant shall agree to provide as needed, either directly or through contractual agreements, laboratory, radiology, and pathology services.

RESPONSE:

MFSMC complies with this Standard.

MFSMC currently provides laboratory, radiology, and pathology services as part of its normal clinical operations. The hospital will continue to provide these services through its internal staff and external contractual relationships.

6. Patient Safety.

The design of surgical facilities or changes to existing surgical facilities shall include features that enhance and improve patient safety. An applicant shall:

(a) Document the manner in which the planning of the project took patient safety into account; and

(b) Provide an analysis of patient safety features included in the design of proposed new, replacement, or renovated surgical facilities;

RESPONSE:

MFSMC complies with this Standard.

See response to **10.24.10.04 Acute Care Hospital Review Standards, 12** above.

7. Construction Costs.

The cost of constructing surgical facilities shall be reasonable and consistent with current industry cost experience.

(a) Hospital projects.

(i) The projected cost per square foot of a hospital construction or renovation project that includes surgical facilities shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include:

1. The amount of the projected construction cost and associated capitalized construction cost that exceeds the Marshall Valuation Service® benchmark; and

2. Those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

(b) Ambulatory Surgical Facilities.

(i) The projected cost per square foot of an ambulatory surgical facility construction or renovation project shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost by 15% or more, then the applicant's project shall not be approved unless the applicant demonstrates the reasonableness of the construction costs. Additional independent construction cost estimates or information on the actual cost of recently constructed surgical facilities similar to the proposed facility may be provided to support an applicant's analysis of the reasonableness of the construction costs.

RESPONSE:

MFSMC complies with this Standard.

See Attachment 28, Marshall & Swift Valuation.

8. Financial Feasibility.

A surgical facility project shall be financially feasible. Financial projections filed as part of an application that includes the establishment or expansion of surgical facilities and services shall be accompanied by a statement containing each assumption used to develop the projections.

(a) An applicant shall document that:

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the likely service area population of the facility;

(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 facility or, if a new facility, the recent experience of similar facilities;

(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 facility, or, if a new facility, the recent experience of similar facilities; and

(iv) The facility 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 of initiating operations.

(b) A project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project may be approved upon demonstration that overall facility financial performance will be positive and that the services will benefit the facility's primary service area population.

RESPONSE:

MFSMC complies with this Standard.

See response to **10.24.10.04 Acute Care Hospital Review Standards, (13)** above.

9. Preference in Comparative Reviews.

In the case of a comparative review of CON applications to establish an ambulatory surgical facility or provide surgical services, preference will be given to a project that commits to serve a larger proportion of charity care and Medicaid patients. Applicants' commitment to provide charity care will be evaluated based on their past record of providing such care and their proposed

RESPONSE:

This Standard is Not Applicable.

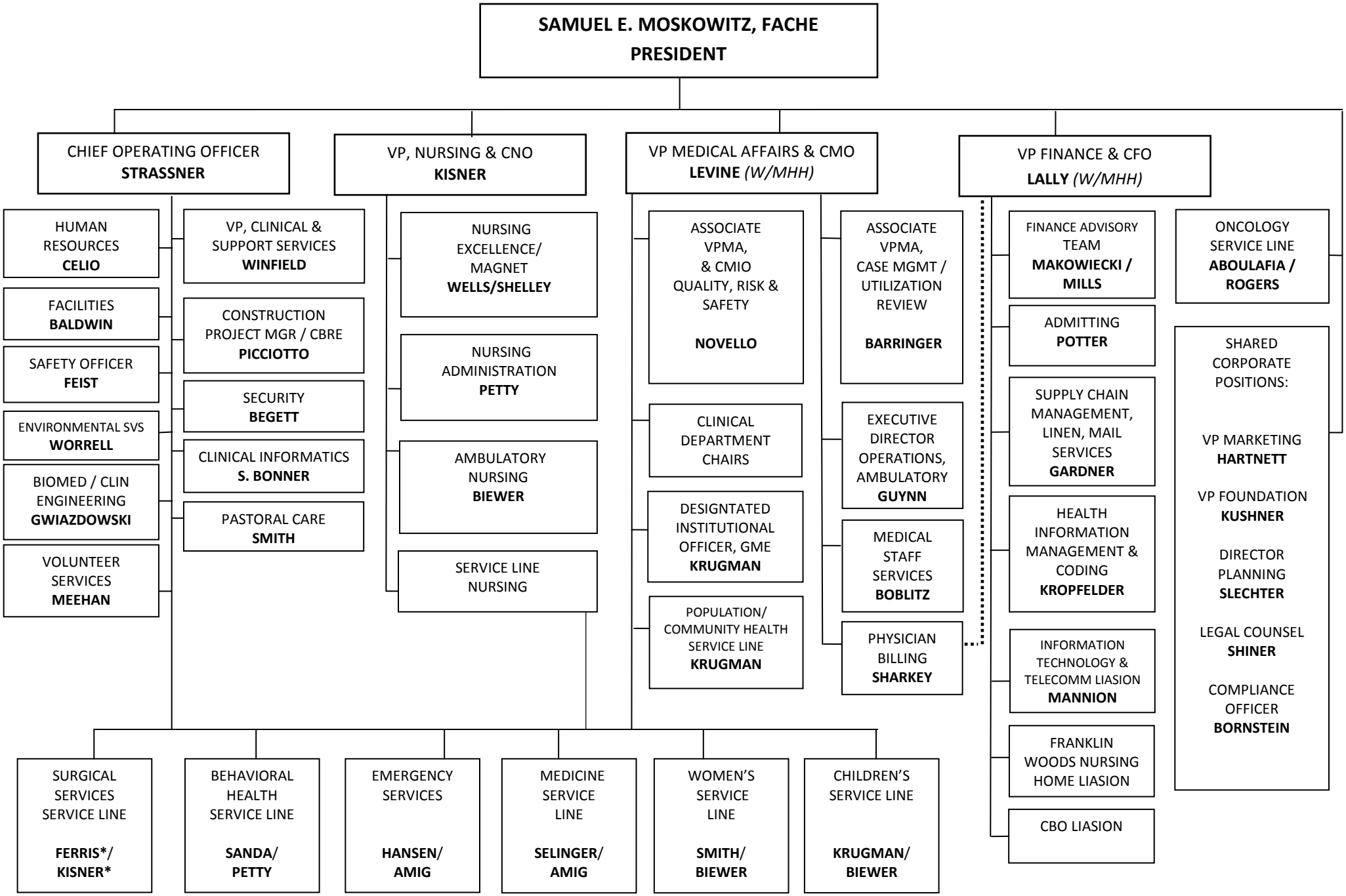
The hospital is not seeking to add a new service or expand an existing surgical service. As a replacement of an existing MFSMC service, this project falls outside the scope of a comparative review.

MedStar Franklin Square Medical Center

Attachment 1: MFSMC Organization Chart

Updated: 7-28-16

MEDSTAR FRANKLIN SQUARE MEDICAL CENTER - ORGANIZATIONAL CHART



*Interim

Attachment 2: 8A. Executive Summary of Project

MedStar Franklin Square Medical Center (MFSMC) proposes to replace its current surgical services facilities, including its sixteen outdated operating rooms and support areas, with a new two-story building located on the hospital campus just south of MFSMC's inpatient tower. The project will consist of 75,000 SF of new construction and 600 SF of renovation, and will include a connection between the new building and the inpatient tower. The project will create one consolidated OR facility containing fourteen ORs and support spaces. This represents a decrease of two ORs in the hospital's current inventory of sixteen ORs.

The weighted average age for MFSMC's sixteen ORs is about 35 years. This project is intended to correct aging facilities, square footage limitations and functional deficiencies and inefficiencies. The contemporary industry standard for OR square footage is 600 SF of clear floor area. MFSMC's ORs fall well short of this standard and thus cannot accommodate the variety of intra-operative technology and surgical equipment that have become standard in the performance of surgical procedures. In addition, because its sixteen ORs are located in two geographically separate areas of the hospital, functional inefficiencies can be corrected with this project.

In 2005, the age of the hospital plant and its outmoded infrastructure led hospital leadership to develop an MFSMC Master Facility Plan. Phase I of that plan included a replacement facility for the hospital's inpatient and emergency services. This phase was completed in 2010 with the opening of MFSMC's new patient tower. Phase II of the plan included a replacement of the hospital's operating rooms and support spaces. The plan to replace MFSMC's ORs thus flows directly from its Master Facility Plan. The proposed facility has a projected cost of $70M, and the funding sources are comprised of approximately $40M tax-exempt debt and $30M million cash and fund raising.

Attachment 3: 8B. Comprehensive Project Description

MedStar Franklin Square Medical Center (MFSMC) proposes to replace its current sixteen outdated operating rooms (ORs), pre-operative spaces, post-operative spaces, support spaces and mechanical infrastructure by constructing an efficient, new facility on its campus that will contain fourteen operating rooms and associated support spaces. The project consists of the construction of a new two-story 75,000 SF replacement facility and 600 SF of renovation of existing space. The replacement facility will include a total of twelve Mixed Use General Purpose ORs and two Mixed Use Special Purpose ORs, and as noted, will result in a net decrease of two ORs in the hospital's licensed OR inventory.

In FY16 (July 2015-June 2016), MFSMC had an inventory of fifteen Mixed Use General Purpose ORs and one Mixed Use Special Purpose OR. However, one of the Mixed Use General Purpose ORs has been utilized as a Mixed Use Special Purpose room and will be identified as such in the MHCC Supplemental Survey: Surgery Capacity, 2016.

MFSMC's sixteen ORs are organized in two "pods" in two separate locations in the original hospital (i.e., not the new Patient Tower). These ORs were built in three phases: (1) six ORs were built in the central wing of the facility as part of the construction of the original hospital in 1969; (2) four ORs adjacent to the existing six rooms were added in 1978; (3) and six ORs, as well as a separate pre-operative, post-operative and support space, were constructed in a different location within the hospital in 1989. These final six ORs were designed for ambulatory surgery and so are smaller than MFSMC's other ORs and are located near one of the hospital's entrances. In 2002, four of the original ORs were expanded by combining existing spaces. In 2003, the hospital created an interventional vascular suite and converted one of its ambulatory surgery ORs into a procedure room. Currently, the hospital provides surgical services in one pod of eleven operating rooms and a second pod of five operating rooms. The weighted-average age for MFSMC's sixteen ORs is about 35 years.

Even with these renovations, MFSMC's ORs fall well short of the industry best practice standard of 600 SF per General Use OR. None of the hospital's fourteen general purpose ORs meet this standard. Eleven of the rooms range between 325-375 SF, one is 450 SF, and three range between 515-530 SF. Entrance doors are too small, especially given the hospital's busy bariatric surgery program, and the clear floor area within the ORs does not facilitate the number

of clinicians often necessary for contemporary surgical procedures nor the necessary mobility of clinicians within the room. Further, these square footages are not designed to accommodate the variety of intra-operative technology and surgical equipment that have become standard in the performance of surgical procedures. Imaging technology such as X-ray, fluoroscopy, and ultrasound, minimally invasive surgical approaches such as laparoscopy and robotic surgery, and instrumentation for certain types of common procedures such as total joint replacements have space requirements that are poorly accommodated by MFSMC's ORs. This size deficiency results in inefficient use of the ORs (i.e., the issue of matching cases to those MFSMC ORs able to accommodate the cases), and creates in-room "crowding" that presents challenges to the maintenance of sterile technique and increases risks for surgical site infection.

However, these facility deficiencies are not the only issues driving the hospital's decision to replace its ORs. As noted above, MFSMC currently provides surgical services in two pods, one containing eleven ORs and the second containing five ORs, located in geographically separate areas of the hospital. This model requires a duplication of staff to cover the second pre-operative, post-operative and support spaces. It also limits the sharing of staff to adjust to the ebb and flow of case start times during the day, as well as emergent or urgent procedures. Taken together, the age of plant, square footage and functional deficiencies create a physical infrastructure that is no longer able to support the delivery of surgical services at MFSMC.

In 2005, the age of the hospital plant and its outmoded infrastructure led hospital leadership to develop an MFSMC Master Facility Plan. Phase I of that plan included a replacement facility for the hospital's inpatient and emergency services. This phase was completed in 2010 with the opening of MFSMC's new patient tower. Phase II of the plan included a replacement of the hospital's operating rooms and support spaces. The plan to replace MFSMC's ORs thus flows directly from its Master Facility Plan.

The project will be implemented in one phase of construction on 3.112 acres on the MedStar Franklin Square Medical Center Campus with a connection back to the existing hospital at the Ground Level and Level 1. The project consists of the construction of a new two-story replacement facility that will include a total of twelve general operating rooms, one hybrid operating room and one interventional pulmonology room and the required support areas. Renovation of approximately 600 SF of exiting corridor (Interior Finish Upgrades) will occur on the ground level of the existing facility to enhance the public concourse connection from the new

Surgical Services Replacement Facility to the existing hospital. Renovation will also occur at Level 1 of the existing facility where the new facility will connect to the existing hospital. The estimated cost of the project is $70M, and the funding sources are comprised of approximately $40M tax-exempt debt and $30M million cash and fund raising.

As noted, the new facility will consist of two floors. The Ground Level of the facility serves as the main arrival floor for surgical outpatients via the new outpatient drop-off and entry. The lobby space will serve as a way-finding point for outpatients with views to exterior courtyards and the drop-off area and will connect patients and visitors via a public concourse back to the existing hospital. Registration has been functionally located adjacent to the lobby space to assist with patient way finding and reduce patient travel distances. Separate flow patterns have been designed for public and patient/staff movement. From registration patients will move into the adjacent Prep and Phase II - Recovery areas. Patients will be moved via the elevator directly to the operating rooms from the Phase I – Post-Anesthesia Care Unit (PACU). The PACU has been located immediately adjacent to the operating rooms on Level 1. Outpatients will return to Phase II – Recovery via the elevator and then will be discharged. Inpatients will return to their patient room after leaving the PACU via the new connection. Staff and support areas have been functionally located on the Ground Level and Level 1 for desired adjacencies.

The Surgical Services Replacement Facility space program[1] is included as Attachment 6. Project drawings are enclosed as a separate attachment.

This project is anticipated to be one Construction Bid Package.

[1]This project will result in the current surgical facility being vacated. MFSMC is evaluating options for the best and highest future use of the space.

Attachment 4: DGSF

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
OPERATION, FACILITY					
Nursing Unit			600		600
Operation, Facility		67,996			67,996
Mechanical		7,004			7,004
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
Total					75,600

Attachment 5: 10D. Site Control

SP 2014-005
J.O. 000-0000-0000
Item l& 2 R
Election District 14c6

THIS DEED OF EXCHANGE made this _____ day of October, in the year 2015, by and between HH MEDSTAR HEALTH, INC., a Maryland corporation, (formerly known as HELIX HEALTH SYSTEM, INC.), the party of the first part, and BALTIMORE COUNTY, MARYLAND, a body corporate and politic, the party of the second part (hereinafter referred to as the "County").

WHEREAS, the party of the first part, is the fee simple owner of all that parcel of land situate, lying and being in the Fourteenth (14th) Election District of Baltimore County, State of Maryland, and more particularly described in a Deed from The Franklin Square Hospital Center, Inc., dated April 11, 1989, and recorded among the Land Records of Baltimore County, Maryland in Liber SM 8145 folio 156 (hereinafter referred to as the "Substitute Property"), said Substitute Property labeled and shown on Drawing SP2014-005-1 (the "Fee Taking Area"), attached hereto and incorporated hereby;

WHEREAS, the party of the second part, is the fee simple owner of all that property situate, lying and being in the Fourteenth (14th) Election District of Baltimore County, State of Maryland, and more particularly described in Deeds dated April 13, 1971 and recorded among the Land Records of Baltimore County in Liber OTG 5181, folio 157, from The Franklin Square Hospital of Baltimore City, Incorporated, a body corporate of the State of Maryland; and September 9, 1975 and recorded in the Land Records of Baltimore County in Liber EHK 5575 folio 327 from The Franklin Square Hospital of Baltimore City, Incorporated, a body corporate of the State of Maryland (hereinafter referred to as "Property"), said property labeled and shown on Drawing SP 2014-005-2R (the "Area to be Released"), attached hereto and incorporated hereby;

WHEREAS, pursuant to the 2003 Baltimore County Code, Article 3, Title 9, Subtitle 103, as amended from time to time, the County Administrative Officer submitted a Report and Recommendation to the County Council for review of the proposed exchange, providing for the release of the County's existing Property in exchange for the conveyance of a Substitute Property (hereinafter referred to as "Exchange"), and the matter was called to vote of the Council and was

approved thereby on July 6, 2015, and the County Executive, or his designee, has approved the Exchange; and

WHEREAS, the parties of the first and second part desire to effectuate the Exchange, requiring the grant and conveyance of the fee simple Substitute Property from the party of the first part unto the party of the second part and the release and the grant and conveyance of the above noted fee simple Property owned by the party of the second part unto the party of the first part.

NOW, THEREFORE, in consideration of the premises and the sum of Zero Dollars ($0), the receipt and sufficiency of which is hereby acknowledged:

A. GRANT. The party of the first part hereby grants and conveys unto the County its successors and assigns, all that certain parcel of Substitute Property in fee simple described as the "FEE TAKING AREA" on Drawing SP2014 -005-1 and consisting of 170,753 sq. ft. (3.920 Ac).

B. RELEASE AND GRANT. The said County hereby releases and grants and conveys unto party of the first part, its successors and assigns, in fee simple all those parcels of real property, situated in Baltimore County, State of Maryland, and described as "TOTAL AREA TO BE RELEASED, AREA = 135,557 Sq. Ft (3.112 Ac) +/-", consisting of "Area 'A' To Be Released, Area = 129,162 Sq. Ft./2.965 Ac. +/-," "Area 'B' To Be Released, Area = 841 Sq. Ft./0.019 Ac. +/-;" and "Area 'C' To Be Released, Area = 5,554 Sq. Ft./0.127 Ac. +/-," on Drawing No. SP2014- 005-02R.

ALL OF THE PARCELS BEING CONVEYED HEREWITH TOGETHER WITH the buildings and improvements thereupon, and the rights, alleys, ways, waters, privileges, appurtenances and advantages thereto belonging, or in anywise appertaining.

TO HAVE AND TO HOLD the described parcels of land and premises to the said party of the first part and the second part, its successors and/or assigns, as applicable, in fee simple.

SUBJECT TO any and all easements, rights-of-way, conditions, covenants, restrictions, reservations and exceptions of record.

THE PARTY OF THE FIRST PART certifies that this conveyance is not part of a transaction in which there is a sale, lease, exchange or other transfer of all or substantially all of the property and assets of the said corporate grantor.

AS WITNESS the due execution hereof by the aforenamed parties of the first and second parts.

WITNESS/ATTEST:

HH MEDSTAR HEALTH, INC.

By: _____ (SEAL)
Name: Joel Bryan
Title: Authorized Officer

STATE OF MARYLAND, COUNTY OF ~~BALTIMORE~~ HOWARD, to wit:

I HEREBY CERTIFY, that on this 5th day of October, in the year 2015, before me, the subscriber, a Notary Public, personally appeared Joel Bryan and he/she as Authorized Officer being authorized to do so, executed the foregoing Deed of Exchange for the purposes therein contained by signing the name of HH MedStar Health, Inc. by himself/herself as such officer, and IN MY PRESENCE SIGNED AND SEALED THE SAME.

AS WITNESS my hand and Notarial Seal.

_____
Notary Public

My Commission expires: 11/24/2016

(Signatures Continue on Next Page)

DM2\5707466 5

This is to certify that the within instrument was prepared by an attorney admitted to practice before the Court of Appeals of Maryland.

ATTEST:

BALTIMORE COUNTY, MARYLAND

_____

BY: _____
Fred Homan
County Administrative Officer

STATE OF Maryland, COUNTY OF Baltimore to wit:

I HEREBY CERTIFY that on this 5th day of October, in the year 2015, before me, the subscriber, a Notary Public, personally appeared FRED HOMAN, County Administrative Officer of Baltimore County, and he acknowledged the foregoing Deed to be the act of said body corporate and politic, and IN MY PRESENCE SIGNED AND SEALED THE SAME.

AS WITNESS my Hand and Notarial Seal.

LACHELLE IMWIKO
Notary Public-Maryland
Baltimore County
My Commission Expires
3/27/17

Notary Public

My Commission Expires: 3/27/17

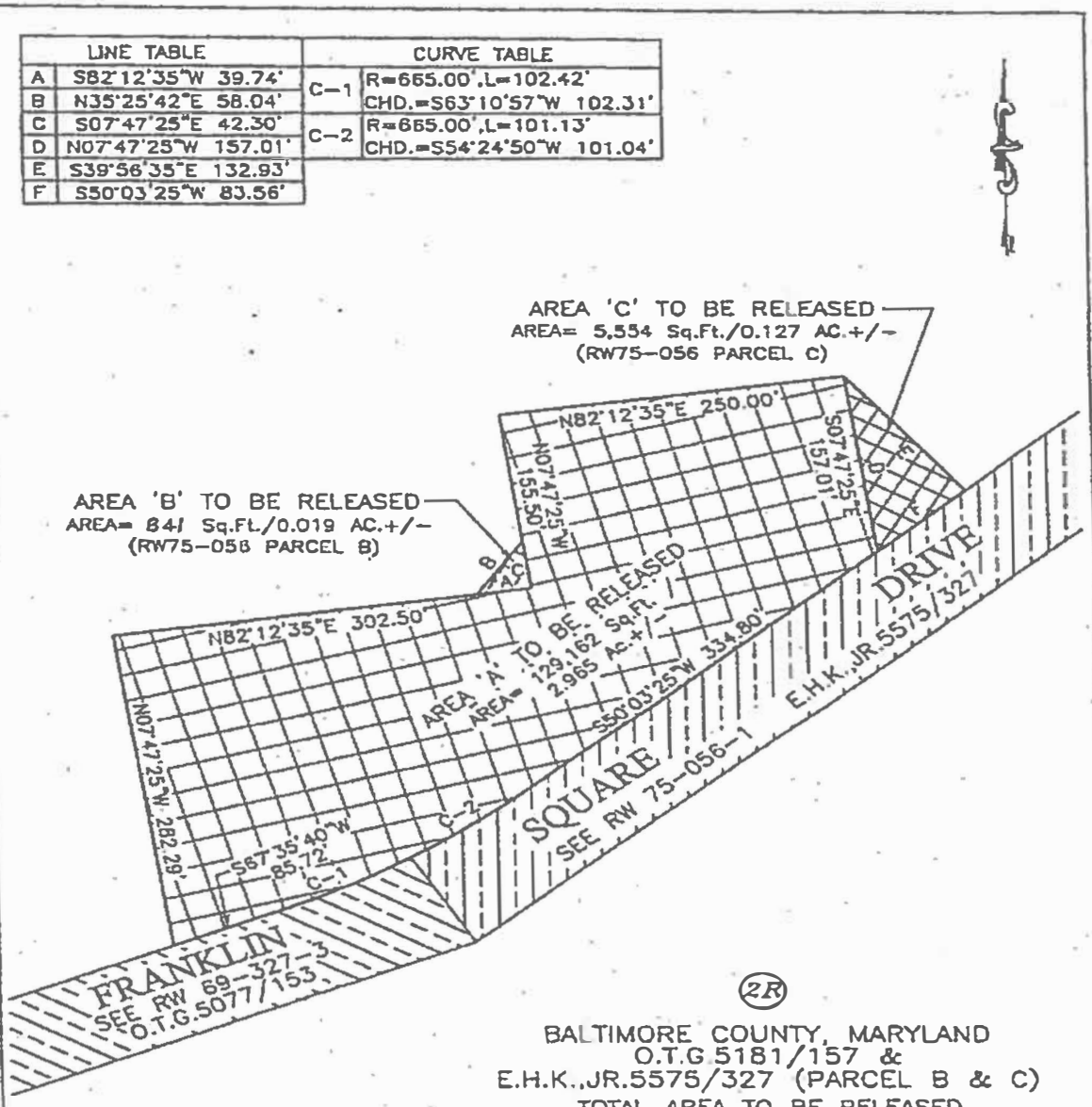
APPROVED FOR LEGAL FORM AND SUFFICIENCY*
(Subject to Execution by the Duly Authorized Administrative Official and/or Chairman of the County Council, as indicated)

OFFICE OF THE COUNTY ATTORNEY
(*Approval of Legal Form and Sufficiency Does Not Convey Approval Or Disapproval of the Substantive Nature of This Transaction. Approval is Based Upon Typeset Document-All Modifications Require Re-Approval.)

DM2\5707466.5

LINE TABLE	
A	S82°12'35"W 39.74'
B	N35°25'42"E 58.04'
C	S07°47'25"E 42.30'
D	N07°47'25"W 157.01'
E	S39°56'35"E 132.93'
F	S50°03'25"W 83.56'

CURVE TABLE	
C-1	R=665.00',L=102.42'
	CHD.=S63°10'57"W 102.31'
C-2	R=665.00',L=101.13'
	CHD.=S54°24'50"W 101.04'



2R

BALTIMORE COUNTY, MARYLAND
O.T.G.5181/157 &
E.H.K.,JR.5575/327 (PARCEL B & C)
TOTAL AREA TO BE RELEASED
AREA= 135,557 Sq.Ft. /
3.112 Ac.+/-

BALTIMORE COUNTY — REAL ESTATE COMPLIANCE

DISTRICT NO. 14 C6 — POSITION SHEET NO. — CONSTRUCTION PLAN NO. — FEDERAL PROJECT NO. — MARYLAND PROJECT NO.

APPROVED ... DIRECTOR OF PUBLIC WORKS — DATE

APPROVED ... REAL ESTATE COMPLIANCE — DATE 3.3.15

APPROVED ... DIVISION CHIEF — DATE 3-3-15

AREA TO BE ACQUIRED — REVERTIBLE SLOPE EASEMENT — TEMPORARY CONSTRUCTION AREA — EXISTING COUNTY R/W — AREA TO BE RELEASED — TEMPORARY SLOPE EASEMENT

ITEM NO. — REFERENCE

SURVEYOR — DATE — REF. NO.

REVISIONS

DRAWN BY	MTY
PLAT CHECKED	MTY
AREA CHECKED	MTY
TITLE APPROVED	MTY

SCALE: 1"= 100'

B.C. JOB ORDER NO. 'O'

SP 2014-005-2R

DM2\5707466 5

Surgical Services Replacement Facility

Date: August 5, 2016

Ground Floor

Element	Proposed Quantity	Proposed Net SF	Total Proposed Net SF	Comments
1.00 PUBLIC AREAS				
1.01 Vestibule	1	175	175	
1.02 Lobby	1	1,650	1,650	
1.03 Reception Desk	1	125	125	
1.04 Registration/ Check-in	1	620	620	
1.05 Consultation/Private Registration	1	165	165	
1.06 Registration Work	1	295	295	
1.07 Family Waiting	75	25	1,875	
1.08 Coffee / Vending	1	85	85	
1.09 Toilet: Public	2	195	390	accessible
1.10 Toilet: Family	1	95	95	accessible
1.10 Alcove: Wheelchair/Stretcher	1	60	60	
1.11 Pre-Admission Testing	1	1575	1,575	
1.12 EVS	1	125	125	
Sub-Total, PUBLIC AREAS			***7,235***	***Net Square Feet***
			1.5	Grossing Factor
			10,853	**Departmental Gross SF**
2.00 PATIENT PREP/RECOVERY				***Pre-op & Phase II Recovery***
2.01 Prep Room	14	120	1,680	private rooms
2.02 Phase II Room	18	120	2,160	private rooms
2.03 Nurse Station / Charting	3	240	720	
2.04 Alcove: Emergency Equipment	1	20	20	
2.05 Alcove: Cart Storage	4	20	80	
2.06 Toilet: Patient	5	65	325	
2.07 Toilet: Staff	2	65	130	unisex
2.08 Clean Utility / Linen	1	225	225	
2.09 Soiled Utility / Soiled Holding	1	225	225	
2.10 Medication/ Nourishment	2	85	170	
2.11 Equipment Storage	1	225	225	
2.12 Manager Office	1	115	115	
Sub-Total, PATIENT PREP/RECOVERY			***6,075***	***Net Square Feet***
			1.55	Grossing Factor
			9,416	**Departmental Gross SF**
3.00 PROCEDURE AREA				
3.01 Clean Case Cart Holding	1	340	340	
3.02 Soiled Case Cart	2	250	500	
Sub-Total, PROCEDURE AREA			***840***	***Net Square Feet***
			1.25	Grossing Factor
			1,050	**Departmental Gross SF**
4.00 STAFF SUPPORT				

Surgical Services Replacement Facility

Date: August 5, 2016

Ground Floor

Element	Proposed Quantity	Proposed Net SF	Total Proposed Net SF	Comments
4.01 Locker: Male	1	750	750	shared w/ Pre-op, Phase II Recovery and PACU
4.02 Locker: Female	1	750	750	shared w/ Pre-op, Phase II Recovery and PACU
4.03 Toilet/Shower	2	325	650	Male/Female; 4 stalls each
4.04 Team Lounge	1	375	380	
4.05 Perioperative Administration	1	2450	2,460	
4.06 Conference / Teaching	2	220	440	
4.07 EVS	1	120	120	
Sub-Total, STAFF SUPPORT			***5,550***	***Net Square Feet***
			1.2	Grossing Factor
			6,660	**Departmental Gross SF**
TOTAL DEPARTMENTAL GROSS SQUARE FEET			**27,979**	DGSF
		x	1.1	Building Grossing Factor (Individual Floor Only
GROUND FLOOR GROSS SQUARE FEET			**30,777**	**Building Gross SF**

Notes:
1. Net square feet is the area inside a room, excluding walls, chases…
2. Department gross square feet (DGSF) includes corridors and wall thicknesses.
3. Building gross square feet (BGSF) includes elevators, elevator lobbies, shafts, mechanical equipment rooms, electric distribution rooms, and exterior wall thicknesses.
4. Grossing factor allows for 8' corridors, assuming this area serves inpatients as well as outpatients.

Surgical Services Replacement Facility

Date: August 5, 2016

First Floor

Element	Proposed Quantity	Proposed Net SF	Total Proposed Net SF	Comments
1.00 PROCEDURE AREA				
1.01 Control	1	235	235	
1.02 Holding	4	105	420	
1.03 Operating Room (Hybrid)	1	800	800	
1.04 Hybrid O.R. Equipment	1	135	135	
1.05 Hybrid O.R. Control	1	135	135	
1.06 Operating Room	8	675	5,400	
1.07 Operating Room	2	700	1,400	
1.08 Operating Room	2	650	1,300	
1.09 Operating Room (Bronchoscopy)	1	715	715	
1.10 Vestibule	1	125	125	
1.11 Physician Dictation	4	30	120	
1.12 Scrub	14	15	210	1 per OR
1.13 Clean Core/ Sub-Sterile	14	230	3,220	230 sf / OR
1.14 Alcove: Stretcher	14	30	420	
1.15 Alcove: Equipment	6	35	210	
1.16 Anesthesia Workroom / Storage	1	1050	1,050	
1.17 Soiled Utility / Holding	1	295	295	
1.18 Equipment Storage	1	1000	1,000	Dispersed in 3-4 rooms
1.19 EVS	1	75	75	off semi-restricted area
Sub-Total, PROCEDURE AREA			***17,265***	***Net Square Feet***
			1.55	Grossing Factor
			26,761	**Departmental Gross SF**
2.00 PACU				***Phase I Recovery***
2.01 PACU Statio	20	110	2,200	
2.02 PACU (Isolation)	1	135	135	
2.03 Nurse Work Area	2	245	490	
2.04 Toilet: Staff	1	55	55	unisex
2.05 Toilet: Patient	1	55	55	unisex
2.06 Alcove: Cart Storage	2	20	40	
2.07 EVS	1	60	60	
2.08 Clean Utility / Linen	1	235	235	
2.09 Soiled Utility / Soiled Holding	1	175	175	
2.10 Medication/ Nourishment	1	80	80	
2.11 Equipment Storage	1	200	200	
Sub-Total, PACU			***3,725***	***Net Square Feet***
			1.55	Grossing Factor
			5,774	**Departmental Gross SF**

Surgical Services Replacement Facility

Date: August 5, 2016

First Floor

Element	Proposed Quantity	Proposed Net SF	Total Proposed Net SF	Comments
4.00 STAFF SUPPORT				
4.01 Locker: Male	0	700	0	on Entry Level
4.02 Locker: Female	0	700	0	on Entry Level
4.03 Toilet/Shower	0	300	0	on Entry Level
4.04 Team Lounge	1	520	520	shared w/ PACU
4.05 Physician Dictation/ Lounge	1	275	275	shared w/ PACU
4.06 Toilet: Staff	1	75	75	unisex
4.07 Perioperative Administration	0	0	0	
4.08 Conference / Teaching	0	200	0	
Sub-Total, STAFF SUPPORT			***870***	***Net Square Feet***
			1.2	Grossing Factor
			1,044	**Departmental Gross SF**
TOTAL DEPARTMENTAL GROSS SQUARE FEET			**33,579**	DGSF
		x	1.1	Building Grossing Factor (Individual Floor Only
FIRST FLOOR GROSS SQUARE FEET			**36,936**	**Building Gross SF**
Ground Floor BGSF			***30,777***	
First Floor BGSF			***36,936***	
Mechanical/Electrical Room			***6,500***	
Connection to Existing Hospital			***750***	
Total Building Gross Square Feet			***74,963***	
Total DGSF			***56,965***	

Notes:
1. Net square feet is the area inside a room, excluding walls, chases…
2. Department gross square feet (DGSF) includes corridors and wall thicknesses.
3. Building gross square feet (BGSF) includes elevators, elevator lobbies, shafts, mechanical equipment rooms, electric distribution rooms, and exterior wall thicknesses.
4. Grossing factor allows for 8' corridors, assuming this area serves inpatients as well as outpatients.

Attachment 7: 13. Features of Project Construction, A. Table C

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	37,591	
First Floor	37,409	600
Second Floor		
Third Floor		
Fourth Floor		
Average Square Feet	**37,500**	
Perimeter in Linear Feet	**Linear Feet**	
Basement	880	
First Floor	868	
Second Floor		
Third Floor		
Fourth Floor		
Total Linear Feet	**1,748**	
Average Linear Feet	**874**	
Wall Height (floor to eaves)	**Feet**	
Basement	14	
First Floor	18	
Second Floor		
Third Floor		
Fourth Floor		
Average Wall Height	**15**	
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger	5	
Freight		
Sprinklers	**Square Feet Covered**	
Wet System	75,000	
Dry System	2,970	
Other	**Describe Type**	
Type of HVAC System for proposed project		
Type of Exterior Walls for proposed project		

Attachment 8: 13. Features of Project Construction, A. Table D

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	*Additional Instruction*
SITE PREPARATION COSTS			
Normal Site Preparation			*As defined by Marshall Valuation Service, includes excavation for foundation, backfill and finish grading*
Utilities from Structure to Lot Line			*For typical setback*
Subtotal included in Marshall Valuation Costs			*Calculate the sum of normal site preparation and utilities from structure to lot line*
Site Demolition Costs	**$331,349**		
Storm Drains	**$183,160**		
Rough Grading	**$432,228**		
Hillside Foundation			
Paving	**$314,951**		
Exterior Signs			
Landscaping	$314,757		
Walls	$158,056		
Yard Lighting	$96,848		
Other *(Specify/add rows if needed)*	$55,988		Undercut Clay Layer
Subtotal On-Site excluded from Marshall Valuation Costs	**$1,887,336**		*Calculate sum of all on-site costs excluded from MVS*
OFFSITE COSTS			
Roads			
Utilities	$896,550		Sanitary Sewer Connections
Jurisdictional Hook-up Fees			
Other *(Specify/add rows if needed)*			
Subtotal Off-Site excluded from Marshall Valuation Costs	**$896,550**		*Calculate sum of all off-site costs excluded from MVS*
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$2,783,886**	**$0**	*Ensure that sum includes costs excluded from MVS*
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$2,783,886**	**$0**	*Ensure that sum includes all costs*

*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.

Attachment 9: Part II: TABLE E. PROJECT BUDGET

	Hospital Building	*Other Structure*	*Total*
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. Land Purchase	**$ -**	**$ -**	**$ -**
b. New Construction			
(1) Building	$ 39,863,917		$ 39,863,917
(2) Fixed Equipment	$ 2,547,768		$ 2,547,768
(3) Site and Infrastructure	$ 2,783,886		$ 2,783,886
(4) Architect/Engineering Fees	$ 4,740,077		$ 4,740,077
(5) Permits (Building, Utilities, Etc.)	$ 954,000		$ 954,000
SUBTOTAL	**$ 50,889,648**	**$ -**	**$ 50,889,648**
c. Renovations			
(1) Building	$180,000		$ 180,000
(2) Fixed Equipment (not included in construction)			$ -
(3) Architect/Engineering Fees			$ -
(4) Permits (Building, Utilities, Etc.)			$ -
SUBTOTAL	**$ 180,000**	**$ -**	**$ 180,000**
d. Other Capital Costs			
(1) Movable Equipment	$ 9,596,155		$ 9,596,155
(2) Contingency Allowance	$ 2,985,346		$ 2,985,346
(3) Gross interest during construction period	$ 3,967,000		$ 3,967,000
(4) Other *(Specify/add rows if needed)*	$ -		$ -
SUBTOTAL	**$ 16,548,501**	**$ -**	**$ 16,548,501**
TOTAL CURRENT CAPITAL COSTS	**$ 67,618,149**	**$ -**	**$ 67,618,149**
e. Inflation Allowance	$ 1,588,851		$ 1,588,851
TOTAL CAPITAL COSTS	**$ 69,207,000**	**$ -**	**$ 69,207,000**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees	$ 614,000		$ 614,000
b. Bond Discount	$ 179,000		$ 179,000
c. Legal Fees	$ -		$ -
d. Non-Legal Consultant Fees	$ -		$ -
e. Liquidation of Existing Debt	$ -		$ -
f. Debt Service Reserve Fund	$ -		$ -
g. Other	$ -		$ -
SUBTOTAL	***$ 793,000***	***$ -***	**$ 793,000**
3. Working Capital Startup Costs	$ -	$ -	$ -
TOTAL USES OF FUNDS	***$ 70,000,000***	***$ -***	***$ 70,000,000***
B. Sources of Funds			
1. Cash	$ 10,000,000		$ 10,000,000
2. Philanthropy (to date and expected)	$ 20,000,000		$ 20,000,000
3. Authorized Bonds	$ 39,670,000		$ 39,670,000
4. Interest Income from bond proceeds listed in #3	$ 330,000		$ 330,000
5. Mortgage	$ -		$ -
6. Working Capital Loans	$ -		$ -
7. Grants or Appropriations			
a. Federal	$ -		$ -
b. State	$ -		$ -
c. Local	$ -		$ -
8. Other *(Specify/add rows if needed)*	$ -		$ -
TOTAL SOURCES OF FUNDS	***$ 70,000,000***	***$ -***	***$ 70,000,000***
Annual Lease Costs (if applicable)			
1. Land	$ -		$ -
2. Building	$ -		$ -
3. Major Movable Equipment	$ -		$ -
4. Minor Movable Equipment	$ -		$ -
5. Other *(Specify/add rows if needed)*	$ -		$ -

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.

Attachment 10: TABLE F – STATISTICAL PROJECTIONS – ENTIRE FACILITY

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.					
Fiscal Years Jul-June	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22
1. DISCHARGES									
a. General Medical/Surgical*	14,748	14,076	13,793	13,938	14,160	14,188	14,266	14,281	14,271
b. ICU	1,260	1,276	1,198	1,175	1,180	1,185	1,185	1,185	1,185
Total MSGA	**16,008**	**15,352**	**14,991**	**15,113**	**15,340**	**15,373**	**15,451**	**15,466**	**15,456**
c. Pediatric	459	481	280	275	270	280	275	275	280
d. Obstetric	3,090	3,203	3,030	3,030	3,030	3,030	3,030	3,030	3,030
e. Acute Psychiatric[1]	1,972	2,205	2,255	2,255	2,260	2,260	2,265	2,250	2,255
Total Acute	***21,529***	***21,241***	***20,556***	***20,673***	***20,900***	***20,943***	***21,021***	***21,021***	***21,021***
f. Rehabilitation	0	0	0	0	0	0	0	0	0
g. Comprehensive Care	0	0	0	0	0	0	0	0	0
h. Other (Specify/add rows of needed)	0	0	0	0	0	0	0	0	0
TOTAL DISCHARGES	***21,529***	***21,241***	***20,556***	***20,673***	***20,900***	***20,943***	***21,021***	***21,021***	***21,021***
2. PATIENT DAYS									
a. General Medical/Surgical*	65,979	63,789	64,196	57,584	58,631	58,822	59,173	59,173	59,173
b. ICU	7,560	7,725	7,066	7,050	6,962	6,992	6,992	6,992	6,992
Total MSGA	**73,539**	**71,514**	**71,262**	**64,634**	**65,593**	**65,814**	**66,165**	**66,165**	**66,165**
c. Pediatric	930	1,195	720	720	720	720	720	720	720
d. Obstetric	7,875	7,984	7,567	7,567	7,567	7,567	7,567	7,567	7,567
e. Acute Psychiatric	10,562	12,649	12,750	12,805	12,805	12,805	12,805	12,805	12,805
Total Acute	***92,906***	***93,342***	***92,299***	***85,726***	***86,685***	***86,906***	***87,257***	***87,257***	***87,257***
f. Rehabilitation	0	0	0	0	0	0	0	0	0
g. Comprehensive Care	0	0	0	0	0	0	0	0	0
h. Other (Specify/add rows of needed)	0	0	0	0	0	0	0	0	0
TOTAL PATIENT DAYS	***92,906***	***93,342***	***92,299***	***85,726***	***86,685***	***86,906***	***87,257***	***87,257***	***87,257***

* 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.

[1]Includes only those patients discharged from MFSMC's Psychiatric Unit. Some patients cared for on medical floors are discharged with Psychiatric MS-DRGs. These patient are not included in this count. They are included in the General Medical/Surgical count.

Attachment 10: TABLE F – STATISTICAL PROJECTIONS – ENTIRE FACILITY (con't)

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

	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.					
Indicate CY or FY	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)									
a. General Medical/Surgical*	4.5	4.5	4.7	4.1	4.1	4.1	4.1	4.1	4.1
b. ICU	6.0	6.1	5.9	6.0	5.9	5.9	5.9	5.9	5.9
Total MSGA	4.6	4.7	4.8	4.3	4.3	4.3	4.3	4.3	4.3
c. Pediatric	2.0	2.5	2.6	2.6	2.7	2.6	2.6	2.6	2.6
d. Obstetric	2.5	2.5	2.5		2.5	2.5	2.5	2.5	2.5
e. Acute Psychiatric	5.4	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7
Total Acute	4.3	4.4	4.5	4.1	4.1	4.1	4.2	4.2	4.2
f. Rehabilitation	-	-	-	-	-	-	-	-	-
g. Comprehensive Care	-	-	-	-	-	-	-	-	-
h. Other (Specify/add rows of needed)	-	-	-	-	-	-	-	-	-
TOTAL AVERAGE LENGTH OF STAY	**4.3**	**4.4**	**4.5**	**4.1**	**4.1**	**4.1**	**4.2**	**4.2**	**4.2**
4. NUMBER OF LICENSED BEDS									
a. General Medical/Surgical*	233	240	250	239	245	245	245	245	245
b. ICU/CCU	28	28	28	28	28	28	28	28	28
Total MSGA	**261**	**268**	**278**	**267**	**273**	**273**	**273**	**273**	**273**
c. Pediatric	9	9	9	9	9	9	9	9	9
d. Obstetric	37	37	37	37	37	37	37	37	37
e. Acute Psychiatric	40	40	40	40	40	40	40	40	40
Total Acute	***347***	***354***	***364***	***353***	***359***	***359***	***359***	***359***	***359***
f. Rehabilitation	0	0	0	0	0	0	0	0	0
g. Comprehensive Care	0	0	0	0	0	0	0	0	0
h. Other (Specify/add rows of needed)	0	0	0	0	0	0	0	0	0
TOTAL LICENSED BEDS	***347***	***354***	***364***	***353***	***359***	***359***	***359***	***359***	***359***

Attachment 10: TABLE F – STATISTICAL PROJECTIONS – ENTIRE FACILITY

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

	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.					
Indicate CY or FY	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*									
a. General Medical/Surgical*	77.6%	72.8%	70.2%	66.0%	65.6%	65.8%	66.0%	66.2%	66.2%
b. ICU	74.0%	75.6%	69.0%	69.0%	68.1%	68.4%	68.2%	68.4%	68.4%
Total MSGA	**77.2%**	**73.1%**	**70.0%**	**66.3%**	**65.8%**	**66.0%**	**66.2%**	**66.4%**	**66.4%**
c. Pediatric	28.3%	36.4%	21.9%	21.9%	21.9%	21.9%	21.9%	21.9%	21.9%
d. Obstetric	58.3%	59.1%	55.9%	56.0%	56.0%	56.0%	55.9%	56.0%	56.0%
e. Acute Psychiatric	72.3%	86.6%	87.1%	87.7%	87.7%	87.7%	87.5%	87.7%	87.7%
Total Acute	**73.4%**	**72.2%**	**69.3%**	**66.5%**	**66.2%**	**66.3%**	**66.4%**	**66.6%**	**66.6%**
f. Rehabilitation	-	-	-	-	-	-	-	-	-
g. Comprehensive Care	-	-	-	-	-	-	-	-	-
h. Other (Specify/add rows of needed)	-	-	-	-	-	-	-	-	-
TOTAL OCCUPANCY %	**73.4%**	**72.2%**	**69.3%**	**66.5%**	**66.2%**	**66.3%**	**66.4%**	**66.6%**	**66.6%**
6. OUTPATIENT VISITS									
a. Emergency Department[2]	88,833	86,609	81,946	81,802	81,016	80,300	79,590	93,746	93,746
b. Same-day Surgery[3]	12,746	13,352	12,655	12,950	13,080	13,211	13,343	13,343	13,343
c. Laboratory[4]									
d. Imaging[4]									
e. Other (Specify/add rows of needed)[5]	292,608	340,800	342,502	345,927	349,386	352,880	355,527	355,527	355,527
TOTAL OUTPATIENT VISITS	***394,187***	***440,761***	***437,103***	***440,679***	***443,482***	***446,391***	***448,460***	***462,616***	***462,616***
7. OBSERVATIONS**									
a. Number of Patients	10,078	10,699	10,841	10,742	10,742	10,646	10,646	10,646	10,646
b. Hours	416,221	487,874	501,938	425,383	418,938	404,548	399,225	383,256	372,610

[2]Excludes ED pateint visits that resulted in an admission.

[3]This data represents all MFSMC patient visits with a Same Day Surgery Code, including endoscopy, interventional pain, etc. Some of these cases do not take place in MFSMC's ORs and so are not included in the OR Need calulation.

[4]MFSMC accounts for Imaging and Laboratory volume in Relative Value Units (RVUs) not patient visits. For consistency in the summing of outpatient visits, MFSMC is not including the RVUs here. MFSMC will forward the Commission staff the appropriate RVU data at the staff's request.

[5]Includes clinic visits, physician office visits, etc. Part of the variance between FY14 and FY15 is due to better capturing of outpatient visit data.

Attachment 11: MFSMC Financial Projection Assumptions

Below are the assumptions related to MFSMC's Financial Projections for the FY16-FY22 time period.

A. FY16 revenue and expense projections are based on actual data through March FY16.

B. FY17 revenue and expense projections are based on the hospital's approved budget for FY17.

C. FY18-FY22 projections are based on the following assumptions:

a. Revenues

1.) Inflationary Growth:

a. HSCRC annual revenue inflation assumed to grow at 2% per year from FY18-FY22 prior to any incremental rate associated with the capital project

b. Professional fee annual revenue inflation assumed to be 1.5% from FY18-FY22

i. Professional fee revenue also grows with volumes over the forecasted period

2.) Contractuals, Bad Debt, and Charity

a. Contractuals: Contractuals are expected to hold relatively constant as **a** percent of gross revenue over the forecasted period

i. HSCRC contractuals equal 11% per year from FY18-FY22 which is consistent with the FY17 budget

ii. Professional contractuals equal 53% - 54% per year from FY18-FY22 which is consistent with the FY17 budget

b. Bad Debt: Remains consistent with FY17 budget and is constant at 3.6% of Gross Revenues between FY18-FY22

c. Charity Care and Uncompensated Care Pool: Remains consistent with FY17 budget and is constant at 1% of Gross Revenues between FY18-FY22

3.) Rate Adjustment

a. Beginning in FY20, the projections assume that MFSMC is reimbursed 100% of the interest expense, depreciation and amortization expenses. This reimbursement is captured in the revenue projections submitted. The table below (following page) details these expenses.

Attachment 11: MFSMC Financial Projection Assumptions (con't)

	Projection Years						
	2016	2017	2018	2019	2020	2021	2022
Baseline	(in thousands)						
Depreciation/Amortization	$22,768	$23,614	$23,504	$23,364	$21,744	$21,167	$20,748
Interest	$7,640	$7,966	$8,137	$8,057	$7,840	$7,762	$7,684
Project Depreciation, Amortization, and Interest							
Depreciation/Amortization	$0	$0	$26	$26	$1,404	$2,782	$2,782
Interest	$0	$0	$0	$0	$1,983	$1,950	$1,914
Total Depreciation, Amortization, and Interest							
Depreciation/Amortization	$22,768	$23,614	$23,530	$23,390	$23,148	$23,949	$23,530
Interest	$7,640	$7,966	$8,137	$8,057	$9,823	$9,712	$9,598

4.) Other operating revenue
   a. FY18-FY19 includes a reduction of 6.4% in FY18 and a reduction of 2.9% in FY19 due to the decline in meaningful use revenue.
   b. FY20-FY22 does not include any growth or decline in other operating revenues

b) **Expenses**

FY18-FY22 expense assumptions are made up of the following components: inflationary assumptions associated with expense growth, variability assumptions that link the activity at the hospital with growth in expenses absent inflation, expense savings associated with changes in one time or short term expenses, savings associated with management initiatives to achieve operating targets, cost savings associated with the Surgical Services Replacement project and increased costs, through depreciation and interest, associated with the project.

The specific assumptions are as follows:

1.) Inflationary Growth Assumptions (FY18-FY22):
   a. Salary and Wages grown at 3% annually
      i. Benefits remained constant as a percentage of salaries at approximately 20%
   b. Professional Fees grown at 2% annually
   c. Medical Supplies grown at 1.5% annually
   d. Other Supplies grown at 2% annually
   e. Drugs and Pharmaceuticals grown at 7% in FY18 and 6% annually
   f. Purchased Services grown at 3% annually from FY18 – FY22
   g. Utilities & Other Expenses grown at 2% annually from FY18 – FY22
   h. MedStar Corporate Shared Services (services provided to all MedStar Hospitals and allocated back to each hospital) grown at 3% annually from FY18 – FY22
   i. All expense inflation prior to savings initiatives as described below (#3)

Attachment 11: MFSMC Financial Projection Assumptions (con't)

2.) Expense Variability Assumptions (as a function of patient volumes)

a. The projections utilized estimates of variability of expense classes in relation to volume activity at the Hospital. A 100% variability assumption would imply that costs move in a 1:1 relation with volumes. A 0% variability assumption would imply that costs do not move at all in relation to volumes. The table to the right highlights the variability assumptions broken out by major expense class.

Variability of Expense	Variability
Routine Salaries	80.0%
Ancillary Salaries	50.0%
Other Salaries	10.0%
Physicians Salaries	0.0%
Administrative Salaries	10.0%
Contract Labor	0.0%
Professional Fees	10.0%
Medical Supplies	100.0%
Other Supplies	30.0%
Drugs and Pharmaceuticals	100.0%
Purchased Services	30.0%
Insurance	20.0%
Utilities	0.0%
Shared Services	0.0%
Other Expenses	20.0%
Facilities	20.0%

3.) Expense reductions and savings initiatives

a) The projections include savings meant to counteract inflationary pressures. The savings will result from a MedStar Health-wide performance and operational excellence initiative that will enable and accelerate MFSMC's ability to optimally deliver efficient and effective, high quality patient care at a high value to our patients and the Maryland's Healthcare System. The initiative is focusing on the following:

i. Identifying and implementing cost reduction strategies in multiple administrative support services through operational improvements, enhanced 'systemness', rationalized service levels and innovation

ii. Improved performance through enhanced clinical productivity

iii. Reducing 20 FTEs, about $2M in salary expenses resulting from the consolidation of the current two separate OR suites into one facility

Attachment 11: MFSMC Financial Projection Assumptions (con't)

iv. Realignment of resources and reductions in management overhead through rationalized spans-of-control and a streamlined organizational structure

v. Creation of greater enterprise-wide synergies in the oversight of our employed provider network

vi. Improving the process of care as it relates to length-of-stay management across the continuum of care and management of observation status patients

vii. Enhancing the strategic positioning of the organization's Supply Chain function, including external relationships, internal organization and governance structure and core process management

The table below details savings by major category and specific initiative/purpose on an incremental basis that have been included in the financial projections:

	Projection Years				
	2018	2019	2020	2021	2022
Identified Savings ($000s) - Incremental	(in thousands)				
OR Efficiency Gains - Salaries/Wages			$963	$1,021	
Performance Transformation Savings - Salaries/Wages				$1,764	$2,753
Performance Transformation Savings - Supplies	$2,781	$2,060	$1,339	$445	$704
Performance Transformation Savings - Purchased Services	$102			$218	$341
Performance Transformation Savings - Other				$584	$906
Consulting Fee Deduction	$515				
Cerner MedConnect - One Time Costs (50%)	$1,706				
Total	**$5,104**	**$2,060**	**$2,302**	**$4,032**	**$4,703**

4.) Non-Operating expenses: Assumptions associated with the financing costs of the project

a. Total bond size of $39.6 million with level P&I payments in forecast
b. No Land Purchase Assumed
c. Project is to begin in FY18, construction period assumed for 2 years
d. First full year of depreciation and interest in FY21
e. Assumed Cost of issuance for debt at 2% of debt funding; Bond Interest Rate at 5%
f. Average life of project assumed to be 25 years

The table below summarizes the debt service assumptions for the project.

Attachment 11: MFSMC Financial Projection Assumptions (con't)

	Projection Years				
	2018	2019	2020	2021	2022
Debt Service - OR Project	(in thousands)				
Interest Expense [1]	$1,983	$1,983	$1,983	$1,950	$1,914
Principal Payment	N/A	N/A	$679	$713	$749
Total	**$1,983**	**$1,983**	**$2,662**	**$2,663**	**$2,663**

Note (1): Interest expense is capitalized in FY18 & FY19

Attachment 12: TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns 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	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
1. REVENUE									
a. Inpatient Services	$ 355,074	$ 342,280	$ 346,037	$ 357,938	$ 358,480	$ 358,578	$ 360,759	$ 361,560	$ 361,539
b. Outpatient Services	$ 325,220	$ 321,486	$ 345,100	$ 351,370	$ 351,464	$ 351,138	$ 353,230	$ 354,017	$ 353,996
Gross Patient Service Revenues	***$ 680,294***	***$ 663,766***	***$ 691,137***	***$ 709,308***	***$ 709,945***	***$ 709,717***	***$ 713,990***	***$ 715,577***	***$ 715,534***
c. Allowance For Bad Debt	$ 18,522	$ 18,511	$ 24,476	$ 25,801	$ 25,824	$ 25,816	$ 25,971	$ 26,029	$ 26,028
d. Contractual Allowance	$ 174,400	$ 149,425	$ 151,549	$ 155,810	$ 156,139	$ 156,022	$ 156,607	$ 156,776	$ 156,771
e. Charity Care	$ 10,517	$ 2,956	$ 6,646	$ 6,965	$ 6,971	$ 6,969	$ 7,011	$ 7,027	$ 7,026
Net Patient Services Revenue	***$ 476,855***	***$ 492,874***	***$ 508,466***	***$ 520,732***	***$ 521,010***	***$ 520,909***	***$ 524,400***	***$ 525,745***	***$ 525,709***
f. Other Operating Revenues (Specify/add rows if needed)	$ 13,341	$ 12,281	$ 12,894	$ 11,392	$ 10,667	$ 10,367	$ 10,367	$ 10,367	$ 10,367
NET OPERATING REVENUE	***$ 490,196***	***$ 505,155***	***$ 521,360***	***$ 532,124***	***$ 531,677***	***$ 531,276***	***$ 534,767***	***$ 536,112***	***$ 536,076***
2. EXPENSES									
a. Salaries & Wages (including benefits)	$ 252,303	$ 258,764	$ 274,010	$ 280,213	$ 281,247	$ 281,422	$ 280,899	$ 278,255	$ 275,502
b. Contractual Services	$ 3,532	$ 4,704	$ 4,795	$ 4,597	$ 4,601	$ 4,601	$ 4,603	$ 4,575	$ 4,532
c. Interest on Current Debt	$ 9,586	$ 8,916	$ 7,640	$ 7,966	$ 8,137	$ 8,057	$ 7,840	$ 7,762	$ 7,684
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,983	$ 1,950	$ 1,914
e. Current Depreciation	$ 24,345	$ 24,281	$ 22,768	$ 23,614	$ 23,504	$ 23,364	$ 21,744	$ 21,167	$ 20,748
f. Project Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,378	$ 2,756	$ 2,756
g. Current Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
h. Project Amortization	$ -	$ -	$ -	$ -	$ 26	$ 26	$ 26	$ 26	$ 26
i. Supplies	$ 76,019	$ 75,260	$ 74,060	$ 73,026	$ 70,924	$ 69,002	$ 67,916	$ 67,471	$ 66,767
j. Other Expenses (Specify/add rows if needed)	$ 61,397	$ 71,457	$ 82,581	$ 89,241	$ 89,212	$ 89,222	$ 89,247	$ 88,691	$ 87,829
k. Purchased Services	$ 41,619	$ 44,339	$ 45,974	$ 36,469	$ 34,409	$ 34,422	$ 34,457	$ 34,239	$ 33,897
TOTAL OPERATING EXPENSES	**$ 468,801**	**$ 487,721**	**$ 511,828**	**$ 515,126**	**$ 512,060**	**$ 510,116**	**$ 510,093**	**$ 506,892**	**$ 501,655**
3. INCOME									
a. Income From Operation	**$ 21,395**	**$ 17,434**	**$ 9,532**	**$ 16,998**	**$ 19,617**	**$ 21,160**	**$ 24,674**	**$ 29,220**	**$ 34,421**
b. Non-Operating Income	$ 349	$ 39							
SUBTOTAL	***$ 21,744***	***$ 17,473***	***$ 9,532***	***$ 16,998***	***$ 19,617***	***$ 21,160***	***$ 24,674***	***$ 29,220***	***$ 34,421***

Attachment 12: TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY (con't)

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns 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	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
4. PATIENT MIX									
a. Percent of Total Revenue									
1) Medicare	42.6%	43.1%	43.8%	43.8%	43.8%	43.8%	43.8%	43.8%	43.8%
2) Medicaid	20.8%	25.5%	24.9%	24.9%	24.9%	24.9%	24.9%	24.9%	24.9%
3) Blue Cross	11.2%	10.3%	9.4%	9.4%	9.4%	9.4%	9.4%	9.4%	9.4%
4) Commercial Insurance	11.0%	8.6%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
5) Self-pay	6.0%	3.7%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
6) Other	8.6%	8.8%	9.9%	9.9%	9.9%	9.9%	9.9%	9.9%	9.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days									
1) Medicare	42.6%	43.1%	43.8%	43.8%	43.8%	43.8%	43.8%	43.8%	43.8%
2) Medicaid	20.8%	25.5%	24.9%	24.9%	24.9%	24.9%	24.9%	24.9%	24.9%
3) Blue Cross	11.2%	10.3%	9.4%	9.4%	9.4%	9.4%	9.4%	9.4%	9.4%
4) Commercial Insurance	11.0%	8.6%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
5) Self-pay	6.0%	3.7%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
6) Other	8.6%	8.8%	9.9%	9.9%	9.9%	9.9%	9.9%	9.9%	9.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Attachment 13: TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns 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	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
1. REVENUE									
a. Inpatient Services	$ 355,074	$ 342,280	$ 346,037	$ 357,938	$ 365,649	$ 373,064	$ 382,717	$ 391,132	$ 398,878
b. Outpatient Services	$ 325,220	$ 321,486	$ 345,100	$ 351,370	$ 358,493	$ 365,323	$ 374,729	$ 382,971	$ 390,554
Gross Patient Service Revenues	***$ 680,294***	***$ 663,766***	***$ 691,137***	***$ 709,308***	***$ 724,143***	***$ 738,388***	***$ 757,447***	***$ 774,103***	***$ 789,431***
c. Allowance For Bad Debt	$ 18,522	$ 18,511	$ 24,476	$ 25,801	$ 26,340	$ 26,859	$ 27,552	$ 28,158	$ 28,716
d. Contractual Allowance	$ 174,400	$ 149,425	$ 151,549	$ 155,810	$ 159,712	$ 163,238	$ 167,563	$ 171,547	$ 175,443
e. Charity Care	$ 10,517	$ 2,956	$ 6,646	$ 6,965	$ 7,110	$ 7,250	$ 7,437	$ 7,601	$ 7,751
Net Patient Services Revenue	***$ 476,855***	***$ 492,874***	***$ 508,466***	***$ 520,732***	***$ 530,981***	***$ 541,041***	***$ 554,895***	***$ 566,797***	***$ 577,521***
f. Other Operating Revenues (Specify/add rows if needed)	$ 13,341	$ 12,281	$ 12,894	$ 11,392	$ 10,667	$ 10,367	$ 10,367	$ 10,367	$ 10,367
NET OPERATING REVENUE	***$ 490,196***	***$ 505,155***	***$ 521,360***	***$ 532,124***	***$ 541,648***	***$ 551,408***	***$ 565,262***	***$ 577,164***	***$ 587,888***
2. EXPENSES									
a. Salaries & Wages (including benefits)	$ 252,303	$ 258,764	$ 274,010	$ 280,213	$ 289,275	$ 297,726	$ 305,678	$ 311,678	$ 317,919
b. Contractual Services	$ 3,532	$ 4,704	$ 4,795	$ 4,596	$ 4,692	$ 4,786	$ 4,884	$ 4,953	$ 5,009
c. Interest on Current Debt	$ 9,586	$ 8,916	$ 7,640	$ 7,966	$ 8,137	$ 8,057	$ 7,840	$ 7,762	$ 7,684
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,983	$ 1,950	$ 1,914
e. Current Depreciation	$ 24,345	$ 24,281	$ 22,768	$ 23,614	$ 23,504	$ 23,364	$ 21,744	$ 21,167	$ 20,748
f. Project Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,378	$ 2,756	$ 2,756
g. Current Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
h. Project Amortization	$ -	$ -	$ -	$ -	$ 26	$ 26	$ 26	$ 26	$ 26
i. Supplies	$ 76,019	$ 75,260	$ 74,060	$ 73,026	$ 73,732	$ 74,473	$ 76,227	$ 78,603	$ 80,865
j. Other Expenses (Specify/add rows if needed)	$ 61,397	$ 71,457	$ 82,581	$ 89,241	$ 91,487	$ 93,833	$ 96,257	$ 98,162	$ 99,822
k. Purchased Services	$ 41,619	$ 44,339	$ 45,974	$ 36,469	$ 35,442	$ 36,519	$ 37,653	$ 38,564	$ 39,387
TOTAL OPERATING EXPENSES	**$ 468,801**	**$ 487,721**	**$ 511,828**	**$ 515,125**	**$ 526,295**	**$ 538,784**	**$ 553,670**	**$ 565,622**	**$ 576,130**
3. INCOME									
a. Income From Operation	**$ 21,395**	**$ 17,434**	**$ 9,532**	**$ 16,999**	**$ 15,353**	**$ 12,624**	**$ 11,592**	**$ 11,542**	**$ 11,758**
b. Non-Operating Income	$ 349	$ 39							
SUBTOTAL	***$ 21,744***	***$ 17,473***	***$ 9,532***	***$ 16,999***	***$ 15,353***	***$ 12,624***	***$ 11,592***	***$ 11,542***	***$ 11,758***
c. Income Taxes									
NET INCOME (LOSS)	***$ 21,744***	***$ 17,473***	***$ 9,532***	***$ 16,999***	***$ 15,353***	***$ 12,624***	***$ 11,592***	***$ 11,542***	***$ 11,758***

Attachment 13: TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY (con't)

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns 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	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
4. PATIENT MIX									
a. Percent of Total Revenue									
1) Medicare	42.6%	43.1%	43.8%	43.8%	43.8%	43.8%	43.8%	43.8%	43.8%
2) Medicaid	20.8%	25.5%	24.9%	24.9%	24.9%	24.9%	24.9%	24.9%	24.9%
3) Blue Cross	11.2%	10.3%	9.4%	9.4%	9.4%	9.4%	9.4%	9.4%	9.4%
4) Commercial Insurance	11.0%	8.6%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
5) Self-pay	6.0%	3.7%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
6) Other	8.6%	8.8%	9.9%	9.9%	9.9%	9.9%	9.9%	9.9%	9.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days									
Total MSGA									
1) Medicare	42.6%	43.1%	43.8%	43.8%	43.8%	43.8%	43.8%	43.8%	43.8%
2) Medicaid	20.8%	25.5%	24.9%	24.9%	24.9%	24.9%	24.9%	24.9%	24.9%
3) Blue Cross	11.2%	10.3%	9.4%	9.4%	9.4%	9.4%	9.4%	9.4%	9.4%
4) Commercial Insurance	11.0%	8.6%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
5) Self-pay	6.0%	3.7%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
6) Other	8.6%	8.8%	9.9%	9.9%	9.9%	9.9%	9.9%	9.9%	9.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Attachment 14: 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)
1. Regular Employees											
Administration (List general categories,											
Office/Clerical	247	$ 47,255	$ 11,660,496				-6	$ 47,255	$ (268,399)	241	$ 11,392,096
Management	107	$ 194,575	$ 20,908,604				-2	$ 194,575	$ (481,271)	105	$ 20,427,333
Total Administration	354	$ 91,948	$ 32,569,099				-8	$ 91,948	$ (749,670)	346	$ 31,819,429
Direct Care Staff (List general											
RN	784	$ 97,374	$ 76,297,557	-15	$ 92,201	$ (1,383,017)	-4	$ 97,374	$ (391,229)	765	$ 74,523,311
Care Associates	215	$ 41,907	$ 8,990,509				-1	$ 41,907	$ (46,100)	213	$ 8,944,409
Physicians	158	$ 347,834	$ 55,066,805				-1	$ 347,834	$ (282,365)	158	$ 54,784,440
Intern/Residnets	79	$ 85,890	$ 6,796,463				0	$ 85,890	$ (34,850)	79	$ 6,761,613
Other Direct Care	140	$ 115,902	$ 16,227,977				-1	$ 115,902	$ (83,212)	139	$ 16,144,765
Total Direct Care	1376	$ 118,774	$ 163,379,311	-15	$ 92,201	$ (1,383,017)	-7	$ 118,774	$ (837,756)	1353	$ 161,158,538
Support Staff (List general categories,											
Technologists	216	$ 75,585	$ 16,362,945	-6	$ 62,873	$ (377,238)	-4	$ 75,585	$ (316,001)	206	$ 15,669,706
Medical Assistants	72	$ 40,694	$ 2,915,410				-1	$ 40,694	$ (56,302)	70	$ 2,859,108
Clinical Pharmacist	32	$ 153,757	$ 4,945,136				-1	$ 153,757	$ (95,500)	32	$ 4,849,635
Other Support Staff	75	$ 149,879	$ 11,285,485				-1	$ 149,879	$ (217,945)	74	$ 11,067,540
Service/Trade	242	$ 39,664	$ 9,582,439				-5	$ 39,664	$ (185,056)	237	$ 9,397,383
Other Non Patient Care	393	$ 64,850	$ 25,490,016				-8	$ 64,850	$ (492,262)	385	$ 24,997,754
Total Support	1030	$ 68,510	$ 70,581,432	-6	$ 62,873	$ (377,238)	-20	$ 68,510	$ (1,363,066)	1004	$ 68,841,127
REGULAR EMPLOYEES TOTAL	**2760**	**$ 96,569**	**$ 266,529,842**	**-21**	**$ 83,822**	**$ (1,760,256)**	**-35**	**$ 84,054**	**$ (2,950,492)**	**2704**	**$ 261,819,094**
2. Contractual Employees											
Administration (List general categories,											
Total Administration			$ -			$ -			$ -		$ -
Direct Care Staff (List general											
Contracted FTEs	29	$ 475,104	$ 13,682,995			$ -			$ -	29	$ 13,682,995
Total Direct Care Staff	29	$ 475,104	$ 13,682,995			$ -			$ -	29	$ 13,682,995
Support Staff (List general categories,											
Total Support Staff			$ -			$ -			$ -	0	$ -
CONTRACTUAL EMPLOYEES TOTAL	**29**	**$ 475,104**	**$ 13,682,995**	**0**	**$ -**	**$ -**	**0**	**$ -**	**$ -**	**29**	**$ 13,682,995**
Benefits (State method of calculating benefits below)**:**											
Constant as a percent of salaries (~20											
TOTAL COST	**2789**		**$ 280,212,837**	**-21**		**$ (1,760,256)**	**-35**		**$ (2,950,492)**		**$ 275,502,089**

* The projected FTEs and cost for the entire facility should equal the current number of FTEs and cost plus changes in FTEs and cost related to the proposed project plus other expected changes in staffing.

MEDSTAR HEALTH, INC.

Consolidated Financial Statements and Supplementary Schedules

June 30, 2015 and 2014

(With Independent Auditors' Report Thereon)

MEDSTAR HEALTH, INC.

Table of Contents

KPMG LLP
1 East Pratt Street
Baltimore, MD 21202-1128

Independent Auditors' Report

The Board of Directors
MedStar Health, Inc.:

We have audited the accompanying consolidated financial statements of MedStar Health, Inc. (the Corporation), which comprise the consolidated balance sheets as of June 30, 2015 and 2014, and the related consolidated statements of operations and 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 Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; 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 audit 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.

KPMG

Opinion

In our opinion, the consolidated financial statements referred to above present fairly in all material respects, the financial position of MedStar Health, Inc. as of June 30, 2015 and 2014, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Schedules 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits 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.

KPMG LLP

October 2, 2015

MEDSTAR HEALTH, INC.

Consolidated Balance Sheets

June 30, 2015 and 2014

(Dollars in millions)

Assets		2015	2014
Current assets:			
Cash and cash equivalents	$	572.3	599.9
Investments		74.9	61.4
Assets whose use is limited or restricted		61.3	61.3
Receivables:			
From patient services (less allowances for uncollectible accounts of $207.0 in 2015 and $188.8 in 2014)		584.1	558.0
Other		93.0	69.6
		677.1	627.6
Inventories		60.4	56.3
Prepaids and other current assets		33.1	31.8
Total current assets		1,479.1	1,438.3
Investments		1,002.2	869.5
Assets whose use is limited or restricted		554.7	548.9
Property and equipment, net		1,197.4	1,152.9
Interest in net assets of foundation		63.0	64.9
Goodwill and other intangible assets, net		258.2	226.5
Other assets		136.3	146.8
Total assets	$	4,690.9	4,447.8

(Continued)

MEDSTAR HEALTH, INC.

Consolidated Balance Sheets

June 30, 2015 and 2014

(Dollars in millions)

Liabilities and Net Assets		2015	2014
Current liabilities:			
Accounts payable and accrued expenses	$	433.8	419.6
Accrued salaries, benefits, and payroll taxes		348.2	304.9
Amounts due to third-party payors, net		83.5	85.7
Current portion of long-term debt		19.5	60.5
Current portion of self insurance liabilities		88.4	86.3
Other current liabilities		147.9	125.3
Total current liabilities		1,121.3	1,082.3
Long-term debt, net of current portion		1,323.0	1,192.6
Self insurance liabilities, net of current portion		310.6	312.4
Pension liabilities		293.0	234.3
Other long-term liabilities, net of current portion		137.3	137.6
Total liabilities		3,185.2	2,959.2
Net assets:			
Unrestricted net assets:			
MedStar Health, Inc.		1,319.0	1,322.2
Noncontrolling interests		15.3	5.2
Total unrestricted net assets		1,334.3	1,327.4
Temporarily restricted		131.9	121.8
Permanently restricted		39.5	39.4
Total net assets		1,505.7	1,488.6
Total liabilities and net assets	$	4,690.9	4,447.8

See accompanying notes to consolidated financial statements.

MEDSTAR HEALTH, INC.

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2015 and 2014

(Dollars in millions)

	2015	2014
Operating revenues:		
Net patient service revenue:		
Hospital inpatient services	$ 2,130.3	2,088.8
Hospital outpatient services	1,427.9	1,362.9
Physician services	756.1	662.2
Other patient service revenue	123.3	114.8
Total net patient service revenue	4,437.6	4,228.7
Provision for bad debts	206.7	193.2
Total net patient service revenue, net of provision for bad debts	4,230.9	4,035.5
Premium revenue	561.3	357.9
Other operating revenue	235.0	234.7
Net operating revenues	5,027.2	4,628.1
Operating expenses:		
Personnel	2,591.5	2,455.3
Supplies	741.5	696.7
Purchased services	844.0	682.6
Other operating	452.6	426.3
Interest expense	47.9	50.1
Depreciation and amortization	188.9	181.4
Total operating expenses	4,866.4	4,492.4
Earnings from operations	160.8	135.7
Nonoperating gains (losses):		
Investment income	16.1	13.3
Net realized gains on investments	43.2	68.6
Unrealized gains on derivative instrument	1.1	1.4
Unrealized (losses) gains on investments, net	(75.9)	91.6
Loss on extinguishment of debt	(25.2)	—
Income tax provision	(8.2)	(3.9)
Other nonoperating losses	(0.6)	(2.0)
Total nonoperating (losses) gains	(49.5)	169.0
Excess of revenues over expenses	$ 111.3	304.7

(Continued)

MEDSTAR HEALTH, INC.

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2015 and 2014

(Dollars in millions)

	2015	2014
Unrestricted net assets:		
Excess of revenues over expenses	$ 111.3	304.7
Acquired noncontrolling interests	10.8	—
Change in funded status of defined benefit plans	(118.5)	(2.1)
Distributions to noncontrolling interests	(2.9)	(3.7)
Net assets released from restrictions used for purchase of property and equipment and other	6.2	1.7
Increase in unrestricted net assets	6.9	300.6
Temporarily restricted net assets:		
Contributions	25.6	17.1
Realized net gains on restricted investments	2.0	3.1
Change in unrealized (losses) gains on restricted investments	(2.4)	3.4
(Decrease) increase in net assets of foundation	(1.9)	10.1
Net assets released from restrictions	(13.2)	(10.9)
Increase in temporarily restricted net assets	10.1	22.8
Permanently restricted net assets:		
Realized net gains on marketable restricted investments	0.3	0.1
Change in unrealized (losses) gains on restricted investments	(0.2)	0.2
Increase in permanently restricted net assets	0.1	0.3
Increase in net assets	17.1	323.7
Net assets, beginning of year	1,488.6	1,164.9
Net assets, end of year	$ 1,505.7	1,488.6

See accompanying notes to consolidated financial statements.

MEDSTAR HEALTH, INC.

Consolidated Statements of Cash Flows

Years ended June 30, 2015 and 2014

(Dollars in millions)

	2015	2014
Cash flows from operating activities:		
Change in net assets	$ 17.1	323.7
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	188.9	181.4
Amortization of bond financing costs, premiums and discounts	(2.5)	(1.2)
(Gain) loss on sale of property and equipment	(0.1)	0.2
Change in funded status of defined benefit plans	118.5	2.1
Realized net gains on marketable investments	(45.5)	(71.8)
Change in unrealized losses (gains) of marketable investments	78.5	(95.2)
Decrease (increase) in net assets of foundation	1.9	(10.1)
Unrealized gain on derivative instrument	(1.1)	(1.4)
Net settlement payment on derivative instrument	3.6	3.7
Loss on extinguishment of debt	25.2	—
Distributions to noncontrolling interests	2.9	3.7
Deferred income tax provision	6.1	3.6
Provision for bad debts	206.7	193.2
Temporarily and permanently restricted contributions	(25.6)	(17.1)
Acquired noncontrolling interests	(10.8)	—
Gain on sale of consolidated joint venture, net of noncontrolling interests	—	(1.2)
Changes in operating assets and liabilities:		
Receivables	(255.9)	(224.3)
Inventories and other assets	(7.8)	(28.5)
Accounts payable and accrued expenses	71.8	107.0
Amounts due to third-party payors	(2.2)	19.0
Other liabilities	(44.8)	25.0
Net cash provided by operations	324.9	411.8
Cash flows from investing activities:		
(Purchases) proceeds of investments and assets whose use is limited or restricted, net	(111.2)	81.5
Purchases of alternative investments	(109.6)	(240.7)
Proceeds from sales of alternative investments	35.9	128.8
Proceeds from sale of consolidated joint venture	—	5.4
Net settlement payment on derivative instrument	(3.6)	(3.7)
Purchases of property and equipment, and other	(252.4)	(221.3)
Net cash used in investing activities	(440.9)	(250.0)
Cash flows from financing activities:		
Proceeds from long-term borrowings	511.6	—
Repayments of long-term borrowings	(21.9)	(20.5)
Repayments of refinanced bonds and other borrowings	(420.2)	—
Payment of deferred issuance costs	(3.8)	(0.2)
Temporarily and permanently restricted contributions	25.6	17.1
Distributions to noncontrolling interests	(2.9)	(3.7)
Net cash provided by (used in) financing activities	88.4	(7.3)
(Decrease) increase in cash and cash equivalents	(27.6)	154.5
Cash and cash equivalents at beginning of year	599.9	445.4
Cash and cash equivalents at end of year	$ 572.3	599.9
Supplemental disclosure of cash flow information:		
Interest paid	$ 50.8	50.8
Noncash investing and financing activities:		
Accounts payable for fixed asset purchases	$ 19.5	17.0

See accompanying notes to consolidated financial statements.

(1) Description of Organization and Summary of Significant Accounting Policies

(a) Organization

MedStar Health, Inc. (MedStar or the Corporation) is a tax-exempt, Maryland membership corporation which, through its controlled entities and other affiliates, provides and manages healthcare services in the region encompassing Maryland, Washington D.C. and Northern Virginia. The Corporation became operational on June 30, 1998 by the transfer of the membership interests of Helix Health, Inc. (Helix – a not-for-profit Maryland Corporation) and Medlantic Healthcare Group, Inc. (Medlantic – a not-for-profit Delaware Corporation) in exchange for the guarantee of the debt of both Helix and Medlantic by the Corporation. The trade names of the principal tax-exempt and taxable entities of the Corporation are:

Tax-Exempt

- MedStar Ambulatory Services (formerly known as Bay Development Corporation)
- MedStar Franklin Square Medical Center
- MedStar Georgetown University Hospital
- MedStar Good Samaritan Hospital
- MedStar Harbor Hospital
- MedStar Health Research Institute
- MedStar Health Visiting Nurse Association, Inc.
- MedStar Medical Group, LLC
- MedStar Montgomery Medical Center
- MedStar National Rehabilitation Network
- MedStar Southern Maryland Hospital Center
- MedStar St. Mary's Hospital
- MedStar Surgery Center, Inc.
- MedStar Union Memorial Hospital
- MedStar Washington Hospital Center
- Church Home and Hospital of the City of Baltimore, Inc.
- HH MedStar Health, Inc.

Taxable

- Greenspring Financial Insurance, LTD.
- MedStar Enterprises, Inc. and Subsidiaries

- MedStar Family Choice, Inc.
- MedStar Physician Partners, Inc.
- Parkway Ventures, Inc. and Subsidiaries
- RadAmerica II, LLC

(b) Basis of Presentation

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with U.S. generally accepted accounting principles (U.S. GAAP). All majority owned subsidiaries, direct member entities and controlled affiliates are consolidated. All entities where the Corporation exercises significant influence but for which it does not have control are accounted for under the equity method. All other entities are accounted for under the cost method. All significant intercompany accounts and transactions have been eliminated.

(c) Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant changes to estimates resulting from amounts settled, or tentatively settled, related to prior year third party cost reports (see note 9) resulted in gains of approximately $22.1 during the year ended June 30, 2015. Significant changes to estimates resulting from amounts settled, or tentatively settled, related to prior year third party cost reports and amounts settled associated with the purchase of MedStar Southern Maryland Hospital Center resulted in gains of approximately $20.0 during the year ended June 30, 2014. Future results could differ from current estimates.

(d) Cash Equivalents

All highly liquid investments with a maturity date of three months or less when purchased are considered to be cash equivalents.

(e) Investments and Assets Whose Use is Limited or Restricted

The Corporation's investment portfolio is considered trading, with the exception of the alternative investments, and is classified as current or noncurrent assets based on management's intention as to use. All securities are reported at fair value principally based on quoted market prices in the consolidated balance sheets. The Corporation has elected to use the fair value option to account for its alternative investments. The fair value of alternative investments is determined based on the Net Asset Value (NAV) of the shares in each investment company or partnership. Purchases and sales of securities are recorded on a trade-date basis.

Investments in unconsolidated affiliates are accounted for under the cost or equity method of accounting, as appropriate, and are included in other assets in the consolidated balance sheets. The Corporation utilizes the equity method of accounting for its investments in entities over which it

exercises significant influence. The Corporation's equity income or loss is recognized in other operating revenue on the consolidated statements of operations and changes in net assets.

Assets whose use is limited or restricted include assets held by trustees under bond indenture, self-insurance trust arrangements, assets restricted by donor, and assets designated by the Board of Directors for future capital improvements and other purposes over which it retains control and may, at its discretion, use for other purposes. Amounts from these funds required to meet current liabilities have been classified in the consolidated balance sheets as current assets.

Investment income (interest and dividends), realized gains and losses on investment sales, and unrealized gains and losses are reported as nonoperating gains and losses in the excess of revenues over expenses in the accompanying consolidated statements of operations and changes in net assets unless the income or loss is restricted by the donor or law. Investment income and realized gains and losses on funds held in trust for self-insurance purposes is included in other operating revenue. Investment income and net gains and losses that are restricted by the donor are recorded as a component of changes in temporarily or permanently restricted net assets, in accordance with donor imposed restrictions. Realized gains and losses are determined based on the specific security's original purchase price or adjusted cost if the investment was previously determined to be other-than-temporarily impaired.

(f) Inventories

Inventories, which primarily consist of medical supplies and pharmaceuticals at many of the operating entities, are stated at the lower of cost or market, with cost being determined primarily under the average cost or first-in, first-out methods.

(g) Property and Equipment

Property and equipment acquisitions are recorded at cost and are depreciated or amortized over the estimated useful lives of the assets. Estimated useful lives range from three to forty years. Amortization of assets held under capital leases is computed using the shorter of the lease term or the estimated useful life of the leased asset and is included in depreciation and amortization expense. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. Depreciation is computed on a straight-line basis. Major classes and estimated useful lives of property and equipment are as follows:

Leasehold improvements	Lease term
Buildings and improvements	10–40 years
Equipment	3–20 years

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

long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Management routinely evaluates the carrying value of its long-lived assets for impairment. No significant impairment charges were recorded against the carrying value of the Corporation's long-lived assets during the years ended June 30, 2015 and 2014.

(h) Interest in Net Assets of Foundation

The Corporation recognizes its rights to assets held by a recipient organization, which accepts cash or other financial assets from a donor and agrees to use those assets on behalf of or transfer those assets, the return on investment of those assets, or both, to the Corporation. Changes in the Corporation's economic interests in the financially interrelated organization are recognized in the consolidated statements of operations and changes in net assets as a component of changes in temporarily restricted net assets.

(i) Goodwill and Other Intangible Assets

Goodwill is an asset representing the future economic benefits arising from other assets acquired in a business combination that are not individually identified and separately recognized. As of June 30, 2015 and 2014, the Corporation had one reporting unit, which included all subsidiaries of the Corporation and held goodwill, net on its balance sheet of $219.2 and $190.2, respectively. Goodwill is evaluated for impairment annually using a qualitative assessment to determine whether there are events or circumstances that indicate it is more likely than not that the reporting unit's fair value is less than its carrying amount. Based on this qualitative assessment, the Corporation determined that there was no goodwill impairment for the years ended June 30, 2015 and 2014.

Other intangible assets are recorded at fair value and amortized over their estimated useful lives. Other intangible assets were $48.2 and $42.4 as of June 30, 2015 and 2014, respectively, and related accumulated amortization was $9.2 and $6.1, respectively. The Corporation recognized amortization expense of $3.1 and $2.4 for the years ended June 30, 2015 and 2014, respectively, related to identifiable intangible assets.

(j) Internal-Use Software

The Corporation capitalizes the direct costs, including internal personnel costs, associated with the implementation of new information systems for internal use. The Corporation capitalized internal costs of $3.4 and $0.9 during the years ended June 30, 2015 and 2014, respectively. Capitalized amounts are amortized over the estimated lives of the software, which is generally three to five years.

(k) Financing Costs

Financing costs incurred in issuing bonds have been capitalized and are included in other assets on the consolidated balance sheets. These costs are being amortized over the estimated duration of the related debt using the effective interest method. Accumulated amortization totaled $4.0 and $5.6 as of June 30, 2015 and 2014, respectively.

(l) Estimated Professional Liability Costs

The provision for estimated self-insured professional liability claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. These estimates are based on actuarial analysis of historical trends, claims asserted and reported incidents. The receivables related to such claims are recorded at their net realizable value.

(m) Leases

Lease arrangements, including assets under construction, are capitalized when such leases convey substantially all the risks and benefits incidental to ownership. Capital leases are amortized over either the lease term or the life of the related assets, depending upon available purchase options and lease renewal features. Amortization related to capital leases is included in the consolidated statements of operations and changes in net assets within depreciation and amortization expense.

(n) Derivative

The Corporation utilizes a derivative financial instrument to manage its interest rate risks associated with tax-exempt debt. The Corporation does not hold or issue derivative financial instruments for trading purposes. The derivative instrument is recorded on the consolidated balance sheets at its fair value. The Corporation's current derivative investment does not qualify for hedge accounting; therefore, the changes in fair value have been recognized in the accompanying consolidated statements of operations and changes in net assets as mark-to-market adjustments in nonoperating gains (losses). The fair market value of the derivative instrument is included in other long-term liabilities in the accompanying consolidated balance sheets.

(o) Net Patient Service Revenue and Net Patient Accounts Receivable

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments due to future audits, reviews and investigations. The differences between the estimated and actual amounts are recorded as part of net patient service revenue in future periods as the amounts become known, or as years are no longer subject to audit, review or investigation. Payment arrangements include prospectively determined rates per discharge, fee-for-service, discounted charges, and per diem payments. Hospital inpatient services, hospital outpatient services, physician services, and other patient service revenues are recognized when the services are rendered based on billable charges. Other patient service revenue primarily consists of home care, long-term care and other non-hospital patient services.

The Corporation's policy is to write-off all patient receivables which are identified as uncollectible. Patient accounts receivable are reduced by an allowance for uncollectible accounts to reserve for accounts which are expected to become uncollectible in future years. In evaluating the collectability of accounts receivable, the Corporation analyzes historical collections and write-offs and identifies trends for each of its major payor sources of revenue and amounts due from patients to estimate the appropriate allowance for uncollectible accounts and provision for bad debts.

(p) Charity Care

The Corporation provides care to patients who meet certain criteria under its charity care policies without charge or at amounts less than established rates. Because the Corporation does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

(q) Premium Revenue

Premium revenue consists of amounts received from the State of Maryland, the District of Columbia and the Centers for Medicare and Medicaid Services (CMS) by the Corporation's managed care organization for providing medical services to subscribing participants, regardless of services actually performed. The managed care organization provides services primarily to enrolled Medicaid and Medicare beneficiaries. This revenue is recognized ratably over the contractual period for the provision of services. Medical expenses of the managed care organization include actuarially determined estimates of the ultimate costs for both reported claims and claims incurred but unreported and are included in purchased services on the consolidated statements of operations and changes in net assets.

(r) Grants

Federal grants are accounted for as either an exchange transaction or as a contribution based on terms and conditions of the grant. If the grant is accounted for as an exchange transaction, revenue is recognized as other operating revenue when earned. If the grant is accounted for as a contribution, the revenues are recognized as either other operating revenue, or as temporarily restricted contributions depending on the restrictions within the grant.

(s) Contributions

Unconditional promises to give cash and other assets to the Corporation are reported at fair value at the date the promise is received. Conditional promises to give are reported at fair value at the date the condition is met. 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. 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 changes in net assets as net assets released from restrictions in other operating revenue. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted net assets and reported within other operating revenue in the accompanying consolidated financial statements.

(t) Meaningful Use Incentives

Under certain provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), federal incentive payments are available to hospitals, physicians and certain other professionals (Providers) when they adopt, implement or upgrade certified electronic health record (EHR) technology and become "meaningful users," as defined under ARRA, of EHR technology in ways that demonstrate improved quality, safety and effectiveness of care. Incentive payments are paid out over varying transitional schedules depending on the type of incentive (Medicare and Medicaid) and recipient (hospital or eligible provider). Eligible hospitals can attest for both Medicare and Medicaid incentives,

while physicians must select to attest for either Medicare or Medicaid incentives. For Medicare incentives, eligible hospitals receive payments over four years while eligible physicians receive payments over five years. For Medicaid incentives, eligible hospitals receive payments based on the relevant State adopted payment structure and physicians receive payments over six years.

The Corporation recognizes EHR incentives when it is reasonably assured that the Corporation will successfully demonstrate compliance with the meaningful use criteria. During the years ended June 30, 2015 and 2014, certain hospitals and physicians satisfied the meaningful use criteria. As a result, the Corporation recognized $28.1 and $23.4 of EHR incentives during the years ended June 30, 2015 and 2014, respectively, in other operating revenue.

(u) Excess of Revenues over Expenses

The consolidated statements of operations and changes in net assets include a performance indicator, which is the excess of revenues over expenses. Changes in unrestricted net assets that are excluded from excess of revenues over expenses, include contributions of long-lived assets (including assets acquired using contributions that by donor restriction were to be used for the purpose of acquiring such assets), contributions from and acquisitions of and distributions to noncontrolling interests, and defined benefit obligations in excess of recognized pension cost, among others.

(v) Income Taxes

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in the period that includes the enactment date. Any changes to the valuation allowance on the deferred tax asset are reflected in the year of the change. The Corporation accounts for uncertain tax positions in accordance with the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 740, *Income Taxes*.

(w) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Corporation or individual operating units has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation or individual operating units in perpetuity.

(x) Fair Value of Financial Instruments

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

Cash and cash equivalents, receivables, other current assets, other assets, current liabilities and long-term liabilities: The carrying amount reported in the consolidated balance sheets for each of these assets and liabilities approximates their fair value.

(Dollars in millions)

The fair value of investments, assets whose use is limited or restricted and the interest rate swap is discussed in note 3. The fair value of long term debt is discussed in note 6.

(y) New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued *Accounting Standards update (ASU) 2014-09, Revenue from Contracts with Customers (Topic 606)*. This ASU establishes principles for reporting useful information to users of financial statements about the nature, amount, timing, and uncertainty of revenue and cash flows arising from the entity's contracts with customers. Particularly, that an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. ASU 2014-09 is effective for fiscal year 2019. The Corporation expects to record a decrease in net patient service revenue and a corresponding decrease in bad debt expense upon adoption of the standard.

(z) Reclassifications

Certain prior year amounts have been reclassified to conform with current period presentation, the effect of which is not material.

(2) Investments and Assets Whose Use is Limited or Restricted

Investments and assets whose use is limited or restricted as of June 30, 2015 and 2014, at fair value consist of the following:

	2015	2014
Cash and cash equivalents	$ 87.6	82.8
Fixed income securities and funds	393.1	356.2
Equity securities	604.1	559.3
Alternative investments:		
Commingled equity funds	243.6	194.2
Inflation hedging equity, commodity, fixed income fund	58.8	72.4
Hedge fund of funds and private equity	305.9	276.2
Total investments and assets whose use is limited or restricted	1,693.1	1,541.1
Less short-term investments and assets whose use is limited or restricted	(136.2)	(122.7)
Long-term investments and assets whose use is limited or restricted	$ 1,556.9	1,418.4

(Dollars in millions)

Assets whose use is limited or restricted as of June 30, 2015 and 2014, included in the table above, consist of the following:

	2015	2014
Funds held by trustees	$ 30.7	60.5
Self-insurance funds	293.4	256.6
Funds restricted by donors for specific purposes and endowment	80.5	86.1
Funds designated by board	211.4	207.0
Total assets whose use is limited or restricted	616.0	610.2
Less assets required for current obligations	(61.3)	(61.3)
Long-term assets whose use limited or restricted	$ 554.7	548.9

Investment income and realized and unrealized gains (losses) for assets whose use is limited, cash equivalents and investments are comprised of the following for the years ended June 30, 2015 and 2014:

	2015	2014
Other operating revenue:		
Investment income and realized gains	$ 18.5	8.5
Nonoperating gains:		
Investment income	16.1	13.3
Net realized gains on investments	43.2	68.6
Unrealized (losses) gains on investments	(75.9)	91.6
	(16.6)	173.5
Other changes in net assets:		
Realized net gains on temporarily and permanently restricted net assets	2.3	3.2
Change in unrealized (losses) gains on temporarily and permanently restricted net assets	(2.6)	3.6
Total investment return	$ 1.6	188.8

(Continued)

(Dollars in millions)

(3) Fair Value of Financial Instruments

The Corporation follows the guidance within FASB ASC Topic 820, *Fair Value Measurement (ASC 820)*, which defines fair value and establishes methods used to measure fair value. The fair value hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). A financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement. The three levels of the fair value hierarchy under ASC 820 are described below:

- Level 1 – Quoted prices in active markets for identical assets or liabilities at the measurement date;
- Level 2 – Observable inputs other than quoted prices for the asset, either directly or indirectly observable, that reflect assumptions market participants would use to price the asset based on market data obtained from sources independent of the Corporation.
- Level 3 – Unobservable inputs that reflect the Corporations own assumptions about the assumptions market participants would use to price an asset based on the best information available in the circumstances.

The Corporation has incorporated an Investment Policy Statement (IPS) into the investment program. The IPS, which has been formally adopted by the Corporation's Board of Directors, contains numerous standards designed to ensure adequate diversification by asset class and geography. The IPS also limits all investments by manager and position size, and limits fixed income position size based on credit ratings, which serves to further mitigate the risks associated with the investment program. As of June 30, 2015 and 2014, management believes that all investments were being managed in a manner consistent with the IPS.

The following table illustrates the actual allocations of the Corporation's primary long-term investment portfolio as of June 30:

	Actual allocation June 30, 2015	Actual allocation June 30, 2014
Publicly traded equities – domestic	29%	26%
Publicly traded equities – international	14	14
Fixed income securities	14	16
Alternative investments:		
Commingled equity funds	13	12
Inflation hedging equity, commodity, fixed income fund	5	9
Hedge funds	21	20
Private equities	1	1
Cash	3	2
Total	100%	100%

The table below presents the Corporation's investable assets and liabilities as of June 30, 2015, aggregated by the three level valuation hierarchy:

(Dollars in millions)

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 659.9	—	—	659.9
U.S. Treasury bonds	75.6	—	—	75.6
U.S. agency mortgage backed securities	151.8	—	—	151.8
Corporate bonds	—	132.8	—	132.8
Fixed income mutual funds	0.4	—	—	0.4
All other fixed income securities	3.2	29.3	—	32.5
Equity mutual funds & ETF's	147.4	—	—	147.4
Common stocks	456.7	—	—	456.7
Alternative investments:				
Commingled funds	—	243.6	—	243.6
Inflation hedging equity, commodity, fixed income fund	—	58.8	—	58.8
Private equity	—	—	16.6	16.6
Hedge funds:				
Custom hedge fund	—	—	59.7	59.7
Other hedge funds	—	—	229.6	229.6
Total assets	$ 1,495.0	464.5	305.9	2,265.4

	Level 1	Level 2	Level 3	Total
Liabilities:				
Interest rate swap	$ —	13.9	—	13.9
Total liabilities	$ —	13.9	—	13.9

(Dollars in millions)

The table below presents the Corporation's investable assets and liabilities as of June 30, 2014, aggregated by the three level valuation hierarchy:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 682.7	—	—	682.7
U.S. Treasury bonds	71.1	—	—	71.1
U.S. agency mortgage backed securities	92.8	—	—	92.8
Corporate bonds	—	82.1	—	82.1
Fixed income mutual funds	0.8	76.9	—	77.7
All other fixed income securities	5.4	27.1	—	32.5
Equity mutual funds & ETF's	121.8	—	—	121.8
Common stocks	437.5	—	—	437.5
Alternative investments:				
Commingled equity funds	—	194.2	—	194.2
Inflation hedging equity, commodity, fixed income fund	—	72.4	—	72.4
Private equity	—	—	17.0	17.0
Hedge funds:				
Custom hedge fund	—	—	58.8	58.8
Other hedge funds	—	—	200.4	200.4
Total assets	$ 1,412.1	452.7	276.2	2,141.0
Liabilities:				
Interest rate swap	$ —	15.0	—	15.0
Total liabilities	$ —	15.0	—	15.0

For the years ended June 30, 2015 and 2014, there were no significant transfers between Levels 1, 2 or 3.

(Dollars in millions)

Changes to the fair values based on the Level 3 inputs are summarized as follows:

	Private equity	Hedge funds	Total
Balance as of June 30, 2013	$ 16.4	160.1	176.5
Additions:			
Contributions/purchases	1.4	204.3	205.7
Disbursements:			
Withdrawals/sales	(3.4)	(125.4)	(128.8)
Net change in value	2.6	20.2	22.8
Balance as of June 30, 2014	17.0	259.2	276.2
Additions:			
Contributions/purchases	2.9	21.6	24.5
Disbursements:			
Withdrawals/sales	(4.8)	—	(4.8)
Net change in value	1.5	8.5	10.0
Balance as of June 30, 2015	$ 16.6	289.3	305.9

The following summarizes redemption terms for the hedge fund-of-funds vehicles held as of June 30, 2015:

	Custom Hedge Fund			
	Fund 1	Fund 2	Fund 3	Fund 4
Redemption timing:				
Redemption frequency	Quarterly	68% monthly – quarterly 32% quarterly – annually	Quarterly	Quarterly
Required notice	70 days	within 90 days	90 days	65 days
Audit reserve:				
Percentage held back for audit reserve	10%	up to 10%	10%	10%
Gates:				
Potential gate holdback	—	—	—	—
Potential gate release timeframe	—	—	—	—

The hedge funds include three hedge funds-of-funds and one custom hedge fund. The custom fund is structured as a multi-strategy hedge fund with the Corporation as the sole investor. The investment objective and strategies used by the hedge funds-of-funds and custom hedge fund are similar. The investment objective is to achieve positive absolute returns with low volatility, achieved through investments with multiple

(Dollars in millions)

underlying managers who are investing across various strategies. Strategies utilized within these hedge funds include, but are not limited to:

- *Credit/Distressed* includes investment companies that focus mainly on opportunities in corporate fixed income securities of companies that are in financial distress, or perceived financial distress, or going through a restructuring or re-organization.
- *Event Driven* includes investment companies that focus on identifying securities that would benefit from the occurrence of a major corporate event.
- *Global Macro* includes investment companies that employ broad mandates to invest globally across all asset classes, including interest rates, currencies, commodities, and equities, in order to benefit from market movements within various countries.
- *Equity Long/Short* includes investment companies that maintain long and short positions in publicly traded equities in order to capture opportunities driven by their perception of securities or industries being overvalued or undervalued.
- *Relative Value* includes investment companies that seek to identify valuation discrepancies between related securities, utilizing fundamental and quantitative techniques to establish equities, fixed income, and derivative positions.

Investments in hedge funds are typically carried at estimated fair value. Fair value is based on the Net Asset Value (NAV) of the shares in each investment company or partnership. Such investment companies or partnerships mark-to-market or mark-to-fair value the underlying assets and liabilities in accordance with U.S. GAAP. Realized and unrealized gains and losses of the investment companies and partnerships are included in their respective operations in the current year. Changes in unrealized gains or losses on investments, including those for which partial liquidations were effected in the course of the year, are calculated as the difference between the NAV of the investment at year-end less the NAV of the investment at the beginning of the year, as adjusted for contributions and redemptions made during the year and certain lock-up provisions. Generally, no dividends or other distributions are paid.

The following summarizes the status of contributions to the private equity fund-of-funds vehicles held as of June 30, 2015:

		Total commitment	Percentage of commitment contributed	Percentage of commitment remaining
Fund 1	$	11.0	95.0%	5.0%
Fund 2		7.1	95.3	4.7
Fund 3		7.1	90.0	10.0
Fund 4		10.0	14.3	85.7
Fund 5		5.0	23.5	76.5
Total	$	40.2		

(Dollars in millions)

Investments in private equity funds, typically structured as limited partnership interests, are carried at fair value using NAV or equivalent as determined by the General Partner in the absence of readily ascertainable market values. Distributions under this investment structure are made to investors through the liquidation of the underlying assets. It is expected to take up to ten years to fully distribute the proceeds of those assets. The fair value of limited partnership interests is generally based on fair value capital balances reported by the underlying partnerships, subject to management review and adjustment. Security values of companies traded on exchanges, or quoted on NASDAQ, are based upon the last reported sales price on the valuation date. Security values of companies traded over the counter, but not quoted on NASDAQ, and securities for which no sale occurred on the valuation date are based upon the last quoted bid price. The value of any security for which a market quotation is not readily available may be its cost, provided however, that the General Partner adjusts such cost value to reflect any bona fide third-party transactions in such a security between knowledgeable investors, of which the General Partner has knowledge. In the absence of any such third-party transactions, the General Partner may use other information to develop a good faith determination of value. Examples include, but are not limited to, discounted cash flow models, absolute value models, and price multiple models. Inputs for these models may include, but are not limited to, financial statement information, discount rates, and salvage value assumptions.

The valuation of both marketable and nonmarketable securities may include discounts to reflect a lack of liquidity or extraordinary risks, which may be associated with the investment. Determination of fair value is performed on a quarterly basis by the General Partner. Because of the inherent uncertainty of valuation, the determined values may differ significantly from the values that would have been used had a ready market for those investments existed.

(4) Property and Equipment

Property and equipment as of June 30, 2015 and 2014 is as follows:

	2015	2014
Land	$ 84.1	83.8
Buildings and improvements	1,346.9	1,281.9
Equipment	1,801.2	1,746.4
	3,232.2	3,112.1
Less accumulated depreciation and amortization	(2,139.2)	(2,025.6)
	1,093.0	1,086.5
Construction-in-progress	104.4	66.4
	$ 1,197.4	1,152.9

Construction-in-progress includes a variety of ongoing capital projects at the Corporation as of June 30, 2015 and 2014. Depreciation and amortization expense related to property and equipment amounted to $185.7 and $178.5 for the years ended June 30, 2015 and 2014, respectively.

(Dollars in millions)

On April 1, 2015, the Corporation and Shah Associates, M.D, P.A. (Shah Associates or the Practice) closed on an asset purchase agreement, whereby the Corporation purchased substantially all of the assets and assumed certain obligations of the Practice and invested in certain real estate and management services joint ventures with Shah Associates. The Practice is a multispecialty medical group serving Southern Maryland and has joined the Corporation under the name MedStar Shah Medical Group (included within MedStar Medical Group, LLC). Through this agreement, the Corporation added more than 85 providers in 17 medical specialties with offices throughout Southern Maryland. As a result of the transaction, the Corporation recognized approximately $28.0 of goodwill and other intangible assets, approximately $25.0 of property, plant and equipment and approximately $8.0 of other liabilities. The consolidated financial statements include the operations of the Practice since the closing date.

(5) Other Assets

Other assets as of June 30, 2015 and 2014 consist of the following:

	2015	2014
Deferred financing costs, net	$ 10.8	13.1
Investments in unconsolidated entities	14.9	15.2
Reinsurance receivables	33.1	47.3
Deferred tax asset	21.7	26.3
Other assets	55.8	44.9
	$ 136.3	146.8

The Corporation has investments in other healthcare related organizations that are accounted for under the equity method which total $14.9 and $15.2 at June 30, 2015 and 2014, respectively. Under the equity method, original investments are recorded at cost and adjusted by the Corporation's share of the undistributed earnings or losses of these organizations. The related ownership interest in these organizations ranges from 8% to 50%. The Corporation's share of earnings in these organizations was $2.6 and $3.1 for the years ended June 30, 2015 and 2014, respectively, and are recognized in other operating revenue in the consolidated statements of operations and changes in net assets. Certain other nonconsolidated entities are recorded under the cost method.

(Dollars in millions)

(6) Debt

As of June 30, 2015 and 2014, the Corporation's outstanding borrowings include the following:

	2015	2014
Maryland Health and Higher Educational Facilities:		
Authority revenue bonds:		
5.25% Term bonds (Series 1998A, due 2038)	$ 82.0	82.0
5.25% Term bonds (Series 1998B, due 2038)	57.0	57.0
4.25%–5.75% Serial bonds (Series 2004, due 2009–2025)	4.6	21.6
5.375% Term bonds (Series 2004, due 2024)	—	49.7
5.50% Term bonds (Series 2004, due 2033)	—	80.1
4.75% Term bonds (Series 2007, due 2042)	—	56.0
5.25% Term bonds (Series 2007, due 2046)	—	89.0
2.00%–5.00% Serial bonds (Series 2011, due 2012–2023)	37.4	44.7
5.00% Term bonds (Series 2011, due 2031)	5.6	5.6
5.00% Term bonds (Series 2011, due 2041)	35.4	35.4
2.19% Direct Purchase (Series 2012, due 2017–2022)	38.6	38.6
3.00%–5.00% Serial bonds (Series 2013A, due 2016–2028)	60.9	60.9
5.00% Term bonds (Series 2013A, due 2038)	17.3	17.3
5.00% Term bonds (Series 2013A, due 2041)	25.0	25.0
4.00% Term bonds (Series 2013A, due 2041)	14.6	14.6
3.00%–5.00% Serial bonds (Series 2013B, due 2025–2033)	60.8	60.8
4.00% Term bonds (Series 2013B, due 2038)	45.0	45.0
5.00% Term bonds (Series 2013B, due 2038)	44.0	44.0
2.00%-5.00% Serial bonds (Series 2015, due 2016-2033)	180.4	—
5.00% Term bonds (Series 2015, due 2038)	35.2	—
5.00% Term bonds (Series 2015, due 2042)	75.2	—
4.00% Term bonds (Series 2015, due 2045)	66.4	—
Plus unamortized net premium	75.8	28.0
	961.2	855.3

(Continued)

(Dollars in millions)

		2015	2014
District of Columbia Hospital Revenue Bonds:			
Multimodal revenue bonds:			
0.02%–0.11% at June 30, 2015 Serial bonds (Series 1998A due 2008-2038) (0.03%–0.08% at June 30, 2014	$	122.9	125.9
2.75%–5.00% Serial bonds (Series 1998B, due 2008–2019)		6.4	9.6
5.00% Term bonds (Series 1998B, due 2028)		—	20.2
5.00% Term bonds (Series 1998B, due 2038)		—	33.9
2.75%–5.00% Serial bonds (Series 1998C, due 2008–2019)		6.4	9.7
5.50% Term bonds (Series 1998C, due 2028)		—	20.1
5.00% Term bonds (Series 1998C, due 2038)		—	34.0
Less unamortized net discount		—	(1.3)
		135.7	252.1
MedStar Health, Inc. Taxable Revenue Bonds:			
0.80%-3.70% Serial bonds (Series 2015, due 2016-2031)		100.9	—
Other:			
Notes payable to financial institutions or state agencies under mortgages (floating rates ranging between 1.1%–6.2%) and other		14.9	15.9
Line of credit due August 2016 (0.18%–0.84% at June 30, 2015 and 0.18%–0.80% at June 30, 2014)		129.8	129.8
		144.7	145.7
Total debt		1,342.5	1,253.1
Less current portion of long-term debt		(19.5)	(60.5)
Long-term debt, net	$	1,323.0	1,192.6

Scheduled maturities on borrowings, for the next five fiscal years and thereafter are as follows:

2016	$	19.5
2017		155.6
2018		26.7
2019		27.5
2020		28.4
Thereafter		1,009.0
	$	1,266.7

The fair value of outstanding tax exempt bonds is estimated to be $1,109.3 and $1,145.4 as of June 30, 2015 and 2014, respectively. The fair value of other long-term debt approximates its carrying value.

In December 1998, the Maryland Health and Higher Education Facilities Authority (MHHEFA) and the District of Columbia (District) issued bonds (Series 1998 Bonds) on behalf of the Corporation. Bond proceeds of approximately $588.6 were loaned to the Corporation under separate loan agreements with MHHEFA and the District upon execution of obligations pursuant to the Master Trust Indenture. The District issued $300.0 of Multimodal Revenue Bonds, including $150.0 Series 1998A ($30.3 repaid through August 2015), $75.0 Series 1998B ($14.2 repaid through August 2015 and $55.9 advance refunded in conjunction with the MHHEFA Series 2015 financing described below), and $75.0 Series 1998C ($14.2 repaid through August 2015 and $55.9 advance refunded in conjunction with the MHHEFA Series 2015 financing described below).

The District Series 1998A bonds, which consist of three tranches totaling $119.7 at August 2015, trade as uninsured Variable Rate Demand Obligations backed by bank letters of credit. The Series 1998A Tranche I bonds which remained outstanding in August 2015 consisted of approximately $39.9 bonds trading in a daily mode backed by a letter of credit issued by Wells Fargo Bank, National Association (formerly Wachovia Bank, National Association) and remarketed by J.P. Morgan Securities Inc. The letter of credit expires in March 2017. In the event of a failed remarketing, the Tranche I bonds would be tendered to the bank and repaid over a four-year period, beginning 367 days following the date of the failed remarketing. The Series 1998A Tranche II bonds totaled $39.9 in August 2015. These bonds trade in a weekly mode and are remarketed by TD Securities. The letter of credit backing these bonds was issued by TD Bank, National Association and expires in April 2018. In the event of a failed remarketing, the Tranche II bonds would be tendered to the bank and repaid over a five-year period, beginning 367 days following the failed remarketing. The Series 1998A Tranche III bonds totaled $39.9 in August 2015. These bonds trade in a weekly mode and are remarketed by Citigroup Global Markets Inc. The letter of credit backing these bonds was issued by PNC Bank, National Association. The term of the letter of credit is five years, and expires in May 2017. In the event of a failed remarketing, the Tranche III bonds would be tendered to the bank and repaid over a four-year period, beginning 367 days following the failed remarketing. No portion of the Series 1998A bonds has been put at June 30, 2015 and 2014, respectively. The $4.9 Series 1998B and $4.9 Series 1998C bonds (as of August 2015) are at a fixed rate, insured by Assured Guaranty, Ltd. (Assured; formerly Financial Security Assurance, Inc.). The reimbursement obligation with respect to the letters of credit are evidenced and secured by obligations issued by the Corporation under the Master Trust Indenture.

MHHEFA issued $283.5 of Revenue Bonds, including the $166.6 Series 1998A ($82.0 outstanding after August 2015) and $116.9 Series 1998B ($57.0 outstanding after August 2015). All Series 1998 MHHEFA bonds were issued at fixed rates. Principal and interest under the Series 1998 MHHEFA bonds are insured under municipal insurance policies with Assured and Ambac. Of the original Series 1998 MHHEFA bonds, $51.7 was refinanced in March 2013 in conjunction with the MHHEFA Series 2013A financing described below.

Related to the District borrowings, the Corporation entered into an interest rate swap with Wells Fargo Bank, National Association in a notional amount totaling $150.0 (reduced to $91.3 at August 2015). The swap agreement expires in fiscal year 2027. The interest rate swap is part of a comprehensive and long-term capital

structure strategy. The purpose of the swap is to mitigate the effect of potential interest rate volatility and minimize the variability of the Corporation's average cost of capital. Under the terms of the swap, the Corporation pays a fixed rate and receives a variable rate. Collateral is only required to be posted under the swap in the event that the Corporation's credit ratings are downgraded by two rating agencies below the BBB – or Baa2 – level. To date, no collateral postings have been required. As of June 30, 2015 and 2014, the variable interest rate under these agreements was 0.12% and 0.10%, respectively. The fixed rate was 3.6875% as of June 30, 2015 and 2014. The variable rates are capped at 14.0%. The change in fair value of the swap is reported in nonoperating gains (losses) in the statements of operations and changes in net assets.

In February 2004, MHHEFA issued $170.3 in fixed rate bonds (Series 2004 Bonds) on behalf of the Corporation. The proceeds of the Series 2004 Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. $142.5 of the Series 2004 Bonds were refunded in conjunction with the MHHEFA Series 2015 financing described below, and the remaining bonds were fully repaid as of August 2015.

In January 2007, MHHEFA issued $145.0 in fixed rate bonds (Series 2007 Bonds) on behalf of the Corporation. The Series 2007 Bonds were issued at a premium, resulting in total proceeds of $148.6. The proceeds of the Series 2007 Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. The Series 2007 bonds were advance refunded in conjunction with the MHHEFA Series 2015 financing described below.

In November 2011, MHHEFA issued $94.9 in bonds (Series 2011 Bonds) on behalf of the Corporation. The proceeds of the Series 2011 Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. The Series 2011 Bonds were issued as $53.9 serial bonds maturing 2012 through 2023 ($24.0 repaid through August 2015), $5.6 term bonds maturing 2031, and $35.4 term bonds maturing 2041. The Series 2011 Bonds maturing on or after August 2022 are subject to redemption or purchase at the option of the Corporation prior to maturity beginning in 2021. The Series 2011 Bonds were issued at fixed rates. The proceeds from this transaction were used to refund $20.2 of the MHHEFA Series 1998 A&B bonds, to refund debt outstanding on the Corporation's Revolving Credit Facility, and to refund certain debt associated with MedStar St. Mary's Hospital.

In June 2012, the Corporation entered into a $38.6 MHHEFA Direct Purchase financing transaction with JP Morgan Chase Bank, N.A. (the Series 2012 Bond). The proceeds from the transaction were used to redeem certain outstanding MHHEFA Series 1998A bonds that were due to mature in 2018 as well as a portion of the outstanding MHHEFA Series 1998 A&B bonds due to mature in 2028. The repayment of the Series 2012 Bond is evidenced by an obligation issued under the Master Trust Indenture. The term of the Series 2012 Bond is ten years and the repayment terms approximate the previous repayment terms of the Series 1998 bonds that were refunded. Covenants, conditions, and security for the Series 2012 Bond is similar to the revolving credit agreement.

In March 2013, MHHEFA issued $117.8 in bonds (Series 2013A Bonds) on behalf of the Corporation. The Series 2013A Bonds were issued at a premium, resulting in total proceeds of $128.7. The proceeds of the Series 2013A Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. The Series 2013A Bonds were issued as

$60.9 serial bonds maturing 2016 through 2028, $17.3 term bonds maturing 2038, $25.0 term bonds due 2041, and $14.6 term bonds maturing 2041. The Series 2013A Bonds maturing on or after August 2024 are subject to redemption or purchase at the option of the Corporation prior to maturity beginning in 2023. The Series 2013A Bonds were issued at fixed rates. The proceeds from the transaction were used to refund $51.7 of the MHHEFA Series 1998 A&B bonds, to fund various capital projects and capitalized interest on those projects.

In May 2013, MHHEFA issued $149.8 in bonds (Series 2013B Bonds) on behalf of the Corporation. The Series 2013B Bonds were issued at a premium, resulting in total proceeds of $159.4. The proceeds of the Series 2013B Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. The Series 2013B Bonds were issued as $60.8 serial bonds maturing 2025 through 2033, $45.0 term bonds maturing 2038, and $44.0 term bonds maturing 2038. The Series 2013B Bonds maturing on or after August 2024 are subject to redemption or purchase at the option of the Corporation prior to maturity beginning in 2023. The Series 2013B Bonds were issued at fixed rates. The proceeds from the transaction were used to refinance a portion of the bridge loan put in place when MedStar acquired the assets of Southern Maryland Hospital Center in December 2012.

In February 2015, MHHEFA issued $357.2 in bonds (Series 2015 MHHEFA Bonds) on behalf of the Corporation. The Series 2015 MHHEFA Bonds were issued at a premium, resulting in total proceeds of $410.8. The proceeds of the Series 2015 MHHEFA Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. The Series 2015 MHHEFA Bonds were issued as $180.4 serial bonds maturing 2016 through 2033, $35.2 term bonds maturing 2038, $75.2 term bonds maturing 2042, and $66.4 term bonds maturing 2045. The Series 2015 MHHEFA Bonds maturing on or after August 2025 are subject to redemption or purchase at the option of the Corporation prior to maturity beginning in 2025. The Series 2015 MHHEFA Bonds were issued at fixed rates. The proceeds from the transaction were used to advance refund the MHHEFA Series 2007 bonds, refund a portion of the MHHEFA Series 2004 bonds, and advance refund a portion of the District 1998B and 1998C bonds.

In February 2015, MedStar Health, Inc. issued $100.9 in fixed rate bonds, issued at par, in the taxable market (Series 2015 Taxable Bonds) on behalf of the Corporation. The Series 2015 Taxable Bonds were issued as parity bonds under the Master Trust Indenture. The Series 2015 Taxable Bonds were issued as serial bonds maturing 2016 through 2031, and are subject to optional redemption prior to their respective maturities at a make-whole redemption price, together with accrued interest thereon to the redemption date. The proceeds from the transaction were used to finance and refinance the acquisition and renovation of ambulatory care facilities.

The Corporation, which is currently the sole member of an "obligated group" as defined in the Master Trust Indenture, is bound by the provisions of the Master Trust Indenture for payment of any outstanding obligations under existing loan agreements. All of the hospitals and certain other affiliates (the guarantors) of the Corporation are parties to a guaranty agreement pursuant to which they jointly and severally guaranty the payment and performance of the obligations under the Master Trust Indenture. The obligations of the guarantors under the Guaranty Agreement are collateralized by deeds of trust granted by the hospitals. Under the Master Trust Indenture and the deeds of trust, as collateral for the payments due thereunder, the

Corporation and its hospital affiliates, have granted a security interest in their revenues subject to permitted encumbrances.

Under the Master Trust Indenture, the Corporation is required to maintain, among other covenants, a maximum annual debt service coverage ratio of not less than 1.10. Under the loan agreements relating to the Series 1998 Bonds, the Corporation is required to maintain a historical debt service coverage ratio of not less than 2.0 and to maintain at least 65 days cash on hand. In the event the Corporation does not meet either of these requirements, it is required to fund a trustee-held debt service reserve fund securing the Series 1998 Bonds. The amount to be deposited shall equal the lesser of: 10% of the principal amount of such outstanding bonds, or the largest annual debt service with respect to such bonds in any future year, or 125% of the average annual debt service of future years. As of June 30, 2015 and 2014, there were no funds required to be held in the debt service reserve fund for the Series 1998 Bonds.

The Corporation maintains a $250.0 revolving credit agreement provided by a group of banks. The facility has a three-year term expiring in August 2016. The facility is evidenced by an obligation issued under the Master Trust Indenture. The outstanding balance on the facility was $129.8 at June 30, 2015 and 2014. The facility includes certain covenants, including a requirement to maintain Days Cash on Hand of 70 days, measured semi-annually at each June 30 and December 31, and a Debt Service Coverage ratio of 1.25, measured quarterly on a rolling four quarters basis. In addition, the Corporation is required to maintain a minimum credit rating of Baa2 or its equivalent from at least two of Moody's Investor's Service, Standard & Poor's, and Fitch Ratings. In addition, the Corporation maintains a $30.0 letter of credit facility, provided by a single lender, which is also evidenced by an obligation issued under the Master Trust Indenture. This facility is principally used to securitize certain regulatory obligations under various insurance programs, and has terms and conditions similar to the revolving credit agreement. The facility has a three-year term expiring in August 2016. However, the standby letters of credit issued under the facility can be canceled at the bank's option each year. As of June 30, 2015 and 2014, standby letters of credit issued pursuant to the facility were $21.2 and $18.2, respectively. No amounts have been drawn by the beneficiaries under the standby letters of credit.

(7) Retirement Plans

The Corporation has two qualified defined benefit pension plans (MedStar Health, Inc. Pension Equity Plan (PEP) and MedStar Health, Inc. Cash Balance Retirement Plan (CBRP)) covering substantially all full-time employees hired before 2005. MedStar St. Mary's Hospital also has a defined benefit plan that substantially covers all employees of MedStar St. Mary's Hospital. Participation in all plans has been closed to new entrants and all plans are frozen to future benefit accruals.

Benefits under the plans are substantially based on years of service and the employees' career earnings. The Corporation contributes to the plans based on actuarially determined amounts necessary to provide assets sufficient to meet benefits to be paid to plan participants and to meet the minimum funding requirements of the Employee Retirement Income Security Act of 1974, as amended by the Pension Protection Act of 2006, and Internal Revenue Service regulations. Effective July 1, 2000, employees of the Transferred Businesses (note 17) became participants in one of the Corporation's pension plans and are reflected in the pension information provided below.

(Dollars in millions)

The Corporation's investment policies are established by the MedStar Health, Inc.'s Investment Committee, which is comprised of members of the Board of Directors, other community leaders, and management. Among its responsibilities, the Investment Committee is charged with establishing and reviewing asset allocation strategies, monitoring investment manager performance, and making decisions to retain and terminate investment managers. Assets of each of the Corporation's pension plans are managed in a similar fashion by the same group of investment managers. The Corporation has incorporated an Investment Policy Statement (IPS) into the investment program. The IPS, which has been formally adopted by the Corporation's Board of Directors, contains numerous standards designed to ensure adequate diversification by asset class and geography. The IPS also limits all investments by manager and position size, and limits fixed income position size based on credit ratings, which serves to further mitigate the risks associated with the investment program. As of June 30, 2015 and 2014, management believes that all investments were being managed in a manner consistent with the IPS.

The following table illustrates the actual allocations of the Corporation's pension plans' investment portfolio as of June 30:

	Actual allocation June 30, 2015	**Actual allocation June 30, 2014**
Publicly traded equities – domestic	29%	30%
Publicly traded equities – international	11	10
Fixed income securities	15	16
Alternative investments:		
Commingled equity funds	15	14
Inflation hedging equity, commodity, fixed income fund	4	5
Hedge funds	20	18
Private equities	2	2
Cash	4	5
Total	100%	100%

(Dollars in millions)

The table below presents the Corporation's pension plans' investable assets as of June 30, 2015 aggregated by the three level valuation hierarchy:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 47.1	—	—	47.1
U.S. Treasury bonds	50.5	—	—	50.5
U.S. agency mortgage backed securities	24.7	—	—	24.7
Corporate bonds	—	67.0	—	67.0
All other fixed income securities	1.0	14.2	—	15.2
Equity mutual funds and ETF's	73.8	—	—	73.8
Common stocks	344.5	—	—	344.5
Alternative investments:				
Commingled funds	—	155.2	—	155.2
Inflation hedging equity, commodity, fixed income fund	—	43.3	—	43.3
Private equity	—	—	18.5	18.5
Hedge funds:				
Custom hedge fund	—	—	47.6	47.6
Other hedge funds	—	—	156.4	156.4
Total assets	$ 541.6	279.7	222.5	1,043.8

(Continued)

(Dollars in millions)

The table below presents the Corporation's pension plans' investable assets as of June 30, 2014 aggregated by the three level valuation hierarchy:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 50.1	—	—	50.1
U.S. Treasury bonds	42.8	—	—	42.8
U.S. agency mortgage backed securities	24.0	—	—	24.0
Corporate bonds	—	37.2	—	37.2
Fixed income mutual funds	—	47.2	—	47.2
All other fixed income securities	1.2	13.2	—	14.4
Equity mutual funds and ETF's	74.5	—	—	74.5
Common stocks	346.1	—	—	346.1
Alternative investments:				
Commingled equity funds	—	145.2	—	145.2
Inflation hedging equity, commodity, fixed income fund	—	55.4	—	55.4
Private equity	—	—	17.0	17.0
Hedge funds:				
Custom hedge fund	—	—	48.1	48.1
Other hedge funds	—	—	144.9	144.9
Total assets	$ 538.7	298.2	210.0	1,046.9

For the years ended June 30, 2015 and 2014, there were no significant transfers between Levels 1, 2 or 3.

(Dollars in millions)

Changes to the fair values based on the Level 3 inputs are summarized as follows:

	Private equity	Hedge funds	Total
Balance as of June 30, 2013	$ 17.0	111.4	128.4
Additions:			
Contributions/purchases	1.3	149.3	150.6
Disbursements:			
Withdrawals/sales	(3.4)	(83.2)	(86.6)
Net change in value	2.1	15.5	17.6
Balance as of June 30, 2014	17.0	193.0	210.0
Additions:			
Contributions/purchases	4.2	6.0	10.2
Disbursements:			
Withdrawals/sales	(4.9)	—	(4.9)
Net change in value	2.2	5.0	7.2
Balance as of June 30, 2015	$ 18.5	204.0	222.5

The following summarizes redemption terms for the hedge fund-of-funds vehicles held as of June 30, 2015:

	Custom Hedge Fund			
	Fund 1	Fund 2	Fund 3	Fund 4
Redemption timing:				
Redemption frequency	Quarterly	68% monthly – quarterly 32% quarterly – annually	Quarterly	Quarterly
Required notice	70 days	within 90 days	90 days	65 days
Audit reserve:				
Percentage held back for audit reserve	10%	up to 10%	10%	10%
Gates:				
Potential gate holdback	—	—	—	—
Potential gate release timeframe	—	—	—	—

(Continued)

The hedge funds include three hedge funds-of-funds and one custom hedge fund. The custom fund is structured as a multi-strategy hedge fund with the Corporation as the sole investor. The investment objective and strategies used by the hedge funds-of-funds and custom hedge fund are similar. The investment objective is to achieve positive absolute returns with low volatility, achieved through investments with multiple underlying managers who are investing across various strategies. Strategies utilized within these hedge funds include, but are not limited to:

- *Credit/Distressed* includes investment companies that focus mainly on opportunities in corporate fixed income securities of companies that are in financial distress, or perceived financial distress, or going through a restructuring or re-organization.
- *Event Driven* includes investment companies that focus on identifying securities that would benefit from the occurrence of a major corporate event.
- *Global Macro* includes investment companies that employ broad mandates to invest globally across all asset classes, including interest rates, currencies, commodities, and equities, in order to benefit from market movements within various countries.
- *Equity Long/Short* includes investment companies that maintain long and short positions in publicly traded equities in order to capture opportunities driven by their perception of securities or industries being overvalued or undervalued.
- *Relative Value* includes investment companies that seek to identify valuation discrepancies between related securities, utilizing fundamental and quantitative techniques to establish equities, fixed income, and derivative positions.

Investments in hedge funds are typically carried at estimated fair value. Fair value is based on the Net Asset Value (NAV) of the shares in each investment company or partnership. Such investment companies or partnerships mark-to-market or mark-to-fair value the underlying assets and liabilities in accordance with U.S. GAAP. Realized and unrealized gains and losses of the investment companies and partnerships are included in their respective operations in the current year. Changes in unrealized gains or losses on investments, including those for which partial liquidations were effected in the course of the year, are calculated as the difference between the NAV of the investment at year-end less the NAV of the investment at the beginning of the year, as adjusted for contributions and redemptions made during the year and certain lock-up provisions. Generally, no dividends or other distributions are paid.

(Dollars in millions)

The following summarizes the status of contributions to the private equity fund-of-funds vehicles held as of June 30, 2015:

		Total commitment	Percentage of commitment contributed	Percentage of commitment remaining
Fund 1	$	9.0	95.0%	5.0%
Fund 2		8.5	95.3	4.7
Fund 3		8.5	90.0	10.0
Fund 4		5.0	11.5	88.6
Fund 5		5.0	23.5	76.5
Fund 6		5.0	38.0	62.0
Total	$	41.0		

Investments in private equity funds, typically structured as limited partnership interests are carried at fair value using NAV or equivalent as determined by the General Partner in the absence of readily ascertainable market values. Distributions under this investment structure are made to investors through the liquidation of the underlying assets. It is expected to take up to ten years to fully distribute the proceeds of those assets. The fair value of limited partnership interests is generally based on fair value capital balances reported by the underlying partnerships, subject to management review and adjustment. Security values of companies traded on exchanges, or quoted on NASDAQ, are based upon the last reported sales price on the valuation date. Security values of companies traded over the counter, but not quoted on NASDAQ, and securities for which no sale occurred on the valuation date are based upon the last quoted bid price. The value of any security for which a market quotation is not readily available may be its cost, provided however, that the General Partner adjusts such cost value to reflect any bona fide third party transactions in such a security between knowledgeable investors, of which the General Partner has knowledge. In the absence of any such third party transactions, the General Partner may use other information to develop a good faith determination of value. Examples include, but are not limited to, discounted cash flow models, absolute value models, and price multiple models. Inputs for these models may include, but are not limited to, financial statement information, discount rates, and salvage value assumptions.

The valuation of both marketable and nonmarketable securities may include discounts to reflect a lack of liquidity or extraordinary risks, which may be associated with the investment. Determination of fair value is performed on a quarterly basis by the General Partner. Because of the inherent uncertainty of valuation, the determined values may differ significantly from the values that would have been used had a ready market for those investments existed.

The Corporation has established a long-term investment return target of 7.75% for both the PEP and CBRP in 2015 and 2014, respectively. These assumptions are based on historical returns achieved in the investment portfolios and represent the return that can reasonably be expected to be generated on a similarly structured portfolio in the future.

(Dollars in millions)

The Corporation recognizes the funded status of defined benefit pension plans in the consolidated balance sheets and the recognition in unrestricted net assets of unrecognized gains or losses, prior service costs or credits and transition assets or obligations. The funded status is measured as the difference between the fair value of the plan's assets and the projected benefit obligation of the plan. The measurement date for the plans is June 30.

The following are deferred pension costs which have not yet been recognized in periodic pension expense but instead are accrued in unrestricted net assets, as of June 30, 2015 and 2014. Unrecognized actuarial losses represent unexpected changes in the projected benefit obligation and plan assets over time, primarily due to changes in assumed discount rates and investment experience. Unrecognized prior service cost is the impact of changes in plan benefits applied retrospectively to employee service previously rendered. Deferred pension costs are amortized into annual pension expense over the expected future lifetime for active employees with frozen benefits.

	Amounts in unrestricted net assets to be recognized during the next fiscal year	Amounts recognized in unrestricted net assets as of June 30, 2015	Amounts recognized in unrestricted net assets as of June 30, 2014
Net actuarial loss	$ 17.4	667.9	549.4

The following table sets forth the plans' funded status and amounts recognized in the accompanying consolidated financial statements as of June 30, 2015 and 2014:

	2015	2014
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 1,278.8	1,183.0
Interest cost	57.0	59.1
Actuarial loss	53.7	89.9
Benefits paid	(55.1)	(53.2)
Benefit obligation at end of year	1,334.4	1,278.8
Change in plan assets:		
Plan assets at fair value at beginning of year	1,046.9	881.0
Actual return on plan assets	(3.7)	143.2
Company contributions	55.7	75.9
Benefits paid	(55.1)	(53.2)
Plan assets at fair value at end of year	1,043.8	1,046.9
Funded status/net amount recognized	$ (290.6)	(231.9)

(Dollars in millions)

The amounts recognized in the consolidated financial statements consist of the following as of June 30:

	2015	2014
Pension assets (included in other assets)	$ 2.4	2.4
Pension liabilities	(293.0)	(234.3)

The Corporation has estimated $77.0 for its defined benefit contributions for the fiscal year ending June 30, 2015. The accumulated benefit obligation is $1,334.4 and $1,278.8 at June 30, 2015 and 2014, respectively.

Expected fiscal year benefit payments for all defined benefit plans is as follows:

2016	$ 60.5
2017	62.6
2018	66.7
2019	69.7
2020	74.6
2021–2025	409.0
	$ 743.1

Net periodic pension (income) expense for the years ended June 30, 2015 and 2014 is as follows:

	2015	2014
Interest cost on projected benefit obligation	$ 57.0	59.1
Return on plan assets	(77.7)	(69.6)
Recognized actuarial loss	16.4	14.2
Net periodic pension (income) expense	$ (4.3)	3.7

(Continued)

(Dollars in millions)

The assumptions used in determining net periodic pension expense and accrued pension costs shown above are as follows:

	2015	2014
Discount rates for obligations at year end:		
MedStar Health, Inc. Pension Equity Plan	4.70%	4.65%
MedStar Health, Inc. Cash Balance Retirement Plan	4.50	4.50
MedStar St. Mary's Hospital Pension Plan	4.35	4.25
Discount rates for pension cost:		
MedStar Health, Inc. Pension Equity Plan – July 1 – June 30	4.65%	5.20%
MedStar Health, Inc. Cash Balance Retirement Plan – July 1 – June 30	4.50	5.05
MedStar St. Mary's Hospital Pension Plan – July 1 – June 30	4.25	5.00
Expected long-term rate of return on plan assets – PEP and CBRP	7.75%	7.75%
Expected long-term rate of return on plan assets – MedStar St. Mary's Hospital	7.50	7.50

In 2015, the mortality assumption for the plans was updated to reflect recently published general industry mortality tables. Those tables were adjusted to reflect a slightly lower level of long-term improvement in life expectancy.

The Corporation also has various contributory, tax deferred annuity and savings plans with participation available to certain employees. The Corporation matches employee contributions up to 3.0% of compensation in certain plans. The Corporation contributed approximately $29.1 and $27.3 during the years ended June 30, 2015 and 2014, respectively.

(8) Business and Credit Concentrations

The Corporation provides healthcare services through its inpatient and outpatient care facilities located in the State of Maryland, the District of Columbia and Northern Virginia. The Corporation generally does not require collateral or other security in extending credit; however it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits receivable under their health insurance programs, plans or policies (e.g., Medicare, Medicaid, Blue Cross, Workers' Compensation, health maintenance organizations (HMOs) and commercial insurance policies).

(Dollars in millions)

The Corporation estimates the allowance for uncollectible accounts based on the aging of accounts receivable, historical collection experience, payor mix and other relevant factors. A significant portion of the allowance for uncollectible accounts relates to self-pay patients, as well as co-payments and deductibles owed by patients with insurance. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients. Other factors include the volume of patients through the emergency departments and the increased level of co-payments and deductibles due from patients with insurance. These factors continuously change and can have an impact on collection trends and the estimation process.

The activity in the allowance for uncollectible accounts is summarized as follows for the years ended June 30, 2015 and 2014:

		2015	2014
Beginning balance	$	188.8	204.3
Provision for bad debts		206.7	193.2
Write-offs, net of recoveries		(188.5)	(208.7)
Ending balance	$	207.0	188.8

As of June 30, 2015 and 2014, the Corporation's allowance for uncollectible accounts was approximately 26.2% and 25.3%, respectively, as a percentage of patient service receivables. The Corporation's provision for bad debts represents 4.7% and 4.6% of net patient service revenue for the years ended June 30, 2015 and 2014, respectively.

A summary of net patient service revenue by major category of payor for the years ended June 30, 2015 and 2014 is as follows:

		2015	2014
Medicare and Medicare HMO	$	34%	37%
Medicaid and Medicaid HMO		13	11
Carefirst Blue Cross Blue Shield		23	19
Other commercial and managed care payors		23	24
Self-pay		7	9
	$	100%	100%

(Continued)

(Dollars in millions)

A summary of net patient receivables by major category of payor as of June 30, 2015 and 2014 is as follows:

	2015	2014
Medicare and Medicare HMO	27%	27%
Medicaid and Medicaid HMO	19	18
Carefirst Blue Cross Blue Shield	15	14
Other commercial and managed care payors	33	33
Self-pay	6	8
	100%	100%

Certain Maryland-based hospital charges are subject to review and approval by the Health Services Cost Review Commission (HSCRC). The HSCRC has jurisdiction over hospital reimbursement in Maryland by agreement with the Centers for Medicare and Medicaid Services (CMS). This agreement is based on a waiver from the Medicare Prospective Payment System reimbursement principles granted under Section 1814(b) of the Social Security Act.

Under the Maryland HSCRC rate methodology, amounts payable for services in 2015 and 2014 to Maryland hospital patients under the Medicare and Medicaid insurance programs are computed at 94% of regulated charges. This discount amount does not include MCO granted discounts for medical education. Hospital patients under the Blue Cross and approved health maintenance organization insurance programs are computed at 98% of regulated charges. Maryland accounts receivable from these third-party payors have been adjusted to reflect the difference between charges and the payable amounts.

In January 2014, CMS approved Maryland's new waiver for a five-year period beginning January 1, 2014 for inpatient and outpatient hospital services. The new waiver ties hospital per capita revenue growth to the state's economic growth of 3.58% and will require growth in Medicare spending per beneficiary in Maryland to be 0.5% below the national average. CMS can require the State to submit a corrective action plan if targets for a given performance year are not met. The new waiver also imposes quality measures and encourages population health management.

In connection with the new waiver, the HSCRC introduced new revenue arrangements, including the Global Budget Revenue (GBR) model. This new model for Maryland Hospitals moves payment to hospitals from each individual service to a total revenue for each hospital or a combination of hospitals to provide hospitals flexibility in the objectives of better care for individuals, higher levels of overall population health, and improved health care affordability. It removes the financial incentive from increasing volume and provides incentive to work with partners to provide care in the appropriate setting. The Corporation entered into a GBR arrangement covering five of its seven Maryland hospitals during the year ended June 30, 2014. In August 2014, the Corporation also entered into GBR arrangements for its remaining two Maryland hospitals. The GBR arrangement is expected to be in place at least three years, but will be renewed annually unless terminated by either party with 180 days prior notice. The Corporation recognized hospital inpatient and outpatient regulated revenue under the new arrangement for the hospitals covered under the arrangement for the years ended June 30, 2015 and 2014.

(Dollars in millions)

The Budget Control Act of 2011 (the Budget Control Act) mandated significant reductions and spending caps on the federal budget for fiscal years 2012 through 2021. As part of this legislation, a 2% reduction in Medicare spending, known as Sequestration, was implemented beginning April 1, 2013 and the Corporation's Medicare payments subsequent to that date were reduced by the mandatory 2%. It is not possible to determine how future congressional actions to reduce the federal deficit in order to end Sequestration will impact the Corporation's revenues.

Through its MedStar Family Choice, Inc. subsidiary, the Corporation enters into fee-for-service and capitation agreements with independent health professionals and organizations to provide covered services to eligible enrollees where such services cannot be provided by its employed physicians or controlled entities. This subsidiary has contracts to provide Medicare and Medicaid services to those within Maryland and the District of Columbia. Premium revenue primarily consists of the following:

		2015	2014
Maryland Medicaid	$	309.5	204.2
District of Columbia Medicaid		212.4	152.1
Total Medicaid	$	521.9	356.3
Maryland Medicare	$	36.4	0.0
District of Columbia Medicare		2.6	1.2
Total Medicare	$	39.0	1.2

Medical and clinical expenses from these agreements include claim payments, capitation payments, and estimates of outstanding claims liabilities for services provided prior to the balance sheet date. The estimates of outstanding claims liabilities of $62.3 and $52.2 as of June 30, 2015 and 2014, respectively, are based on management's analysis of historical claims paid reports and review of health services utilization during the period and are included in accounts payable and accrued expenses on the consolidated balance sheets. Changes in these estimates are recorded in the period of change. Claims payments and capitation payments are expensed in the period services are provided to eligible enrollees.

(9) Certain Significant Risks and Uncertainties

The Corporation provides general healthcare services in the State of Maryland, the District of Columbia and Northern Virginia. As a healthcare provider, the Corporation is subject to certain significant inherent risks, including the following:

- Dependence on revenues derived from reimbursement by the federal Medicare and state Medicaid programs;
- Regulation of hospital rates by the State of Maryland HSCRC;
- Government regulation, government budgetary constraints and proposed legislative and regulatory changes, and;
- Lawsuits alleging malpractice or other claims.

Such inherent risks require the use of certain management estimates in the preparation of the Corporation's consolidated financial statements and it is reasonably possible that a change in such estimates may occur.

The Medicare and state Medicaid reimbursement programs represent a substantial portion of the Corporation's revenues and the Corporation's operations are subject to a variety of other federal, state and local regulatory requirements. In addition, changes in federal and state reimbursement funding mechanisms and related government budgetary constraints could have a significant adverse effect on the Corporation. Similarly, failure by the Corporation to maintain required regulatory approvals and licenses and/or changes in related regulatory requirements could have a significant adverse effect.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount. Management periodically reviews recorded amounts receivable from or payable to third-party payors and may adjust these balances as new information becomes available. In addition, revenue received under certain third-party agreements is subject to audit. During 2015 and 2014, certain of the Corporation's prior year third-party cost reports were audited and settled, or tentatively settled, by third-party payors. Adjustments resulting from such audits and management reviews of unaudited years and open claims are reflected as adjustments to revenue in the year that the adjustment becomes known. Although certain other prior year cost reports submitted to third-party payors remain subject to audit and retroactive adjustment, management does not expect any material adverse settlements.

The healthcare industry is subject to numerous laws and regulations from federal, state and local governments, and the government has increased enforcement of Medicare and Medicaid anti-fraud and abuse laws, as well as physician self referral laws (Stark laws and regulation). The Corporation's compliance with these laws and regulations is subject to periodic governmental inquiries, and the Corporation has responded appropriately to any such inquiries. The Corporation is aware of certain asserted and unasserted legal claims by the government, and from time to time, the Corporation may agree to resolve certain legal claims asserted by the government. The Corporation will continue to monitor all government inquiries and respond appropriately. The final outcomes of these government investigations cannot be determined at this time.

Recent federal initiatives have prompted a national review of federally funded healthcare programs. To this end, the federal government, and many states, implemented programs to audit and recover potential overpayments to providers from the Medicare and Medicaid programs. Since June 2010, the Corporation's hospitals have received audit requests from the Medicare Recovery Audit Contractor (RAC) program. These RAC audit requests have focused on medical necessity of inpatient admissions and hospital coding practices. In addition, the hospitals have continued to receive routine audit requests from other Medicare and Medicaid contractors and the Office of Inspector General. The Corporation's hospitals have cooperated with each of these audit requests and implemented a program to track and manage their effect. In October 2014, in response to a global settlement offer made by the Centers of Medicare and Medicaid Services (CMS), the Corporation's hospitals submitted requests to settle certain outstanding appeals of claims denied by the RAC and other Medicare contractors on the basis of patient status. The hospitals entered into settlements with CMS and have received initial settlement payments of approximately $11.0, which have been reflected as adjustments to revenue in the current period.

(Dollars in millions)

As a result of recently enacted and pending federal healthcare reform legislation, rules and regulations, substantial changes are occurring in the United States healthcare system. These include numerous provisions affecting the delivery of healthcare services, the financing of healthcare costs, reimbursement to healthcare providers and the legal obligations of health insurers, providers and employers. These provisions are currently slated to take effect at specified times over the next decade. This federal healthcare reform legislation did not significantly affect the 2015 or 2014 consolidated financial statements.

The Corporation, in the normal course of business, is a party to legal and regulatory proceedings. These include a lawsuit filed in June 2011 by several MedStar Washington Hospital Center (MWHC) employees alleging violations by the Corporation of wage-hour laws. The plaintiffs in this action are seeking certification of a class that would include hourly employees at all of the Corporation's hospitals. The Corporation is opposing class certification and taking other steps to defend itself and the hospitals in this litigation. The final outcome of litigation cannot be determined at this time. In April 2014, another lawsuit was filed in federal court alleging similar wage-hour violations as the 2011 action. This lawsuit seeks to certify a class to include hourly employees at six of the Company's hospitals; and in August 2015, plaintiffs added a seventh MedStar hospital to this litigation. The Corporation will oppose class certification and otherwise defend itself and the hospitals in this matter.

In June 2015, MWHC agreed on a new collective bargaining agreement with the union that represents its nurses, National Nurses United. That agreement provides for a four-year term through May 31, 2019.

The Corporation, in the normal course of business, is a party to a number of legal and regulatory proceedings. Management does not expect that the results of these proceedings will have a material adverse effect on the consolidated financial position or results of operations of the Corporation.

(10) Self-Insurance Programs

The Corporation maintains self-insurance programs for professional and general liability risks, employee health and workers' compensation. Estimated liabilities have been recorded based on actuarial estimation of reported and incurred but not reported claims. The combined accrued liabilities for these programs at June 30, 2015 and 2014 were as follows:

	2015	2014
Professional and general liability	$ 344.6	345.4
Employee health	20.2	18.9
Workers' compensation	34.2	34.4
Total liabilities	399.0	398.7
Less current portion	(88.4)	(86.3)
	$ 310.6	312.4

(Continued)

The Corporation's self insurance program for professional and general liability is responsible for the following exposures as of June 30, 2015:

(a) For professional liability during the periods of July 1, 2013 to June 30, 2014 and July 1, 2014 to June 30, 2015, for all MedStar entities except MedStar Montgomery Medical Center (MMMC) and MedStar St. Mary's Hospital (MSMH), the Corporation is responsible for the first $5.0 exposure for each and every claim plus an additional exposure above the first $5.0 self-insured retention referred to as an "inner aggregate."

For the period July 1, 2013 to December 31, 2013, the applicable inner aggregate was an inner aggregate that was in effect for the 12 month period January 1, 2013 through December 31, 2013. This inner aggregate exposes the Corporation to up to $3.0 per claim with an aggregate for the 12 month period of $6.0 above the $5.0 per claim self-insured retention for all claims incurred during the period January 1, 2013 through December 31, 2013.

For the period January 1, 2014 to June 30, 2014, the applicable inner aggregate was in effect for the 12 month period of January 1, 2014 to December 31, 2014. This inner aggregate exposes the Corporation to up to $3.0 per claim with a $6.0 annual aggregate above the Corporation's $5.0 per claim self-insured retention for all claims incurred during the period January 1, 2014 to December 31, 2014.

For the period January 1, 2015 to June 30, 2015, the applicable inner aggregate was in effect for the 12 month period of January 1, 2015 to December 31, 2015. This inner aggregate exposes the Corporation to up to $3.0 per claim with a $6.0 annual aggregate above the Corporation's $5.0 per claim self-insured retention for all claims incurred during the period January 1, 2015 to December 31, 2015.

Effective December 10, 2012, Southern Maryland Hospital joined the Corporation as MedStar Southern Maryland Hospital Center (MSMHC). MSMHC is covered for all professional liability exposure for activities on or after December 10, 2012 under the same program of coverage described above. The Corporation did not assume responsibility for MSMHC exposure or any tail claims that might arise in future years related to activities that occurred prior to the acquisition by the Corporation.

For MMMC and MSMH, the Corporation is responsible for the first $2.0 exposure for each claim (not subject to the inner aggregate structures noted above).

(b) For general liability, the Corporation is responsible for the first $3.0 exposure for each claim (for MMMC and MSMH, the first $2.0 exposure for each claim). General liability claims are not subject to the inner aggregate excess retention as described above. MSMHC is covered for general liability exposure for activities on or after December 10, 2012 under the Corporation's general liability program.

(c) Commercial excess re-insurance has been purchased above the self-insured retentions described above in multiple layers and in twin towers; one for professional and one for general liability. Effective January 1, 2013, the Corporation purchased an additional layer of commercial excess re-insurance.

(Dollars in millions)

During the period of January 1, 2013 through June 30, 2015, each tower has eight layers of excess re-insurance which provides coverage of up to $125.0 per claim and $125.0 in the annual aggregate. The Corporation maintains reinsurance contracts with various "A" rated commercial insurance companies.

The professional and general liabilities as of June 30, 2015 and 2014 have been discounted at a rate of 1.75%. The workers' compensation liabilities as of June 30, 2015 and 2014 have been discounted at a rate of 1.50%.

Assets available to fund these liabilities are held in separate accounts (see note 2). Contributions required to fund professional and general liability, employee health benefits and workers' compensation programs are determined by the plans' administrators based on appropriate actuarial assumptions. The professional and general liability programs are administered through an offshore wholly owned captive insurance company, Greenspring Financial Insurance Limited (GFIL), which is domiciled in the Grand Cayman Islands.

(11) Unrestricted Net Assets

The Corporation accounts for and presents noncontrolling interests in a consolidated subsidiary as a separate component of the appropriate class of consolidated net assets. The income attributable to noncontrolling interests is included within operating income on the consolidated statements of operations and changes in net assets. The following table presents a reconciliation of the changes in consolidated unrestricted net assets attributable to the Corporation's controlling interest and noncontrolling interest, including amounts such as the performance indicator and other changes in unrestricted net assets as of and for the years ended June 30, 2015 and 2014:

	MedStar Health, Inc.	Noncontrolling interests	Total unrestricted net assets
Balance as of June 30, 2013	$ 1,017.4	9.4	1,026.8
Excess of revenues over expenses	302.4	2.3	304.7
Change in funded status of defined benefit plans	(2.1)	—	(2.1)
Net assets released for property and equipment and other	4.5	(2.8)	1.7
Distributions to noncontrolling interests	—	(3.7)	(3.7)
Increase (decrease) in unrestricted net assets	304.8	(4.2)	300.6
Balance as of June 30, 2014	1,322.2	5.2	1,327.4

(Dollars in millions)

	MedStar Health, Inc.	Noncontrolling interests	Total unrestricted net assets
Excess of revenues over expenses	$ 109.1	2.2	111.3
Change in funded status of defined benefit plans	(118.5)	—	(118.5)
Net assets released for property and equipment	6.2	—	6.2
Acquired noncontrolling interests	—	10.8	10.8
Distributions to noncontrolling interests	—	(2.9)	(2.9)
(Decrease) increase in unrestricted net assets	(3.2)	10.1	6.9
Balance as of June 30, 2015	$ 1,319.0	15.3	1,334.3

(12) Temporarily and Permanently Restricted Net Assets

Temporarily and permanently restricted net assets as of June 30, 2015 and 2014 are available for the following purposes:

	2015	2014
Temporary restrictions:		
Interest in net assets of foundation	$ 63.0	64.9
Other	68.9	56.9
	$ 131.9	121.8
Permanent restrictions:		
Investments to be held in perpetuity, the income from which is available to support healthcare services	$ 39.5	39.4

Temporarily restricted net assets are available for the purposes of purchasing property and equipment, providing health education, research and other healthcare services.

(13) Endowment Net Assets

The Corporation's endowments consist of individual donor-restricted funds established for a variety of purposes. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

(a) Interpretation of Relevant Law

The Corporation has interpreted the State Prudent Management of Institutional Funds Act (SPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this

(Dollars in millions)

interpretation, the Corporation classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the organization in a manner consistent with the standard of prudence prescribed by SPMIFA. In accordance with SPMIFA, the Corporation considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

(1) The duration and preservation of the fund

(2) The purposes of the Corporation and the donor-restricted endowment fund

(3) General economic conditions

(4) The possible effect of inflation and deflation

(5) The expected total return from income and the appreciation of investments

(6) Other resources of the Corporation

(7) The investment policies of the Corporation

(b) Endowment Net Assets Consist of the Following as of June 30, 2015

	Unrestricted	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds	$ —	5.2	39.5	44.7
Total endowed net assets	$ —	5.2	39.5	44.7

(c) Endowment Net Assets Consist of the Following as of June 30, 2014

	Unrestricted	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds	$ —	6.6	39.4	46.0
Total endowed net assets	$ —	6.6	39.4	46.0

(d) Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or SPMIFA requires the Corporation to retain as a fund of perpetual duration. In accordance with U.S. GAAP, there were no deficiencies of this nature that are reported in unrestricted net assets as of June 30, 2015 and 2014.

(e) Investment Strategies

The Corporation has adopted policies for corporate investments, including endowment assets, that seek to maximize risk-adjusted returns with preservation of principal. Endowment assets include those assets of donor-restricted funds that the Corporation must hold in perpetuity or for a donor-specified period(s). The endowment assets are invested in a manner that is intended to hold a mix of investment assets designed to meet the objectives of the account. The Corporation expects its endowment funds, over time, to provide an average rate of return that generates earnings to achieve the endowment purpose.

To satisfy its long-term rate-of-return objectives, the Corporation relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Corporation employs a diversified asset allocation structure to achieve its long-term return objectives within prudent risk constraints.

The Corporation monitors the endowment funds returns and appropriates average returns for use. In establishing this practice, the Corporation considered the long-term expected return on its endowment. This is consistent with the Corporation's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term as well as to provide additional real growth through new gifts and investment return.

(14) Income Taxes

The Corporation and the majority of its subsidiaries are not-for-profit corporations as defined in Section 501(c)(3) of the Internal Revenue Code (the Code) and are exempt from federal income taxes under Section 501(a) of the Code. The Corporation's tax-exempt businesses generate nominal amounts of unrelated business income subject to income tax. For corporate income tax purposes, the Corporation has two consolidated groups of for-profit, taxable entities. The parent companies of these groups are Parkway Ventures, Inc. and MedStar Enterprises, Inc.

The Corporation's taxable subsidiaries have approximately $218.5 of net operating loss (NOL) carryforwards as of June 30, 2015, which expire in varying periods through 2035, available to offset future taxable income. This NOL carryforward represents $83.0 of gross deferred tax assets. In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible. Management considers the scheduled reversal of deferred tax liabilities, projected future taxable income, and tax planning strategies in making this assessment. During the years ended June 30, 2015 and 2014, the Corporation decreased its net deferred tax asset by $6.1 and $3.6,

respectively, which was recorded in nonoperating income. The remaining amount of the deferred tax asset considered realizable, $21.7 as of June 30, 2015, could be reduced if estimates of future taxable income during the carry forward period are reduced. The current tax provisions for the years ended June 30, 2015 and 2014 were immaterial.

(15) Charity Care and Other Community Benefits

MedStar Health is committed to ensuring that patients within the communities it serves who lack financial resources have access to necessary hospital services. MedStar Health and its healthcare facilities serve the emergency health care needs of everyone who visits the facilities regardless of a patient's ability to pay for care; and assist those patients who are admitted through the admissions process for non-urgent and urgent, medically necessary care who cannot pay for the care they receive.

In meeting this commitment, MedStar Health's facilities work with uninsured patients to gain an understanding of each patient's financial resources prior to admission (for scheduled services) or prior to billing (for emergency services). Based on this information and patient eligibility, the Corporation's facilities assist uninsured and certain underinsured patients that meet medical hardship criteria who reside within the communities served. This assistance is provided in one or more of the following ways:

- Assist with enrollment in publicly-funded entitlement programs (e.g. Medicaid and Medicare programs).
- Assist with consideration of funding that may be available from other charitable organizations.
- Provide charity care and financial assistance according to applicable guidelines, including considerations for patients that may be underinsured and for those that may be suffering from a medical hardship.
- Provide financial assistance for payment of facility charges using a sliding scale based on patient family income and financial resources.
- Offer periodic payment plans to assist patients with financing their healthcare services.

Eligibility criteria for financial assistance consider patient's household income in relation to the federal poverty guidelines and the equity value of real property and/or other assets. By definition, free care is available to uninsured patients in households between 0% and 200% of the federal poverty line. Reduced cost-care is based on a sliding-scaled and is available to uninsured patients in households between 200% and 400% of the federal poverty line.

In addition to charity care, the Corporation also funds unpaid costs of services provided to persons covered by publicly-funded programs and numerous programs designed to benefit the healthcare interests of the communities it serves. Examples of these programs are health education programs and services, health information and referral services, school-based clinics, public health screenings and home care. The costs associated with these programs are recorded in the appropriate operating expense categories.

The Corporation's hospitals utilize a cost to charge ratio methodology to convert charity care to cost. The estimated cost of services provided is determined based on the relationship of total operating costs to gross charges. Total operating costs for purposes of this ratio exclude bad debt expense as well as costs associated with community benefit activities. Total gross patient charges are then offset with any related

(Dollars in millions)

reimbursements. The Corporation provided $26.1 and $45.5 of charity care at cost during the years ended June 30, 2015 and 2014, respectively, based on the cost to charge ratio. The reduction in charity care is a result of expanded coverage under the Affordable Care Act (ACA), contributing to a shift from self-pay to Medicaid and Medicaid managed care. In addition, the ACA contains a number of provisions intended to improve quality and reduce spending related to the Medicare program. The reduction in spending on the Medicare program, which includes readmission penalties, a reduction in disproportionate share payments, and reduction in payment rates, is intended to offset the cost of expanding coverage under the ACA.

(16) Leases

The Corporation is obligated under various operating leases with initial terms of one year or more. Aggregate future minimum payments as of June 30, 2015 are as follows:

2016	$	64.5
2017		57.1
2018		49.9
2019		45.1
2020		36.8
2021 and Thereafter		182.7
	$	436.1

Certain leases include provisions allowing the minimum rental payments to be adjusted annually for increases in operating costs and, in some cases, real estate taxes attributable to leased property. Total rental expense for all operating leases amounted to approximately $72.7 and $65.9 during the years ended June 30, 2015 and 2014, respectively.

(17) Commitments and Contingencies

In February 2000 and on June 30, 2000, the Corporation and Georgetown University (the University) signed certain definitive agreements whereby the Corporation would receive through purchase or capital lease substantially all of the assets (including working capital) owned by the University that constitutes the MedStar Georgetown University Hospital, the Community Practice Network, the Faculty Practice Group and certain office buildings and a parking lot on the campus (collectively referred to as the Transferred Businesses). These agreements became effective July 1, 2000 and transferred control of the identified physical plant and other real property assets of the Transferred Businesses to the Corporation for use as an academic medical center for a minimum of ninety-eight years. At the end of the one hundred and fifty year lease term (including a fifty-two year renewal), the University shall convey all leased assets, excluding the underlying land, to the Corporation for a nominal amount and enter into a rent-free ground lease for the Corporation's use. This transaction was accounted for under the purchase method of accounting effective July 1, 2000.

In recognition of the value of the transaction, the Corporation shall annually pay the University 50% of the amount by which the combined operating earnings before interest, taxes, depreciation and amortization (EBITDA), as defined in the asset purchase agreement, of certain entities of the Corporation in the

Washington D.C. area (collectively referred to as the Washington Clinical Enterprises) exceeds $60.0, subject to certain adjustments. These additional payments expire when cumulative payments reach $70.0. The Corporation has paid $52.7 to the University as of June 30, 2015 and is expected to pay the remaining $17.3 by June 30, 2016.

The Corporation also entered into an Academic Affiliation and Operations Agreement (Affiliation Agreement) with the University. The purpose of this agreement is to make available to the University the facilities of the Transferred Businesses and provide the Corporation with a first-class University medical center. The University shall make payments to the Corporation determined by multiplying the University School of Medicine's total undergraduate tuition revenue by 36% for providing teaching services. The Corporation recognized $12.9 and $12.3 of tuition revenue during the years ended June 30, 2015 and 2014, respectively. In support of academic programs at the University, for each fiscal year following the termination of the additional payment terms in the asset purchase agreement described above, the Corporation shall pay to the University 17.5% of the operating EBITDA of the Washington Clinical Enterprises in excess of $60.0, subject to certain adjustments. No amounts have been paid under this Affiliation Agreement through June 30, 2015.

The Corporation and the University also entered into a Research Agreement to sustain and advance a program of health-related University research at the Transferred Business facilities. Under this agreement the University is required to reimburse the Corporation for certain costs incurred by the Corporation in support of University sponsored research. Amounts reimbursed to the Corporation were $2.8 and $2.7 for the years ended June 30, 2015 and 2014, respectively.

MedStar Georgetown University Hospital and the University are parties to a fixed fee shared services agreement. Georgetown University provided to MedStar Georgetown University Hospital the following services: utilities, telephone/IT services, transportation services and library services. Expenses charged for such services were $14.3 and $13.6 for the years ended June 30, 2015 and 2014, respectively.

The MedStar Washington Hospital Center campus is subject to the lien of a Permitted Encumbrance in the amount of $21.5 to the United States government. This encumbrance was created in the deed of the hospital property from the United States government to MedStar Washington Hospital Center in February 1960. There is no repayment date for this lien stated in the deed. Under enabling legislation, repayment could be required after a determination that the property is no longer required for hospital services or the property is disposed of, in which event all or a portion of the lien may be payable to the government. This lien is subordinated to the Deed of Trust on the MedStar Washington Hospital Center campus.

(Dollars in millions)

(18) Functional Expenses

The Corporation considers integrated health services, research and management and general to be its primary functional categories for purposes of expense classification. Management and general include information systems, general corporate management, advertising and marketing. Functional categories of expenses for the years ended June 30, 2015 and 2014 are as follows:

		2015	2014
Integrated health services	$	3,885.9	3,532.4
Management and general		946.2	924.7
Research		30.0	30.4
Fundraising		4.3	4.9
	$	4,866.4	4,492.4

(19) Subsequent Events

Management evaluated all events and transactions that occurred after June 30, 2015 and through October 2, 2015. The Corporation did not have any events that were required to be recognized or disclosed.

Attachment 16: MFSMC Docket No. 05-03-2173

MARYLAND HEALTH CARE COMMISSION

Certificate of Need

TO: Carl J. Schindelar
President
Franklin Square Hospital Center
9000 Franklin Square Drive
Baltimore, Maryland 21237

July 20, 2006
(Date)

RE: Expansion of Hospital Facilities

05-03-2173
(Docket No.)

PROJECT DESCRIPTION

Franklin Square Hospital Center ("FSHC" or the "Hospital") will construct a 388,015 gross square feet ("GSF") five-story (above grade) addition on the eastern side of the existing main hospital building. This new construction will house the following facilities and services:

- Basement level – mechanical rooms, primary electrical service and distribution rooms, service/storage/repair/maintenance shops and offices;

- First floor – a replacement emergency department ("ED") with 70 treatment spaces allocated among six treatment zones (triage, "fast track," adult emergent care, cardiac/trauma, psychiatric, and pediatric). The pediatric zone will integrate ED treatment space and a nine-bed inpatient pediatric unit replacing the existing pediatric unit. The first floor will also include a new main entrance lobby, waiting areas, gift shop, and retail pharmacy;

- Second floor – two intensive care units totaling 50 beds, replacing the hospital's existing intensive care units; and

- Floors three through five – two 36-bed general medical/surgical units on each floor, for a total of 216 medical/surgical beds.

The project will result in a total physical bed capacity at FSHC of 378 acute care beds, an increase of 16 beds over current acute care bed capacity. It will add 125 patient rooms.

The project will include construction of a four-level parking garage, with approximately 1,100 parking spaces. The project will also involve relocation of the existing loading dock and incinerator, the creation, through renovation, of a circulation corridor linking the new dock location with the existing circulation facilities of the hospital, renovation to provide additional needed corridor connection between the new construction and the existing hospital structure, and the development of new power generation and mechanical systems capabilities and the modernization of existing building systems, adequate to power, heat, ventilate, and air condition the post-project hospital facilities.

Planned use of vacated space, as of July, 2006, included expansion of outpatient services on the first floor of the existing hospital and administrative services on the upper floors, where inpatient nursing units are being vacated.

The estimated current capital cost of the project is $161,837,234. Inflation and interest during the construction period are estimated to add $45.4 million and financing and other cost requirements are estimated to add $17.7 million dollars for a total project cost of $224,878,180. FSHC plans to fund the project through bond indebtedness of $162.2 million, $42.5 million in cash equity, $9.4 million in fundraising, and $10.9 million in interest income from the bond proceeds. The Hospital is not requesting a rate increase for the project at this time.

ORDER

The Maryland Health Care Commission reviewed the Staff Report and Recommendation and, based on this analysis and the record in this review, ordered, on July 20, 2006, that a CON be issued for the project, subject to the following conditions:

1. Upon completion of the project, FSHC will not place any of the nine MSGA nursing units replaced by the MSGA beds being constructed in the new addition or the former pediatric unit into operation for routine inpatient care without Commission approval; and

2. Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude the cost associated with the excess square footage of the new nursing units, which is calculated to be $5,327,100, using the fully adjusted MVS ("Marshall Valuation Service") estimated cost per square foot for the new construction.

PERFORMANCE REQUIREMENTS

In accordance with COMAR 10.24.01.12, the project is subject to the following performance requirements:

Phase 1 - Roadways, Utilities, and Surface Parking:

1. Obligation of not less than $7.5 million, or 51% of the total capital expenditure for Phase 1 of the project, as documented by a binding construction contract no later than July 20, 2007, which is 12 months from the date of this Certificate of Need; and

2. Completion of the first approved phase of construction within 24 months after the effective date of the binding construction contract for Phase 1.

Phase 2 – Parking Garage:

1. Obligation of not less than $12.7 million, or 51% of the total capital expenditure for Phase 2 of the project, as documented by a binding construction contract no later than 12 months after completion of Phase 1 of the project; and

2. Completion of the second approved phase of construction within 24 months after the effective date of the binding construction contract for Phase 2.

Phase 3 – New Patient Tower:

1. Obligation of not less than $128.6 million, or 51% of the total capital expenditure for Phase 3 of the project, as documented by a binding construction contract no later than 12 months after completion of Phase 2 of the project; and

2. Completion of the third approved phase of construction within 36 months after the effective date of the binding construction contract for Phase 3.

Franklin Square Hospital Center must notify the Commission, in its Quarterly Reports, when the hospital executes the binding construction contract for the project and when Phase 1 of the project is complete, because the deadlines for completing the project are based on these dates.

Failure to meet these performance requirements will render this Certificate of Need void, subject to the requirements of COMAR 10.24.01.12F through I.

PROPOSED CHANGES TO APPROVED PROJECT

Before making any changes to the facts in the Certificate of Need application approved by the Commission, Franklin Square Hospital Center must notify the Commission in writing and receive Commission approval of each proposed change, including the obligation of any funds above those approved by the Commission in this Certificate of Need, in accordance with COMAR 10.24.01.17.

SUBMISSION OF PROJECT DRAWINGS TO DHMH

The project's architect or engineer is required to contact the Plans Review and Approval section of the Department of Health and Mental Hygiene, to ascertain the specific information concerning the project's drawings and specifications that the law requires to be submitted and approved prior to the initiation of construction.

QUARTERLY STATUS REPORTS

Franklin Square Hospital Center must submit quarterly status reports to the Commission, beginning October 20, 2006, three months from the date of this Certificate of Need, and continuing through the completion of the project.

REQUEST FOR FIRST USE REVIEW

Franklin Square Hospital Center must request in writing, not less than 60 days but not more than 120 days before the first use of each portion of the new and renovated space, a first use review from the Commission and the Office of Health Care Quality specifying the anticipated date of first use. The Commission will review the request in consultation with the Office of Health Care Quality, and in accordance with COMAR 10.24.01.18., to determine whether the project conforms to the Certificate of Need. First use approval remains in effect for 90 days. If the space is not occupied within 90 days of approval, Franklin Square Hospital Center shall reapply for first use review.

ACKNOWLEDGMENT OF RECEIPT OF CON

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

MARYLAND HEALTH CARE COMMISSION

Rex W. Cowdry, M.D.
Executive Director

cc: Wendy Kronmiller, Office of Health Care Quality
Pierre Vigilance, M.D., Baltimore County Health Department
Howard Jones, Office of Plans Review, DHMH
Robert Murray, Executive Director, HSCRC

STATE OF MARYLAND

Marilyn Moon, Ph.D.
CHAIR

Rex W. Cowdry, M.D.
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION
4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

November 30, 2007

VIA TELECOPIER TO 443.777.7904 AND U.S.MAIL

Eric Slechter, Planning Director
Franklin Square Hospital Center
9000 Franklin Square Drive
Rosedale, Maryland 21237

Re: Franklin Square Hospital Center
Docket No. 05-03-2173

Dear Mr. Slechter:

Maryland Health Care Commission staff has reviewed the proposed changes in the design of the above-referenced expansion and renovation project at Franklin Square Hospital Center ("FSHC") that was authorized by the Commission in July, 2006.

These changes include:

- An 8-level building addition with no basement and a smaller footprint rather than the approved 6-level building addition, including basement. The addition will have six floors of medical/surgical/gynecologic/ addictions ("MSGA") beds rather than the four floors of MSGA beds in the approved plan;

- The replacement emergency department on the first floor, which continues to incorporate a 9-bed pediatric unit, is redesigned to incorporate 80 emergency department ("ED") treatment spaces rather than the 70 in the approved CON application;

- A 20,432 square foot mechanical eighth floor will fulfill the functions of the originally planned basement level of the addition;

- The reconfiguration of the nursing unit floors will involve new construction of 24 more medical/surgical patient rooms and 8 fewer intensive care patient rooms, for a net increase of 16 single occupancy rooms and beds in the newly constructed building addition. The approved total bed capacity for the project would remain at 378 beds

through the retirement of 16 additional existing medical/surgical beds, of the total 42 existing medical/surgical beds which FSHC intended to continue in operation; and

- An 18,000 square foot "power plant" will be constructed rather than the two basement-level emergency power substations and new generator plant in the original project.

Franklin Square Hospital Center estimates that the project, with the design changes outlined above, can be implemented at a lower current capital cost ($190,500,500 compared to the approved capital cost of $207,200,000) and a lower total project cost ($193,368,591 compared to the approved total project cost of $224,878,180.)[1] You have indicated that, in this most recent estimate of new construction, the cost for "new construction," "other capital costs," and the "inflation allowance," totaling $175 million, are very firm, because of the existence of guaranteed price contract agreements. With respect to financing and other project cash requirements, the project cost savings are wholly attributable to the elimination of the requirement for a debt service reserve fund, estimated at $15.2 million in the approved project estimate. In correspondence provided earlier this year, you outlined that it was determined that "the security package currently in place under the System's (MedStar Health) existing Master Trust Indenture and supplements thereto provided sufficient security for investors. Therefore, a debt service reserve fund was not needed."

The information FSHC has provided indicates that the format of the primary project component, the addition of a tower, incorporating a first floor replacement emergency department and pediatric unit, and replacement of most of the hospital's MSGA beds in the remaining floors, remains unchanged. The tower addition will have a smaller footprint. This reduced perimeter will necessitate the incorporation of two additional levels for MSGA beds and, overall, the tower will contain smaller nursing units on each of the upper floors than originally planned, but without any changes in overall planned bed capacity. A mechanical penthouse floor will replace the basement level. Given these facts, the proposed design changes are not considered to represent "changes in physical plant design" of a "significance" requiring Commission review and approval. As noted above, the capital cost of the project is not increasing. Rather, it is now estimated to be lower than the cost approved.

The substantive change in clinical service capacity proposed by FSHC is the increase in emergency department treatment spaces. The hospital currently has 89 total ED "beds," consisting of 54 treatment beds, 13 non-treatment beds, and 22 observation/holding beds, which are substandard, hall-way space added to decompress the congested ED situation. The replacement ED approved for FSHC in 2006 was planned to provide 77 patient "beds", which FSHC characterized as 70 "treatment beds and 7 non-treatment beds, which included a decontamination/HAZMAT bed and 6 triage beds. FSHC's final design, using a smaller footprint, incorporates 80 treatment spaces rather than the 70 approved in the CON application.

The American College of Emergency Physicians ("ACEP") publication, *Emergency Department Design*, which was referenced as a guideline in the review of this project, recommends, as appropriate, a range of 50 to 68 treatment beds for EDs experiencing 90,000 visits and 55 to 75 treatment beds for EDs with 100,000 visits. FSHC projected over 100,000

[1] Quarterly Progress Report, October 20, 2007

ED visits by 2011, when the proposed replacement ED is projected to come on line, and this projection was found to be conservative by MHCC in its review of the project. ED demand has outpaced the projections included in FSHC's CON application. The hospital is reported to have experienced 98,270 total ED visits in FY2006.[2] If ED demand at FSHC increases by 9% between 2006 and 2012 (which was the rate of growth projected by FSHC in its CON application for the period of 2005 to 2011), FSHC would be projected to experience demand for 107-108,000 ED visits by 2012.[3] ACEP recommends a range of 60 to 82 treatment spaces at annual visit volumes of 110,000 visits. At 110,000 ED visits, 80 treatment spaces would be utilized at approximately 1,375 visits per bed per year. This is in line with recently recorded average statewide utilization experience in Maryland (1,343 ED visits per treatment space, statewide, in FY2006).

The addition of ED treatment space capacity is not a specifically regulated category of project under Maryland's CON program (as is, for example, the addition of inpatient beds) and changing the planned capacity of a hospital ED is not an impermissible modification. Given the information considered above, the additional ED treatment spaces incorporated into the final design are in line with trends in ED demand at FSHC and are not viewed as a significant change, with respect to physical plant design, given that the first level of the building addition, which will house the replacement ED, encompasses less building space.

FSHC has provided information indicating that the other three types of changes requiring Commission approval are not occurring. The projected operating expense and revenue increases are within the 10% annual inflation allowance, the project financing mechanisms involved are not changing, and the location of the project is not changing. For these reasons, Commission approval of the redesigned project is not required.

Please call me at 410-764-3261 if you have any questions.

Sincerely,

Paul E. Parker, Chief
Certificate of Need

cc: Pamela Barclay
Suellen Wideman, AAG
Pierre Vigilance, M.D., Health Officer, Baltimore County

[2] HSCRC, Financial Date Base, FY2006

[3] This is a substantially more moderate rate of growth in ED visit volume than FSHC has recently experienced. ED visits at FSHC increased over 40% between 2000 and 2005).

Attachment 18: Surgery Standards, A1. Information Regarding Charges/Range of Services

Patient Rights and Responsibilities

The Board of Directors and Administration of MedStar Franklin Square Medical Center affirm that, as a patient receiving care at the MedStar Franklin Square Medical Center, you have the right to:

Receive Reasonable and Necessary Medical Care

- When able, the hospital must makea reasonable RESPONSE to your request for care, regardless of race, religion, sex, color, national ongin, sexual onentat1on, gender 1dent1ty
  or ab,hty to pay The hospital w,11 prov,d<! evaluation, treatment and **refcmal** to other sources of care as medically needed.
- When medically advisable, youmaybe transferred to another facility This will happen only after you have received complete information about the need for the transfer and other options You will be informed of nsks, benefits and options You will not be transferred until the other fac1hty agrees to c1ccept you
- You have the nght to request, accept or reiect measures and treatment necessary to relieve pam and suffering m accordance with customary medical practice
- You have the nght to mformat1on about your contmumg healthcare needs m the form of discharge mstruct1ons
- You ,ind your family have the right to be involved m yourtreatment and the planof care Youhave the nght to be mformed of that plan of care
- You have the right to mformat1on about Advance Directives (hvmg will and/or medical power of attorney) These documents may express your choices about medical care These documents may also 1dent1fy your choice of someone to be your dec1s1on maker 1f you cannot make dec1s1ons for yourself
-

Refusal of Care

- You may refuse treatment to the extent permitted bylaw and you will be informed of the medical results of that action If you refuse arecommended treatment. you will befully informed of potential outcomes Youwill also receive other needed and available care 1f you agree, and will be referred toother care options as needed

Respect and Privacy

- You have the right to be treated with respect d1gn1ty and consideration at alltimes
- You hava the nght to receive treatment m privacy Whenever possible, you will receive careout ofs,ght ofother patients, v1s1tors and employees You have the right to expect thc:it only ind1v1duals involved m your care or in educc:it,on programs that are part of the hospital's m1ss1on will dtscuss your cond1tton
- Information that 1dent1f1es you and your cond1t1on 1s conf1dent1al Maryland law or federal regulation l1m1ts disclosure of such 1nformat1on Generally, your medical mformat1on ts available tohospitalemployees and others associated with your care With limited exceptions set forth m the law, your records cannot be released to others. unless we have your perm1s-s1on
- " You have the right to be involved m every aspect or your care To support that involvement MedStar Franklin Squareoffers counseling, pain management and other comfort care measures

Information

- You have the r1gh1 lo current mformauon about your diagnosis, treatment and prognosis tn terms you can understand When a patient 1s not physically or mentally able to understand this 1nformat1on, 1t must be made available to the legally 1dent1f1ed person making dec1s1ons on your behalf
- You have the nght to review your medical records withthe doctor Youalso have the right to have the information explained except when restncted by law
- You have the right to mformat1on necessary to give informed consent to any elective treatment or procedure You have the nght to knowabout·
  - the s1gmf1cant nsks and benefits
  - probable length of treatment
  - your recuperationtime
  - options forcare
- In hfe.threatenmg emergencies, you may need to receive treatment before consent 1s obtained
- " You have the nght to see and obtain a copy or your health record
- You also have the right to know the names and roles of everyone mvolved in your care
- You have the right to information about any relat1onsh1p that the hospital may have with other healthcare and educational mst1tut1 ons as 1t relates to your care
- You have the nght to receive examine and obtain an explanation or your bill, regardless of the source of payment
- Youhave the nght to asafe environment
- You have the right to access protective services (services that determine the need for protective intervention correction of hazardous hvmg cond1t1ons. mvest1gat1on of abuse, neglect, etc)
- You have a right to obtain a 11st of disclosures we have made

The Board of Directors and Administration of MedStar Franklin Square Medical Center affirm that, as a patient receiving care at Franklin Square, you are responsible for:

- Showmgcons1derat1ontootherpatients and staff This mcludes respectmg other patients' pnvacy and their need for qwet in order to rest and recuperate Failure to comply may result m admm1strat1ve discharge
- Tellmg us everything about your current condition and past medical history This includes 1nformat1on about anyprescnpt1on and non•prescriptton medications you are taking
- Letting your doctor and nurse know whether you have an Advance D1rect1ve (hvmg will, medical power of attorney) Advance D1rect1ves include mformat1on about your wishes regarding care dec1s1ons should you become unable to make dec1s1ons for yourself You must supply a copy to the hospital
- Being available for treatment and med,cat1ons
- Prov1d1ng accurate information and/or makmg necessary correspondence for prompt payment
- Prov1d1ng accurate information and/or making necessary arrangements for prompt payment of bolls
- Asking questions when you do notunderstand information or instructions If you believe you cannot followthrough with your treatment, you are responsible for mform1ng your healthcare team

Making Healthcare Decisions in Advance

Making Healthcare Decisions in Advance

Maryland law gives you the nght to make many healthcare dec1s1ons madvance One way to do this 1s with a written advance directive, which states your treatment preferences, especially about Itfe-sustammg procedures, and names an agent to make your healthcare dedsions if you cannot

When you come to the hospital, you will be asked 1f you already have an advance directive If you do, you will be asked to provide a copy so that 1t can be included m your hospital chart If you would like to develop an advance d1rect1ve, ask your nurse to notify a case manager to assist you.

Naming a Healthcare Agent

You can allow anyone to be your healthcare agent, except for an employee of the healthcare facility where you are receiving care Choose your agent carefully, and make sure he or she knows what you want Your agent will them follow your wishes, even 1f your friends or family disagree

What Happens If You Do Not Make

No one can deny you healthcare because you do not have an advance directive, but you should know what happens legally if you do not.

Maryland law allows a surrogate to make medical dec1s1ons for you 1f you have not named a healthcare agent and are no longer able to decide treatment issues yourself. Your closest relative will be asked to make these dec1s1ons If there 1s no one to be a surrogate, the court might appoint a guardian to make your medical dec1s1ons. This may be .someone who does not know you personally

Advance d1rect1ve forms are available 1n the Case Management Office. If you have questions or want more mformat1on, ask your doctor, nur,;e or social worker, or call 443-777-7547.

Concerns and Questions

You have the nght to have your questions and concerns addressed by the staff of this hospital, starting with the manager of the department, your physician , any supervisory staff and our senior leadership

You may also contact the Customer Help Line at 443-777 -6555 We will thoroughly investigate all pat1ent safety concerns If your concerns about patient safety and quality are not resolved , we encourage you to contact the Jomt Comm1ss1on

You can reach the Joint Comm1ss1on at 1-800-994-6610 or ema,I your complaints to complamt@Jomtcomm1ss1on org You can reach the Department of Health and Mental Hygiene at 1-877-402-8218 or download the Complaint Report Form at http//dhmh maryland gov/ohcq (search "complaint form")

medstarfranklin.org

MedStar Franklin Square Medical Center

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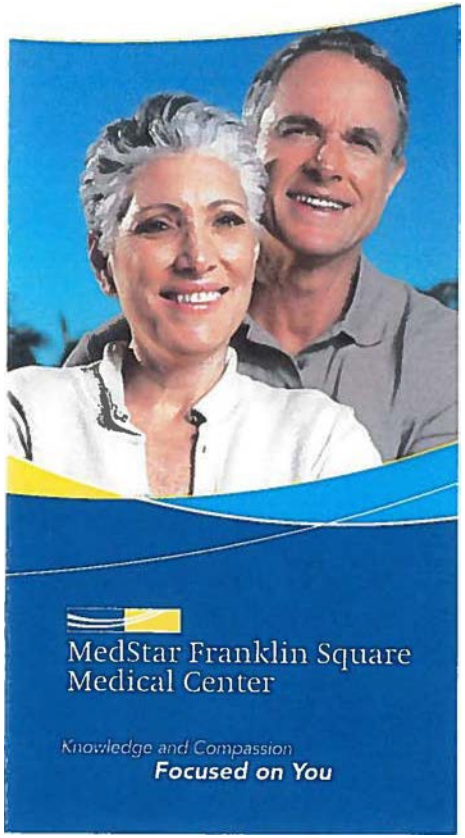
443 777 7900 '''

Patient Rights and Responsibilities & Making Healthcare Decisions in Advance



Attachment 19: Surgery Standards, A2. Charity Care Policy

MedStar Health

Corporate Policies

Title:	**Corporate Financial Assistance Policy**	**Section:**	
Purpose:	To ensure uniform management of the MedStar Health Corporate Financial Assistance Program within all MedStar Health Hospitals.	**Number:**	
Forms:		**Effective Date:**	07/01/2016

Policy

1. As one of the region's leading not-for-profit healthcare systems, MedStar Health is committed to ensuring that uninsured patients and underinsured patients meeting medical hardship criteria within the communities we serve who lack financial resources have access to emergency and medically necessary hospital services. MedStar Health and its healthcare facilities will:

   1.1 Treat all patients equitably, with dignity, respect, and compassion.
   1.2 Serve the emergency health care needs of everyone who presents to our facilities regardless of a patient's ability to pay for care.
   1.3 Assist those patients who are admitted through our admission process for non-urgent, medically necessary care who cannot pay for the care they receive.
   1.4 Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep its hospitals' doors open for all who may need care in the community.

Scope

1. In meeting its commitments, MedStar Health's facilities will work with their uninsured patients seeking emergency and medically necessary care to gain an understanding of each patient's financial resources. Based on this information and eligibility determination, MedStar Health facilities will provide financial assistance to uninsured patients who reside within the communities we serve in one or more of the following ways:

   1.1 Assist with enrollment in publicly-funded entitlement programs (e.g., Medicaid).
   1.2 Refer patients to State or Federal Insurance Exchange Navigator resources.
   1.3 Assist with consideration of funding that may be available from other charitable organizations.
   1.4 Provide financial assistance according to applicable policy guidelines.
   1.5 Provide financial assistance for payment of facility charges using a sliding-scale based on the patient's household income and financial resources.
   1.6 Offer periodic payment plans to assist patients with financing their healthcare services.

Definitions

1. **Free Care**

   100% Financial Assistance for medically necessary care provided to uninsured patients with household income between 0% and 200% of the FPL.

2. **Reduced Cost-Care**

   Partial Financial Assistance for medically necessary care provided to uninsured patients with household income between 200% and 400% of the FPL.

3. **Underinsured Patient**

   An "Underinsured Patient" is defined as an individual who elects third party insurance coverage with high out of pocket insurance benefits resulting in large patient account balances.

4. **Medical Hardship**

   Medical debt, incurred by a household over a 12-month period, at the same hospital that exceeds 25% of the family household income. This means test is applied to uninsured and underinsured patients with income up to 500% of the Federal Poverty Guidelines.

5. **MedStar Uniform Financial Assistance Application**

   A uniform financial assistance data collection document. The Maryland State Uniform Financial Assistance Application will be used by all MedStar hospitals regardless of the hospital geographical location.

6. **MedStar Patient Information Sheet**

   A plain language summary that provides information about MedStar's Financial Assistance Policy, and a patient's rights and obligations related to seeking and qualifying for free or reduced cost medically necessary care. The Maryland State Patient Information Sheet format, developed through the joint efforts of Maryland Hospitals and the Maryland Hospital Association, will be used by all MedStar hospitals regardless of the hospital geographical location.

7. **AGB – Amount Generally Billed**

   Amounts billed to patients who qualify for Reduced-Cost Sliding Scale Financial Assistance.

Responsibilities

1. Each facility will widely publicize the MedStar Financial Assistance Policy by:

   1.1 Providing access to the MedStar Financial Assistance Policy, Financial Assistance Applications, and MedStar Patient Information Sheet on all hospital websites and patient portals.
   1.2 Providing hard copies of the MedStar Financial Assistance Policy, MedStar Uniform Financial Assistance Application, and MedStar Patient Information Sheet to patients upon request.

   1.3 Providing hard copies of the MedStar Financial Assistance Policy, MedStar Uniform Financial Assistance Application, and MedStar Patient Information Sheet to patients upon request by mail and without charge.

   1.4 Providing notification and information about the MedStar Financial Assistance Policy by:

      1.4.1 Offering copies as part of all registration or discharges processes, and answering questions on how to apply for assistance.
      1.4.2 Providing written notices on billing statements.
      1.4.3 Displaying MedStar Financial Assistance Policy information at all hospital registration points.
      1.4.4 Translating the MedStar Financial Assistance Policy, MedStar Uniform Financial Assistance Application, and the Medstar Patient Information Sheet into primary languages of all significant populations with Limited English Proficiency.

   1.5 MedStar Health will provide public notices yearly in local newspapers serving the hospital's target population.

   1.6 Providing samples documents and other related material as attachments to this Policy

      1.6.1 Appendix #1 – MedStar Uniform Financial Assistance Application
      1.6.2 Appendix #2 - MedStar Patient Information Sheet
      1.6.3 Appendix #3 – Translated language listing for all significant populations with Limited English Proficiency (documents will be available upon request and on hospital websites and patient portals
      1.6.4 Appendix #4 – Hospital Community Served Zip Code listing
      1.6.5 Appendix # 5 – MedStar Financial Assistance Data Requirement Checklist
      1.6.6 Appendix #6 – MedStar Financial Assistance Contact List and Instructions for Obtaining Free Copies and Applying for Assistance
      1.6.7 Appendix #7 - MedStar Health FAP Eligible Providers

2. MedStar will provide a financial assistance probable and likely eligibility determination to the patient within two business days from receipt of the initial financial assistance application.

   2.1 Probable and likely eligibility determinations will be based on:

      2.1.1 Receipt of an initial submission of the MedStar Uniform Financial Assistance application.

   2.2 The final eligibility determination will be made and communicated to the patient based on receipt and review of a completed application.

      2.2.1 Completed application is defined as follows:

         2.2.1.a All supporting documents are provided by the patient to complete the application review and decision process.
         - See Appendix #5 – MedStar Financial Assistance Data Requirement Checklist
         2.2.1.b Application has been approved by MedStar Leadership consistent with the MedStar Adjustment Policy as related to signature and dollar limits protocols.
         2.2.1.c Pending a final decision for the Medicaid application process.

3. MedStar Health believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Financial assistance and periodic payment plans available under this policy will not be available to those patients who fail to fulfill their responsibilities. For purposes of this policy, patient responsibilities include:

3.1 Comply with providing the necessary financial disclosure forms to evaluate their eligibility for publicly-funded healthcare programs, charity care programs, and other forms of financial assistance. These disclosure forms must be completed accurately, truthfully, and timely to allow MedStar Health's facilities to properly counsel patients concerning the availability of financial assistance.

3.2 Working with the facility's Patient Advocates and Patient Financial Services staff to ensure there is a complete understanding of the patient's financial situation and constraints.

3.3 Making applicable payments for services in a timely fashion, including any payments made pursuant to deferred and periodic payment schedules.

3.4 Providing updated financial information to the facility's Patient Advocates or Customer Service Representatives on a timely basis as the patient's financial circumstances may change.

3.5 It is the responsibility of the patient to inform the MedStar hospital of their existing eligibility under a medical hardship during the 12 month period.

3.6 In the event a patient fails to meet these responsibilities, MedStar reserves the right to pursue additional billing and collection efforts. In the event of non-payment billing, and collection efforts are defined in the MedStar Billing and Collection Policy. A free copy is available on all hospital websites and patient portals via the following URL: **www.medstarhealth.org/FinancialAssistance ,** or by call customer service at 1-800-280-9006.

4. Uninsured patients of MedStar Health's facilities may be eligible for full financial assistance or partial sliding-scale financial assistance under this policy. The Patient Advocate and Patient Financial Services staff will determine eligibility for full financial assistance and partial sliding-scale financial assistance based on review of income for the patient and their family (household), other financial resources available to the patient's family, family size, and the extent of the medical costs to be incurred by the patient.

5. **ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE**

5.1 Federal Poverty Guidelines. Based on household income and family size, the percentage of the then-current Federal Poverty Level (FPL) for the patient will be calculated.

5.1.1 Free Care: Free Care (100% Financial Assistance) will be available to uninsured patients with household incomes between 0% and 200% of the FPL. FPL's will be updated annually.

5.1.2 Reduced Cost-Care: Reduced Cost-Care will be available to uninsured patients with household incomces between 200% and 400% of the FPL. Reduced Cost-Care will be available based on a sliding-scale as outlined below. Discounts will be applied to amounts generally billed (ABG). FPL's will be updated annually.

5.1.3 Ineligibility. If this percentage exceeds 400% of the FPL, the patient will not be eligible for Free Care or Reduced Cost-Care assistance (unless determined eligible based on Medical Hardship criteria, as defined below). FPL's will be updated annually.

5.2 Basis for Calculating Amounts Charged to Patients: Free Care or Reduced-Cost Care Sliding Scale Levels:

	Financial Assistance Level Free / Reduced-Cost Care	
Adjusted Percentage of Poverty Level	**HSCRC-Regulated Services**	**Washington Facilities and non-HSCRC Regulated Services**
0% to 200%	100%	100%
201% to 250%	40%	80%
251% to 300%	30%	60%
301% to 350%	20%	40%
351% to 400%	10%	20%
more than 400%	no financial assistance	no financial assistance

5.3 **MedStar Health Hospitals** will comply with IRS 501(r) requirements on limiting the amounts charged to uninsured patients seeking emergency and medically necessary care.

5.3.1 The MedStar Health calculation for AGB will be the amount Medicare would allow for care, including amounts paid or reimbursed and amounts paid by individuals as co-payments, co-insurance, or deductibles.

5.3.2 Amounts billed to patients who qualify for Reduced-Cost Sliding Scale Financial Assistance will not exceed the amounts generally billed (AGB).

Example:

GROSS CHARGES	MEDICARE ALLOWABLE AGB AMOUNT	**PATIENT ELIGIBLE FOR SLIDING SCALE ASSISTANCE	FINANCIAL ASSISTANCE AMOUNT APPROVED AS A % OF THE MEDICARE ALLOWABLE AGB AMOUNT	PATIENT RESPONSIBILITY
$1,000.00	**$800.00**	**40%**	**$320.00**	**$480.00**
**** Sliding Scale % will vary per Section 5.2 - Basis for Calculating Amounts Charge Patients in this Policy**				

6. **FINANCIAL ASSISTANCE: ADDITIONAL FACTORS USED TO DETERMINE ELIGIBILITY FOR MEDICAL ASSISTANCE: MEDICAL HARDSHIP.**

6.1 MedStar Health will provide Reduced-Cost Care to patients with household incomes between 200% and 500% of the FPL that, over a 12 month period, have incurred medical debt at the same hospital in excess of 25% of the patient's household income. Reduced Cost-Care will be available based on a sliding-scale as outlined below.

6.2 A patient receiving reduced-cost care for medical hardship and the patient's immediate family members shall receive/remain eligible for Reduced Cost medically necessary care when seeking subsequent care for 12 months beginning on the date which the reduced-care was received. It is the responsibility of the patient to inform the MedStar hospital of their existing eligibility under a medical hardship during the 12 month period.

6.3 If a patient is eligible for Free Care / Reduced-Cost Care, and Medical Hardship, the hospital will employ the more generous policy to the patient.

6.4 Medical Hardship Reduced-Care Sliding Scale Levels:

	Financial Assistance Level – Medical Hardship	
Adjusted Percentage of Poverty Level	**HSCRC-Regulated Services**	**Washington Facilities and non-HSCRC Regulated Services**
Less than 500%	**Not to Exceed 25% of Household Income**	**Not to Exceed 25% of Household Income**

7. **METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE: INCOME AND ASSET DETERMINATION**.

7.1 Patients may obtain a Financial Assistance Application and other informational documents:
7.1.1 On Hospital Websites and Patient Portals via the following URL: **www.medstarhealth.org/FinancialAssistance**
7.1.2 From Hospital Patient Advocates and/or Admission / Registration Associates
7.1.3 By contacting Patient Financial Services Customer Service
- See Appendix #6 – Financial Assistance Contact List and Instruction for Obtaining Free Copies and How to Apply for Assistance

7.2 MedStar Health will evaluate the patient's financial resources **EXCLUDING**:

7.2.1 The first $250,000 in equity in the patient's principle residence
7.2.2 Funds invested in qualified pension and retirement plans where the IRS has granted preferential treatment
7.2.3 The first $10,000 in monetary assets e.g., bank account, stocks, CD, etc

7.3 MedStar Health will use the MedStar Uniform Financial Assistance Application as the standard application for all MedStar Health Hospitals. MedStar Health will require the patient to supply all documents necessary to validate information to make eligibility determinations.

7.4 Financial assistance applications and support documentation will be applicable for determining program eligibility one (1) year from the application date. Additionally, MedStar Health will consider for eligibility all accounts (including bad debts) 6 months prior to the application date.

8. **PRESUMPTIVE ELIGIBILTY**

8.1 Patients already enrolled in certain means-tested programs are deemed eligible for free care on a presumptive basis. Examples of programs eligible under the MedStar Health Financial Assistance Program would include but are not limited to:

8.1.1 Maryland Supplemental Nutritional Assistance Program (SNAP)
8.1.2 Maryland Temporary Cash Assistance (TCA)
8.1.3 All Dual eligible Medicare / Medicaid Program – SLMB QMB
8.1.4 All documented Medicaid Spend Down amounts as documented by Department of Social Services
8.1.5 Other Non-Par Payer Programs

MedStar Health will continually evaluate any publicly-funded programs for eligibility under the Presumptive Eligibility provision of this policy.

8.2 Additional presumptively eligible categories will include with minimal documentation:

8.2.1 Homeless patients as documented during the registration/clinical intake interview processes.
8.2.2 Deceased patients with no known estate based on medical record documentation, death certificate, and confirmation with Registrar of Wills.
8.2.3 All patients resulting from other automated means test scoring campaigns and databases.

9. MEDSTAR HEALTH FINANCIAL ASSISTANCE APPEALS

9.1 In the event a patient is denied financial assistance, the patient will be provided the opportunity to appeal the MedStar Health denial determination.

9.2 Patients are required to submit a written appeal letter to the Director of Patient Financial Services with additional supportive documentation.

9.3 Appeal letters must be received within 30 days of the financial assistance denial determination.

9.4 Financial assistance appeals will be reviewed by a MedStar Health Appeals Team. Team members will include the Director of Patient Financial Services, Assistance Vice President of Patient Financial Services, and the hospital's Chief Financial Officer.

9.5 Denial reconsideration decisions will be communicated, in writing, within 30 business days from receipt of the appeal letter.

9.6 If the MedStar Health Appeals Panel upholds the original denial determination, the patient will be offered a payment plan.

10. PAYMENT PLANS

10.1 MedStar Health will make available payment plans, per the MedStar Corporate Payment Plan Policy, to uninsured or underinsured patients with household income above 200% of the Federal Poverty Guidelines who do not meet eligibility criteria for the MedStar Financial Assistance or Financial Assistance Programs.

10.2 Patients to whom discounts, payment plans, or financial assistance are extended have continuing responsibilities to provide accurate and complete financial information. In the event a patient fails to meet these continuing responsibilities, MedStar Health will pursue collections of open patient balances per the MedStar Corporate Billing and Collection Policy. MedStar reserves the right to reverse financial assistance account adjustments and pursue the patient for original balances owed.

11. BAD DEBT RECONSIDERATIONS AND REFUNDS

11.1 In the event a patient who, within a two (2) year period after the date of service was found to be eligible for free care on that date of service, MedStar Health will initiate a review of the account(s) to determine the appropriateness for a patient refund for amounts collected exceeding $25.

11.2 It is the patient's responsibility to request an account review and provide the necessary supportive documentation to determine free care financial assistance eligibility.

11.3 If the patient fails to comply with requests for documentation, MedStar Health will document the patient's non-compliance. The patient will forfeit any claims to a patient refund or free care assistance.

11.4 If MedStar Health obtains a judgment or reports adverse information to a credit reporting agency for a patient that was later to be found eligible for free care, MedStar Health will seek to vacate the judgment or strike the adverse information.

are working to improve language accessibility within their states; and

• Recommendations for state-specific capacity building for the 20 states intended to enhance statewide language access, which will include the development of language access plans.

An objective review of was conducted that assessed the grantee's application using criteria related to the project's approach, the organization's capacity, and the development of costs for the project's budget.

Statutory Authority: Section 310 of the Family Violence Prevention and Services Act, as amended by Section 201 of the CAPTA Reauthorization Act of 2010, Pub. L. 111–320.

Christopher Beach,

Senior Grants Policy Specialist, Division of Grants Policy, Office of Administration.

[FR Doc. 2016–01329 Filed 1–22–16; 8:45 am]

BILLING CODE 4184–32–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Annual Update of the HHS Poverty Guidelines

AGENCY: Department of Health and Human Services.

ACTION: Notice.

SUMMARY: This notice provides an update of the Department of Health and Human Services (HHS) poverty guidelines to account for last calendar year's increase in prices as measured by the Consumer Price Index.

DATES: *Effective Date:* January 25, 2016, unless an office administering a program using the guidelines specifies a different effective date for that particular program.

ADDRESSES: Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services, Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: For information about how the guidelines are used or how income is defined in a particular program, contact the Federal, state, or local office that is responsible for that program. For information about poverty figures for immigration forms, the Hill-Burton Uncompensated Services Program, and the number of people in poverty, use the specific telephone numbers and addresses given below.

For general questions about the poverty guidelines themselves, contact Kendall Swenson, Office of the Assistant Secretary for Planning and Evaluation, Room 422F.5, Humphrey Building, Department of Health and Human Services, Washington, DC 20201—telephone: (202) 690–7507—or visit *http://aspe.hhs.gov/poverty/.*

For information about the percentage multiple of the poverty guidelines to be used on immigration forms such as USCIS Form I–864, Affidavit of Support, contact U.S. Citizenship and Immigration Services at 1–800–375–5283.

For information about the Hill-Burton Uncompensated Services Program (free or reduced-fee health care services at certain hospitals and other facilities for persons meeting eligibility criteria involving the poverty guidelines), contact the Health Resources and Services Administration Information Center at 1–800–275–4772. You also may visit *http://www.hrsa.gov/gethealthcare/affordable/hillburton/.*

For information about the number of people in poverty, visit the Poverty section of the Census Bureau's Web site at *http://www.census.gov/hhes/www/poverty/poverty.html* or contact the Census Bureau's Customer Service Center at 1–800–923–8282 (toll-free) and *https://ask.census.gov* for further information.

SUPPLEMENTARY INFORMATION:

Background

Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)) requires the Secretary of the Department of Health and Human Services to update the poverty guidelines at least annually, adjusting them on the basis of the Consumer Price Index for All Urban Consumers (CPI–U). The poverty guidelines are used as an eligibility criterion by the Community Services Block Grant program and a number of other Federal programs. The *poverty guidelines* issued here are a simplified version of the *poverty thresholds* that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty.

As required by law, this update is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI–U). The guidelines in this 2016 notice reflect the 0.1 percent price increase between calendar years 2014 and 2015. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. In rare circumstances, the rounding and standardizing adjustments in the formula result in small decreases in the poverty guidelines for some household sizes even when the inflation factor is not negative. In order to prevent a reduction in the guidelines in these rare circumstances, a minor adjustment was implemented to the formula beginning this year. In cases where the year-to-year change in inflation is not negative and the rounding and standardizing adjustments in the formula result in reductions to the guidelines from the previous year for some household sizes, the guidelines for the affected household sizes are fixed at the prior year's guidelines. As in prior years, these 2016 guidelines are roughly equal to the poverty thresholds for calendar year 2015 which the Census Bureau expects to publish in final form in September 2016.

The poverty guidelines continue to be derived from the Census Bureau's current official poverty thresholds; they are not derived from the Census Bureau's new Supplemental Poverty Measure (SPM).

The following guideline figures represent annual income.

2016 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family/household	Poverty guideline
1	$11,880
2	16,020
3	20,160
4	24,300
5	28,440
6	32,580
7	36,730
8	40,890

For families/households with more than 8 persons, add $4,160 for each additional person.

2016 POVERTY GUIDELINES FOR ALASKA

Persons in family/household	Poverty guideline
1	$14,840
2	20,020
3	25,200
4	30,380
5	35,560
6	40,740
7	45,920
8	51,120

For families/households with more than 8 persons, add $5,200 for each additional person.

2016 POVERTY GUIDELINES FOR HAWAII

Persons in family/household	Poverty guideline
1	$13,670
2	18,430
3	23,190
4	27,950
5	32,710
6	37,470
7	42,230
8	47,010

For families/households with more than 8 persons, add $4,780 for each additional person.

Separate poverty guideline figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period. (Note that the Census Bureau poverty thresholds—the version of the poverty measure used for statistical purposes—have never had separate figures for Alaska and Hawaii.) The poverty guidelines are not defined for Puerto Rico or other outlying jurisdictions. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office that administers the program is generally responsible for deciding whether to use the contiguous-states-and-DC guidelines for those jurisdictions or to follow some other procedure.

Due to confusing legislative language dating back to 1972, the poverty guidelines sometimes have been mistakenly referred to as the ''OMB'' (Office of Management and Budget) poverty guidelines or poverty line. In fact, OMB has never issued the guidelines; the guidelines are issued each year by the Department of Health and Human Services. The poverty guidelines may be formally referenced as ''the poverty guidelines updated periodically in the **Federal Register** by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).''

Some federal programs use a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines), as noted in relevant authorizing legislation or program regulations. Non-Federal organizations that use the poverty guidelines under their own authority in non-Federally-funded activities also may choose to use a percentage multiple of the guidelines.

The poverty guidelines do not make a distinction between farm and non-farm families, or between aged and non-aged units. (Only the Census Bureau poverty thresholds have separate figures for aged and non-aged one-person and two-person units.)

Note that this notice does not provide definitions of such terms as ''income'' or ''family,'' because there is considerable variation in defining these terms among the different programs that use the guidelines. These variations are traceable to the different laws and regulations that govern the various programs. This means that questions such as ''Is income counted before or after taxes?'', ''Should a particular type of income be counted?'', and ''Should a particular person be counted as a member of the family/household?'' are actually questions about how a specific program applies the poverty guidelines. All such questions about how a specific program applies the guidelines should be directed to the entity that administers or funds the program, since that entity has the responsibility for defining such terms as ''income'' or ''family,'' to the extent that these terms are not already defined for the program in legislation or regulations.

Dated: January 21, 2016.

Sylvia M. Burwell,

Secretary of Health and Human Services.

[FR Doc. 2016–01450 Filed 1–22–16; 8:45 am]

BILLING CODE 4150–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Allergy and Infectious Diseases; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Microbiology, Infectious Diseases and AIDS Initial Review Group; Microbiology and Infectious Diseases Research Committee.

Date: February 18–19, 2016.

Time: 8:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: The Ritz-Carlton Hotel, Plaza II, 1150 22nd Street NW., Washington, DC 20037.

Contact Person: Frank S. De Silva, Ph.D., Scientific Review Officer, Scientific Review Program, Division of Extramural Activities, Room #3E72A, National Institutes of Health/NIAID, 5601 Fishers Lane, MSC 9834, Bethesda, MD 20892934, (240) 669–5023, *fdesilva@niaid.nih.gov.*

Name of Committee: National Institute of Allergy and Infectious Diseases Special Emphasis Panel; ''Comprehensive Resources for HIV Microbicides and Biomedical Prevention (N01)''.

Date: February 18, 2016.

Time: 10:30 a.m. to 5:00 p.m.

Agenda: To review and evaluate contract proposals.

Place: National Institutes of Health Room 3F100, 5601 Fishers Lane, Rockville, MD 20892 (Telephone Conference Call).

Contact Person: Jay R. Radke, Ph.D., AIDS Review Branch, Scientific Review Program, Division of Extramural Activities, Room #3G11B, National Institutes of Health, NIAID, 5601 Fishers Lane, MSC–9823, Bethesda, MD 20892–9823, (240) 669–5046, *jay.radke@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.855, Allergy, Immunology, and Transplantation Research; 93.856, Microbiology and Infectious Diseases Research, National Institutes of Health, HHS)

Dated: January 19, 2016.

Natasha M. Copeland,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2016–01313 Filed 1–22–16; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Submission for OMB Review; 30-Day Comment Request; Media-Smart Youth Leaders Program

SUMMARY: Under the provisions of section 3507(a)(1)(D) of the Paperwork Reduction Act of 1995, the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development, National Institutes of Health (NIH) has submitted to the Office of Management and Budget (OMB) a request for review and approval of the information collection listed below. This proposed information collection was previously published in the **Federal Register** on October 16, 2015, pages 62541–62542, and allowed 60 days for public comment. One public comment was received. The purpose of this notice is to allow an additional 30 days for public comment. The *Eunice Kennedy Shriver* National Institute of Child Health and Human Development, National Institutes of Health, may not conduct or

MEDSTAR PATIENT INFORMATION SHEET

MedStar Health Financial Assistance Policy (FAP)
MedStar Health is committed to ensuring that uninsured patients within its service area who lack financial resources have access to emergency and medically necessary hospital services. If you are unable to pay for medical care, have no other insurance options or sources of payment including Medical Assistance, litigation or third-party liability, you may qualify for Free or Reduced Cost Medically Necessary Care.

MedStar Health meets or exceeds the legal requirements by providing financial assistance to those individuals in households below 200% of the federal poverty level and reduced cost-care up to 400% of the federal poverty level and will not exceed the amounts generally billed (AGB).

Patient's Rights
MedStar Health will work with their uninsured patients to gain an understanding of each patient's financial resources.

- They will provide assistance with enrollment in publicly-funded entitlement program (e.g. Medicaid) or other considerations of funding that may be available from other charitable organizations.
- If you do not qualify for Medical assistance, or financial assistance, your may be eligible for an extended payment plan for hospital medical bills.
- If you believe you have been wrongfully referred to a collection agency, you have the right to contact the hospital to request assistance. (See contact information below).

Patients' Obligation
MedStar Health believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

- Cooperate at all times by providing complete and accurate insurance and financial information.
- Provide requested data to complete Medicaid applications in a timely manner.
- Maintain compliance with established payment plan terms.
- Notify us timely at the number listed below of any change in circumstances.

Contacts:
Call 1-800-280-9006 with questions concerning:

- Your hospital bill.
- Your rights and obligations with regards to your hospital bill.
- How to apply for Maryland Medicaid.
- How to obtain copies of the MedStar Financial Assistance Policy and Application by mail.
- How to apply for MedStar Health's Financial Assistance Program for free or reduced cost-care.
- Language translations for all FAP related documents and information can be found on hospital website and patient portals.

To obtain free copies of our Financial Assistance Policy and Application, and instructions on applying please visit our website at: www.medstarhealth.org/FinancialAssistance , or visit the Admitting Department at any MedStar Hospital.

For information about Maryland Medical Assistance
Contact your local Department of Social Services
1-800-332-6347 TTY: 1-800-925-4434
Or visit: www.dhr.state.md.us

For information about DC Medical Assistance
Contact your local Department of Human Services
(202) 671-4200 TTY: 711
Or visit: dhs@dc.gov

Physician charges are not included in hospital bills and are billed separately.

Attachment 22: Surgery Standards, A3. Quality of Care

MFSMC complies with all mandated federal, state, and local health and safety regulations, applicable Joint Commission on Accreditation of Healthcare Organizations and other appropriate national accrediting organization standards, and all applicable state certification standards. MFSMC's most recent review by the Joint Commission was successfully completed in May 2016. The surveyors noted the hospital as an exemplar in quality and safety engagement demonstrated by physicians and staff. Attached as Attachments 22-24 are Letters of Accreditation and a copy of the Joint Commission accreditation letter to the Hospital documenting the survey results from 2016.

It should also be noted that MFSMC continues to focus significant effort and resources on enhancing the quality of care it delivers to its patients beyond compliance with jurisdictional regulations and accrediting body standards. MFSMC has identified and implemented numerous strategies in alignment with our MedStar corporate partners to improve the quality of care and safety provided by the Hospital. These include:

- The addition of two physician Assistant Vice Presidents, one dedicated to quality, risk, safety, informatics and population health and the other dedicated to case management utilization review.
- The implementation of an Interdisciplinary Model of Care (IMOC) delivery model
- A high reliability and safety (HRO) program that included training, a patient safety event reporting system, event review and resolution process, safety coaches, and continues an active oversight plan for sustainment of a " Zero Harm" High Reliability Organization
- Patient Family Quality and Safety Advisory Council
- Initiatives to enhance patient experience
- Enhanced electronic medical record for both inpatient and outpatient venues

Other enhancements include the selection and monitoring of objective, measurable quality indicators through the Balanced Scorecard approach. Yearly goals are determined in through the quality infrastructure. The Quality Safety and Risk department facilitates abstraction of data, analysis. It also provides performance improvement guidance to the multidisciplinary teams organized to improve and sustain quality of care and safety.

As a result of our MedStar Health system affiliation we have access to the MedStar Institute of Innovation, research and grant development, a simulation center and other quality and safety resources. Because of these enhancements, the Hospital has achieved significant gains in the quality of care it delivers to its patients, as evidenced by MFSMC's ratings on MHCC's Maryland Hospital Performance Evaluation Guide; http://hospitals. Health grove.com/d/d/Maryland and on the Department of Health and Human Services Hospital Compare site; https://www.medicare. gov/hospitalcompare/profile.html#profTab=0&ID= 210015&state= MD&lat=0&lng=0&name=MEDSTAR%20FRANKLIN%20SQUARE%20 MEDICAL%20CENTER&Distn=0.0

In addition, the Hospital has been awarded numerous quality recognitions from third party evaluators in the past few years for Quality, Service and the Environment noted below.

Quality

- The 2016 Mission: Lifeline Receiving Center SILVER Recognition Award, which demonstrates adherence to clinical guidelines to support better outcomes for acute coronary syndrome patients
- Accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).
- Maryland Patient Safety Center (MPSC) Minogue Award
- American Heart/American Stroke Association's Gold Award
- Target Stroke Honor Roll
- Designated as “Senior Friendly” by NICHE (Nursing Improving Care for Healthsystem Elders) for 2016
- Designated Aetna Institute of Quality for Orthopedic Care - Spine Surgery
- Stroke State Certification & Accreditation and The Joint Commission Disease Specific Care certification
- Accreditation Council for Graduate Medical Education
- Institutional Accreditation, 5 years Continued Accreditation
- Accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).

Service

- 2012 "Best Place to Work"
- 2011 "Best Place to Work"
- Breast-feeding-Friendly Workplace Award

Environment

- 2016 Practice Greenhealth Emerald Award
- 2015 Practice Greenhealth Partner for Change Award
- 2012 Practice Greenhealth Partner for Change Award
- 2009 Practice Greenhealth Partner Recognition Award
- 2010 EPA Trailblazer Award

MFSMC is fully committed to offer high quality healthcare to the communities it serves, and will continue to focus its resources on achieving greater gains in the quality of care it provides to its patients.

July 18, 2016

Samuel Moskowitz
President
Franklin Square Hospital Center
9000 Franklin Square Drive
Baltimore, MD 21237-3998

Joint Commission ID #: 6247
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 07/18/2016

Dear Mr. Moskowitz:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- **Comprehensive Accreditation Manual for Hospitals**

This accreditation cycle is effective beginning May 07, 2016 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark Pelletier

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

August 27, 2013

Mr. Sam Moskowitz, Administrator
MedStar Franklin Square Medical Center
9000 Franklin Square Drive
Baltimore, MD 21237-3901

Dear Mr. Moskowitz:

This is to acknowledge receipt of a license fee of $3,000.00 and a completed application for a license to operate MedStar Franklin Square Medical Center. We have also received the survey findings of The Joint Commission which reports that your hospital has been granted accreditation effective for three years beginning May 10, 2013. This license is therefore issued to reflect the accreditation date.

In accordance with Health-General Article 19-323, this license will remain in effect for the term of accreditation by The Joint Commission. The Department of Health and Mental Hygiene retains the authorities as specified in Health-General Article 19-308, 308.2, 309, 310, and may revoke this license for failure to comply with its provisions. It is the hospital's authority to operate an Acute General Hospital.

This license should be displayed in a conspicuous place, at or near the entrance to the hospital, plainly visible and easily read by the public.

Sincerely,

Patricia Tomsko Nay, M.D.

Patricia Tomsko Nay, MD, Director
Office of Health Care Quality

cc: Maryland Health Care Commission
Maryland Health Services Cost Review Commission
Office of Operations & Eligibility Services
Office of Health Services
Baltimore City Health Department
Ann Elliott, CareFirst BlueCross BlueShield of Maryland
License File

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. 03-014

Issued to:

MedStar Franklin Square Medical Center
9000 Franklin Square Drive
Baltimore, MD 21237-3901

Type of Facility: Acute General Hospital

Date Issued: May 10, 2013

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Section 318 Annotated Code of Maryland, 1982 Edition, and subsequent supplements and is subject to any and all statutory provisions, including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration Date: August 10, 2016

Patricia Tomko May MD

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

Franklin Square Hospital Center
Centered on You
I.iedStar Health
9000 Franklin Square Drive
Baltimore, Maryland 21237-3988
443-777 7000
www.franklInsquare.org

* T 2 0 7 1 B - 2 7 *

PHYSICIAN'S ORDERS: Patient Transfer to Another Hospital (EMTALA)

../ Discharge Patient and Transfer Patient to Accepting Facility — Date of Transfer:

Accepting Facility: D UMH D St. Joseph D Univ. of MD D JHH D Other (suecify)

Accepting Physician/Phone #: — Date and Time:

Transferred by: D Private Vehicle Ambulance : D ALS D BLS D Helicopter D Police

Accompanied by : D **RN** D MD D Family D Paramedic D EMT D Police D Other

Reason For Transfer: Complete either section I or 2

1. D Services are unavailable at Franklin Square Hospital and (Please indicate reason):
   - D Patient is stable but requires special services. (suecify) _____
   - D Patient is stable but no inpatient beds are immediately available.
   - D Patient is not stable but special services are required to stabilize.
   - D Patient is not stable but benefit of transfer outweigh risk.

2. D Services are available at Franklin Square Hospital but: (Please indicate reason):
   - D Patient is stable and requests transfer.
   - D Patient is stable and private physician requests transfer and patient agrees.
   - D Patient is not stable but patient/surrogate requests transfer and AMA form has been completed .

Risks of Transfer: All transfers have inherent risks of delays or accidents in transit, pain/discomfort upon movement and limited medical capacity of transport units that may limit care in the event of a crisis.

D Additional risks that may occur in transfer: _____

D No additional risks listed

Benefits of Transfer:

D Access to needed care and/or equipment D Access to specialists or services unavailable at FSHC

D Other (Please Specify)

Nursing Checklist:

D Copy of Medical Records with Patient D Patient Valuables with Patient/Family D MD Transfer (dictation) Note

D Lab and X/Ray Report/Films with Patient D Nursing Report Called to Receiving Facility

D Medication Reconciliation form D Handoff Communication tool

Departure Vital Signs:

BP Pulse Respiration 02: Liters % Sat. Temp.

_____ MD/DO/PA/NP _____ RN/LPN Signature Printed

Name or SMS#/Provider ID# Signature

_____ _____

Date Time Date Time

I Consent To Transfer To The Above Named Facility, and I Understand the Risks and Benefits of the Transfer

_____ _____

Patient/Surrogate Signature Witness Signature

_____ _____

Date Time Date Time

T-20718-27 (Rev. 03/09) Original – Medical Record
(Orders) Xerox copy – Accepting Institution

Attachment 26: 2. Need - Minimum Utilization for Establishment of a New or Replacement Facility.

Current and Projected Surgical Case Volume

Comprehensive actual historical data regarding Maryland hospital's inpatient discharges is available through the HSCRC Discharge Database/The St. Paul Group. However there is no similar data set for outpatient visits, including ambulatory surgery visits. As a result, it is not possible to present a count of total current or historical inpatient and outpatient surgical cases originating from MFSMC's service area, or a projection of future surgical cases originating from the service area.

Because this is the case, in discussions with MHCC staff it was agreed that in lieu of service area volume projections, MFSMC will report its own actual surgical volume for the FY14-FY16 (projected) period and present a FY17-FY22 MFSMC surgical volume forecast based on the hospital's historical volume trends. The FY17-FY22 period extends through the proposed project completion and the second year of full occupancy.

The table below reflects the hospital's actual data for FY14-FY15, its projected surgical cases for FY16 based on 9 months of actual data, its MedStar Board-approved budgeted volume for FY17, and its projected volume in the FY18-FY22 period.

MFSMC Surgical Volume - FY14-FY15 Actual, FY16 Projected, FY17-FY22 Forecast

	Actual		Proj.	Forecast Years						% Chg.
	FY14	FY15[1]	FY16	FY17	FY18	FY19	FY20	FY21[2]	FY22	FY15-FY22
Total Surgical Cases[3]	**13,786**	**12,908**	**12,055**	**12,304**	**12,588**	**12,777**	**12,969**	**12,969**	**12,969**	**0.5%**

[1]Most recent competed fiscal year at time of analysis; base year for projection
[2]Anticipated first full year of occupancy
[3]Excludes Endoscopy, Interventional Pain, and other procedures that take place outside of MFSMC's ORs

MFSMC surgical volume has declined 12.6% in the FY14-FY16. This decline was driven by departures from the hospital's medical staff, primarily in the specialties of urology and vascular surgery. MFSMC is strengthening these two programs and has replaced or is in the process of replacing the departed providers. For these reasons, the hospital is confident that it will recapture the volume lost in the period. Using FY15 as the base year, the hospital is projecting a growth of 0.5% in the forecast period of FY15-FY22. This represents volume growth in the FY16-FY22 period of 7.6%, returning MFSMC to slightly above its FY15 volume.

For the purpose of validating the reasonableness of this forecast, the hospital engaged two respected national healthcare intelligence companies to project MFSMC surgical volumes for

the same period. Using proprietary software, these companies projected the impact of changes in drivers of healthcare utilization on the volume of surgical services in MFSMC's service area, using MFSMC's FY15 actual volume data as a base year and publicly available forecasts for population growth and other demographic indicators. The comprehensive set of drivers of healthcare utilization included epidemiology, economics, technology and innovations, payor dynamics, National Quality Initiatives such as Potentially Avoidable Admissions, 30-day Readmission, Population Health, shifts in hospital and non-hospital healthcare utilization, etc. It was assumed in both volume forecasts that there would be no change in MFSMC's market position in the forecast period.

Both companies projected MFSMC to achieve a volume in the FY17-FY22 period that is higher than MFSMC's internal projection. One forecast was moderately higher than MFSMC's forecast and one was significantly higher. This result is consistent with MFSMC's recent experience with its third party forecast partners. Since this is the case, the hospital is confident that its forecast is reasonable.

Operating Room Need

In order to determine the number of operating rooms MFSMC will need to meet this projected need for surgical services, the hospital performed a calculation using MHCC's standards and the following assumptions and methodology:

1)	Mixed Use General Purpose OR Target Minutes/Year/Room:	60 min. x 1,900 hr. = 114,000 min./ rm./yr.
2)	Special Purpose OR Target Minutes/ Year/Room:	Actual Experience (see table below)
3)	Mixed Use General Purpose Average Minutes/Procedure:	Actual experience and expected future mix of cases (see table below)
4)	Special Purpose Average Minutes/ Procedure:	Actual experience (see table below)
5)	Average Room Turnaround Time:	25 minutes

First, MFSMC calculated the total number of OR minutes based on its forecasted Mixed Use General Purpose and Special Purpose case volume. Second, it added room turn around time for its estimated number of non-first-case-of-day cases (Total cases ***less*** First cases of day (238 days/year *x* number of ORs) ***x*** 25 min./case). Adding procedure minutes and turn around time minutes, the hospital arrived at Total OR minutes. It then divided Total OR Minutes by 144,000 min./yr. to calculate the number of ORs needed for the total operating room minutes generated by the forecasted case volume.

The table below summarizes the results of this calculation.

	Actual		Proj.	Forecast Years					
CASES	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY211	FY22
Total Surgical Cases	**13,786**	**12,908**	**12,055**	**12,304**	**12,588**	**12,777**	**12,969**	**12,969**	**12,969**
Mixed Use General Purpose	11,956	11,335	11,142	11,358	11,589	11,718	11,779	11,779	11,779
Special Purpose - Endovascular	1,278	984	402	435	480	540	660	660	660
Special Purpose - Interv. Pulmonology	552	589	511	511	519	519	530	530	530
MINUTES									
Total Minutes	**1,586,647**	**1,528,350**	**1,442,962**	**1,450,688**	**1,472,027**	**1,493,077**	**1,524,868**	**1,524,868**	**1,524,868**
Total Average Minutes/Case	**115**	**118**	**120**	**118**	**117**	**117**	**118**	**118**	**118**
Mixed Use General Purpose (MGP)	1,430,408	1,395,580	1,365,983	1,374,318	1,390,680	1,406,160	1,425,711	1,425,711	1,425,711
MGP Average Minutes/Case[1]	120	123	123	121	120	120	121	121	121
Special Purpose - Endovascular (SPE)	106,690	81,214	33,145	32,051	36,228	41,798	52,938	52,938	52,938
SPE Average Minutes/Case	83	83	82	74	75	77	80	80	80
Special Purpose - Interv. Pulmonology(SPIP)	49,549	51,556	43,834	44,319	45,119	45,119	46,219	46,219	46,219
SPIP Average Minutes/Case	90	88	86	87	87	87	87	87	87
ROOM NEED									
Total Room Need	**14.55**	**14.24**	**13.98**	**14.06**	**14.20**	**14.33**	**14.51**	**14.51**	**14.51**
Mixed Use General Purpose	12.55	12.24	11.98	12.06	12.20	12.33	12.51	12.51	12.51
Special Purpose - Endovascular	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Special Purpose - Interv. Pulmonology	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0

As the table above indicates, MFSMC is projecting a need of approximately 14.5 ORs in the forecast period. The proposed project will create 14 ORs.

Maintain Availability/Access to Care

The hospital will meet the 0.5 OR excess demand for surgical services that its model projects by:

(1) Eliminating capacity restrictions that result from the need to match procedures with rooms. Since in the new surgical pavilion all the ORs will have a minimum clear floor area of 600 SF, all rooms will be able to accommodate all General Purpose cases, thus increasing capacity.

(2) The MHCC benchmark for General Purpose OR utilization is 1,900 hrs./year. Assuming an eight hour operating day, this yields a total of 238 operating days/year. However, because MFSMC is an acute care hospital, it provides urgent and emergent surgical care to its community. Therefore, it maintains one or two ORs open 24 hours a day 365 days/yr., and performs some urgent and emergent cases outside of "normal Monday-Friday 8 hour operating day" hours. In the FY14-FY16 period, 4.5% of OR minutes occurred on weeknights[1] and 5.5% of OR minutes occurred on weekends. For this reason, it is projected that 10% of MFSMC OR cases will occur in these "off" hours in the forecast period. This has the effect of increasing the capacity of MFSMC's surgical services by about 10% above the 1,900 hrs./rm./yr. MHCC Standard. The hospital projects a 0.5 OR shortfall at the MHCC Standard to meet the projected surgical services need of its service area. With an inventory or 14 ORs, this represents 3.5% of the hospital's OR capacity. The factors noted above effectively increase the hospital's OR

[1] Total minutes of cases with start times after 5PM M-F.

capacity by 10%, providing the capacity necessary to meet the surgical services needs projected for its service area, even apart from the expected capacity gains from (1) above.

For these reasons, the hospital is confident that it will meet the needs for surgical services for patients in its service area with 14 operating rooms.

Note:

As part of its ongoing efforts to meet the surgical needs of the communities it serves in the lowest cost settings possible, MedStar Health wishes to transfer the two ORs that MFSMC is removing from its inventory to an ambulatory setting in the Timonium area. MedStar Health will be submitting a formal request to this effect to the Commission at a future date.

Attachment 27: Availability of More Cost-Effective Alternatives

MFSMC's proposed project has two primary goals. The first goal is to design and construct a replacement facility for the hospital's antiquated ORs that brings the hospital into compliance with all appropriate standards for the delivery of surgical services. These include, but are not limited to, appropriate room dimensions to provide necessary clear floor area and floor to floor space, as well as other infrastructure. The second goal is to improve the efficiency of the delivery of surgical services at MFSMC by reducing the number of ORs in the hospital's inventory from sixteen to fourteen and by creating one consolidated surgical services delivery model, eliminating duplication of services and improving work flow and staff sharing. Please consult section *8b. Comprehensive Program Description* for more details.

The table on the following page compares the two options that the hospital has identified, *Option 1 – Renovate in Place* and *Option 2 – New Construction*. *See Section I. Achieving Project Goals* for a comparison of the success of each option in achieving these goals.

A secondary set of project goals has to do with the renovation/new construction process itself. The hospital has the goal of creating the desired outcome in the most cost effective manner, with the shortest project timeline and with the least disruption to the delivery of surgical and other hospital services during project construction.

The table on the following page also compares the two options that the hospital has identified along these three measures. They are *II. Project Cost*, *II. Project Timeline*, and *IV. Disruption of Services During Renovation/Construction.*

Attachment 27: Comparison of Options
Availability of More Cost-Effective Alternatives

Measure	Option 1: Renovate in Place*	Option 2: New Construction
I. Achieving Project Goals		
A. Correct current OR physical plant deficiencies related to FGI/ Industry Norms.	**Does Not Achieve Project Goal**	**Achieves Project Goal**
(1) Current facility lacks the square footage to accommodate 14 ORs with a minimum of 600 SF of clear floor area.	Available square footage of footprint does not provide an area necessary for 14 ORs with a minimum 600 SF of clear floor area.	Provides space for 14 ORs with a minimum 600 SF of clear floor area.
(2) Current facility does not meet Standard of 16 FT floor to floor space	This deficiency cannot be mitigated. It is cost prohibitive.	Provides Standard 16 FT floor to floor space in all rooms
B. Improve Operational Efficiency	**Does Not Achieve Project Goal**	**Achieves Project Goal $2.0M/Year**
(1) Reduce need for staff and eliminate duplicated services	The deficiency in existing square footage noted in A(1) prevents the consolidation of all surgical services into one location. This limits the opportunity for expense reduction associated with the eliminating the current duplication of series (pre-op, post-op, etc.)	Provides full consolidation of surgical services and full potential for expense reductions. Consolidating the hospital's two currently separate locations will create staffing efficiencies through the elimination of duplicated services and the streamlining of existing services through improved design and adjacencies.
II. Project Cost	**$97M**	**$70M**
	Renovations in place incur costs associated with demolition, infrastructure upgrades, etc., that are both time consuming and costly. Moreover, one impact of a long project schedule is the additional expense associated with cost inflation in later project years.	
III. Project Timeline	**75 Months**	**24 Months**
	Because the project would entail ongoing OR functioning and construction/renovation in the same location, there will a repeated sequential process of room closure - renovation - room re-opening. This will significantly lengthen the project duration.	New construction on a separate site, unencumbered by mixing ongoing services with simultaneous renovations, provides the shortest project timeline.
IV. Disruption of Services During Renovation/Construction	**Significant Disruption to Current Services**	**No Disruption to Current Services**
	A renovation in place project produces significant disruptions to currently surgical services and other related services: (1) Significant noise disruptions in the OR (2) Heightened risk to sterile climate (3) Significant scheduling and access disruptions (4) Department displacements	New construction on a separate site eliminates disruption to current services.

*This option assumes renovation of the existing OR space in the central core of the original hospital and an expansion into other adjacent spaces that are currently housing other hospital functions. The space available for renovation does not yield enough square footage to achieve the proscribed 600 SF clear floor area in its ORs.

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

The Marshall Valuation Service ("MVS") analysis is set forth below. MFSMC must clarify the nomenclature that the CON Application Table Packet Table C. Construction Characteristics uses. The lowest floor on the Table is called "Basement." In this project, the ground floor is not a basement. Because of the slope of the property, this building is, in fact a ground floor.

I. Marshall Valuation Service Benchmark
New Construction

Type			Hospital
Construction Quality/Class			Good/A
Stories			2
Average Perimeter			874
Average Floor to Floor Height			16.00
Square Feet			75,000
	Average floor Area		37,500
A. Base Costs			
	Basic Structure	$	365.78
	Elimination of HVAC cost for adjustment		0
	HVAC Add-on for Mild Climate		0
	HVAC Add-on for Extreme Climate		0
Total Base Cost			$365.78

Adjustment for Departmental Differential Cost Factors		1.588
Adjusted Total Base Cost		$581.04
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$581.04
C. Multipliers		
Perimeter Multiplier		0.90568
	Product	$526.23
Height Multiplier		1.091888685
	Product	$574.59
Multi-story Multiplier		1.000
	Product	$574.59
D. Sprinklers		
	Sprinkler Amount	$3.07
Subtotal		$577.66
E. Update/Location Multipliers		
Update Multiplier		1.02
	Product	$589.21
Location Multiplier		1.02
	Product	$600.99
Calculated Square Foot Cost Benchmark		**$600.99**

In the above calculation, MFSMC has included a factor to adjust for the cost differential by department. In Section 87, Page 8 of the MVS, MVS provides departmental cost differentials for the construction of each type of area of a hospital, providing a multiplier which should be multiplied against the average hospital construction cost. MFSMC has applied these factors using the departmental categories and factors supplied by MVS. The categories and factors applied to each of the floors are shown below.

On July 18, 2016, Andrew Solberg, the consultant on this project who has prepared the MVS analysis, emailed the MVS Support Team and asked the following question:

> Under Nursing Services, the list of departments includes both "Operation, Facility" and "Operating Suite, Total." Can you please define "Operation, Facility?" I am trying to figure out if I should use one of these categories or the other.

On July 24, 2016, Jordan Stoffel, Technical Support Specialist, Real Estate and Government, Insurance and Spatial Solutions, CoreLogic replied:

> Section 87 is a very general guide:
> Room = Individual room dedicated to either operating or obstetrical use.
> Suite = More than on one dedicated room plus patient prep and staging area along with ready equipment storage.
> Facility = May consist of a series of Suites and individual operating rooms plus staff offices, dedicated lounge areas for staff, guest waiting, ready equipment storage and supporting rooms such as a cystoscopy room or x-ray.

As a result of this guidance, MFSMC used Operation, Facility as the basis for this analysis:

Floor	***Department***	***Dept. Area (SF)***	***MVS Department Name***	***MVS Differential Cost Factor***	***Cost Factor X SF***
	Surgery Suite	67,996	Operation Facility	1.68	114,233.64
	Mechanical	7,004	Mechanical	0.70	4,902.65
	Total	75,000		1.59	119,136.29

II. Project Costs

The Project costs are calculated as follows:

A. Base Calculations	Actual		Per Sq. Foot
Building	$39,863,917	$	531.52
Fixed Equipment	$2,547,768	$	33.97
Site Preparation	$2,783,886	$	37.12
Architect/Engineering Fees	$4,740,077	$	63.20
Permits	$954,000	$	12.72
Capitalized Construction Interest +Financing Costs	$3,763,593	$	50.18
Subtotal	$54,653,241	$	728.71

As directed by MHCC staff years ago, only the Capitalized Construction Interest associated with the "Building" cost applies in the MVS analysis. The Capitalized Construction Interest allocable to the Building cost was calculated as follows:

Capitalized Construction Allocation

	New	Renovation				
Building Cost	$39,863,917	$180,000	Total			
Subtotal Cost	$48,341,880	$180,000				
Subtotal/Total	99.6%	0.4%	$48,521,880			
Cap Interest	$4,564,006	$16,994		Cap Interest		Financing Fees
Building/Subtotal	82.5%	100.0%	$4,581,000	$3,967,000	+	$614,000
Building Cap Interest	$3,763,593	$16,994				

However, this project includes a considerable amount of costs for facets of the project that would not be included in the MVS average, such as demolition, canopies, etc. Associated Capitalized Construction Interest for those items included in the "Building" cost center are included as Extraordinary costs.

B. Extraordinary Cost Adjustments

	Project Costs	Associated Capitalized Interest For Those Items in "Building"	Associated A&E Fees	Total	
Building Demolition	$331,349		$34,752	**$366,100**	Site
Storm Drains	$183,160		$19,210	**$202,369**	Site
Rough Grading	$432,228		$45,332	**$477,560**	Site
Utilities - Offsite	$896,550		$94,029	**$990,579**	Site
Paving	$314,951		$33,032	**$347,982**	Site
Landscaping	$314,757		$33,011	**$347,768**	Site
Walls	$158,056		$16,577	**$174,633**	Site
Yard Lighting	$96,848		$10,157	**$107,006**	Site
Excavation Undercut and Groundwater Mitigation	$539,513		$56,584	**$596,097**	Site
Remove Clay Layer 24"	$55,988		$5,872	**$61,860**	Site
Structure for Vertical Expansion	$218,081	$20,589	$22,872	**$261,543**	Building
Foundation Retaining Walls & Waterproofing	$485,530	$45,839	$50,922	**$582,291**	Building
Interstitial Slab	$294,400	$27,795	$30,876	**$353,071**	Building
Permit Fees - Off-site Sanitary	$279,000		$29,261	**$308,261**	Perm
Impact "Fees"	$225,000		$23,598	**$248,598**	Perm
Canopy	$116,000	$10,952	$12,166	**$139,118**	Building
Screen Wall	$158,056		$16,577	**$174,633**	Site
Hardscaping / Landscaping	$290,545		$30,472	**$321,017**	Site
Pneumatic Tube	$100,000	$9,441	$10,488	**$119,929**	Building
Remote Utility Connections	$3,795,500	$358,337	$398,069	**$4,551,906**	Building
LEED Silver Equivalency	$1,451,381	$137,026	$152,220	**$1,740,627**	Building
Total Cost Adjustments	$10,736,892	$609,979	$1,126,077	**$12,472,948**	
C. Adjusted Project Cost				**$42,180,292**	
Per Square Foot				**$562.40**	

MVS Estimate $600.99
The Project $562.40

		Perimeter						
		800	874	1000		800	874	1000
Area	35000	0.904		0.919		0.904		0.919
	37500					0.9005	**0.90568**	0.9145
	40000	0.897		0.91		0.897		0.91

Area Interpolation

1	0.904	-	0.897	=	0.007
2	37500	-	35000	=	2500
3	40000	-	35000	=	5000
4	2500	/	5000	=	0.5
5	0.007	*	0.5	=	0.0035
6	0.904	-	0.0035	=	0.9005
7	0.919	-	0.91	=	0.009
8	0.009	*	0.5	=	0.0045
9	0.919	-	0.0045	=	0.9145

Perimeter Interpolation

10	1000	-	800	=	200
11	874	-	800	=	74
12	74	/	200	=	0.37
13	0.9145	-	0.9005	=	0.014
14	0.014	*	0.37	=	0.00518
15	0.9005	+	0.00518	=	0.90568

New

Total Square Footage	75,000
Ground	37,591
1	37,409
Average	**37,500**

Perimeter	
Ground	880
1	868
2	
3	

Capitalized Construction Allocation

	New	Renovation			
Building Cost	$39,863,917	$180,000	Total		
Subtotal Cost	$48,341,880	$180,000			
Subtotal/Total	99.6%	0.4%	$48,521,880		
Cap Interest	$4,564,006	$16,994		CapInterest	FinancingFees

Average	**874**		Building/Subtotal	82.5%	100.0%	$4,581,000	$3,967,000	+	$614,000
Wall Height (floor to eaves)		Height X sf	Building Cap Interest	$3,763,593	$16,994				
Ground	14	526,270							
1	18	673,367		Wall Height Interpolation					
2					15				
3					16.00	1.069			
Average	**16.00**	-			16				
		-				1.092			
		1,199,637	**15.99516022**	1	1.069			=	-0.023
				2	16	-	1.092	=	0.99516022
				3	16	-	15	=	1
				4	0.99516	-	15	=	0.99516022
				5	-0.023	/	1	=	-0.0228887
				6	1.069	*	0.9951602	=	**1.09188869**
						-	-0.022889		
				Sprinkler					
					75,000				
					75,000	3.07			
					100,000	**3.07**			
						2.93			
				1	3.07			=	0.14
				2	75,000	-	2.93	=	0
				3	100000	-	75000	=	25000
				4	0	-	75000	=	0
				5	0.14	/	25000	=	0
				6	3.07	*	0	=	**3.07**
						-	0		