11

Certificate
Of
Need
Response to Questions
Application

For

Hospice
Prince George's County

Submitted by:

P-B HEALTH

Home Health Care, Inc.

April 11, 2017

P-B HEALTH
P-B Health Home Care Agency, Inc.
2535 Saint Paul Street
Baltimore, Maryland 21218
410 235-1060 Fax 410 235-1309
TTDY 800-735-2258 Website www.p-bhealth.com

Chief Executive Officer
Jackie D. Bailey, R.N.

Chief Financial Officer
Matthew H. Bailey, Esq.

April 13, 2017

Ms. Ruby Potter
Health Facilities Coordinator
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

SUBJECT: Certification of Submission of Prince Georges County, MD Responses to Questions for CON Application (Matter/Docket No. 16-16-2385)

Ms. Potter,

P-B Health Home Care Agency, Inc. submits to you its certification that Prince Georges County, MD Responses to Questions for CON Application was sent certified mail or hand delivered on or before April 13, 2017 to the following party:

Ms. Ruby Potter, Administrator
Maryland Health Care Commission
Center for Health Care Facilities
Planning & Developing
4160 Patterson Avenue
Baltimore, MD 21215

Mr. Kevin McDonald, Chief – Certificate of Need Division
Center for Health Care Facilities
Planning & Development
Maryland Health Care Commission

4160 Patterson Avenue
Baltimore, MD 21215

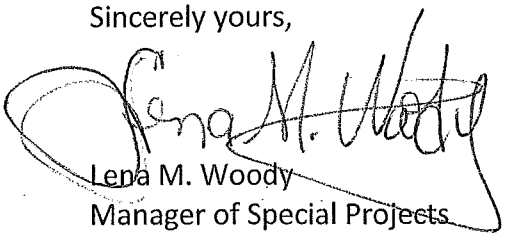
P-B HEALTH
P-B Health Home Care Agency, Inc.
2535 Saint Paul Street
Baltimore, Maryland 21218
410 235-1060 Fax 410 235-1309
TTDY 800-735-2258 Website www.p-bhealth.com

Chief Executive Officer
Jackie D. Bailey, R.N.

Chief Financial Officer
Matthew H. Bailey, Esq.

Mr. Andrew L Solberg
A.L.S HealthCare Consultant Services
5612 Thicket Lane
Columbia, MD 21044

Sincerely yours,



Lena M. Woody
Manager of Special Projects
Finance
P-B Health Home Care Agency, Inc
2535 Saint Paul Street
Baltimore, MD 21218
410-235-1060 x 144
410-235-1309 Fax

Preface

We, at **P-B Health** have structured this document to be responsive and organized for easy reference. **The Certificate of Need Responses to Questions for Prince Georges County documents are as follow:**

Table of Contents

Project Budget

Part III – Consistency with Review Criteria at COMAR 10.24.01.08G (3)

Part IV –, Authorization and Signature

Hospice Application: Charts and Tables Supplement

Appendix J -

While reading this document, you will find that **P-B Health's Response** is in **bold.** This indicates that the answer to the question posed will follow.

Table of Content

MARYLAND HEALTH CARE COMMISSION

16-16-2385
MATTER/DOCKET NO.

DATE DOCKETED

APPLICATION FOR CERTIFICATE OF NEED Responses to Prince Georges County, Maryland Questions: HOSPICE SERVICES

Project Budget

1. Your response to question 1 on the 2/17 letter, which asked that the Source of Funds be listed on Table 1, was that that the "Owner" would be the source of funds. If that statement is meant to convey that the source of funds would be "Cash," as listed on the form as B. 1, it should be shown there. Thus we will need a corrected Table 1.

   P-B Health's Response:

   See the attached revised Table 1 under (**Hospice Charts and Tables, Project Budget**). The Source of Funds is allocated as "Cash."

Application Tables

2. Question 2 in the 2/17 letter asked you to correct a number of apparent inconsistencies in some of the tables. One of the tables you were asked to explain was Table 5. Our question was: "The nursing staff in the original Table 5 was 14; in the resubmitted Table 5 it was 2…there were other differences between the respective staffing tables that do not seem logical. Please explain and correct and resubmit any tables that need correction." In response you submitted a new Table 5, but no explanation was proffered. Complicating matters yet further is the fact that the new Table 5 (staffing information) is significantly different than either of the previous two Table 5s you have submitted. For example, the Nursing staffing line has migrated from 14 in the initial application to 2 in the first completeness response to 0.8 in the latest submission. This mutability is puzzling and needs to be explained.

   P-B Health's Response:

   The application tables as submitted over the several re-submissions should have been accompanied by the following explanation. The initial submission of application tables was based on the revenue and volume projections initially submitted. Table 5 had to be modified when the revenue projections were substantially reduced upon review in the next resubmission. The most recent Table 5 manpower submission was inadvertently submitted for the first year of operation (2018), not the final year shown in Tables 2b and 4 (2021).

   A revised Table 5 is attached under **Hospice Charts and Tables.** In response to question 3 below, **Hospice**

Charts and Tables includes a comprehensive set of tables (Tables 2b (Statistical Projections – Proposed Project), 4 (Revenues and Expenses - Proposed Project), and 5 (Manpower Information). Please note that P-B Health is submitting a Table 5 for each fiscal year shown in Tables 2b and 4.

3. Given that there have been several corrections made to the application Tables – and that there may again be in this next submission – please submit a comprehensive set of final tables (i.e., Tables 1, 2B, 4, and 5; 2A and 3 are not applicable to P-B Health).

P-B Health's Response:

As discussed in P-B Health's response to question 2, attached is a comprehensive set of final tables (i.e., Tables 1, 2B, 4, and 5) under section **Hospice: Tables and Charts.**

Quality

4. Question 3 on the 2/17 letter asked you to demonstrate P-B Health's ability to build a QAPI that meets the requirements of COMAR 10.07.21.09 by completing a form created by staff (adapted from the survey tool used by the Office of Health Care Quality to make such an assessment). Its instructions direct applicants to cite the section of your QAPI and the specific language that addresses the required QAPI content. This was not done. The form is once again attached.

P-B Health's Response:

Please see Appendix I for P-B Health response, including P-B Health's adapted survey tool and its Quality Intervention Improvement Plan.

Viability

5. Question five requested that – in lieu of the audited financial statements that P-B Health stated it does not have – P-B Health provide the alternative offered in the Viability criterion in the CON application. That is: *In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant.* The letter from Mr. Katzen speaks about his affinity for P-B Health and "the Baileys," but does not: a) make clear what Mr. Katzen's role in this project/application is; or b) opine about *the adequacy of financial resources to fund this project.*

P-B Health's Response:

Appendix J includes a letter from Mr. Ron Katzen, CPA with the additional information as requested about the adequacy of financial resources to fund this project.

its attachments are true and correct to the best of my knowledge, information and belief.

Jackie Bailey, CEO

Signature of Owner or Authorized Agent of the Applicant

Jackie Bailey CEO

Print name and title

Date: 4/12/2017

APPENDIX I

QAPI Characteristic as Described by OHCQ	State regulation reference	Location/citation in Applicant's QAPI Provide the section of the policy and the language that addresses the requirement.
Develop, implement and maintain an effective, ongoing, hospice-wide data driven QAPI program	10.07.21.09A & B A. The governing body shall ensure that the hospice care program conducts ongoing quality assurance and utilization review. B. Quality Assurance Program. The governing body shall assure that the hospice care program develops and implements a quality assurance and improvement program to assess and improve the quality of services being provided by the program.	10.07.21.09A & B A .**The Board of Directors** has the final authority and responsibility for the ongoing, comprehensive and integrated Hospice Quality Intervention Program. B. Quality Assurance and Performance (**Responsibility and Authority) this section outlines the entire Quality Assurance Program. Clinical and Management staff participates in the identification of Important Aspects of Care, Indicator Development and Monitoring, Internal Clinical Record Reviews, and Issue Improvement Plans**
Maintain documentary evidence – able to demonstrate operation	10.07.21.09D(2)Maintain records to demonstrate the effectiveness of its quality assurance activities	10.07.21.09D(2) **Internal Clinical Record Review Audits Admission Audits for Hospice** consists of a thorough review of all initial paperwork submitted by the admitting discipline and the admission has been done according to agency policy. This audit also focuses on adequate completion of the Physicians Plan of Treatment, The POT/worksheet, the OASIS SOC Assessment Tool, and the Medication Record. An Admission Audit Review tool is used for this purpose, with findings reported back to the primary nurse on the case. The Clinical Manager ensures that all deficiency areas are corrected within 48-72 hours, and notes correction dates on the audit tool. Retrospective and concurrent chart reviews, Caregivers Satisfaction Surveys, Incident Reports, and Information collected on home hospice visits/hospice aide supervisory visits.
Program capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services	10.07.21.09C(2)Have outcomes and results that are measurable and which may be incorporated into systemic changes in the program's operation;	10.07.21.09C(2) **Monitoring of Important Aspects of Hospice Care** Is a major component of the Quality Assurance and Performance Improvement Program . The following important aspects of care have been identified, and have been prioritized. They have been chosen based on the fact that they are important aspects of Hospice Care.
Must measure, analyze and track quality indicators including adverse patient events	10.07.21.09C(3) Require the systematic collection, review, and evaluation of information and data and the analysis of trends identified through the quality assurance process	10.07.21.09C(3) Responsibility (paragraph 1) Third sentence (Clinical and management staff participates in the identification of important Aspects of Care, Indicator Development and Monitoring, Internal Clinical Record Reviews, and Issue Improvement Plans
Must use quality indicator data in design of program to: monitor effectiveness and	10.07.21.09D(3) Implement changes based upon results of the evaluated data; for example, when problems are identified in the provision of services, the hospice care program shall document corrective actions	10.07.21.09D(3) **Indicator Development paragraph 2 and 3 When an area is identified as needing improvement, an issue Improvement Plan is developed. These problematic issues are identified through indicators analysis, quarterly utilization review**

safety of services and quality of care; identify opportunities for improvement	taken, including ongoing monitoring, revisions of policies and procedures, and educational interventions	**findings, and through clinical record reviews, and other related Quality Assurance Intervention and Performance Improvement Issue Tracking Sheet identify areas of improvement, actions to be taken, responsible parties and follow-up as stated.** **The Quality Assurance Intervention and Performance Improvement Committee receive a report of Issue identification, progress, and resolution at their quarterly meetings. Quality Intervention and Improvement reports are presented to the Professional Advisory Committee quarterly. In, addition, The Board of Directors will receive a report at least annually of the Quality Assurance Intervention and Performance Improvement findings, action taken, and follow-up of actions taken.**
Frequency and detail of data collection must be approved by governing body	10.07.21.09E The hospice care program shall be held accountable by the governing body for accomplishing the goals and standards that are established as part of the quality assurance and improvement system.	10.07.21.09E **The Board of Directors paragraph 1. Indicator Development paragraph 1 and Service Specific Aspects of Care- Other Important aspects of care to be monitored**
Must focus on high risk, high volume or problem prone areas		
PI activities must track adverse patient events, analyze their causes and implement preventive actions	10.07.21.09D(3) Implement changes based upon results of the evaluated data, for example, when problems are identified in the provision of services, the hospice care program shall document corrective actions taken, including ongoing monitoring, revisions of policies and procedures, and educational interventions	10.07.21.09D(3) "The Board of Directors" 2nd paragraph beginning with: **The Quality Assurance and Performance Improvement Committee meets at least quarterly to review all QA/PI** findings, have outcomes and results that are measurable and which may be incorporated into complete changes in the programs operation, and to make recommendations regarding all quality interventions and improvement activities. Follow-up reports and **recommendations (next 3 paragraphs)**
Must measure success and track performance to ensure improvements are sustained		
Number and scope of PIP (performance improvement projects), conducted annually based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity and past performance of the hospice's services and operations	10.07.21.09C(1-6) C. The quality assurance and improvement program shall: (1) Focus on: (a) The needs, expectations, and satisfaction of patients and their families, and (b) All services provided by the hospice care program; (2) Have outcomes and results that are measurable and which may be incorporated into systemic changes in the program's operation; (3) Require the systematic collection, review, and evaluation of information and data and the analysis of trends identified through the quality assurance process; (4) Require that regular reports are prepared and reviewed by the governing body and appropriate personnel; (5) Provide for prompt and appropriate response to	10.07.21.09C(1-6) **Under "Procedure"** Quality Intervention Improvement Plan **Program Objectives 1 thru 8 and Program Goals 1 thru 10 as outlined.**

	incidents when the patient's health and safety is at risk; and (6) Include proactive strategies to improve the quality of services.	
Governing Body- responsible for ensuring that one or more individual(s) who are responsible for operating the QAPI program are designated	10.07.21.09D(4) Identify the individual responsible for performing the quality assurance functions as set forth in this regulation	10.07.21.09D(4) **The Board of Directors section (paragraph 5,6,7** The Quality Assurance and performance improvement committee has been established for the purpose of reviewing all of the QA/PI activities of the agency, and participating in monitoring activities, as previously outlined. The Committee consists of representatives from the management and clinical staff, with input from all disciplines, and departments as appropriate. The Quality Assurance Nurse is chairperson for this committee, and is designated by the Agency Administrator (AA). Etc... **List of Committee Members CEO, QA/PI Nurse, Clinical Managers, Agency Administrator, other Agency Representatives as needed.**

Quality Intervention Improvement Plan

Policy

Quality Intervention Improvement Plan

Procedure

Program Objectives

1. To provide high quality home health/hospice services which meet Medicare Conditions of Participation, State licensure and JCACO home care standards.
2. To improve internal and external communication systems among the staff of the agency, with clients, and with referral sources.
3. To establish and maintain a program of monitoring, implementation, and evaluation in anticipation of continual improvement.
4. To monitor the provision of patient care and patient outcomes, provided by Registered Nurses, Licensed Practical Nurses, Home and Hospice Health Aides, Physical, Occupational and Speech Therapist, and Medical Social Workers to ensure that high quality, efficient services are provided, with minimal risk to the client.
5. To identify deficiency/problem areas in the delivery of patient care services, and to develop appropriate strategies to improve or resolve them.
6. To monitor client satisfaction with services to ensure that needs are being met.
7. To monitor continuity of care between disciplines (i.e. full-time, part-time, and contract staff) and to monitor continuity of care among care providers, so that there are no gaps or delays in care provision.
8. To monitor personnel hired by P-B Health and to evaluate their performance in the provision of patient care.

Program Goals

1. To ensure compliance with regulatory and accreditation agencies with minimal areas of deficiency in service delivery.
2. To improve communication systems among staff, through the quality intervention process and specific action taken.
3. To ensure continual improvement in all aspects of care delivery.
4. To foster the provision of high quality, efficient home/hospice care services by all disciplines, with few deficient areas.

5. To provide opportunities that will take specific action to improve areas of deficiency in the delivery of high quality services to clients.
6. To show high patient satisfaction with services provided and to identify areas where improvement is needed.
7. To keep unusual occurrences, incidents, and events at a minimum.
8. To make recommendations and take action related to improved safety; educational programs for staff and or clients, and improve delivery of client services. This is a result of quality intervention and improvement activities.
9. To make recommendation and take actions which result in improved continuity of care among all disciplines and providers.
10. To improve monitoring of personnel and provide opportunities to identify area that need improvement in terms of performance of job responsibilities.

Responsibility and Authority

The participation of the management staff (Agency Administrator), the clinical staff (Clinical Managers of Clinical Service), and support staff is essential to the successful implementation of an effective quality improvement system. Each level of staff is included in some aspect of comprehensive (QA/PI) Quality Assurance and Performance Improvement program. Clinical and management staff participates in the identification of Important Aspects of Care, Indicator Development and Monitoring, Internal Clinical Record Reviews, and Issue Improvement Plans. The Quality Assurance and Performance Improvement Staff Nurse, is responsible for assessing, planning, implementing, and evaluating the Quality Intervention/Performance Improvement program. The Quality Assurance and Performance Improvement Staff Nurse is also responsible for arranging QA/PI Committee Meetings, preparing QA/PI Reports, and ensuring that appropriate actions are taken, based on recommendations and findings of the QA/PI program activities. Additionally, the Quality Assurance and Performance Improvement Manager is responsible for educating all staff members about the QA/PI program, and their roles and responsibilities related to QA/PI. Non-clinical staff is responsible to participate in data collection, issue improvement plans, preparation of Quality Assurance Committee minute, reports, projects and tools.

The Board of Directors has the final authority and responsibility for the ongoing, comprehensive and integrated Quality Intervention Program. Quality Assurance and Performance Improvement Reports will be presented to the Board annually. All Quality Interventions and Improvement activities are summarized in this report, as well as results of all monitoring activities. The Board delegates authority of the implementation of the QA/PI Program through the Quality Assurance and Performance Improvement Manager, who ultimately is responsible to the Administrator.

The Quality Assurance and Performance Improvement Committee meets at least quarterly to

review all QA/PI findings and to make recommendations regarding all quality interventions and improvement activities.

Follow-up reports and recommendations from the QA/PI Committee are made available to all staff members, through memos and monthly staff meetings. Specific recommendations regarding deficient service areas will go directly to the Clinical Managers.

Quality Assurance and Performance Improvement Committee Quality Assurance and performance Improvement Committee

The Quality Assurance and performance improvement Committee has been established for the purpose of reviewing all of the QA/PI activities of the agency, and participating in monitoring activities, as previously outlined.

The Committee consists of representatives from the management and clinical staff, with input from all disciplines, and departments as appropriate.

The Quality Assurance Nurse is chairperson for this committee, and is designated by the Agency Administrator (AA). Meetings are held at least quarterly, where results of QA/PI activities are reported. Minutes for these meetings are kept on file in the office.

Committee Members
CEO or her designee
QA/PI Nurses
Clinical Managers
Agency Administrator
Other Agency Representatives as needed

Monitoring of Important Aspects of Hospice Care

Monitoring of Important Aspects of Care is a major component of the Quality Assurance and Performance Improvement Program. The following important aspects of care have been identified, and have been prioritized. They have been chosen based on the fact that they are important aspects of Hospice Care.

Service Specific Aspects of Care

1. High Quality Patient Care Planning/Skilled Hospice Nursing Service
2. Provision of Comprehensive Personal Care Service for palliative/hospice
3. Provision of Comprehensive Rehabilitation Services, with adequate and appropriate patient care planning when needed (high volume)

4. Wound Care Management (high volume)
5. Safety Management in the Home by the Hospice Care Personnel

Other Areas:

1. Patient Satisfaction (high volume)
2. Patient Incident & Complaint issue (high volume)
3. HIS
4. CAHPS

Other Important aspects of care to be monitored:

1. Compliance with Infection Control Procedure
2. Interdisciplinary Communication
3. Medication Administration PROCEDURES
4. Skin Care Management

Indicator Development

The evaluation and monitoring of activity P-B Health Hospice Quality assurance Performance and Improvement Plans begin with the development of indicators from the Important Aspects of Care. (See Monitoring and Evaluation of Important Aspects of Care). We have identified a number of important aspects of care and will focus on each area as indicated above. Indicators, and other Quality Intervention and Improvement Activities that are monitored regularly are done so according to a continuous evaluation time line.

When an area is identified as needing improvement, an Issue Improvement Plan is developed. These problematic issues are identified through indicator analysis, quarterly utilization review findings, and through clinical record reviews, and other related Quality Assurance Intervention and Improvement Activities. However, issues may also be identified through other committee meetings, management or staff meetings. Issue improvement plans may lead to the development of other Important Aspects of Care, with subsequent indicator development. The Quality Assurance Intervention and Performance Improvement Issue Tracking Sheet identify areas of improvement, actions to be taken, responsible parties and follow-up as stated.

The Quality Assurance Intervention and Performance Improvement Committee receive a Report of Issue identification, progress, and resolution at their quarterly meetings. Quality Intervention and Improvement reports are presented to the Professional Advisory Committee quarterly. In addition, The Board of Directors will receive a report at least annually of the Quality Assurance Intervention and Performance Improvement findings, action taken, and follow-up of actions taken.

Sources for evaluation include:

- Retrospective and concurrent chart reviews

- Patient Satisfaction Surveys
- Information collected on home hospice visits and on home hospice aide supervisory visits
- Incident Reports

Internal Clinical Record Review Audits:

Admission Audits

The admissions audit consists of a thorough review of all initial paperwork submitted by the admitting discipline. The purpose of this audit is to determine if the admission is appropriate to fit the level of hospice care being provided and if the admission has been done according to agency policy. This audit also focuses on the adequate completion of the Physicians Plan of Treatment. The POT worksheet, the OASIS SOC Assessment Tool, and the Medication Record. An Admission Audit Review tool is used for this purpose, with findings reported back to the primary nurse on the case. The Clinical Manager ensures that all deficiency areas are corrected within 48-72 hours, and notes correction dates on the audit tool. The QA nurse will review the completed admission review tools and work with the Clinical Managers to provide documentation in-services as needed.

Hospice Application Revised: Charts and Tables Supplement

TABLE 1 - PROJECT BUDGET
TABLE 2B: STATISTICAL PROJECTIONS – PROPOSED PROJECT
TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT
TABLE 5: MANPOWER INFORMATION

TABLE 1: PROJECT BUDGET

P-B HEALTH'S RESPONSE:

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

A. Use of Funds

1. Capital Costs (if applicable):

a.	New Construction **(N/A)**	$_____	
(1)	Building	_____	
(2)	Fixed Equipment (not included in construction)	_____	
(3)	Land Purchase	_____	
(4)	Site Preparation	_____	
(5)	Architect/Engineering Fees	_____	
(6)	Permits, (Building, Utilities, Etc)	_____	
SUBTOTAL			$_____
b.	Renovations **(N/A)**		
(1)	Building	$_____	
(2)	Fixed Equipment (not included in construction)	_____	
(3)	Architect/Engineering Fees	_____	
(4)	Permits, (Building, Utilities, Etc.)	_____	
SUBTOTAL			$_____
c.	Other Capital Costs **(N/A)**		
(1)	Major Movable Equipment	_____	
(2)	Minor Movable Equipment	_____	
(3)	Contingencies	_____	
(4)	Other (Specify)	_____	
TOTAL CURRENT CAPITAL COSTS (a - c)			$_____
d.	Non Current Capital Cost **(N/A)**		
(1)	Interest (Gross)	$_____	
(2)	Inflation (state all assumptions, Including time period and rate)	$_____	
TOTAL PROPOSED CAPITAL COSTS (a - d)			$_____

2. Financing Cost and Other Cash Requirements:

a.	Loan Placement Fees	$ 0

b.	Bond Discount	0	
c.	Legal Fees (CON Related)	2,500.00	
e.	Printing **(in house)**	0	
f.	Consultant Fees		
	CON Application Assistance	5,000.00	
	Other (Specify)	0	
g.	Liquidation of Existing Debt	0	
h.	Debt Service Reserve Fund	0	
i.	Principal Amortization Reserve Fund	0	
j.	Other (Specify)	0	
	TOTAL (a - j)	$7,500.00	
3.	Working Capital Startup Costs	$0	
	TOTAL USES OF FUNDS (1 - 3)		$7,500.00

B. Sources of Funds for Project:

1.	Cash	$7,500.00	
2.	Pledges: Gross _____, less allowance for uncollectables _____ = Net	0	
3.	Gifts, bequests	0	
4.	Interest income (gross)	0	
5.	Authorized Bonds	0	
6.	Mortgage	0	
7.	Working capital loans	0	
8.	Grants or Appropriation		
	(a) Federal	0	
	(b) State	0	
	(c) Local	0	
9.	Other (Specify)	0	
	TOTAL SOURCES OF FUNDS (1-9) (Owner)		$ 7,500.00

Lease Costs:		
a. Land	$_____ x _____	= $ 0
b. Building	$_____ x _____	= $ 0
c. Major Movable Equipment	$_____ x _____	= $ 0
d. Minor Movable Equipment	$_____ x _____	= $ 0
e. Other (Specify)	$_____ x _____	= $

TABLE 2B: STATISTICAL PROJECTIONS – PROPOSED PROJECT

P-B HEALTH'S RESPONSE:

	Projected years – ending with first year at full utilization			
CY or FY (circle)	2018	2019	2020	2021
Admissions	50	75	113	169
Deaths	40	60	90	135
Non-death discharges	4	6	9	14
Patients served	46	69	104	155
Patient days	960	1412	2061	2944
Average length of stay	20.9	20.5	19.9	19.0
Average daily hospice census	8	12	18	27
Visits by discipline				
Skilled nursing	1137	1705	2556	3837
Social work	91	136	205	307
Hospice aides	168	252	378	567
Physicians - paid	0	0	0	0
Physicians - volunteer	5	8	12	18
Chaplain	79	119	178	267
Other clinical	204	306	459	713
Licensed beds				
Number of licensed GIP beds	0	0	0	0
Number of licensed Hospice House beds	0	0	0	0
Occupancy %	0	0	0	0
GIP(inpatient unit)	0	0	0	0
Hospice House	0	0	0	0

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

P-B HEALTH'S RESPONSE:

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

	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2018	2019	2020	2021
1. Revenue				
a. Inpatient services **(Respite)**	25,000	37,500	56,250	84,375
b. Hospice House services	0	0	0	0
c. Home care services	235,000	352,500	528,750	793,125
d. Gross Patient Service Revenue	310,000	465,000	697,500	1,046,250
e. Allowance for Bad Debt	(2,350)	(3,525)	(5,288)	(7,931)
f. Contractual Allowance	(50,000)	(75,000)	(112,500)	(168,750)
g. Charity Care	(7,650)	(11,475)	(17,213)	(25,819)
h. Net Patient Services Revenue	250,000	375,000	562,500	843,750

i. Other Operating Revenues (Specify)	0	0	0	0
j. Net Operating Revenue	250,000	375,000	562,500	843,750
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	200,400	300,600	450,900	676,350
b. Contractual Services	20,000	30,000	45,000	67,500
c. Interest on Current Debt	0	0	0	0
d. Interest on Project Debt	4,630	6,945	10,418	15,626
e. Current Depreciation	0	0	0	0
f. Project Depreciation	0	0	0	0
g. Current Amortization	0	0	0	0
h. Project Amortization	1,500	2,250	3,375	5,063
i. Supplies	10,000	15,000	22,500	33,750
j. Other Expenses (Specify)**rent, comm.,ins., and taxes**	22,500	33,750	50,625	75,938
k. Total Operating Expenses	259,030	388,545	582,818	874,226
3. Income				
a. Income from Operation	(9,030)	13,545	20,318	30,476
b. Non-Operating Income	0	0	0	0
c. Subtotal	(9,030)	13,545	20,318	30,476
d. Income Taxes	0	(3,386)	(5,079)	(7,619)
e. Net Income (Loss)	(9,030)	10,159	15,238	22,857

Table 4 Cont.	**Projected Years (ending with first full year at full utilization)**			
CY or FY (Circle)	2018___	2019___	2020___	2021
4. Patient Mix				
A. As Percent of Total Revenue				
1. Medicare	70%	73%	75%	76%
2. Medicaid	10%	10%	12%	12%
3. Blue Cross	5%	4%	4%	3%
4. Other Commercial Insurance	13%	11%	7%	7%

6. Other (Specify)	2%	2%	2%	2%
7. TOTAL	100%	100%	100%	100%
B. As Percent of Patient Days/Visits/Procedures (as applicable)				
1. Medicare	60%	62%	64%	65%
2. Medicaid	18%	18%	20%	20%
3. Blue Cross	5%	4%	4%	3%
4. Other Commercial Insurance	14%	13%	9%	9%
5. Self-Pay	3%	3%	3%	3%
6. Other (Specify)	0	0	0	0
7. TOTAL	100%	100%	100%	100%

ABLE 5. MANPOWER INFORMATION (Fiscal Year 2018)

INSTRUCTIONS: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project. FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration					
Administration	.2	.5	45,000	Employees	24,300
Direct Care					
Nursing	0	.8	60,000	Employees	43,008
Social work/services	0	.4	50,000	Employees	18,000
Hospice aides	0	1.2	30,000	Employees	32,400
Physicians-paid	0	0	0	Contractual	0
Physicians-volunteer	0	.04	300,000	Contractual	5,781
Chaplains	0	.2	45,000	Contractual	8,671
Bereavement staff	0	.6	45,000	Employees	32,400
Other clinical	0	.3	0	Both E/C	28,800/1,927
Support					
Other support	0	.04	188,000	Contractual	3,621
				Benefits*	**21,492**
				TOTAL	**220,400**

* Indicate method of calculating benefits cost

For fiscal year 2018, based P-B Health's current home health salaries for staff as listed above and using Quickbooks, the employee benefits represent an additional 12% of added cost. This includes all employee payroll taxes, PTO, and health benefits. Other Clinical represents Therapy Services. The therapies are Physical, Occupational, and Speech Therapy. Speech Therapy is provided by a non-employee or Contractor; Therapy services provided by employees are costed at $28,800 and the therapy service by the Contractor is $1,927. The total cost associated with employees and contractors is $220,400, where $178,908 is salary and $21,492 is benefits. The total cost associated with contractors is $20,000.

ABLE 5. MANPOWER INFORMATION (Fiscal Year 2019)

INSTRUCTIONS: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project. FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration					
Administration	.2	.8	45,000	Employees	30,000
Direct Care					
Nursing	0	.9	60,000	Employees	53,333
Social work/services	0	.4	50,000	Employees	22,222
Hospice aides	0	1.3	30,000	Employees	40,000
Physicians-paid	0	0	0	Contractual	0
Physicians-volunteer	0	.05	300,000	Contractual	13,333
Chaplains	0	.4	45,000	Contractual	20,000
Bereavement staff	0	.9	45,000	Employees	40,000
Other clinical	0	.4	0	Both E/C	40,000/2,780
Support					
Other support	0	.04	188,000	Contractual	5,576
				Benefits*	**33,356**
				TOTAL	**300,600**

* Indicate method of calculating benefits cost

For fiscal year 2019, based P-B Health's current home health salaries for staff as listed above and using Quickbooks, the employee benefits represent an additional 14.8% in added cost. This cost includes all employee payroll taxes, PTO, and health benefits. Other Clinical represents Therapy Services. The Therapies are Physical, Occupational, and Speech Therapy. Speech Therapy is provided by a non-employee or contractor. Therapy services, provided by employees, are costed at $40,000 and therapy services provided by the Contractor are costed at $2,780. The total cost associated with employees and contractors is $300,600, where $225,555 is salary and $33,356 is benefits. The total cost associated with contractors Is $41,689.

ABLE 5. MANPOWER INFORMATION (Fiscal Year 2020)

INSTRUCTIONS: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project. FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration					
Administration	.2	1.2	45,000	Employees	54,000
Direct Care					
Nursing	0	1.3	60,000	Employees	75,000
Social work/services	0	.7	50,000	Employees	33,333
Hospice aides	0	1.9	30,000	Employees	57,000
Physicians-paid	0	0	0	Contractual	0
Physicians-volunteer	0	.05	300,000	Contractual	20,000
Chaplains	0	.7	45,000	Contractual	30,000
Bereavement staff	0	1.2	45,000	Employees	59,000
Other clinical	0	.7	0	Both E/C	60,000/4,180
Support					
Other support	0	.1	188,000	Contractual	8,353
				Benefits*	**50,033**
				TOTAL	**450,900**

* Indicate method of calculating benefits cost

For fiscal year 2020, based on P-B Health's current home health salaries for staff as listed above and using Quickbooks, the employee benefits represent an additional 14.6% of added cost. This includes all employee payroll taxes, PTO with health and other benefits. Other Clinical represents Therapy Services. The therapies are Physical, Occupational, and Speech Therapy. Speech Therapy is provided by a non-employee or contractor. The therapy services provided by employees are costed at $60,000 and the Therapy services provided by the Contractor are costed at $4,180. The total cost associated with employees and contractors is $450,900, where $342,504 is salary and $50,033 is benefits. The Total cost associated with contractors is $58,363.

ABLE 5. MANPOWER INFORMATION (Fiscal Year 2021)

INSTRUCTIONS: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project. FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration					
Administration	.2	1.8	45,000	Employees	67,500
Direct Care					
Nursing	0	2	60,000	Employees	120,000
Social work/services	0	1	50,000	Employees	50,000
Hospice aides	0	3	30,000	Employees	90,000
Physicians-paid	0	0	0	Contractual	0
Physicians-volunteer	0	.1	300,000	Contractual	30,000
Chaplains	0	1	45,000	Contractual	45,000
Bereavement staff	0	2	45,000	Employees	90,000
Other clinical	0	1	0	Both E/C	90,000/6,240
Support					
Other support	0	.1	188,000	Contractual	12,560
				Benefits*	**75,050**
				TOTAL	**676,350**

* Indicate method of calculating benefits cost

For fiscal year 2021, based on P-B Health's current home health salaries for staff as listed above and using Quickbooks, the employee benefits represent an additional 14.5% of added cost. This includes all employee payroll taxes, and PTO with health and other benefits. Other Clinical represents Therapy Services. The Therapies are Physical, Occupational, and Speech Therapy. Speech Therapy is provided by a non-employee or contractor. Therapy services, provided by employees are costed at $90,000 and therapy services provided by the Contractor is costed at $6,240. The total cost associated with employees and contractors is $676,350, where $518,810 is salary and $75,050 is benefits. The Total cost associated with contractors Is $82,490.

Updated June 2016.

APPENDIX J

Appendix J

Letter of Viability and Financials

Additional signed Affirmations

RONALD M. KATZEN, CPA

101 Schilling Road, Suite 30 • Hunt Valley, Maryland 21031 • Direct Line 410-852-1861

Ronald Katzen's role in this new project would be to review all expenses every month as well as review all revenues when analyzing the bank statements every month.

P-B Health Home Care Agency has a very long history of paying all of their Accounts Payable in a very timely manner. As I spoke to the Accounts Payable Manager on March 30th there was not any balance owed. All invoices are paid promptly as they come in. But for accounting purposes after looking at the disbursements register, I would record the accounts payable balance at $20,000.

As far as capital to fund the new project I have attached three schedules. I have compiled an Accounts Receivable schedule as of 2/28/17 that has a total balance due of $956,560. On my second schedule based on the average monthly bank balances there is over $300,000. Add to that the potential $500,000 Stockholder Loans and there would be a sizeable amount of working capital.

Ronald Katzen
4/6/17

National Brand 45-604 Eye-Ease®
45-304 2-Pack

P-8 Health

Accounts Receivable

2/28/17

Prepared By	Initials	Da
Approved By		

	1	2	3	4
		Amount Owed		
1				
2	2015 MEDICARE	1375829		
3				
4	2016 MEDICARE	2660050		
5				
6	2017 MEDICARE	3434554		
7	January And			
8	February only			
9				
10	2015 Commercial	2953131		
11				
12	2016 Commercial	5275475		
13				
14	2017 Commercial			
15	January And			
16	February only	11695722		
17				
18	Private Duty			
19				
20	THAS	8814200		
21				
22	THAS Nursing	900000		
23				
24	SELF PAY	2049294		
25				
26	SELF PAY Nursing	46400		
27				
28	VA	4090500		
29				
30	VA Nursing	1100000		
31				
32	VCC	(146400)		
33				
34				
35				
36	Total Accounts Receivable	95659785		
37				
38				
39				
40				

National® Brand 45-604 Eye-Ease®
45-304 2-Pack

P-B-Monthly

Cash Balances

Aug 2016 Thru Dec 2016

	Initials	Date
Prepared By		
Approved By		

	1	2	3	4
	Ending Month Balance per reconciliation	Payroll Acct # 5356	Operating Acct # 316	
1				
2	August 2016	121282	35144	
3				
4	September 2016	204073	86652	
5				
6	October 2016	192816	248844	
7				
8	November 2016	251328	122034	
9				
10	December 2016	168189	92663	
11				
12				
13	Monthly Average	187529	126677	
14				
15				
16	Total of Combined Average			314206
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				

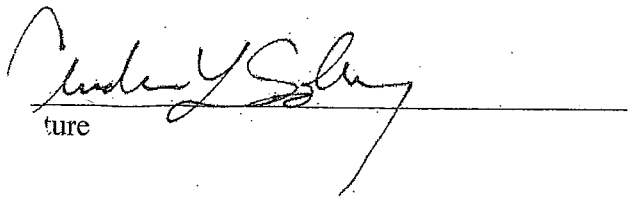
National® 35-606

PB Health
Potential Cash
To Fund New Projects

	Initials	Date
Prepared By		
Approved By		

Accounts Receivable	2-128-119		956520
Stockholders Loan			500000
Average Cash Balances			304219
TOTAL			1760739

I hereby declare and affirm under the penalties of perjury that the facts stated in this Completeness and Additional Information response are true and correct to the best of my knowledge, information, and belief.



ture

4/12/17

Date

its attachments are true and correct to the best of my knowledge, information and belief.

Jana M. Woody

Signature of Owner or Authorized Agent of the Applicant

Jana M. Woody, Mgr. Special Projects

Print name and title

Date: 4/10/17

its attachments are true and correct to the best of my knowledge, information and belief.

Signature of Owner or Authorized Agent of the Applicant

Matthew Barley, CFO

Print name and title

Date: 4/11/17