BAKER DONELSON

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May 25, 2017

VIA HAND DELIVERY AND EMAIL
Kevin McDonald, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Paterson Avenue
Baltimore, Maryland 21215

Re: FutureCare - Homewood
Matter No. 17-24-2396
Responses to the April 27, 2017 Completeness Questions

Dear Mr. McDonald:

On behalf of FutureCare - Homewood Properties, LLC and Charles Street Health Care, LLC d/b/a FutureCare Homewood (collectively "Homewood"), we are hereby submitting the required six (6) copies of our responses to the April 27, 2017 completeness questions regarding the above-referenced project. Full size drawings of the affected floors are included with this filing. We will also provide Word and electronic copies of our responses and exhibits as appropriate.

I hereby certify that a copy of this response has also been forwarded to the appropriate local health planning agency, as noted below.

If any further information is needed, please let us know.

Sincerely,

BAKER, DONELSON, BEARMAN,
CALDWELL & BERKOWITZ, PC

Howard L. Sollins, Shareholder

JJE/tjr
Enclosures

cc: Leana S. Wen, M.D., MSc., FAAEM, Baltimore City Commissioner of Health
Ms. Ruby Potter, Health Facilities Coordination Office
Gary L. Attman, President, FutureCare Health and Management
Brian Finglass, CPA, FutureCare Health & Management Corp.
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
John J. Eller, Esquire

FutureCare Homewood Properties, LLC d/b/a FutureCare Homewood
Matter No. 17-24-2396
Responses to Completeness Questions Received 4/27/17

PART I - PROJECT DRAWINGS

1. **The application directs the applicant to include scalable schematic drawings of the facility having at least at 1/16" scale that are completely legible and include dates. These drawings should include the following, before (existing) and after (proposed), as applicable:**

    a. **Floor plans for each floor affected with all rooms labeled by purpose or function, 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 projects involving new construction and/or site work, a Plot Plan, showing the "footprint" and location of the facility before and after the project.**

    c. **Specify dimensions and square footage of patient rooms.**

Floor plans that accurately reflect the current status of the 1st and 2nd floor areas to be renovated do not exist, and it would take considerable time and expense to create them. Usually the space to be renovated in an existing facility is already in use under the auspices of the existing facility, and for purposes directly related to the services offered by the existing provider. In this case, however, it must be recognized that the 2nd floor space to be renovated is occupied by a commercial tenant, or is unoccupied, and is unrelated to Homewood's services as a provider. With regard to the first floor space, though in part that is being used for dialysis, and other space utilized by the Landlord, the changes in that area will only involve reconfiguring the entrance area. The dialysis services will remain in that area, but are otherwise unaffected by the project, and in any event those dialysis services are not provided by Homewood. Thus, Homewood is not presently using these spaces for its clinical programs or services, and the project therefore does not entail any change in Homewood's present usage of those spaces for its programs and services. Since it would entail needless cost and time to create plans that reflect the current commercial use of those spaces by other parties, we have located and attached the best available documentation of the current layout of the affected spaces.

Regarding the 2nd floor, plans are available from 2007 prepared by other architects that were used by our current architects as a base for the project's Concept Design. Using those plans as a take-off point, old construction drawings were used to supplement that information in preparing the new floor plan previously submitted.

Regarding the 1st floor, plans that were prepared by other architects prior to the implementation of the Dialysis Center were utilized as a base for the project's Concept Design.

Here, too, old construction drawings were used to supplement that information in preparing the new floor plan previously submitted.

In both cases, the areas in these "before" plans that are affected by the new project renovations have been shaded. The new plans, submitted with the CON application (including full size drawings) contain the required and important labeling and dimensions for the affected spaces.

The "before" drawings can be found in Exhibit 12 to this filing.

The thirty private rooms on the newly created 2nd floor are designed to accommodate patients whose conditions require extensive therapy and have needs consistent with FutureCare Vital Strong Heart Strong and Walk Strong Program. In the application, these two programs have been explained as designed to meet the needs of cardiac and orthopedic rehabilitation and recovery. Currently, these programs are housed on the 5th floor of the facility, where the bulk of short term residents reside while at FCH. As a result, they are intermingled with other skilled care patients whose diagnosis may include wound care, infection, enteral support and other skilled services that are not necessarily rehabilitation oriented. By providing an environment more conducive to rehabilitation and short term stays, staff can be better focused on the needs of these residents. The goal and expectation is greater customer satisfaction and shorter length of stays.

Further narrative detail on the nature of the renovations in the affected areas may be found in the original CON application on pages 13-15, and 28.

PART II – PROJECT BUDGET

2. **Please itemize the expenses comprising the "other" in section A.1.c of the budget form.**

Other in section A.1.c.4 shows $320,000. This includes the following:

Construction Manager	$35,000
Cost of Purchasing the Beds	$285,000
Total	$320,000

PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA

State Health Plan Standards

Nonelderly Residents

3. **Please provide a copy of the training overview or materials regarding psychosocial problems facing nonelderly disabled residents.**

Please see Exhibit 13.

Facility Occupancy

4. **Since the occupancy rates vary for each of the nursing units, please provide admission and average length of stay data for each of the nursing units or each type of nursing unit (see table below) for at least three years.**

TABLE D. UTILIZATION PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Account for all inpatient and outpatient volume that produce or will produce revenue. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 3 & 4, 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.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.			
Indicate CY or FY	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
1. ADMISSIONS							
a. Respiratory	33	33	33	33	33	33	33
b. Long Term Care	31	47	40	40	40	40	40
c. Short Term Care	337	349	409	430	453	535	793
TOTAL ADMISSIONS	***401***	***429***	***482***	***503***	***526***	***608***	***866***
2. PATIENT DAYS							
a. Respiratory	10,090	10,164	10,362	10,362	10,362	10,391	10,363
b. Long Term Care	26,697	26,868	27,605	27,605	27,605	27,544	27,473
c. Short Term Care	11,101	11,563	11,673	11,673	11,673	13,573	21,659
TOTAL PATIENT DAYS	***47,888***	***48,595***	***49,640***	***49,640***	***49,640***	***51,508***	***59,495***
3. NUMBER OF BEDS							
a. Respiratory	31	31	31	31	31	31	31
b. Long Term Care	78	78	78	78	78	78	78
c. Short Term Care	39	39	39	39	39	47	69
TOTAL BEDS	***148***	***148***	***148***	***148***	***148***	***156***	***178***
4.AVERAGE LENGTH OF STAY							
a. Respiratory	306	308	314	314	314	315	314
b.Long Term Care	861	572	690	690	690	689	687
c. Short Term Care	33	33	29	27	26	25	27

This table differs from Table E in that Table E reflects the net impact of adding 30 beds. Some short term patients who are in existing beds will be moved to the new unit. Their place

will be filled by patients who have longer lengths of stay. Hence, the Average Length of Stay ("ALOS") on Table E is longer than the ALOS in the Short Term Unit.

5. **Explain the assumptions made in projecting the utilization of each type of unit (Respiratory, Short Term Care, and Long Term Care).**

The Respiratory unit will be utilized by ventilator and tracheostomy residents. FCH based its admissions and patient days on the assumption that the admissions, ALOS, and Occupancy will continue at the historical levels.

The short term units will be utilized as follows:

- 5th floor- medically complex skilled patients
- 2nd floor- orthopedic and cardiac patients

As the letter from MedStar in Exhibit 14 states, the Transitional Care Unit at MedStar Good Samaritan Hospital ("TCU") had an average of 45 admissions per month (540 admissions per year) over the last five years. FCH used TCU admission data as a reference point in determining its short term stay volume assumptions. FCH could not accommodate the number of admissions to the TCU in its additional 30 bed short term unit because (1) some patients who will be in the new unit are short term patients currently staying in other units at FCH and (2) FCH's projected ALOS is longer than that at the TCU. (This is in part because patients who were seen in the TCU were often discharged to other rehabilitation facilities.) FCH's average length of stay for short term residents is currently 33 days. FCH reduced the ALOS assumption over the life of the project to 27 days (in 2021) reflecting FCH's current anticipation that future lengths of short term stays will be lower due to various payor and market factors. Both of the projected short term units will run at a slightly lower occupancy levels because of the higher turnover rate of residents (and the need to prepare the rooms for new residents). Consequently, the number of projected additional short term admissions as a result of the 30 bed expansion will be less than the historical admissions to the Good Samaritan TCU.

The two long term care units will be utilized primarily by lower functioning Medicaid beneficiaries that have long term chronic conditions that require a nursing facility level of care. Admissions and Lengths of Stay were based on historical experience. These units will have the highest occupancies of all the units.

COMAR 10.24.01.08G(3) (b) – NEED

6. **The applicant states that…. "Through the VitalStrong Rehabilitation Programs at FutureCare, the applicant has developed a collaborative relationship with MedStar Health Good Samaritan Hospital to develop the HealthStrong cardiac program, and WalkStrong orthopedic program to offer a state-of-the-art rehabilitative program that seamlessly transitions a patient from the acute setting to the subacute setting. … The 30 new private room unit will cater specifically to this population, featuring HeartStrong and WalkStrong…." Please provide a letter from MedStar Health Good Samaritan Hospital elaborating on its commitment to transfer patients to**

your facility, states where the patients are currently being referred, and speaks to the utilization of the 30 delicensed beds over their last five years in service.

The requested letter is in Exhibit 14.

COMAR 10.24.01.08G(3)(C) – AVAILABILITY OF COST EFFECTIVE ALTERNATIVES

7. **Please provide the cost and timeframe associated with the FutureCare Homewood second floor renovation alternative without adding 30 beds. Compare both the capital and operating costs as well as the impact on profits of this alternative to the chosen alternative.**

Capital costs decrease by $286,025 from $6,799,182 to $6,513,157. This is a combination of elimination of balance of bed purchase of $285,000 (while the bed purchase cost $285,000, $30,000 of that is non-refundable, hence a savings of $255,000) and lower project interest on those borrowings for the duration of the project.

This alternative would result in significantly diminished net income. Exhibit 15 includes a revised Table F which demonstrates that this alternative project would, if it were implemented would show substantially less net income once the unit opens in the fall of 2020. The alternate project is not in the financial best interest of the facility.

COMAR 10.24.01.08G(3)(D) – VIABILITY OF THE PROPOSAL

8. **Provide a complete description of all assumptions that "fed" the utilization and revenue and expense tables associated with the CCF, and the rationale behind those assumptions. At minimum, address the assumptions behind projections of: admissions; length of stay; payor mix; and rates received by payor. Assumptions behind the expense lines should also be included.**

In a May 17, 2017 clarifying email from Angela Clark (MHCC CON Staff) to Howard Sollins (Counsel to FCH), she stated:

> "The applicant also inquired whether utilization, revenue and expense projection assumptions submitted in Exhibit 10 met the list of assumption requirements asked in question 8 in the first completeness letter. Upon review of exhibit 10, commission staff sees no need additional information so applicant can disregard question 8."

9. **Describe the impact of the proposed project on the calculation of the facility's Medicaid rate, in detail; especially the impact on the property and capital portion of that rate.**

The project should have no impact on Medicaid rates. Most components of the rate are set prospectively and will not be affected by the addition of beds. Regarding the nursing component which is adjusted for the facility case mix index (CMI) , we do not believe that the

addition of Medicaid patients due to the expansion will materially alter the facility CMI and therefore will have no rate impact. Regarding the Fair Rental Value (FRV) of the capital component, we are not projecting a change since it is assumed that the 178 beds will continue to be reimbursed at the maximum per bed ceiling on valuation. We assumed that the real estate component of the rate should remain constant with slightly higher real estate taxes being offset by higher patient days.

10. Regarding Table F, please provide the following explanations:

a. Explain the decrease in net income from 2015 to 2016.

Major variances are as follows:

- Lower prior year Medicaid settlement and lower pay for performance award $210,000
- Higher rent $147,000
- Higher management fee $250,000
- Higher bad debt $90,000
- Higher benefits (26.2% vs 24.9%) $105,000
- Higher depreciation $65,000

The remainder of the variance is due to a combination of higher expenses and lower rates

b. Explain how the management fee is determined and explain the increase from 2015 to 2016.

Management fees are discretionary, determined annually, and are limited by an annual cap of 9% of revenue. Substantial services are provided by this management arrangement reflecting costs that would otherwise be incurred directly by the facility such as quality assurance, financial and reimbursement analysis and support, compliance support, human resources support, information technology support and related services.

c. Explain how the facility rental cost is determined and explain the increase from 2016 to the projection for the current year. Explain how future facility rental expenses relate to the proposed building improvements and additional beds.

Please refer to the table below which details the rent calculation. The project envisions borrowings over a 3-year construction period. The debt service on those borrowings is reflected below (line 6), as well as a conversion to a permanent loan at the completion of the project in 2021. The project also envisions the loss of two existing tenants. The loss of rent is reflected on line 12 below partially in 2019 and fully in 2020 and beyond.

1	**Projected Homewood Rent calculation**						
2							
3		2016	2017	2018	2019	2020	2021
4	Operating expenses of Real Estate entity	1,470,112	1,494,895	1,494,895	1,494,895	1,494,895	1,494,637
5							
6	P&I on debt	171,963	171,963	227,091	278,440	328,134	551,700
7							
8	Plus 100k	100,000	100,000	100,000	100,000	100,000	100,000
9							
10	Total Cash required for Real Estate Entity	1,742,075	1,766,858	1,821,986	1,873,335	1,923,029	2,146,337
11							
12	Less Rent non nursing facility	(554,858)	(554,858)	(554,858)	(433,047)	(350,585)	(350,585)
13							
14	Amt of rent due from Homewood	1,187,217	1,212,000	1,267,128	1,440,288	1,572,444	1,795,752

11. Regarding Table G, explain why there is such a large swing in the percent of Medicare and Medicaid days from 2020 to 2021 especially given the relatively small change in the percentage of revenue coming from each payer.

There was a formula error in the worksheets that FCH used for the original application. The corrected 2021 Percent of Inpatient days below should now be as expected in relation to the percentage of revenue.

	Projected Years (endi	
Indicate CY or FY	**2020 3 months**	**2021**
1) Medicare	65.5%	59.3%
2) Medicaid	21.4%	29.6%
3) Blue Cross	0.0%	0.0%
4) Commercial Insurance	13.1%	11.1%
5) Self-pay	0.0%	0.0%
6) Other	0.0%	0.0%
TOTAL	***100.0%***	***100.0%***

12. Table H does not appear to include a calculation of the cash fringe benefits associated with the employees and the total costs to be added as a result of the project do not appear to be consistent with Table G and the projected facility total does not appear to be consistent with Table F. These amounts should be consistent with the projected salaries and wages. Please correct Table H accordingly and/or explain the discrepancies.

Table H shows benefits on page 16 of Exhibit 2, as this screenshot shows.

CONTRACTUAL EMPLOYEES TOTAL			$2,205,416			$756,247			$0	0.0	$2,961,664
Benefits *(State method of calculating benefits below):*			**2,201,248**			**405,741**					**2,606,989**
TOTAL COST	***164.6***		***$12,875,856***	***33.9***		***$2,903,903***	***0.0***		***$0***		***$15,779,760***

Table H ties exactly to the 2017 and 2021 columns on table F.

Total Facility	**2017**	**2021**
Table H	**$12,875,856**	**$15,779,760**
Table F. 2.a. Salaries & Wages (including benefits)	$10,670,441	$12,818,096
Table F. 2.b. Contractual Services	$2,205,416	$2,961,664
Total	**$12,875,857**	**$15,779,760**

The total in the “Projected Changes as a Result Of The Proposed Project” section of Table H also ties to Table G.

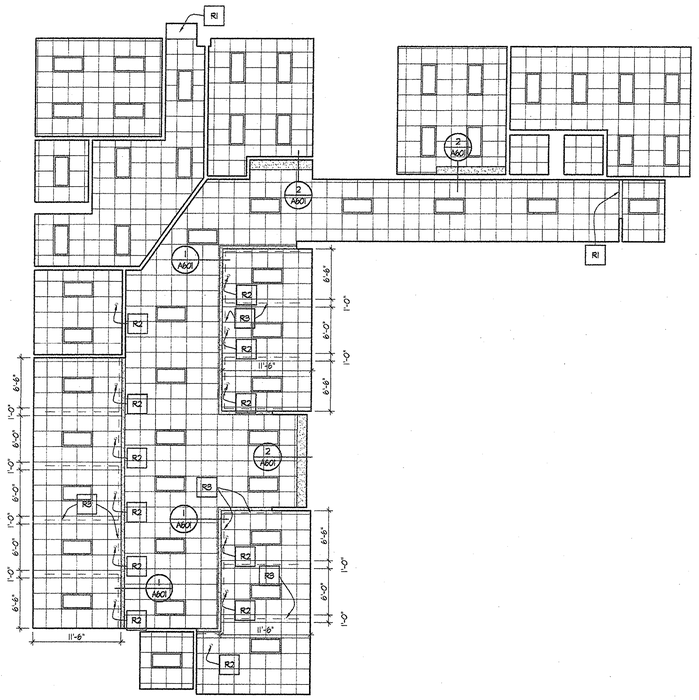
	Project Only
Table H Projected Changes As A Result Of The Proposed Project	**$2,903,903**
Table G. 2.a. Salaries & Wages (including benefits)	$2,147,656
Table G. 2.b. Contractual Services	$756,247
Total	**$2,903,903**

The method used to calculate benefits is the projected actual amounts for payroll taxes, workers compensation, health and welfare programs and paid benefit pay (vacation, holiday, sick, personal, bereavement, jury)

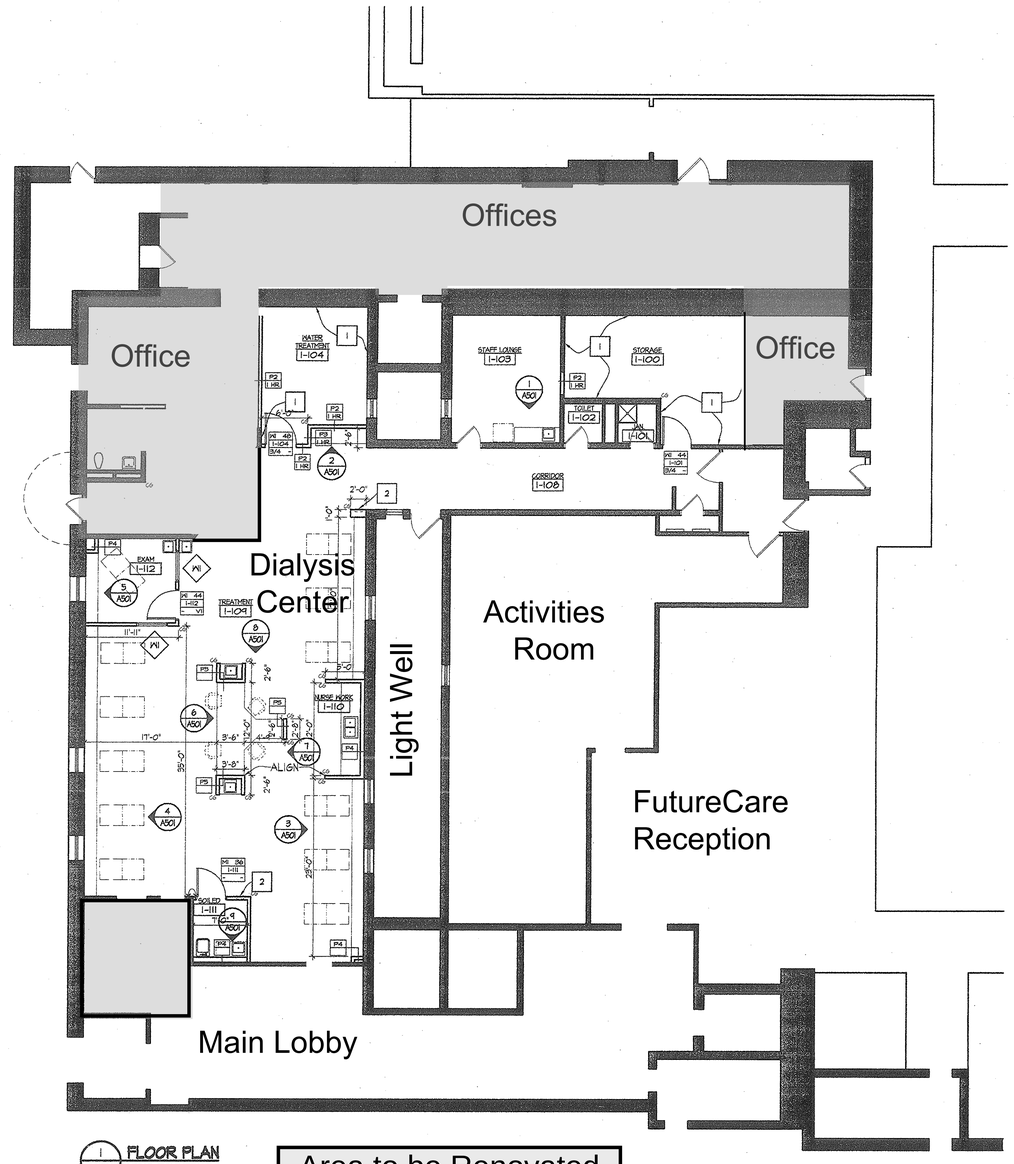
Exhibits

12. Architectural Drawings Showing the Existing Floor
13. Materials Regarding Psychosocial Problems Facing Nonelderly Disabled Residents
14. MedStar Letter
15. Revised Table F for the Alternative of Not Adding 30 Beds
16. Affirmation

EXHIBIT 12



2 A102 REFLECTED CEILING PLAN
SCALE: 1/8 " = 1'-0"



1 A102 FLOOR PLAN
SCALE: 1/8 " = 1'-0"

Area to be Renovated

LEGEND:

- PARTITION
- 2'x2' CEILING PANELS
- GWB CEILING
- 2'x4' RECESSED LIGHT FIXTURE
- 1'x4' RECESSED LIGHT FIXTURE
- CURTAIN TRACK

REFLECTED CEILING NOTES:

(APPLY TO THIS SHEET ONLY)

- R1 EXISTING BULKHEAD
- R2 T.V. MOUNTING BRACKET HUNG FROM STRUCTURE ABOVE.
- R3 CUBICLE CURTAIN AND TRACK - TYPICAL

GENERAL REFLECTED CEILING PLAN NOTES:

1. SEE MECHANICAL/ ELECTRICAL DRAWINGS FOR ADDITIONAL INFORMATION ON ALL DEVICES. SOME ITEMS NOT SHOWN (IE DIFFUSERS, EXIT SIGNS, ETC.)
2. CENTER GRID IN ROOM AS SHOWN UNLESS DIMENSIONS INDICATE OTHERWISE.
3. CENTER ALL FIXTURES INCLUDING SPRINKLER HEADS IN CEILING TILES UNLESS SHOWN OTHERWISE.
4. PORTIONS OF THE SUSPENDED CEILING SYSTEM ARE EXISTING AND ARE TO REMAIN. TAKE NECESSARY PRECAUTIONS TO INSURE SYSTEM IS NOT DAMAGED DURING DEMOLITION AND CONSTRUCTION.
5. PATCH EXISTING CEILINGS AND WALLS TO MATCH ADJACENT EXISTING MATERIAL, GRID, PROFILE, ETC.
6. ALL CEILINGS ARE TO BE INSTALLED AT 8'-0" A.F.F. UNLESS NOTED OTHERWISE.

GENERAL CONSTRUCTION NOTES:

1. CHECK AND VERIFY ALL DIMENSIONS AND CONDITIONS AT THE JOB SITE BEFORE STARTING THE WORK. NOTIFY THE ARCHITECT OF ANY DISCREPANCIES OR POTENTIAL CONFLICTS BEFORE PROCEEDING WITH THE WORK.
2. DIMENSIONS ARE FROM FACE OF GWB OR EXPOSED MASONRY UNLESS OTHERWISE NOTED.
3. THOSE DIMENSIONS WHICH REQUIRE FIELD VERIFICATION ARE IDENTIFIED WITH ±. DIMENSIONS NOT SO NOTED ARE INTENDED TO BE HELD. FIELD VERIFY ALL DIMENSIONS PRIOR TO FABRICATION OR INSTALLATION OF BUILDING COMPONENTS.
4. WHERE DISCREPANCIES OCCUR BETWEEN VARIOUS DRAWINGS OBTAIN CLARIFICATION FROM THE ARCHITECT BEFORE PROCEEDING WITH THE WORK.
5. WHERE SPECIFIC DETAILING IS NOT SHOWN, EXECUTE THE CONSTRUCTION IN A SOUND, WORKMANLIKE MANNER CONSISTENT WITH THE OTHER DETAILING SHOWN.
6. PROVIDE BLOCKING WITHIN PARTITIONS FOR ALL WALL MOUNTED CASEWORK, FURNISHINGS, EQUIPMENT AND ACCESSORIES.
7. ROOM NAMES AND NUMBERS INDICATED ON DRAWINGS ARE FOR CONSTRUCTION PURPOSES ONLY. CLARIFY PERMANENT ROOM IDENTIFICATION WITH THE OWNER.
8. COORDINATE DEMOLITION, PATCHING AND FINISHING WITH MECHANICAL AND ELECTRICAL REQUIREMENTS.
9. EXISTING SURFACES DISTURBED BY DEMOLITION OR NEW CONSTRUCTION SHALL BE PATCHED TO BE FLUSH WITH SURROUNDING SURFACES. THE FINISHED SURFACE IS TO BE LEVEL AND PLUMB TO WITHIN 1/8" IN 10 FEET, UNLESS OTHERWISE SPECIFIED.

CONSTRUCTION NOTES:

(APPLY TO THIS SHEET ONLY)

- 1 SURVEY EXISTING WALLS. VERIFY ALL PENETRATIONS ARE SEALED WITH FIRE-SAFING CAULK. INFILL METAL STUDS AND GWB PER PARTITION TYPE P2 IN AREAS THAT DO NOT EXTEND TO UNDERSIDE OF DECK AND ADD FIRE SAFING INSULATION AT ANY OPENINGS.
- 2 INSTALL FIRE EXTINGUISHER AND CABINET.

LEGEND:

- EXISTING PARTITION TO REMAIN
- PARTITION TYPE P5 UNLESS OTHERWISE NOTED.
- EQUIPMENT OR FURNITURE.
- SURFACES TO ALIGN

0' 4' 8' 16' 24'
1/8"

REVISIONS

NO.	DATE	COMMENTS

SEAL

PROJECT MGR: D. Watts
DESIGNER: D. Watts

Dialysis Corporation of America
2700 North Charles Street
Baltimore, Maryland 21218

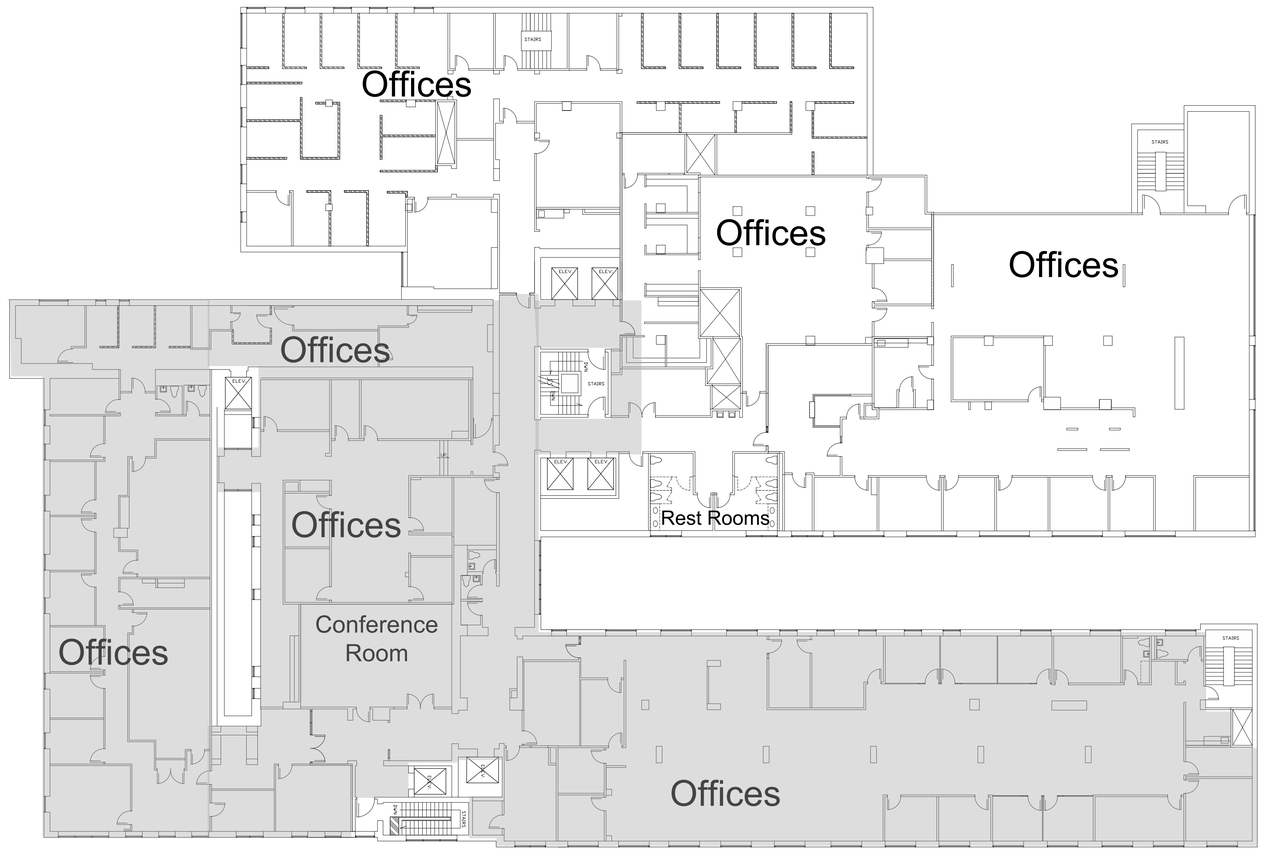
MARSHALL CRAFT ASSOCIATES
Marshall Craft Associates, Inc.
Architecture / Interior Design / Planning
6112 York Road, Baltimore, Maryland 21212-2011
410.532.5151 Fax 410.532.5009

DIALYSIS CORPORATION OF BALTIMORE
Renal Service Expansion

Floor Plan and Reflected Ceiling Plan

SCALE	1/8"=1'-0"
MCA JOB NO	06021
DATE	10/09/07
VERSION	CD

A-102



Area to be Renovated for 30 Bed Unit

0 8' 16' 32'

SCALE: 1/16" = 1'-0"

2700 North Charles Street

Second Floor Tenant Office Space

EXHIBIT 13

YOUNG ADULTS LIVING IN NURSING HOME

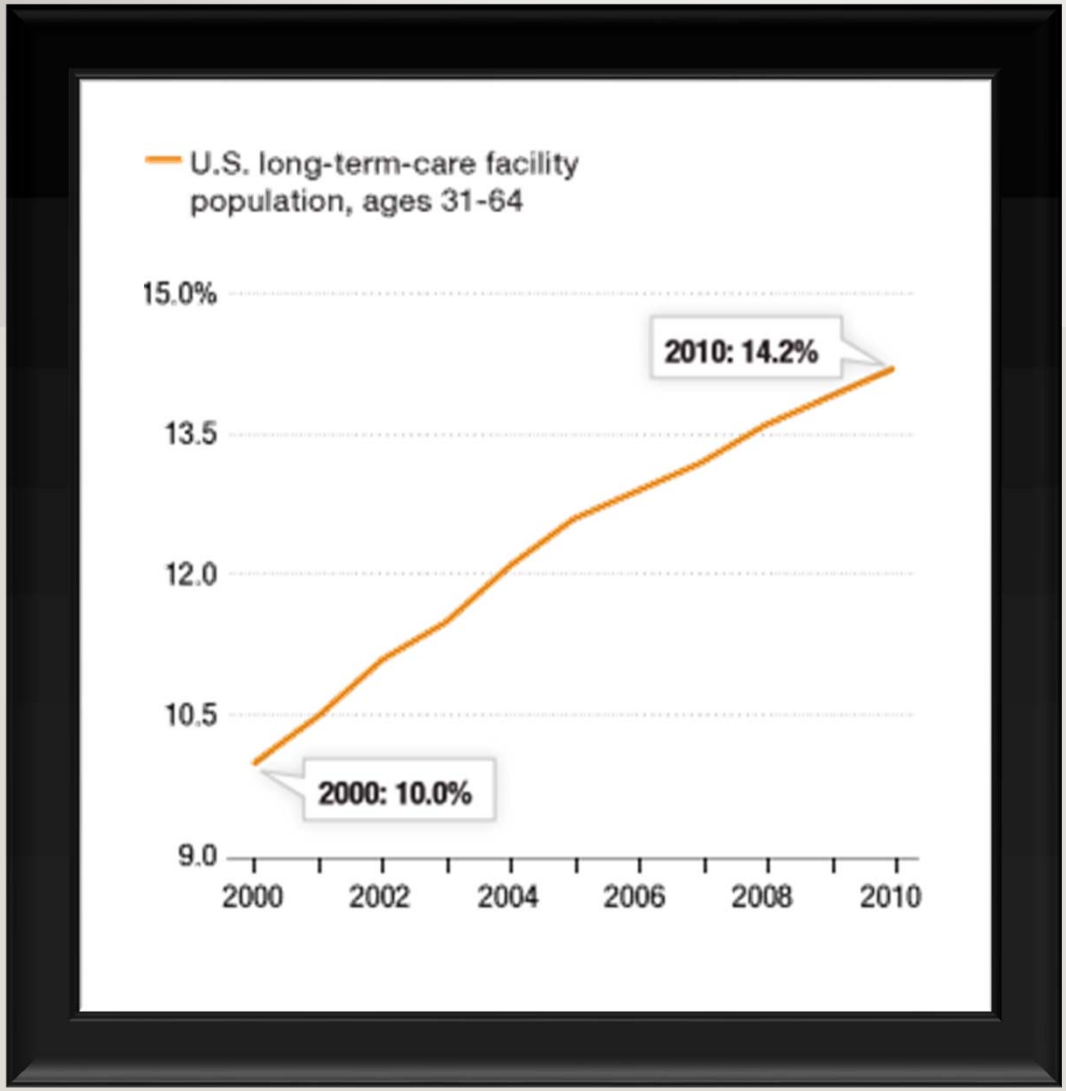
MEETING THEIR PSYCHO-SOCIAL NEEDS

OBJECTIVES FOR THIS COURSE

- Participant will be able to identify who is the Young Adult
- Understand the challenges of managing both young and older adults in a nursing homes
- Develop a working knowledge of Maslow's hierarchy of Need & behavior management
- Learn strategies to address the psycho social needs of the young adult

WHO IS THE YOUNG ADULT

- Residents who are 18 – 55
- Their conditions range from motor vehicle accident to drug overdose, gun shot wounds, alcoholism, AIDS, homelessness, and mental health issues.
- those born with disabilities of a chronic nature with compromising functional disabilities requiring major assistance, i.e. multiple sclerosis, cerebral palsy, etc.
- persons having undergone surgical procedures who require short term therapy before returning home, i.e. hip/knee replacements, cardiac events, etc.



SOURCE: U.S. CENTERS FOR MEDICARE AND MEDICAID SERVICES
CREDIT: ROBERT BENINCASA AND STEPHANIE D'OTREPPE/NPR

WHY A NURSING HOME

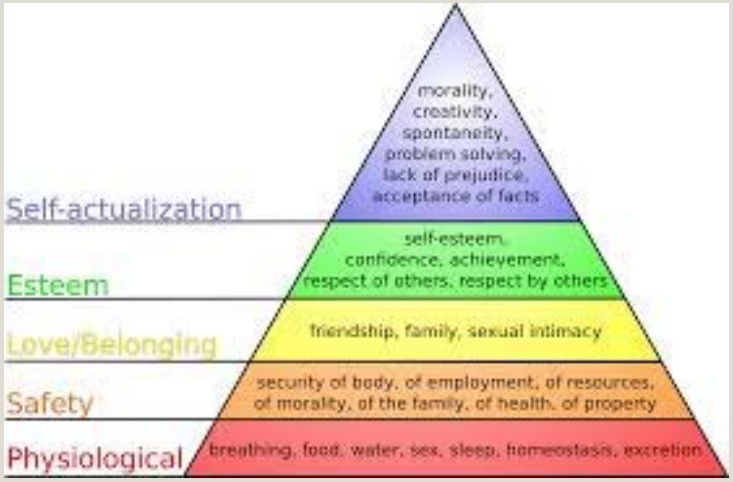
- Funding
- Reimbursement
- Public Policy

PSYCHO SOCIAL CHALLENGES

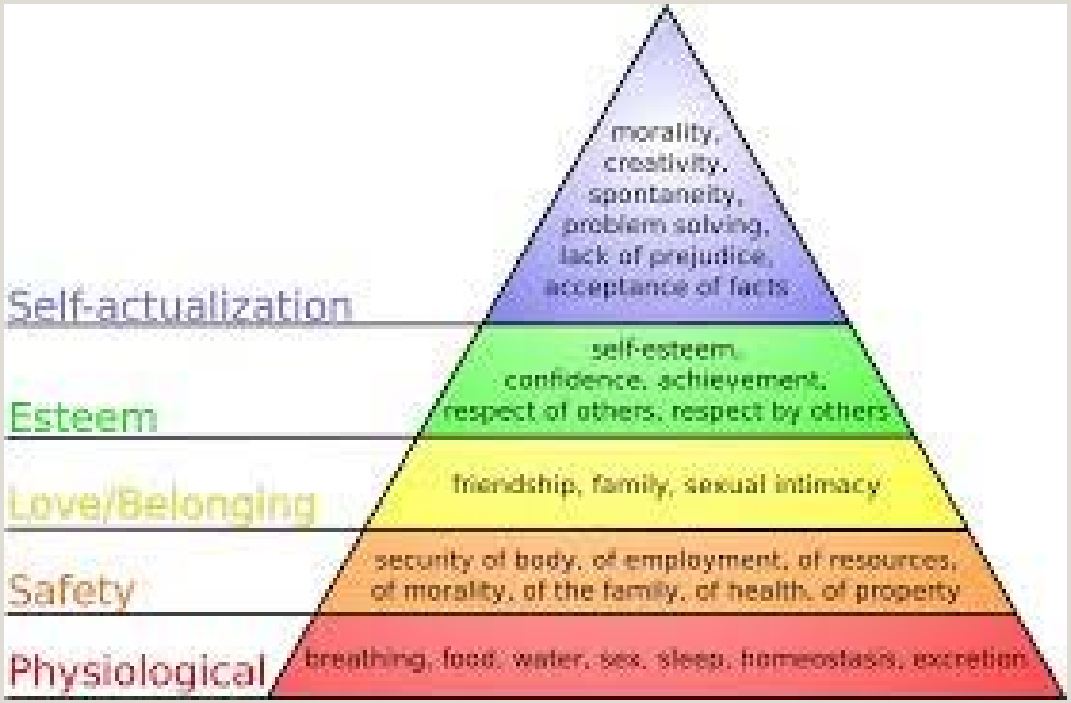
- Young Adults playing a active role in the development of their plan of care
- Individualized Activity Programming that meet the needs of a diverse population
- Loss of self , independence, and lack of coping skills

MASLOW'S HIERARCHY OF NEED

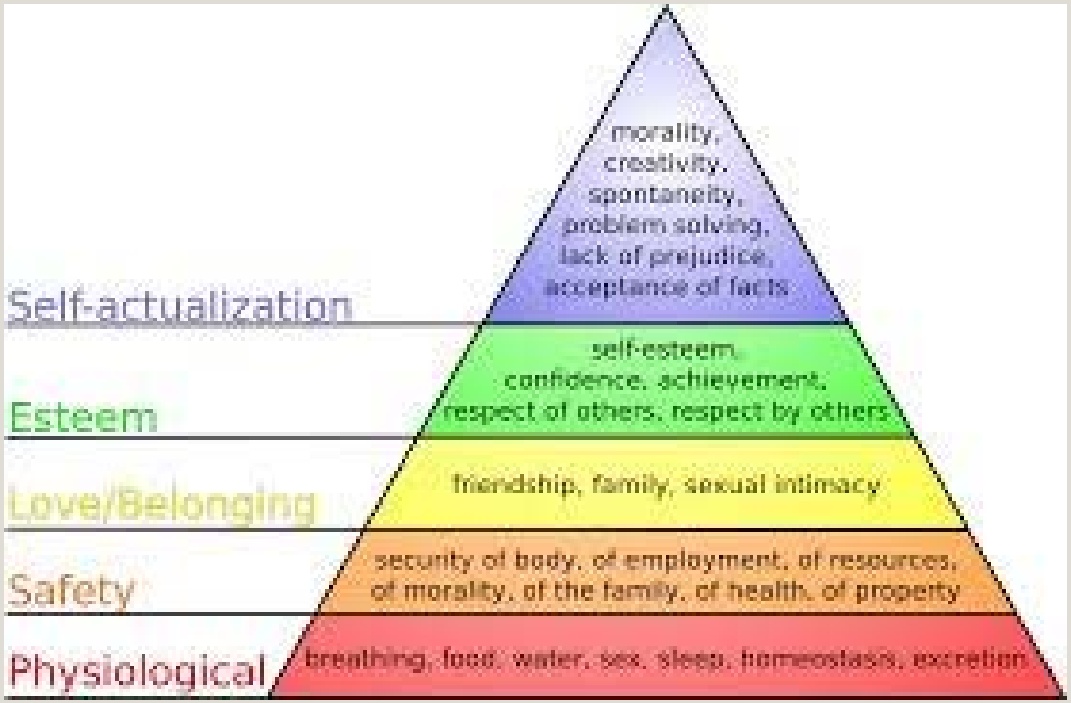
- Support Groups for the Young Adult provided in the Nursing Home



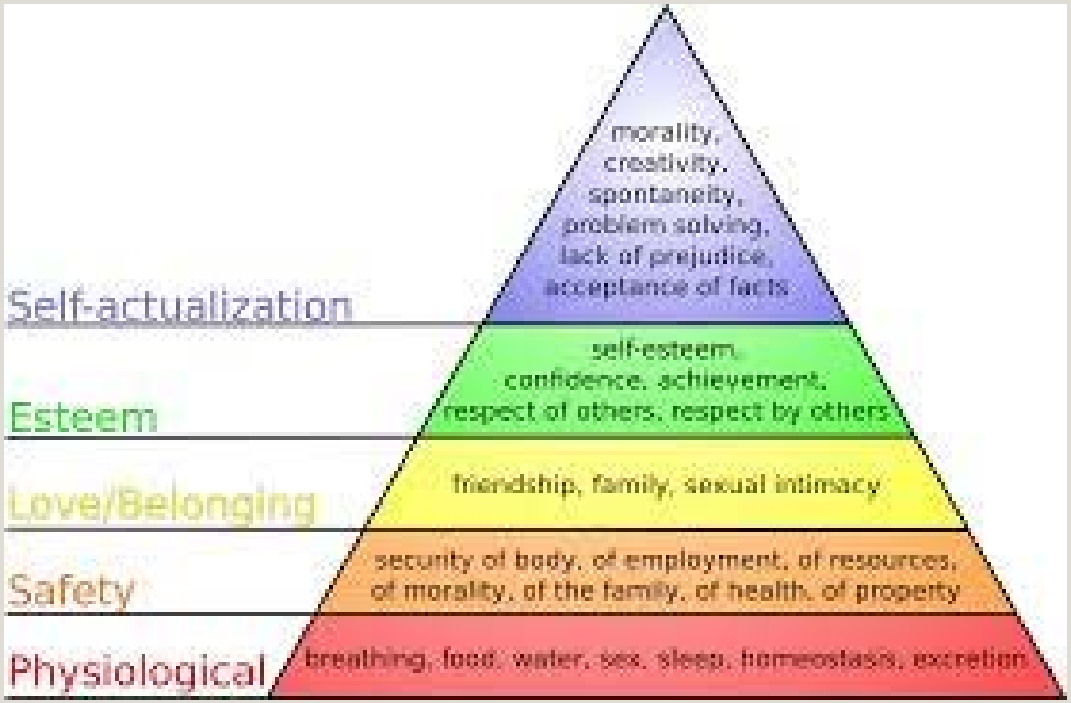
TIER ONE
MEETING PHYSIOLOGICAL NEEDS



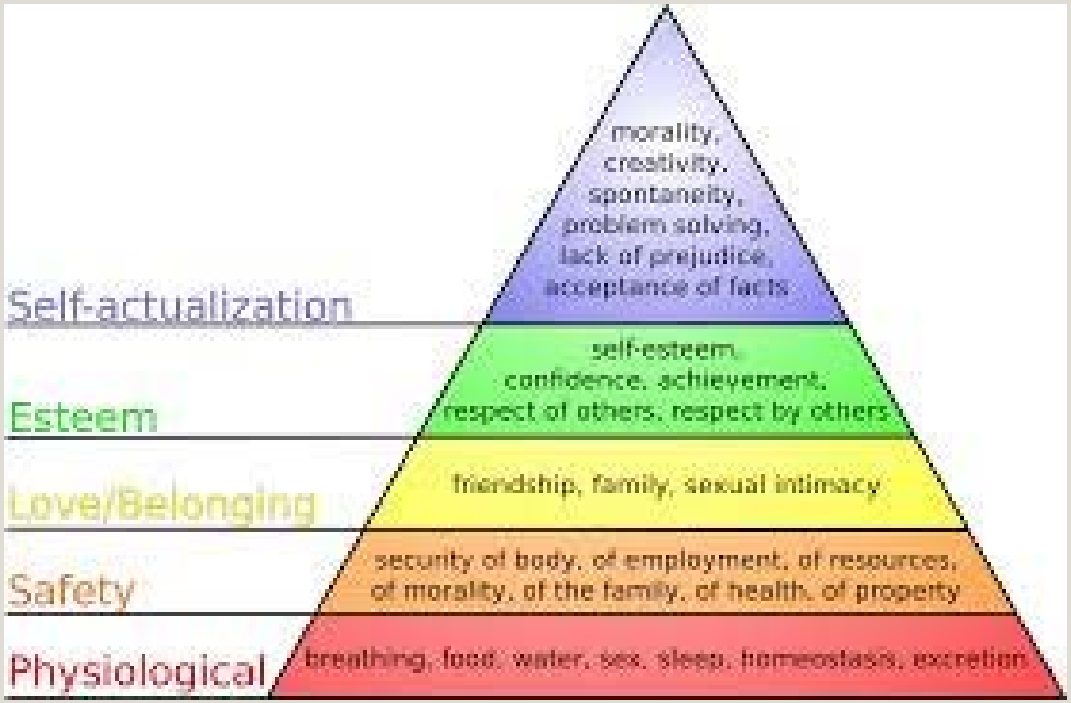
TIER TWO
STABILITY, SAFETY AND SECURITY, FREEDOM FROM FEAR



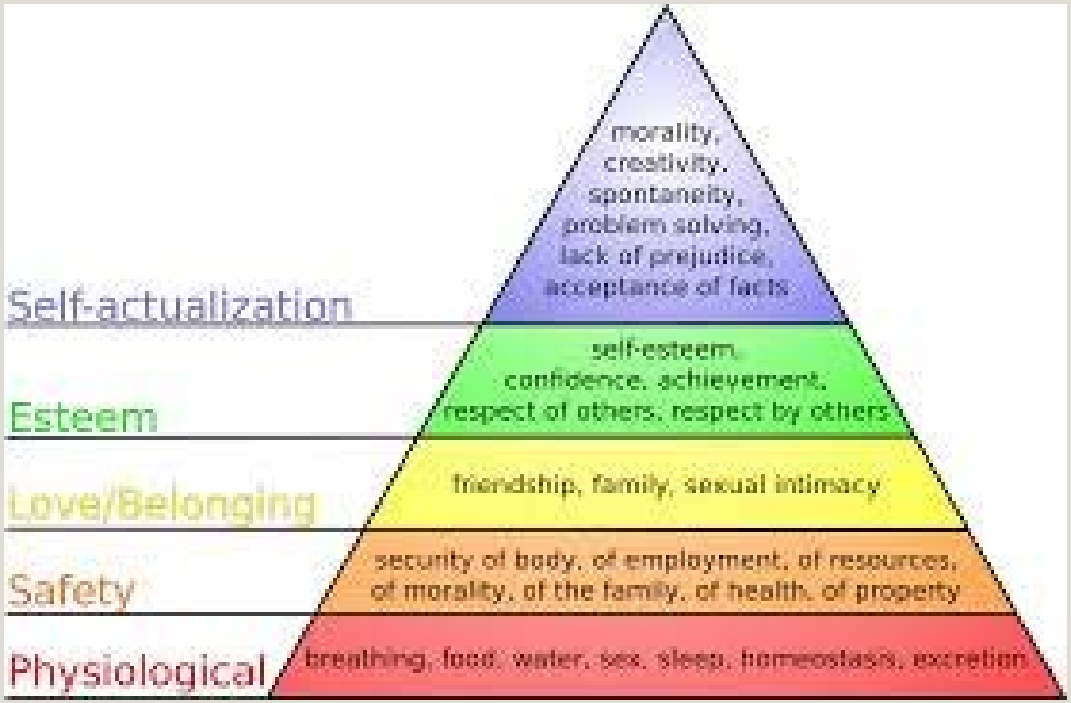
TIER THREE
BELONGING AND LOVE



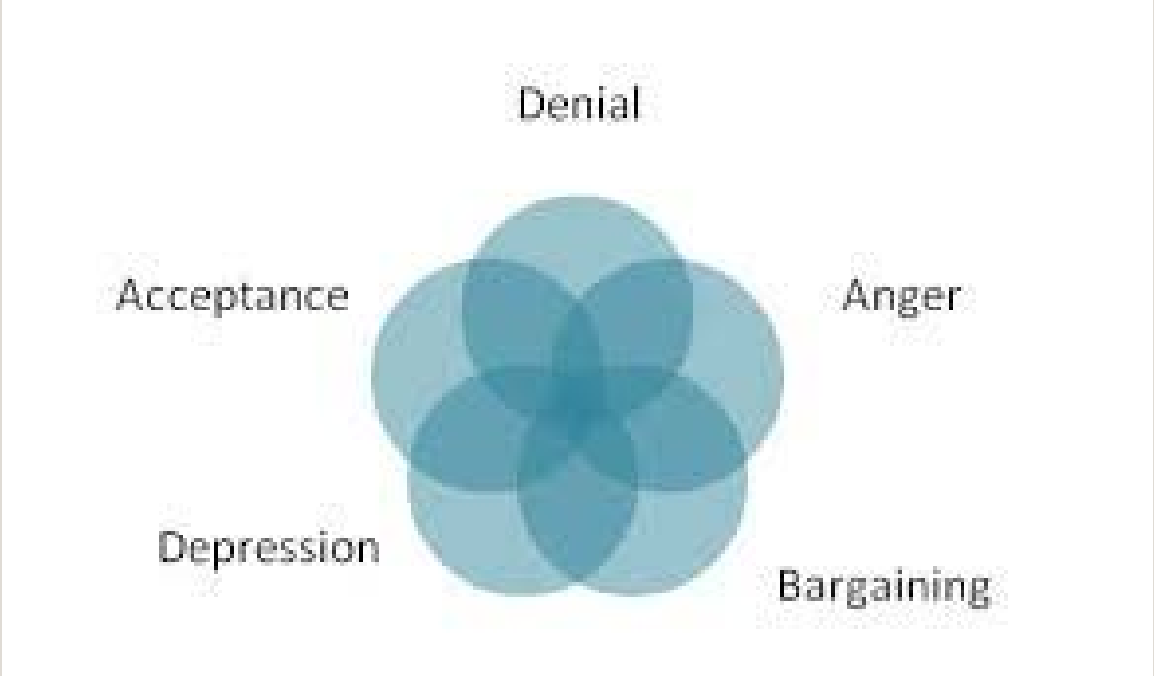
TIER FOUR
ACHIEVEMENT, RECOGNITION AND RESPECT OF MASTERY, SELF-ESTEEM



TIER FIVE
SELF-ACTUALIZATION AND SELF-FULFILLMENT NEEDS



HELPING THE YOUNG ADULT DEAL WITH LOSS



COMMUNICATING FOR SUCCESS WITH THE YOUNG ADULT

- Behaviors are nothing more than a means to communicate when they can not use their words
- The 5 P's of Behavior Management

ENGAGING ACTIVITIES

- **Engaging Activities – Preparation and adjustment are key**

- **Reduce Noise and Visual Distractions**
- **Increase Environmental Cues**

OTHER CONSIDERATIONS

- Caregiver and Family Strain
- Discrimination
- Attitude Barriers
- Socialization
- Relationships
- Employment
- Physical Barriers

COPING WITH DISABILITIES

- Allow the patient time to come to terms with the disability
- Nurture them
- Help them find out what makes them feel better
- Concentrate on the present
- Eliminate stress
- Focus on improvement with small goals

RECOGNIZING DEPRESSION

Depression is a mood disorder

It is a disturbance in thinking and behavior.

It can be painful and psychophysiological debilitating

MORE THAN JUST SADNESS

Affects how one feels about the future and alters basic attitudes about of self.

A feeling of Hopelessness

RECOGNIZING SIGNS AND SYMPTOMS OF DEPRESSION

- Change in previous function
- Inability to experience pleasure
- Negative
- Significant weight loss
- No interest in anything
- Insomnia
- Loss of energy or fatigue
- Decreased concentration
- Indecisiveness
- Feelings of worthlessness
- Poor concentration

INTERVENTIONS

- Encourage verbalization of feelings
- Validate feelings
- Provide support
- Encourage participation in self care
- Encourage activities and socialization
- Monitor safety and thoughts of suicide
- Provide resources
- Suggest support groups

EXHIBIT 14

MedStar Good Samaritan Hospital

5601 Loch Raven Boulevard
Baltimore, MD 21239
443-444-8000 PHONE
410-323-1794 TTY
443-444-4100 FIND-A-DOC
goodsam-md.org

May 19, 2017

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Re: Certificate of Need Application for FutureCare Homewood

Dear Mr. Steffen

We are writing this letter in further support of FutureCare Homewood's CON application. As you know, Brad Chambers, our hospitals' president, sent a letter of strong support of this project referencing our close partnership and care alignment with FutureCare and the Homewood Center in particular. In that letter he referenced the growing volume and importance of the orthopedic and cardiac programs in Baltimore city. Local MedStar hospitals are integrated directly with the VitalStrong programs at FutureCare, including providing physician oversight of both the Cardiac and Pulmonary programs at FutureCare Homewood. There is also close care coordination with the orthopedic groups at MedStar Good Samaritan and Union Memorial hospitals and the leadership of our medical program focusing upon geriatric orthopaedic patients. While patients retain ultimate choice, our enthusiasm for FutureCare Homewood derives from our confidence in the outcomes and care coordination.

With the closure of our transitional care unit (TCU), the patients previously served at the TCU have been disbursed to a variety of skilled nursing centers including FutureCare Homewood, FutureCare at Good Samaritan, other FutureCare facilities and other non-FutureCare skilled nursing facilities. In terms of volume, over the past 5 years the TCU has averaged about 45 admissions a month. We believe that increased capacity at Homewood will increase hospitals' ability to discharge residents at the earliest appropriate opportunity, which will contribute to a lower hospital length of stay and lower overall cost of care in the system.

The patients served at MedStar Good Samaritan Hospital are referred to the most appropriate setting for their particular needs, such as the inpatient acute rehab unit, skilled nursing centers (including in the past the TCU unit), home or assisted living locations. The TCU population tended to be comprised of rehabilitation patients with more comorbidities than patients that were served at many skilled nursing centers. Due to the ability of FutureCare Homewood to handle a very clinically complex

patient population, referrals to this center of patients who would previously have been cared for at our TCU are appropriate. In addition, for a variety of reasons such as infection control and continuity from the hospital environment, the ideal care setting for many of these patients is a private room.

Many members of our discharge planning teams and clinical specialty groups have toured and work closely with FutureCare Homewood, and we anticipate that this relationship will continue to grow for the reasons previously mentioned, including programmatic growth and FutureCare Homewood's ability to keep pace with the care requirements of a clinically complex population.

We appreciate the opportunity to respond to your questions and express our continuing support for this application. If we can provide any further information please let us know. Thank you.

Sincerely,

Martin Binstock, MD
Vice President Medical Affairs
MedStar Good Samaritan Hospital

Stuart Bell, MD
Vice President Medical Affairs
MedStar Union Memorial Hospital

EXHIBIT 15

TABLE F. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. The table should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the utilization projections in Table D reflecting changes in volume and with the costs of the Workforce identified in Table H. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projected revenue and expenses specifying all assumptions used. Applicants must explain why the assumptions are reasonable. Revenue should be projected based on actual charges with calculations detailed in the attachment and Contractual Allowance should not be included if it is a positive adjustment to gross revenue. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**			
1. REVENUE										
a. Inpatient Services	21,203,993	21,541,035	22,148,468	22,148,468	22,148,468	22,456,008	23,617,571			
b. Outpatient Services										
Gross Patient Service Revenues	***$ 21,203,993***	***$ 21,541,035***	***$ 22,148,468***	***$ 22,148,468***	***$ 22,148,468***	***$ 22,456,008***	***$ 23,617,571***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 244,025	$ 331,725	$ 377,081	$ 377,081	$ 377,081	$ 382,309	$ 402,055			
d. Contractual Allowance										
e. Charity Care										
Net Patient Services Revenue	***$ 20,959,968***	***$ 21,209,310***	***$ 21,771,387***	***$ 21,771,387***	***$ 21,771,387***	***$ 22,073,699***	***$ 23,215,516***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 32,484	$ 30,683	$ 56,089	$ 56,089	$ 56,089	$ 55,170	$ 51,099			
NET OPERATING REVENUE	***$ 20,992,452***	***$ 21,239,992***	***$ 21,827,476***	***$ 21,827,476***	***$ 21,827,476***	***$ 22,128,869***	***$ 23,266,615***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 9,873,882	$ 10,242,322	$ 10,670,441	$ 10,670,441	$ 10,670,441	$ 10,972,595	$ 11,746,642			
b. Contractual Services	$ 2,116,025	$ 2,258,780	$ 2,205,416	$ 2,205,416	$ 2,205,416	$ 2,363,571	$ 2,960,846			
c. Interest on Curr Debt-Working Capital	$ 463	$ 16,829	$ 20,299	$ 20,299	$ 20,299	$ 20,299	$ 20,299			
d. Interest on Project Debt-incl in rent	$ -	$ -	$ -	$ -	$ -	$ -	$ -			
e. Current Depreciation	$ 189,364	$ 254,742	$ 352,800	$ 352,800	$ 352,800	$ 352,800	$ 352,800			
f. Project Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -			
g. Current Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -			
h. Project Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -			
i. Supplies	$ 1,003,776	$ 950,412	$ 921,316	$ 921,316	$ 921,316	$ 923,814	$ 930,931			
j. Other Expenses (Specify/add rows if needed)	$ -	$ -	$ -	$ -	$ -	$ -	$ -			
Pharmacy	$ 683,785	$ 718,634	$ 765,084	$ 765,084	$ 765,084	$ 824,040	$ 1,076,973			
Management Fee	$ 1,644,000	$ 1,894,000	$ 1,932,000	$ 1,932,000	$ 1,932,000	$ 1,932,000	$ 1,932,000			
Other Administration	$ 245,486	$ 280,606	$ 257,465	$ 257,465	$ 257,465	$ 258,250	$ 256,411			
Food	$ 365,374	$ 371,680	$ 357,904	$ 357,904	$ 357,904	$ 357,681	$ 355,273			
Utilities	$ 10,631	$ 325	$ 993	$ 993	$ 993	$ 992	$ 986			
Taxes/Property/ Insurance	$ 1,025,728	$ 1,087,292	$ 1,123,659	$ 1,123,659	$ 1,123,659	$ 1,102,496	$ 968,534			
Rental of Facility	$ 1,040,000	$ 1,187,217	$ 1,212,000	$ 1,267,128	$ 1,440,288	$ 1,572,444	$ 1,779,600			
Equipment rental/Repairs & Maint	$ 190,788	$ 379,281	$ 378,118	$ 378,118	$ 378,118	$ 379,858	$ 386,286			
Transportation Services	$ 135,634	$ 148,456	$ 124,538	$ 124,538	$ 124,538	$ 127,888	$ 141,806			
TOTAL OPERATING EXPENSES	**$ 18,524,936**	**$ 19,790,576**	**$ 20,322,034**	**$ 20,377,162**	**$ 20,550,322**	**$ 21,188,728**	**$ 22,909,386**	**$ -**	**$ -**	**$ -**
3. INCOME										
a. Income From Operation	**$ 2,467,516**	**$ 1,449,417**	**$ 1,505,442**	**$ 1,450,314**	**$ 1,277,154**	**$ 940,141**	**$ 357,229**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income										
SUBTOTAL	***$ 2,467,516***	***$ 1,449,417***	***$ 1,505,442***	***$ 1,450,314***	***$ 1,277,154***	***$ 940,141***	***$ 357,229***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 2,467,516***	***$ 1,449,417***	***$ 1,505,442***	***$ 1,450,314***	***$ 1,277,154***	***$ 940,141***	***$ 357,229***	***$ -***	***$ -***	***$ -***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	26.4%	30.3%	32.1%	32.1%	32.1%	34.5%	43.5%			
2) Medicaid	64.2%	61.1%	60.9%	60.9%	60.9%	58.2%	47.9%			
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
4) Commercial Insurance	6.6%	6.2%	5.2%	5.2%	5.2%	5.5%	6.9%			
5) Self-pay	1.7%	1.1%	0.5%	0.5%	0.5%	0.5%	0.5%			
6) Other	1.1%	1.3%	1.3%	1.3%	1.3%	1.2%	1.2%			
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Inpatient Days										
1) Medicare	19.3%	21.8%	23.5%	23.5%	23.5%	25.8%	35.6%			
2) Medicaid	71.4%	68.8%	69.1%	69.1%	69.1%	66.4%	54.8%			
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
4) Commercial Insurance	6.2%	6.3%	5.1%	5.1%	5.1%	5.5%	7.4%			
5) Self-pay	1.9%	1.4%	0.7%	0.7%	0.7%	0.7%	0.7%			
6) Other	1.3%	1.6%	1.5%	1.5%	1.5%	1.5%	1.5%			
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***

EXHIBIT 16

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.

Signature

5/22/17

Date

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.

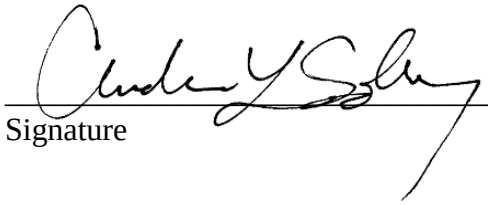
Leslie D. Goldsmith

Signature

5/19/17

Date

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.



Signature

5/23/17

Date