TABLE OF ATTACHMENTS
(Revised March 15, 2019)

ATTACHMENT 15

Craig P. Tanio, M.D.
CHAIR

STATE OF MARYLAND

Ben Steffen
EXECUTIVE DIRECTOR

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

October 2, 2015

Walter C. Smith
Director, State Regulatory Affairs
HealthSouth Corporation
3660 Grandview Parkway, Suite 200
Birmingham, Alabama 35243

Re: Request for Determination of Coverage
HealthSouth Chesapeake Rehabilitation Hospital
220 Tilghman Road, Salisbury, Maryland

Dear Mr. Smith:

I write in response to your letter of June 26, 2015 seeking a determination whether a Certificate of Need (CON) is required for Rehabilitation Hospital Corporation of America, LLC d/b/a HealthSouth Chesapeake Rehabilitation Hospital, a special rehabilitation hospital located at 220 Tilghman Road, Salisbury (Wicomico County), Maryland to: (1) increase its bed capacity by five beds, from 54 to 59; and (2) make a capital expenditure of approximately $3 million for renovation and construction of patient care areas. You have stated that the project will be funded out of cash reserves and will not result in increased patient charges.

The request to add five beds is made in accordance with COMAR 10.24.01.03E(2)(a)(i), which allows a special rehabilitation hospital to increase its bed complement by ten beds or 40% (whichever is less) of the current bed capacity without a CON as long as it has been at least two years since its last change in licensed bed capacity. Maryland Health Care Commission (MHCC) records indicate that HealthSouth Chesapeake Rehabilitation Hospital has not increased its bed capacity in at least two years, and thus would be able to increase by five beds without CON review.

You state that the capital expenditure of approximately $3 million will cover: the addition of 6,729 square feet of new construction to provide space for the addition of a total of 14 new private patient rooms (resulting from the addition of the five beds and the conversion of nine semi-private rooms to private rooms); and the renovation of 1,962 square feet of existing space which will create additional therapy gym space to accommodate the increase in patients.

This projected cost is well below the current capital threshold of $11.75 million and, under COMAR 10.24.01.02A(5), does not require a CON on that basis. For these reasons, Commission staff determines that certificate of need review is not required for the

Sincerely,

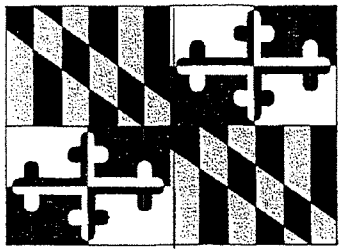
Ben Steffen
Executive Director

cc: Patricia Nay, M.D., Office of Health Care Quality
Lori Brewster, Wicomico County Health Department
Donna Kinzer, HSCRC

ATTACHMENT 16

MHCC

Maryland Health Care Commission



Certificate of Need (CON)

Monthly Status Report

May 1, 2018 through June 30, 2018

Ben Steffen
Executive Director

Robert E. Moffit, Ph.D.
Chair

MHCC Certificate of Need (CON) - Monthly Status Report

May 1, 2018 through June 30, 2018

Determination of CON Coverage (pursuant to COMAR 10.24.01.14B)

Exemption Type Waiver Beds

Project Applicant	*Project Description*	*Determination*	*Project Costs*	*Date of Determination*	*Reason For Determination*
Charlotte Hall Veterans Home St. Mary's Co.	Addition of 40 comprehensive care facility beds to the facility	Not Reviewable		6/15/2018	Not subject to CON Review Health General Article 19-114(d)(2)
Adventist Rehabilitation Hospital Montgomery Co.	Request to increase license capacity of the facility by 10 inpatient rehabilitation beds for a total of 97 inpatient rehabilitation beds	Not Reviewable		5/23/2018	Not subject to CON Review, COMAR 10.24.01.03E(2)(a)
HealthSouth Chesapeake Rehabilitation Hospital Wicomico Co.	Request to increase licensed capacity of the facility by 5 comprehensive inpatient rehabilitation beds for a total of 64 inpatient rehabilitation beds	Not Reviewable		5/25/2018	Not subject to CON Review, COMAR 10.24.01.03E(2)(a)

ATTACHMENT 17

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT (Augmented)

INSTRUCTIONS: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.

Before the Project							After Project Completion						
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/2018	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity				Licensed Beds: At Project Completion
			Room Count			Bed Count			Room Count			Bed Count	
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity	
ACUTE CARE							ACUTE CARE						
General Medical/ Surgical*					0	0	General Medical/ Surgical*				0	0	
					0	0					0	0	
SUBTOTAL Gen. Med/Surg*							SUBTOTAL Gen. Med/Surg*						
ICU/CCU					0	0	ICU/CCU				0	0	
Other *(Specify/add rows as needed)*					0	0					0	0	
TOTAL MSGA							TOTAL MSGA						
Obstetrics					0	0	Obstetrics				0	0	
Pediatrics					0	0	Pediatrics				0	0	
Psychiatric					0	0	Psychiatric				0	0	
TOTAL ACUTE		0	0	0	0	0	TOTAL ACUTE		0	0	0	0	
NON-ACUTE CARE							NON-ACUTE CARE						
Dedicated Observation**					0	0	Dedicated Observation**				0	0	
Rehabilitation					0	0	Rehabilitation				0	0	
Nursing Unit #1	First Floor	50	0	26	26	52	Nursing Unit #1	First Floor	0	26	26	52	46
Nursing Unit #2	First Floor	14	14	0	14	14	Nursing Unit #2	First Floor	14	0	14	14	14
							Nursing Unit #3	First Floor	14	0	14	14	14
Comprehensive Care					0	0	Comprehensive Care				0	0	
Other *(Specify/add rows as needed)*					0	0	Other *(Specify/add rows as needed)*				0	0	
TOTAL NON-ACUTE		64	14	26	40	66	TOTAL NON-ACUTE		28	26	54	80	74
HOSPITAL TOTAL		64	14	26	40	66	HOSPITAL TOTAL		28	26	54	80	74

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

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

ATTACHMENT 18

Financial assistance policy - Plain Language Summary

Encompass Health Rehabilitation Hospital of Salisbury
220 Tilghman Road
Salisbury, MD 21804
410.546.4600
encompasshealth.com/salisburyrehab

Our hospital provides free or discounted emergency and other medically necessary care to patients who are uninsured or underinsured and who qualify for assistance under its Financial Assistance Policy. Assistance does not apply to elective services or items that are solely for the comfort or convenience of a patient. This document is only a summary. Please refer to the Financial Assistance Policy for complete details.

Eligibility Requirements and Assistance Offered Under the Financial Assistance Policy

Patients who qualify for assistance are eligible for income/asset-based, sliding scale discounts for emergency and other medically necessary care. In general:

- Patients whose family income is equal to or less than 200% of the Federal Poverty Guidelines are generally eligible for free emergency and medically necessary care.
- Patients whose family income is between 200% and 400% of the Federal Poverty Guidelines are generally eligible for a sliding scale discount ranging from 50% to 75% for emergency and other medically necessary care.

A patient who qualifies for assistance under the Financial Assistance Policy will not be charged more for emergency or medically necessary care than amounts generally billed to patients having insurance covering such care.

How to Obtain Copies of the Financial Assistance Policy and Financial Assistance Application

Copies of the Financial Assistance Policy, this plain language summary, and the Financial Assistance Application and associated instructions are available free of charge upon request by writing to the address above. Copies can also be found in the admitting/registration areas of the hospital. These documents may be found online at the website provided above. Translations of these documents to Spanish are available upon request from our hospital and also may be found online at website address above.

How to Apply for Assistance Under the Financial Assistance Policy

To apply for a financial assistance probable determination, please submit an Initial Financial Assistance Application to the address above. Upon receipt of a completed Initial Financial Assistance Application, the hospital will make a probable financial assistance eligibility determination within two business days. If the hospital determines that financial assistance eligibility is probable and the patient wishes to pursue this option, a complete Financial Assistance Application must be submitted to the address above and will be reviewed in order to make a final determination on eligibility for financial assistance.

Further information about the Financial Assistance Policy and assistance with the application process are available from the hospital controller via phone number listed above or in person at the address above.

ATTACHMENT 19

Financial assistance policy

Encompass Health Rehabilitation Hospital of Salisbury
220 Tilghman Road
Salisbury, MD, 21804
410.546.4600
encompasshealth.com/salisburyrehab

Purpose

This policy outlines the circumstances under which the hospital will provide free or discounted emergency or other medically necessary care to eligible patients who are unable to pay for their care, as determined by the hospital in accordance with the eligibility criteria and other terms specified in this policy. Patients are expected to cooperate with the hospital's procedures for obtaining Financial Assistance, securing insurance or other forms of payment, and contributing to the cost of their care based on their ability to pay.

This policy applies to emergency or medically necessary care provided by the hospital. This policy does not apply to care delivered by physicians or other healthcare providers who bill "privately" (separate from the hospital). (See Attachment A for additional information about physicians and other healthcare providers providing care within the hospital.)

This policy does not apply to care that is not emergency or medically necessary care, including elective services or items that are solely for the comfort or convenience of a patient.

Financial Assistance does not apply to amounts that are covered by insurance, governmental programs or other funding sources (which may include, but are not limited to, workers' compensation, automobile or other liability insurance, crime victims' compensation funds, and litigation recoveries). To be eligible for Financial Assistance, a patient is expected to apply for and comply with all processes related to seeking assistance from other insurers and/or third-party sources of payment (including all applicable governmental programs) as requested by hospital staff. Patients who are noncompliant or uncooperative in attempting to obtain insurance coverage, qualification under governmental programs, or payment from third-party sources will not be eligible for Financial Assistance.

A patient will be ineligible for Financial Assistance if the patient, or his or her representative, provides false information or falsified documentation of household size, income, assets, or other pertinent information.

Definitions

Covered Services – emergency or medically necessary care provided by the hospital. Covered Services do not include services that are not emergency or medically necessary care, or care that is provided by physicians or other healthcare providers who bill "privately."

Emergency or medically necessary care – services that are necessary and appropriate to sustain life or to prevent serious deterioration in the health of the patient from injury or disease. Medically necessary will be determined by the treating physician.

Family – includes spouse/domestic partner, children, and any other persons treated as "dependents" for federal income tax purposes.

Financial Assistance – reduction of an eligible patient's account balance for Covered Services under the terms of this policy.

Patient – the individual receiving medical treatment and/or, in the case of an unemancipated minor or other dependent, the parent, legal guardian or other person (guarantor) who is financially responsible for the patient.

Uninsured – a patient who does not have health insurance coverage, is unable to obtain affordable coverage, and is ineligible for government healthcare programs or other third-party payment sources.

Underinsured – a patient who is not uninsured, but whose out-of-pocket medical expenses exceed his or her financial ability to pay.

Policy

Subject to the terms of this policy, Financial Assistance is provided to eligible patients who are uninsured or underinsured.

Eligibility for Financial Assistance, and the amount of Financial Assistance that will be provided, are based on an individualized assessment by the hospital of a patient's financial need, generally determined by measuring the patient's gross family income against the Federal Poverty Guidelines as specified in the Financial Assistance Discount Guidelines in Attachment B, provided that the patient does not have other financial resources that could be used to pay for his or her care. The Financial Assistance Discount Guidelines are adjusted annually to reflect changes in the Federal Poverty Guidelines.

Patients are presumed to be eligible for financial assistance, without completing an application, in the following circumstances:

1. Homelessness
2. Deceased with no estate
3. Mental incapacitation with no one to act on patient's behalf
4. Recent Medicaid coverage, i.e. coverage within three (3) months of admission or discharge.

Presumptive financial assistance will be the most generous assistance available under the Financial Assistance Policy.

A patient determined to be eligible for Financial Assistance will not be billed more than the amount generally billed for emergency or other medically necessary care by hospital to individuals who have insurance covering such care. (See Attachment B for additional information about the "amount generally billed" limitation.)

If a patient is underinsured and is determined to be eligible for Financial Assistance, discounts will only apply to the balance due from the patient after insurance payments and other third-party payment sources have been applied to the account.

For purposes of this policy, "income" includes, but is not limited to, revenue from the following sources (before taxes):

- Wages
- Tips
- Payments from Social Security
- Retirement benefit payments
- Unemployment compensation
- Worker's compensation
- Veterans' benefits
- Public assistance
- Alimony
- Child support
- Pensions
- Regular insurance or annuity payments
- Investment income

For purposes of this policy, "other financial resources" includes, but is not limited to the following:

- Savings
- Checking account
- Medical savings account, healthcare savings account and/or flexible spending account
- Trust fund
- Retirement accounts
- Investment assets
- Other liquid assets
- Equity value of real estate, other than the patient's primary residence
- Benefits from charity organizations
- Pending litigation

To apply for a financial assistance probable determination, a complete Initial Financial Assistance Application is required. Upon receipt of a completed Initial Financial Assistance Application, a determination of probable financial assistance eligibility will be made within two business days.

To apply for Financial Assistance, a complete Financial Assistance Application is required. A complete Financial Assistance Application is inclusive of, but not limited to, disclosure of household size, employment information, income, assets and other financial resources, outstanding financial obligations, and supporting documents (such as recent tax returns, bank statements and pay stubs), as detailed in the Financial Assistance Application and the associated instructions. If documentation proving household income is not available, patients may call the hospital finance department at the phone number listed above to discuss other evidence demonstrating eligibility. Undocumented residents (non-U.S. citizens living as residents in the U.S.) and patients who are without a home address may apply for Financial Assistance. Failure to provide the required information and documentation in a timely manner may result in ineligibility for Financial Assistance.

Complete Financial Assistance Applications should be submitted to the hospital at the address listed above. A hospital finance representative will review the application for completeness. Financial Assistance determinations must be approved by the Facility Controller, and in certain circumstances, by the hospital CEO. The hospital will notify patients in writing of the decision on their eligibility under this policy.

Copies of this policy, a plain language summary of this policy, the Financial Assistance Application, and the associated instructions are available free of charge upon request by writing to the address above. These documents can be found in the admitting/registration areas of the hospital and may also be downloaded at hospital's website.

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Once a patient has been discharged and the patient's balance due has been determined, the Billing Office will mail the patient monthly account statements and make phone calls in an attempt to collect the outstanding balance. If no payment has been received for 120 days, the account may be sent to a third-party collection agency.

The hospital, and any third parties acting on its behalf, do not engage in extraordinary collection actions such as lawsuits, liens, foreclosures, wage garnishment or reporting adverse information to credit agencies.

For additional information, please see the Billing and Collections Policy, which may be downloaded from hospital website. Copies are also available upon request, free of charge, by mail and in admitting/registration areas of the Hospital.

Nondiscrimination & emergency medical care

Hospital does not have a dedicated emergency department. The hospital will appraise emergencies, provide initial treatment, and refer or transfer an individual to another hospital/facility, when appropriate, without discrimination and without regard to whether the individual is eligible for Financial Assistance.

Hospital will not engage in actions that discourage individuals from seeking emergency medical care, such as demanding that an individual pay before receiving initial treatment for emergency medical conditions or permitting debt collection activities that interfere with hospital's appraisal and provision, without discrimination, of such initial treatment.

ATTACHMENT 20

Financial assistance policy - Plain Language Summary

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220 Taghman Road
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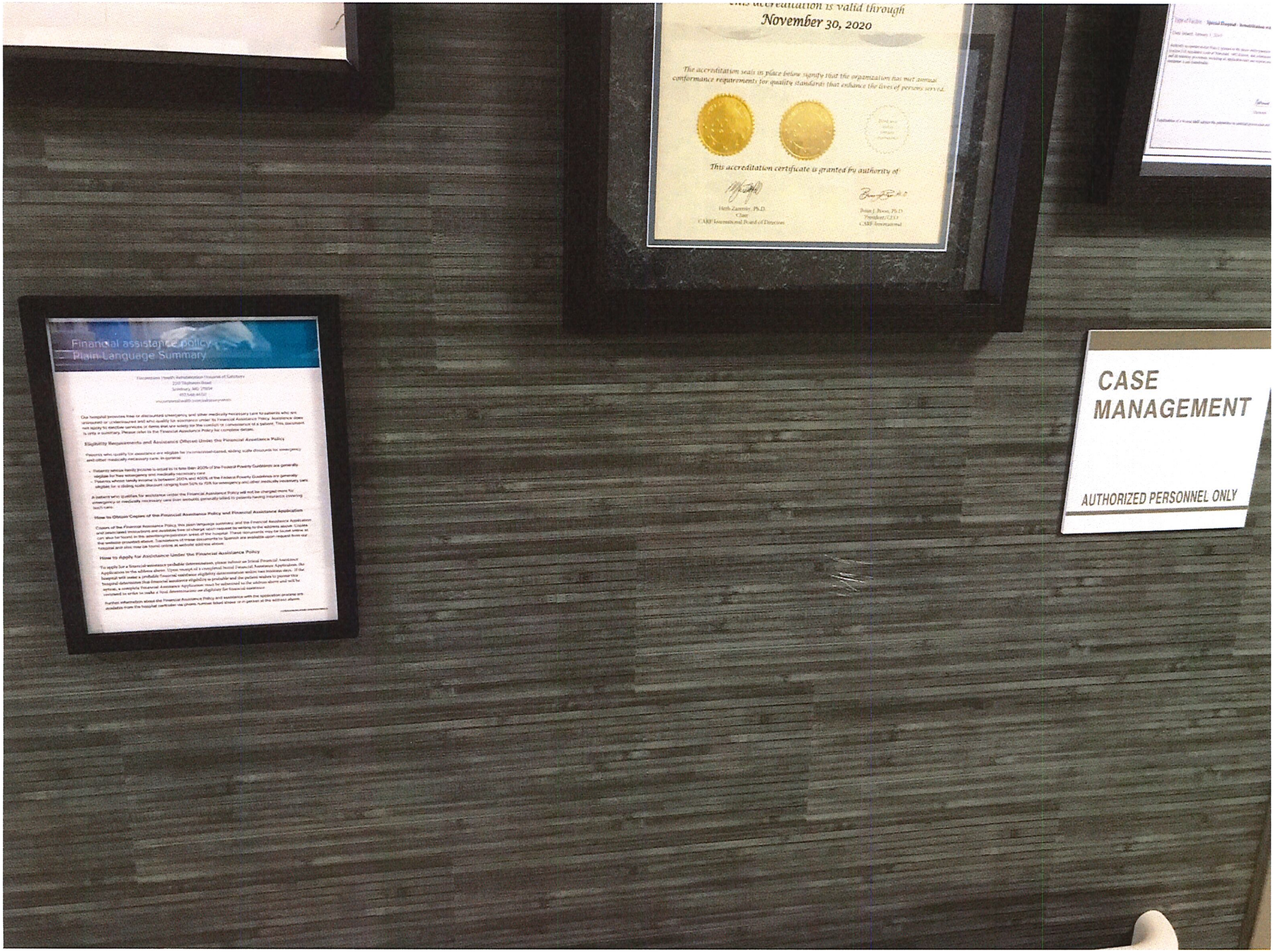
November 30, 2020
This accreditation certificate is granted fru authority of:
Financial assistance policy
Plain Language Summary
CASE
MANAGEMENT
AUTHORIZED PERSONNEL ONLY

ATTACHMENT 21

Financial assistance policy

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Salisbury, MD, 21804
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Once a patient has been discharged and the patient's balance due has been determined, the Billing Office will mail the patient monthly account statements and make phone calls in an attempt to collect the outstanding balance. If no payment has been received for 120 days, the account may be sent to a third-party collection agency.

The hospital, and any third parties acting on its behalf, do not engage in extraordinary collection actions such as lawsuits, liens, foreclosures, wage garnishment or reporting adverse information to credit agencies.

For additional information, please see the Billing and Collections Policy, which may be downloaded from hospital website. Copies are also available upon request, free of charge, by mail and in admitting/registration areas of the Hospital.

Nondiscrimination & emergency medical care

Hospital does not have a dedicated emergency department. The hospital will appraise emergencies, provide initial treatment, and refer or transfer an individual to another hospital/facility, when appropriate, without discrimination and without regard to whether the individual is eligible for Financial Assistance.

Hospital will not engage in actions that discourage individuals from seeking emergency medical care, such as demanding that an individual pay before receiving initial treatment for emergency medical conditions or permitting debt collection activities that interfere with hospital's appraisal and provision, without discrimination, of such initial treatment.

ATTACHMENT 22

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

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

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

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

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

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

Applicant Response: HSCRH is proposing to renovate its existing freestanding rehabilitation hospital to increase its inpatient bed capacity and provide a higher level of flexibility to accommodate the growing need and demand for its services.

This expansion Project is not the first for HSCRH in recent years to accommodate the growing number of patients requiring treatment. In 2015, the Hospital requested a determination from the MHCC whether a proposed expansion project to add five licensed beds and make capital expenditures for renovations and construction of patient care areas required CON review. The MHCC determined that both the addition of five licensed beds, and the proposed capital expenditure of $3 Million for 6,729 square feet of new construction to: 1) provide space for 14 new private patients rooms, and 2) the renovation of 1,962 square feet of existing space to accommodate for additional therapy gym space, did not require CON review. (See Attachment 15).

Subsequently, on May 25, 2018, the MHCC determined that a 5-bed increase in the licensed capacity of HSCRH for a total of 64 inpatient rehabilitation beds was not subject to CON review. (See Attachment 16).

ATTACHMENT 23

Public Health
Prevent. Promote. Protect
Wicomico County Health Department

Wicomico County Health Department

108 East Main Street • Salisbury, Maryland 21801

Lori Brewster, MS, APRN/BC, LCADC • Health Officer

February 19, 2019

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

RE: Support for Encompass Health Rehabilitation Hospital of Salisbury, MD
CON For Ten Bed Expansion

Dear Mr. McDonald:

The Wicomico County Health Department supports Encompass Health Rehabilitation Hospital's of Salisbury, MD Certificate of Need (CON) application to add ten (10) beds to its acute inpatient rehabilitation hospital in Salisbury Maryland. There is a need and desire to add these beds in Wicomico County.

Approving this CON application will provide needed services within our geographic area. On behalf of the Wicomico County Health Department, I encourage you to approve the granting of a Certificate of Need to add ten (10) beds to Encompass Health of Salisbury. The additional ten (10) beds would provide much needed services to Wicomico residents and the surrounding communities.

If I can be of further assistance, please contact me at (410) 543-6930.

Sincerely,

Lori Brewster, MS, APRN/BC, LCADC
Health Officer
Wicomico County Health Department

UNIVERSITY of MARYLAND
EASTERN SHORE

SCHOOL of PHARMACY & HEALTH PROFESSIONS

Department of Physical Therapy

February 21, 2019

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

RE: Support for Encompass Health Rehabilitation Hospital of Salisbury, MD – CON For Ten Bed Expansion

Dear Mr. McDonald:

The Department of Physical Therapy at the University of Maryland Eastern Shore supports Encompass Health Rehabilitation Hospital's (of Salisbury, MD) Certificate of Need (CON) application to add ten (10) beds to its acute inpatient rehabilitation hospital in Salisbury Maryland. There is a need and desire to add these beds in Wicomico County.

Approving this CON application will provide needed services within our geographic area. The Department of Physical Therapy at the University of Maryland Eastern shore encourages you to approve the granting of a Certificate of Need to add ten (10) beds to Encompass Health of Salisbury. The additional ten (10) beds would provide much needed services to Wicomico residents and the surrounding communities.

Sincerely,

Michael C. Rabel, ***PT, MPT, D.Sc., OCS, CEAS***
Associate Professor & Chair
University of Maryland Eastern Shore
Department of Physical Therapy, Hazel Hall, 2nd floor
Princes Anne, MD 21853

ATTACHMENT 24

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.

	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	CY2016	CY2017	CY2018	CY2019	CY2020	CY2021	CY2022	CY2023		
1. DISCHARGES										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	0	0	0	0	0	0	0	0	0	0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
f. Rehabilitation	1,467	1,542	1,605	1,634	1,667	1,780	1,812	1,845		
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL DISCHARGES	*1,467*	*1,542*	*1,605*	*1,634*	*1,667*	*1,780*	*1,812*	*1,845*	*0*	*0*
2. PATIENT DAYS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	0	0	0	0	0	0	0	0	0	0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
f. Rehabilitation	19,784	20,430	21,144	21,659	22,010	23,499	23,919	24,349		
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	*19,784*	*20,430*	*21,144*	*21,659*	*22,010*	*23,499*	*23,919*	*24,349*	*0*	*0*

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.

	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	**CY2016**	**CY2017**	**CY2018**	**CY2019**	**CY2020**	**CY2021**	**CY2022**	**CY2023**		
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA										
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute										
f. Rehabilitation	13.5	13.2	13.2	13.2	13.2	13.2	13.2	13.2		
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL AVERAGE LENGTH OF STAY	13.5	13.2	13.2	13.3	13.2	13.2	13.2	13.2		
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	0	0	0	0	0	0	0	0	0	0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
f. Rehabilitation	59	59	64	64	64	74	74	74		
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL LICENSED BEDS	*59*	*59*	*64*	*64*	*64*	*74*	*74*	*74*	*0*	*0*

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.

	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	**CY2016**	**CY2017**	**CY2018**	**CY2019**	**CY2020**	**CY2021**	**CY2022**	**CY2023**		
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA										
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute										
f. Rehabilitation	91.9%	94.9%	90.5%	92.7%	94.2%	87.0%	88.6%	90.1%	#DIV/0!	#DIV/0!
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL OCCUPANCY %	**91.9%**	**94.9%**	**90.5%**	**92.7%**	**94.2%**	**87.0%**	**88.6%**	**90.1%**	**#DIV/0!**	**#DIV/0!**
6. OUTPATIENT VISITS										
a. Emergency Department										
b. Same-day Surgery										
c. Laboratory										
d. Imaging										
e. Other (Specify/add rows of needed)	10,245	10,054	5,121	1,821	1,821	1,821	1,821	1,821		
TOTAL OUTPATIENT VISITS	***10,245***	***10,054***	***5,121***	***1,821***	***1,821***	***1,821***	***1,821***	***1,821***	***0***	***0***
7. OBSERVATIONS**										
a. Number of Patients										
b. Hours										

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

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

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect c projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the rep an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the ass

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years in order to docu
Indicate CY or FY	**CY2016**	**CY2017**	**CY2018**	**CY2019**
1. REVENUE				
a. Inpatient Services	$ 38,853,785	$ 40,847,989	$ 44,291,192	$ 46,120,118
b. Outpatient Services	$ 2,466,229	$ 2,551,512	$ 1,328,047	$ 450,407
Gross Patient Service Revenues	***$ 41,320,014***	***$ 43,399,501***	***$ 45,619,239***	***$ 46,570,525***
c. Allowance For Bad Debt	$ 396,256	$ 886,829	$ 545,242	$ 477,628
d. Contractual Allowance	$ 14,230,707	$ 13,786,948	$ 14,229,281	$ 14,287,468
e. Charity Care	$ 750	$ 1,266	$ 10,000	$ 441,747
Net Patient Services Revenue	***$ 26,692,301***	***$ 28,724,458***	***$ 30,834,716***	***$ 31,363,682***
f. Other Operating Revenues (Specify/add rows if needed)	$ 43,871	$ 85,427	$ 90,958	$ 90,958
NET OPERATING REVENUE	***$ 26,736,172***	***$ 28,809,885***	***$ 30,925,674***	***$ 31,454,640***
2. EXPENSES				
a. Salaries & Wages (including benefits)	$ 12,362,127	$ 13,307,345	$ 14,080,292	$ 14,397,061
b. Contractual Services	$ 865,684	$ 790,813	$ 770,516	$ 796,047
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation	$ 265,446	$ 211,662	$ 343,090	$ 348,175
f. Project Depreciation				
g. Current Amortization	***$ 126,974***	***$ 126,298***	***$ -***	***$ -***
h. Project Amortization				
i. Supplies	$ 1,073,534	$ 1,121,863	$ 1,237,960	$ 1,114,466
j. Other Expenses (Specify/add rows if needed)				
k. Minor Equip/Leases/Svc Contracts/Rep.&Maint	$ 395,151	$ 431,485	$ 433,256	$ 413,944
l. Legal and Professional Fees	$ 1,614	$ 333	$ 11,140	$ 11,363
m. Director's Fees	$ 102,970	$ 107,624	$ 109,424	$ 127,368
n. Phone and Utilities	$ 387,369	$ 428,923	$ 388,122	$ 382,767
o. Other Variable Costs	$ 794,080	$ 1,040,758	$ 1,005,631	$ 1,082,624
p. Building Rent	$ 1,018,350	$ 1,338,087	$ 1,397,935	$ 1,397,935
q. Other Fixed Costs	$ 327,761	$ 369,126	$ 446,125	$ 445,786
r. Management Fees	$ 1,339,225	$ 1,436,058	$ 1,547,511	$ 1,569,805
TOTAL OPERATING EXPENSES	**$ 19,060,285**	**$ 20,710,375**	**$ 21,771,002**	**$ 22,087,341**
3. INCOME				
a. Income From Operation	**$ 7,675,887**	**$ 8,099,510**	**$ 9,154,672**	**$ 9,367,299**
b. Non-Operating Income (Net Interest)	$ (2,233)	$ (2,684)	$ 2,547	$ 2,547
SUBTOTAL	***$ 7,673,654***	***$ 8,096,826***	***$ 9,157,219***	***$ 9,369,846***
c. Income Taxes	$ 2,927,413	$ 3,148,088	$ 3,860,931	$ 3,936,272
NET INCOME (LOSS)	***$ 4,746,241***	***$ 4,948,738***	***$ 5,296,288***	***$ 5,433,574***
4. PATIENT MIX				
a. Percent of Total Revenue				
1) Medicare	82.7%	87.5%	87.5%	87.5%
2) Medicaid	1.7%	2.0%	2.0%	2.0%
3) Blue Cross	5.8%	5.8%	5.8%	5.8%

4) Commercial Insurance	5.4%	2.3%	2.3%	2.3%
5) Self-pay	0.0%	0.0%	0.0%	0.0%
6) Other	4.4%	2.4%	2.4%	2.4%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days				
1) Medicare	81.8%	85.7%	85.7%	85.7%
2) Medicaid	2.4%	2.7%	2.7%	2.7%
3) Blue Cross	6.6%	7.2%	7.2%	7.2%
4) Commercial Insurance	5.3%	2.3%	2.3%	2.3%
5) Self-pay	0.0%	0.0%	0.0%	0.0%
6) Other	4.0%	2.1%	2.1%	2.1%
TOTAL	***100.1%***	***100.0%***	***100.0%***	***100.0%***

current dollars (no inflation). Projected revenues and expenses should be consistent with the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide assumptions are reasonable. Specify the sources of non-operating income.

(ending at least two years after project completion and full occupancy) Add columns if needed ument that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.

CY2020	CY2021	CY2022	CY2023		
$ 47,051,553	$ 50,241,010	$ 51,144,219	$ 52,075,654		
$ 454,911	$ 459,490	$ 459,490	$ 459,490		
$ 47,506,464	***$ 50,700,500***	***$ 51,603,709***	***$ 52,535,144***	***$ -***	***$ -***
$ 492,208	$ 527,312	$ 536,738	$ 546,459		
$ 14,573,407	$ 15,546,372	$ 15,821,165	$ 16,104,545		
$ 455,127	$ 479,895	$ 486,035	$ 496,716		
$ 31,985,722	***$ 34,146,921***	***$ 34,759,771***	***$ 35,387,424***	***$ -***	***$ -***
$ 90,958	$ 90,958	$ 90,958	$ 90,958		
$ 32,076,680	***$ 34,237,879***	***$ 34,850,729***	***$ 35,478,382***	***$ -***	***$ -***
$ 14,798,217	$ 15,570,815	$ 15,719,392	$ 16,090,833		
$ 820,347	$ 878,853	$ 894,564	$ 910,765		
$ 403,398	$ 409,449	$ 415,590	$ 421,824		
$ -	***$ -***				
$ 1,148,486	$ 1,230,375	$ 1,252,389	$ 1,275,071		
$ 426,581	$ 457,004	$ 465,173	$ 473,598		
$ 10,000	$ 10,000	$ 10,000	$ 10,000		
$ 131,256	$ 140,617	$ 143,130	$ 145,722		
$ 393,767	$ 421,850	$ 429,391	$ 437,167		
$ 1,115,672	$ 1,195,240	$ 1,216,607	$ 1,238,640		
$ 1,431,485	$ 1,465,841	$ 1,501,190	$ 1,537,045		
$ 459,394	$ 492,158	$ 500,956	$ 510,028		
$ 1,617,725	$ 1,722,552	$ 1,753,345	$ 1,785,099		
$ 22,756,328	**$ 23,994,754**	**$ 24,301,727**	**$ 24,835,792**	**$ -**	**$ -**
$ 9,320,352	**$ 10,243,125**	**$ 10,549,002**	**$ 10,642,590**	**$ -**	**$ -**
$ 2,547	$ 2,547	$ 2,547	$ 2,547		
$ 9,322,899	***$ 10,245,672***	***$ 10,551,549***	***$ 10,645,137***	***$ -***	***$ -***
$ 3,916,550	$ 4,304,207	$ 4,432,706	$ 4,472,022		
$ 5,406,349	***$ 5,941,465***	***$ 6,118,843***	***$ 6,173,115***	***$ -***	***$ -***
87.5%	87.5%	87.5%	87.5%		
2.0%	2.0%	2.0%	2.0%		
5.8%	5.8%	5.8%	5.8%		

2.3%	2.3%	2.3%	2.3%		
0.0%	0.0%	0.0%	0.0%		
2.4%	2.4%	2.4%	2.4%		
100.0%	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***

85.7%	85.7%	85.7%	85.7%		
2.7%	2.7%	2.7%	2.7%		
7.2%	7.2%	7.2%	7.2%		
2.3%	2.3%	2.3%	2.3%		
0.0%	0.0%	0.0%	0.0%		
2.1%	2.1%	2.1%	2.1%		
100.0%	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect in
Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the appl
Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Ye needed in orde
Indicate CY or FY	**CY2016**	**CY2017**	**CY2018**	**CY2019**
1. REVENUE				
a. Inpatient Services	$ 38,853,785	$ 40,847,989	$ 44,291,192	$ 45,486,020
b. Outpatient Services	$ 2,466,229	$ 2,551,512	$ 1,328,047	$ 450,407
Gross Patient Service Revenues	***$ 41,320,014***	***$ 43,399,501***	***$ 45,619,239***	***$ 45,936,427***
c. Allowance For Bad Debt	$ 396,256	$ 886,829	$ 545,242	$ 541,312
d. Contractual Allowance	$ 14,230,707	$ 13,786,948	$ 14,229,281	$ 14,094,549
e. Charity Care	$ 750	$ 1,266	$ 10,000	$ 440,287
Net Patient Services Revenue	***$ 26,692,301***	***$ 28,724,458***	***$ 30,834,716***	***$ 30,860,279***
f. Other Operating Revenues (Specify/add rows if needed)	$ 43,871	$ 85,427	$ 90,958	$ 92,786
NET OPERATING REVENUE	***$ 26,736,172***	***$ 28,809,885***	***$ 30,925,674***	***$ 30,953,065***
2. EXPENSES				
a. Salaries & Wages (including benefits)	$ 12,362,127	$ 13,307,345	$ 14,080,292	$ 14,228,047
b. Contractual Services	$ 865,684	$ 790,813	$ 770,516	$ 804,776
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation	$ 265,446	$ 211,662	$ 343,090	$ 348,175
f. Project Depreciation				
g. Current Amortization	***$ 126,974***	***$ 126,298***	***$ -***	***$ -***
h. Project Amortization				
i. Supplies	$ 1,073,534	$ 1,121,863	$ 1,237,960	$ 1,195,003
j. Other Expenses (Specify/add rows if needed)				
k. Minor Equip/Leases/Svc Contracts/Rep.&Maint	$ 395,151	$ 431,485	$ 433,256	$ 416,960
l. Legal and Professional Fees	$ 1,614	$ 333	$ 11,140	$ 11,363
m. Director's Fees	$ 102,970	$ 107,624	$ 109,424	$ 111,623
n. Phone and Utilities	$ 387,369	$ 428,923	$ 388,122	$ 395,919
o. Other Variable Costs	$ 794,080	$ 1,040,758	$ 1,005,631	$ 1,074,342
p. Building Rent	$ 1,018,350	$ 1,338,087	$ 1,397,935	$ 1,397,935
q. Other Fixed Costs	$ 327,761	$ 369,126	$ 446,125	$ 460,385
r. Management Fees	$ 1,339,225	$ 1,436,058	$ 1,547,511	$ 1,569,805
TOTAL OPERATING EXPENSES	***$ 19,060,285***	***$ 20,710,375***	***$ 21,771,002***	***$ 22,014,333***
3. INCOME				
a. Income From Operation	***$ 7,675,887***	***$ 8,099,510***	***$ 9,154,672***	***$ 8,938,732***
b. Non-Operating Income (Net Interest)	$ (2,233)	$ (2,684)	$ 2,547	$ 2,547
SUBTOTAL	***$ 7,673,654***	***$ 8,096,826***	***$ 9,157,219***	***$ 8,941,279***
c. Income Taxes	$ 3,244,209	$ 3,148,088	$ 3,847,796	$ 3,973,061
NET INCOME (LOSS)	***$ 4,429,445***	***$ 4,948,738***	***$ 5,309,423***	***$ 4,968,218***
4. PATIENT MIX				
a. Percent of Total Revenue				
1) Medicare	82.7%	87.5%	87.5%	87.5%
2) Medicaid	1.7%	2.0%	2.0%	2.0%
3) Blue Cross	5.8%	5.8%	5.8%	5.8%
4) Commercial Insurance	5.4%	2.3%	2.3%	2.3%
5) Self-pay	0.0%	0.0%	0.0%	0.0%
6) Other	4.4%	2.4%	2.4%	2.4%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days				

Total MSGA				
1) Medicare	81.8%	85.7%	85.7%	85.7%
2) Medicaid	2.4%	2.7%	2.7%	2.7%
3) Blue Cross	6.6%	7.2%	7.2%	7.2%
4) Commercial Insurance	5.3%	2.3%	2.3%	2.3%
5) Self-pay	0.0%	0.0%	0.0%	0.0%
6) Other	4.0%	2.1%	2.1%	2.1%
TOTAL	***100.1%***	***100.0%***	***100.0%***	***100.0%***

flation. Projected revenues and expenses should be consistent with the projections in Table F.
ication, provide an explanation or basis for the projections and specify all assumptions used.

ears (ending at least two years after project completion and full occupancy) Add columns if r to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.

CY2020	CY2021	CY2022	CY2023		
$ 46,880,278	$ 50,546,214	$ 51,970,606	$ 53,435,137		
$ 454,911	$ 459,490	$ 459,490	$ 459,490		
$ 47,335,189	***$ 51,005,704***	***$ 52,430,096***	***$ 53,894,627***	***$ -***	***$ -***
$ 492,208	$ 530,497	$ 545,362	$ 560,647		
$ 14,521,298	$ 15,639,210	$ 16,072,568	$ 16,518,139		
$ 469,666	$ 517,762	$ 531,796	$ 551,417		
$ 31,852,017	***$ 34,318,235***	***$ 35,280,370***	***$ 36,264,424***	***$ -***	***$ -***
$ 93,714	$ 92,786	$ 93,714	$ 94,651		
$ 31,945,731	***$ 34,411,021***	***$ 35,374,084***	***$ 36,359,075***	***$ -***	***$ -***
$ 15,420,631	$ 17,563,868	$ 18,086,092	$ 18,883,726		
$ 823,286	$ 842,222	$ 861,593	$ 881,410		
$ 403,398	$ 409,449	$ 415,590	$ 421,824		
$ -	***$ -***	***$ -***	***$ -***		
$ 1,221,891	$ 1,249,383	$ 1,277,494	$ 1,306,238		
$ 425,299	$ 433,805	$ 442,481	$ 451,331		
$ 10,000	$ 10,000	$ 10,000	$ 10,000		
$ 159,406	$ 159,400	$ 159,400	$ 159,400		
$ 403,838	$ 411,915	$ 411,915	$ 411,915		
$ 1,099,052	$ 1,124,330	$ 1,150,190	$ 1,176,644		
$ 1,431,485	$ 1,465,841	$ 1,501,190	$ 1,537,045		
$ 467,290	$ 474,300	$ 481,414	$ 488,636		
$ 1,617,725	$ 1,743,567	$ 1,792,425	$ 1,842,659		
$ 23,483,301	**$ 25,888,080**	**$ 26,589,784**	**$ 27,570,828**	**$ -**	**$ -**
$ 8,462,430	**$ 8,522,941**	**$ 8,784,300**	**$ 8,788,247**	**$ -**	**$ -**
$ 2,547	$ 2,547	$ 2,547	$ 2,547		
$ 8,464,977	***$ 8,525,488***	***$ 8,786,847***	***$ 8,790,794***	***$ -***	***$ -***
$ 3,753,493	$ 3,799,883	$ 3,915,653	$ 3,925,484		
$ 4,711,484	***$ 4,725,605***	***$ 4,871,194***	***$ 4,865,310***	***$ -***	***$ -***
87.5%	87.5%	87.5%	87.5%		
2.0%	2.0%	2.0%	2.0%		
5.8%	5.8%	5.8%	5.8%		
2.3%	2.3%	2.3%	2.3%		
0.0%	0.0%	0.0%	0.0%		
2.4%	2.4%	2.4%	2.4%		
100.0%	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***

85.7%	85.7%	85.7%	85.7%		
2.7%	2.7%	2.7%	2.7%		
7.2%	7.2%	7.2%	7.2%		
2.3%	2.3%	2.3%	2.3%		
0.0%	0.0%	0.0%	0.0%		
2.1%	2.1%	2.1%	2.1%		
100.0%	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**CY2020**	**CY2021**	**CY2022**	**CY2023**			
1. DISCHARGES							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	77	189	221	254			
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL DISCHARGES	***77***	***189***	***221***	***254***	***0***	***0***	***0***
2. PATIENT DAYS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	1,016	2,495	2,917	3,353			
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL PATIENT DAYS	***1,016***	***2,495***	***2,917***	***3,353***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute							
f. Rehabilitation	13.2	13.2	13.2	13.2			
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL AVERAGE LENGTH OF STAY	13.2	13.2	13.2	13.2			

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**CY2020**	**CY2021**	**CY2022**	**CY2023**			
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL LICENSED BEDS							
5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute							
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL OCCUPANCY %							
6. OUTPATIENT VISITS							
a. Emergency Department							
b. Same-day Surgery							
c. Laboratory							
d. Imaging							
e. Other (Specify/add rows of needed)							
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***
7. OBSERVATIONS**							
a. Number of Patients							
b. Hours							

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

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

Revised 3-15-2019

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY2020**	**CY2021**	**CY2022**	**CY2023**			
1. REVENUE							
a. Inpatient Services	$ 723,870	$ 6,789,326	$ 6,911,381	$ 7,037,251			
b. Outpatient Services	$ 6,999	$ 62,093	$ 62,093	$ 62,093			
Gross Patient Service Revenues	***$ 730,869***	***$ 6,851,419***	***$ 6,973,474***	***$ 7,099,344***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 7,572	$ 71,258	$ 72,532	$ 73,846			
d. Contractual Allowance	$ 224,206	$ 2,100,861	$ 2,137,995	$ 2,176,290			
e. Charity Care	$ 5,283	$ 48,891	$ 49,411	$ 50,536			
Net Patient Services Revenue	***$ 493,807***	***$ 4,630,408***	***$ 4,713,536***	***$ 4,798,672***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify)	$ 1,399	$ 12,292	$ 12,292	$ 12,292			
NET OPERATING REVENUE	***$ 495,206***	***$ 4,642,700***	***$ 4,725,827***	***$ 4,810,964***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 227,665	$ 2,104,164	$ 2,124,242	$ 2,174,437			
b. Contractual Services	$ 12,621	$ 118,764	$ 120,887	$ 123,076			
c. Interest on Current Debt		$ -	$ -	$ -			
d. Interest on Project Debt		$ -	$ -	$ -			
e. Current Depreciation	$ 6,206	$ 55,331	$ 56,161	$ 57,003			
f. Project Depreciation		$ -	$ -	$ -			
g. Current Amortization	$ -	$ -	$ -	$ -			
h. Project Amortization		$ -	$ -	$ -			
i. Supplies	$ 17,669	$ 166,267	$ 169,242	$ 172,307			
j. Other Expenses (Specify)		$ -	$ -	$ -			
k. Minor Equip/Leases/Svc Contracts/Rep.&Maint	$ 6,563	$ 61,757	$ 62,861	$ 64,000			
l. Legal and Professional Fees	$ 154	$ 1,351	$ 1,351	$ 1,351			
m. Director's Fees	$ 2,019	$ 19,002	$ 19,342	$ 19,692			
n. Phone and Utilities	$ 6,058	$ 57,007	$ 58,026	$ 59,077			
o. Other Variable Costs	$ 17,164	$ 161,519	$ 164,406	$ 167,384			
p. Building Rent	$ 22,023	$ 198,087	$ 202,864	$ 207,709			
q. Other Fixed Costs	$ 7,068	$ 66,508	$ 67,697	$ 68,923			
r. Management Fees	$ 24,888	$ 232,777	$ 236,939	$ 241,230			
TOTAL OPERATING EXPENSES	***$ 264,161***	***$ 2,444,526***	***$ 2,470,532***	***$ 2,526,823***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ 231,046**	**$ 2,198,174**	**$ 2,255,296**	**$ 2,284,140**	**$ -**	**$ -**	**$ -**

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY2020**	**CY2021**	**CY2022**	**CY2023**			
b. Non-Operating Income	$ 39	$ 344	$ 344	$ 344			
SUBTOTAL	***$ 231,085***	***$ 2,198,518***	***$ 2,255,640***	***$ 2,284,485***	***$ -***	***$ -***	***$ -***
c. Income Taxes	$ 60,255	$ 581,650	$ 599,014	$ 604,327			
NET INCOME (LOSS)	***$ 170,830***	***$ 1,616,869***	***$ 1,656,625***	***$ 1,680,157***	***$ -***	***$ -***	***$ -***

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY2020**	**CY2021**	**CY2022**	**CY2023**			
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	87.5%	87.5%	87.5%	87.5%			
2) Medicaid	2.0%	2.0%	2.0%	2.0%			
3) Blue Cross	5.8%	5.8%	5.8%	5.8%			
4) Commercial Insurance	2.3%	2.3%	2.3%	2.3%			
5) Self-pay	0.0%	0.0%	0.0%	0.0%			
6) Other	2.4%	2.4%	2.4%	2.4%			
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	85.7%	85.7%	85.7%	85.7%			
2) Medicaid	2.7%	2.7%	2.7%	2.7%			
3) Blue Cross	7.2%	7.2%	7.2%	7.2%			
4) Commercial Insurance	2.3%	2.3%	2.3%	2.3%			
5) Self-pay	0.0%	0.0%	0.0%	0.0%			
6) Other	2.1%	2.1%	2.1%	2.1%			
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***

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

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY2020**	**CY2021**	**CY2022**	**CY2023**			
1. REVENUE							
a. Inpatient Services	$ 721,235	$ 6,830,569	$ 7,023,055	$ 7,220,964			
b. Outpatient Services	$ 6,999	$ 62,093	$ 62,093	$ 62,093			
Gross Patient Service Revenues	***$ 728,234***	***$ 6,892,663***	***$ 7,085,148***	***$ 7,283,058***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 7,572	$ 71,689	$ 73,698	$ 75,763			
d. Contractual Allowance	$ 223,405	$ 2,113,407	$ 2,171,969	$ 2,232,181			
e. Charity Care	$ 5,498	$ 54,230	$ 55,786	$ 58,090			
Net Patient Services Revenue	***$ 491,759***	***$ 4,653,337***	***$ 4,783,696***	***$ 4,917,024***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)	$ 1,442	$ 12,539	$ 12,664	$ 12,791			
NET OPERATING REVENUE	***$ 493,200***	***$ 4,665,876***	***$ 4,796,360***	***$ 4,929,814***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 237,240	$ 2,373,496	$ 2,444,066	$ 2,551,855			
b. Contractual Services	$ 12,666	$ 113,814	$ 116,431	$ 119,109			
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation	$ 6,206	$ 55,331	$ 56,161	$ 57,003			
f. Project Depreciation							
g. Current Amortization	$ -	$ -	$ -	$ -			
h. Project Amortization							
i. Supplies	$ 18,798	$ 168,836	$ 172,634	$ 176,519			
j. Other Expenses (Specify/add rows of needed)							
k. Minor Equip/Leases/Svc Contracts/Rep.&Maint	$ 6,543	$ 58,622	$ 59,795	$ 60,991			
l. Legal and Professional Fees	$ 154	$ 1,351	$ 1,351	$ 1,351			
m. Director's Fees	$ 2,452	$ 21,541	$ 21,541	$ 21,541			
n. Phone and Utilities	$ 6,213	$ 55,664	$ 55,664	$ 55,664			
o. Other Variable Costs	$ 16,908	$ 151,936	$ 155,431	$ 159,006			
p. Building Rent	$ 22,023	$ 198,087	$ 202,864	$ 207,709			
q. Other Fixed Costs	$ 7,189	$ 64,095	$ 65,056	$ 66,032			
r. Management Fees	$ 24,888	$ 235,617	$ 242,220	$ 249,008			

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

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY2020**	**CY2021**	**CY2022**	**CY2023**			
TOTAL OPERATING EXPENSES	**$ 274,911**	**$ 2,711,476**	**$ 2,789,293**	**$ 2,904,486**	**$ -**	**$ -**	**$ -**
3. INCOME							
a. Income From Operation	**$ 218,290**	**$ 1,954,400**	**$ 2,007,067**	**$ 2,025,328**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income	$ 39	$ 344	$ 344	$ 344			
SUBTOTAL	***$ 218,329***	***$ 1,954,744***	***$ 2,007,411***	***$ 2,025,672***	***$ -***	***$ -***	***$ -***
c. Income Taxes	$ 57,746	$ 513,498	$ 529,142	$ 530,471			
NET INCOME (LOSS)	***$ 160,583***	***$ 1,441,246***	***$ 1,478,269***	***$ 1,495,201***	***$ -***	***$ -***	***$ -***

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

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY2020**	**CY2021**	**CY2022**	**CY2023**			
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	87.5%	87.5%	87.5%	87.5%			
2) Medicaid	2.0%	2.0%	2.0%	2.0%			
3) Blue Cross	5.8%	5.8%	5.8%	5.8%			
4) Commercial Insurance	2.3%	2.3%	2.3%	2.3%			
5) Self-pay	0.0%	0.0%	0.0%	0.0%			
6) Other	2.4%	2.4%	2.4%	2.4%			
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare	85.7%	85.7%	85.7%	85.7%			
2) Medicaid	2.7%	2.7%	2.7%	2.7%			
3) Blue Cross	7.2%	7.2%	7.2%	7.2%			
4) Commercial Insurance	2.3%	2.3%	2.3%	2.3%			
5) Self-pay	0.0%	0.0%	0.0%	0.0%			
6) Other	2.1%	2.1%	2.1%	2.1%			
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE L. WORKFORCE 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 F and G.

	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	
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 G, if submitted).*	**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, add rows if needed)*											
CEO	1.0		$0	0.0		$0			$0	1.0	$0
CNO	1.0		$0	0.0		$0			$0	1.0	$0
Controller	1.0		$0	0.0		$0			$0	1.0	$0
Dir Therapy	1.0		$0	0.0		$0			$0	1.0	$0
Dir HR	1.0		$0	0.0		$0			$0	1.0	$0
Dir Quality	1.0		$0	0.0		$0			$0	1.0	$0
Dir Pharmacy	1.0		$0	0.0		$0			$0	1.0	$0
Total Administration	7.0	$111,974	$783,821	0.0		$0			$0	7.0	$783,821
Direct Care Staff *(List general categories, add rows if needed)*											
Nursing	75.0	$60,835	$4,562,625	19.5	$60,835	$1,186,283			$0	94.5	$5,748,908
Nursing, Contract Labor	2.0	$91,628	$183,256	0.0	$91,628	$0			$0	2.0	$183,256
Therapy	34.3	$74,769	$2,564,577	5.1	$74,769	$381,322			$0	39.4	$2,945,899
Therapy Rehab Tech	6.1	$24,008	$146,449	0.0	$24,008	$0			$0	6.1	$146,449
Pharmacy	4.0	$109,589	$438,356	0.0	$109,589	$0			$0	4.0	$438,356
Care Management	5.8	$73,798	$428,028	1.0	$73,798	$73,798			$0	6.8	$501,826
Dietary	14.7	$36,403	$535,124	1.7	$36,403	$61,885			$0	16.4	$597,009
Total Direct Care	141.9	$62,395	$8,858,415	27.3		$1,703,288			$0	169.2	$10,561,703
Support Staff *(List general categories, add rows if needed)*											
Marketing	9.9	$80,337	$795,336	0.8	$80,337	$64,270			$0	10.7	$859,606
EVS/Maintenance/Supplies	13.5	$32,310	$436,187	0.5	$32,310	$16,155			$0	14.0	$452,342
Clerical	15.7	$40,668	$638,803	0.0	$40,668	$0			$0	15.7	$638,803
Total Support	39.1	$47,834	$1,870,326	1.3		$80,425			$0	40.4	$1,950,751
REGULAR EMPLOYEES TOTAL	***188.0***	***$61,212***	***$11,512,562***	***28.6***		***$1,783,712***			$0	216.6	$13,296,274
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below)* **:**											
CY2018 = 23.4% of Salaries; CY2											
TOTAL COST	***188.0***		***$11,512,562***	***28.6***		***$1,783,712***	***0.0***		***$0***		***$13,296,274***