BAKER DONELSON

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April 7, 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
Certificate of Need Application

Dear Mr. McDonald:

Enclosed please find six copies of a Certificate of Need Application being filed on behalf of FutureCare - Homewood Properties, LLC and Charles Street Health Care, LLC d/b/a FutureCare Homewood (collectively "Homewood") regarding a project to relocate 30 comprehensive care facility beds from MedStar Good Samaritan Hospital to renovated space at Homewood. A full copy of the application will also be emailed to you in searchable PDF and Word forms. One set of full size drawings is included with this filing.

I hereby certify that a copy of the CON application has been provided to the local health department, as required by regulations.

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

Sincerely,
BAKER, DONELSON, BEARMAN,
CALDWELL & BERKOWITZ, PC

Howard L. Sollins /TK
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

For internal staff use:

MARYLAND HEALTH CARE COMMISSION

_____

MATTER/DOCKET NO.

_____

DATE DOCKETED

COMPREHENSIVE CARE FACILITY (NURSING HOME) APPLICATION FOR CERTIFICATE OF NEED

ALL APPLICATIONS MUST FOLLOW THE FORMATTING REQUIREMENTS DESCRIBED IMMEDIATELY BELOW. NOT FOLLOWING THESE FORMATTING INSTRUCTIONS WILL RESULT IN THE APPLICATION BEING RETURNED.

Required Format:

Table of Contents. The application must include a Table of Contents referencing the location of application materials. Each section in the hard copy submission should be separated with tabbed dividers. Any exhibits, attachments, etc. should be similarly tabbed, and pages within each should be numbered independently and consecutively. **The Table of Contents must include:**

- **Responses to PARTS I, II, III, and IV of the COMPREHENSIVE CARE FACILITY (NURSING HOME) application form**

- **Responses to PART IV must include responses to the standards in the State Health Plan chapter, COMAR 10.24.08*, applicable to the type of nursing home project proposed*.**
    - All Applicants must respond to the general standards, COMAR 10.24.08.05A.
    - Applicants proposing *new construction or expansion* of comprehensive care facility beds, including replacement of an existing facility or existing beds, if new outside walls are proposed must also respond to all the standards in COMAR 10.24.08.05B.
    - Applicants only proposing *renovations within existing facility* walls using beds currently shown in the Commission's inventory as authorized to the facility must respond to all the standards in COMAR 10.24.08.05C in addition to the standards in .05A. Applicants for such renovations should not respond to the standards in .05B.
    - All Applicants must respond to the Review Criteria listed at 10.24.01.08G(3)(b) through 10.24.01.08G(3)(f) as detailed in the application form.

- **Identification of each Attachment, Exhibit, or Supplement**

Application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the completeness review process shall use a consecutive numbering scheme, continuing the sequencing from the original application. (For example, if the last exhibit in the application is Exhibit 5, any exhibits used in subsequent responses should begin with Exhibit 6. However, a replacement exhibit that merely replaces an exhibit to the application should have the same number as the exhibit it is replacing, noted as a replacement.

SUBMISSION FORMATS:

We require submission of application materials and the applicant's responses to completeness questions in three forms: hard copy; searchable PDF; and in Microsoft Word.

- **Hard copy:** Applicants must submit six (6) hard copies of the application to:
  Ruby Potter
  Health Facilities Coordinator
  Maryland Health Care Commission
  4160 Patterson Avenue
  Baltimore, Maryland 21215

- **PDF:** Applicants must also submit *searchable* PDF files of the application, supplements, attachments, and exhibits.[1] All subsequent correspondence should also be submitted both by paper copy and as *searchable PDFs*.

- **Microsoft Word:** Responses to the questions in the application and the applicant's responses to completeness questions should also be electronically submitted in Word. Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

PDFs and spreadsheets should be submitted to ruby.potter@maryland.gov and kevin.mcdonald@maryland.gov.

Note that there are certain actions that may be taken regarding either a health care facility or an entity that does not meet the definition of a health care facility where CON review and approval are not required. Most such instances are found in the Commission's procedural regulations at COMAR 10.24.01.03, .04, and .05. Instances listed in those regulations require the submission of specified information to the Commission and may require approval by the full Commission. Contact CON staff at (410) 764-3276 for more information.

A pre-application conference will be scheduled by Commission Staff to cover this and other topics. Applicants are encouraged to contact Staff with any questions regarding an application.

[1] PDFs may be created by saving the original document directly to PDF on a computer or by using advanced scanning technology

TABLE OF CONTENTS

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **FutureCare Homewood**

Address:

Facility Address: 2700 N. Charles Street **Baltimore** **MD** **21218**

Owner (of bed rights proposed to be transferred): The Good Samaritan Hospital of Maryland, Inc.

Applicant: Charles Street Health Care, LLC, d/b/a Future Care Homewood

Street 2700 N Charles St, Baltimore, MD City Baltimore Zip 21218 County Baltimore

2. Name of Owner **Future Care Homewood Properties, LLC**

If Owner is a Corporation, Partnership, or Limited Liability Company, attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the applicant and any related parent entities. Attach a chart that completely delineates this ownership structure.

Owner of real estate and bed rights: Future Care Homewood Properties, LLC
The following are the owners and members of Future Care Homewood Properties, LLC:
The Leonard J. Attman 1995 Trust (50%)
Gary L. Attman (25%)
Alvin M. Powers Family LLC (25%)

3. APPLICANT. *If the application has a co-applicant, provide the following information in an attachment.*

Legal Name of Project Applicant (Licensee or Proposed Licensee):

Future Care Homewood Properties, LLC

Address:

	Baltimore	**21218**	**MD**	**Baltimore City**
Street 2700 N Charles St, Baltimore, MD	City	Zip	State	County
Telephone:	**(410) 554-6300**			

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

Future Care Homewood

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

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

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

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

a. Gary L. Attman, President
Name and Title
FutureCare Health & Management Corporation
b. 8028 Ritchie Highway, Suite 118
Street

c. Pasadena	**21122**	**Anne Arundel**
City	**Zip**	**County**

d. 410-766-6484
Telephone

e. 410-510-1000
Fax No.
Email: gattman@futurecarehealth.com

a. Les Goldschmidt, Vice President of Operations
Name and Title
FutureCare Health & Management Corporation
b. 8028 Ritchie Highway, Suite 210
Street

c. Pasadena	**21122**	**Anne Arundel**
City	**Zip**	**County**

d. 410-766-1995 x 00159
Telephone

e. 410-761-6095
Fax No.
Email: goldschmidtl@futurecarehealth.com

a.	**Howard L. Sollins, Esq** **Name and Title** **Baker Donelson**			a.	**Andrew L. Solberg** **Name and Title** **A.L.S. Healthcare Consultant Services**		
b.	**100 Light Street** **Street**			b.	**5612 Thicket Lane** **Street**		
c.	**Baltimore** **City**	**21202** **Zip**	**Baltimore City** **County**	c.	**Columbia** **City**	**21044** **Zip**	**Howard** **County**
d.	**410-862-1101** **Telephone**			d.	**410-730-2664** **Telephone**		
e.	**443-263-7569** **Fax No.**			e.	**410-730-6775** **Fax No.**		
	Email:	**hsollins@bakerdonelson.com**			**Email:**	**asolberg@earthlink.net**	

7. NAME OF THE OWNER OR PROPOSED OWNER OF THE REAL PROPERTY and Improvements (if different from the licensee or proposed licensee)

Legal Name of the Owner of the Real Property
Future Care Homewood Properties, LLC

Address:

2700 N Charles St, Baltimore, MD	**Baltimore**	**21218**	**MD**	**Baltimore City**
Street	City	Zip	State	County

Telephone: **(410) 554-6300**

If Owner is a Corporation, Partnership, or Limited Liability Company attach a desc ownership structure identifying all individuals that have or will have at least a 5% share in the in the real property and any related parent entities. Attach a chart tha delineates this ownership structure.

Owner of real estate and bed rights: Future Care Homewood Properties, LLC
The following are the owners and members of Future Care Homewood Properties, LLC:
The Leonard J. Attman 1995 Trust (50%)
Gary L. Attman (25%)
Alvin M. Powers Family LLC (25%)

8. NAME OF THE Owner of the Bed Rights (i.e., the person/entity that could sell the beds included in this application to a 3rd party):

Legal Name of the Owner of the Rights to Sell the CCF Beds

Future Care Homewood Properties, LLC

If the Legal Entity that has or will have the right to sell the CCF beds is other than the Licensee or the Owner of the Real Property Identified Above Provide the Following Information.

Address:

2700 N Charles St.	**Baltimore,**	**2128**	**MD**	**Baltimore City**
Street	City	Zip	State	County

Telephone: (855) 633-5655

9. If a management company or companies is or will be involved in the clinical or financial management of the facility or will provide oversight of any construction or renovations proposed as part of this APPLICATION, identify each company or individual that will provide the services and describe the services that will be provided. Identify any ownership relationship between the management company and the owner of the facility and/or the real property or any related entity.

Name of Management Company Future Care Health and Management of Homewood, Inc.

Address:

8028 Ritchie Highway, Suite 118	**Pasadena**	**21122**	**MD**	**Baltimore**
Street	City	Zip	State	County

Telephone: 410-766-6484

10. TYPE OF PROJECT

The following list includes all project categories that require a CON pursuant to COMAR 10.24.01.02(A). Please mark all that apply in the list below.

If approved, this CON would result in (check as many as apply):

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

11. PROJECT DESCRIPTION

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

(1) Brief Description of the project – what the applicant proposes to do
(2) Rationale for the project – the need and/or business case for the proposed project
(3) Cost – the total cost of implementing the proposed project

Purchase and relocation of 30 currently temporarily de-licensed beds from MedStar Good Samaritan Hospital to FutureCare-Homewood and other needed facility upgrades.

B. Comprehensive Project Description: The description should include details regarding:

(1) Construction, renovation, and demolition plans
(2) Changes in square footage of departments and units
(3) Physical plant or location changes
(4) Changes to affected services following completion of the project
(5) Outline the project schedule.

Please see the next page.

Project Description

1. FutureCare

Future Care Homewood is managed by an affiliate of FutureCare Health and Management Corporation ("FutureCare"). The owners of Future Care Homewood Properties, LLC have ownership interests (among other individuals and entities having ownership interests) in the various FutureCare facilities, and they also have ownership interests in FutureCare Health and Management Corporation. Organization charts can be found in Exhibit 1. Founded and based in Maryland since 1986, FutureCare and its affiliates have grown from managing 3 facilities to 14, covering the Baltimore-Washington Metropolitan area. FutureCare is proud to care for Maryland's elderly and disabled citizens and is committed to building and enhancing the communities in which it operates. Currently, FutureCare manages:

FutureCare Canton Harbor
FutureCare Cherrywood
FutureCare Chesapeake
FutureCare Charles Village
FutureCare Courtland
FutureCare Coldspring
FutureCare at Good Samaritan
FutureCare Homewood
FutureCare Irvington
FutureCare Lochearn
FutureCare Northpoint
FutureCare Old Court
FutureCare Pineview
FutureCare Sandtown/Winchester

FutureCare's doctors, staff, and volunteers work closely and compassionately with Residents and families. Together, they create a supportive and caring community, regardless of whether a person's stay is short- or long-term. First and foremost, FutureCare's commitment is to providing high quality nursing and rehabilitative care to those whose health conditions range from clinically complex, with multiple system involvement, to those whose needs require providing a safe, structured environment for those with diminished physical and mental abilities.

FutureCare's commitment to care extends beyond the clinical to the social, emotional, environmental and spiritual lives of residents as well. FutureCare's staff of social workers, activities therapists, housekeepers, laundry and kitchen personnel strives each day to provide meaningful interaction and activities, a clean environment, and nutritious meals to enhance the lives of those in our care.

FutureCare's programs are resident-centered. FutureCare has developed a full range of services tailored to the needs of the elderly and disabled.

Clinical Services

Recognized repeatedly as a Top Employer by the Baltimore Sun, FutureCare has attracted some of the finest registered and licensed practical nurses in the fields of acute and long-term care. These skilled professionals work closely with nurse practitioners and certified nursing assistants to provide round-the-clock care. FutureCare's staff is highly trained and can meet the most complex medical needs, such as:

- post-operative care
- Stroke recovery care
- infusion therapy
- tube feedings
- wound care
- dialysis (hosted through leased arrangements with established providers)
- pain management
- diabetic management
- dementia care
- neuromuscular disease management
- pain Management
- fall management
- palliative care
- ventilator/respiratory care
- Hospice/end-of-life care

Medical Management – Physicians/Nurse Practitioners/Physician Assistants/SNF'st

The FutureCare philosophy of providing the best comprehensive care to residents begins with great medical care. "FutureCare Plus," a program Futurecare pioneered over 15 years ago, places a Licensed, Certified Geriatric Nurse Practitioner at each facility, capable of providing a level of clinical oversight that enhances and insures the quality of care for each resident. Each nurse practitioner works under the guidance of a physician/medical director.

The Certified Geriatric Nurse Practitioner is a registered nurse who has completed advanced training at a masters level and has successfully passed The American Academy of Nurse Practitioners certification examination. They are licensed by the State of Maryland and are allowed to provide comprehensive healthcare services to residents. In collaboration with the residents' attending physician and the facility Medical Director, The FutureCare Plus Nurse Practitioner works with the clinical team to insure thorough assessment, monitoring and follow-up on all clinical issues.

The FutureCare Plus Program allows FutureCare to identify and assess changes in a resident's condition, act quickly and decisively. The Nurse Practitioner can respond

to these changes by writing orders for treatments, medications and other medical interventions, as necessary. The Program provides a consistent and solid process to monitor treatment adjustments, changes in condition and the overall well being of each resident on a daily basis.

The FutureCare Plus program improves clinical care and services by treating issues in the facility before they become acute. FutureCare is committed to providing the highest quality of care and service to each resident. The FutureCare Plus Program is designed to help meet the high clinical goals FutureCare has set. Additionally, FutureCare has four full time physicians on staff to oversee patient clinical management. These physicians oversee not just the nurse practitioners PLUS PROGRAM, but also attending physicians from the community to ensure quality patient clinical management.

Additionally, FutureCare has entered into collaborations with large physician networks such as Post acute Physician Partners, and California Emergency Physicians, , that specialize in rendering clinical care to skilled nursing facility patients. These physicians practice exclusively in the nursing centers, much like hospitalist in hospital settings.

Finally, the FutureCare network includes special consultative relationships in the areas of wound management, cardiovascular health, and respiratory diseases. Specialists under contract include vascular surgeons, cardiologists and pulmonologists.

LYFE Today Program

LYFE Today is another program created by FutureCare, which embodies the values, ideas, and opinion that regenerative care promotes both quality of care and quality of life. FutureCare believes that every individual, regardless of age or disability, wants to and can be an active, contributing member of the community, and that “Our Residents Have Places To Go and Things To Do!” FutureCare recognizes the individuality of each resident through an understanding of their previous lifestyle, preferences and current level of ability. This knowledge enables FutureCare to provide programming that achieves regenerative care.

LYFE programming is individualized for residents to meet them at their current level and to encourage them to realize their full potential. The LYFE Today program consists of four separate groups identified as “Villages”, which collectively make up a community within the facility. Assessments are performed to identify which village a resident belongs. Each village’s programming contains the following key components:

- Self Expression (example: art expression)
- Enrichment programming (example: serve program)
- Lifestyle programming (example: gardening)
- Functional/Mobility programming (example: music and movement)

By keeping residents engaged in meaningful activity throughout the day, they obtain/maintain purpose and achieve an overall happier experience. When staff are creative, respect the dignity and individuality of the resident, and are committed to restoration, a true community of caring will evolve.

Rehabilitation Services

Residents build trusting relationships with knowledgeable physical and occupational therapists and speech pathologists who comprise FutureCare's rehabilitation team. Physical and Occupational Therapists help residents with orthopedic, neurologic, vascular, and a variety of medical diagnoses resulting in pain, abnormality of the body structure, or functional limitations as a result of the acute or chronic illness or injury. Speech Therapists help residents with neurogenic communication and/or swallowing disorders. FutureCare's rehabilitation therapy services strive to restore each Resident's highest possible level of functional independence through individualized treatment plans. Therapists are dedicated to working with the elderly and disabled, which makes them particularly sensitive to developing a rehab plan with a resident's special needs in mind. Therapy services are available seven days per week, which contributes to a rapid recovery and an optimal outcome.

FutureCare's rehabilitation team is dedicated to the important goal of restoring function and improving the overall quality of life for those residents who require it. FutureCare rehabilitation programs treat the effects of disease, injury, and disability of the elderly or others with a chronic illness by:

- Evaluating and assessing referred Residents.
- Developing an appropriate treatment plan, based on assessed needs and including objective, measurable short- and long-term goals.
- Applying and assessing the individual's response to treatment.
- Educating Residents and caregivers about rehabilitation principles, interventions, equipment, and techniques.
- Participating in discharge planning.

The evaluation, assessment, and treatment are provided by FutureCare's licensed Physical, Occupational, and Speech Therapists to achieve functional outcomes that:

- Promote health.
- Prevent or reduce disability.
- Maximize independent functioning.
- Facilitate the highest quality of life.

Social Services

The support of a social worker can assist residents and their families in easing

the transition from home to FutureCare. Individual conferences and support groups offer everyone a time to become familiar with the individualized treatment plan, Advance Directives, Resident Bill of Rights, to share and plan ahead.

FutureCare's social workers also orchestrates discharge planning. For those residents and Residents who are able to return home or to a setting of lesser care, the social workers will coordinate home care services, meal on wheels the delivery of needed medical equipment and any other service that is prescribed by the resident's physician.

Dietary Services

Maintaining a healthy or therapeutic diet is important to FutureCare's residents' quality of life. The Registered Dietician works with highly trained food service staff to meet individual requirements. Staff works closely with each resident and the resident's physician to accommodate food preferences and special dietary considerations.

At FutureCare, holidays are still a time to share family traditions. Residents are encouraged to invite their families for special fare and a fun-filled time.

Recreation Services

Being a resident does not mean being inactive. FutureCare offers a variety of recreational and social programs such as arts and crafts, musical events, church services, and more to entertain, comfort, or maintain or cultivate a new hobby or interest.

Resident Councils gives each resident a voice in the life of the facility. From making suggestions for menu selections to holiday parties, FutureCare encourages residents to shape their world.

Housekeeping and Laundry Services

Building special friendships in order to be responsive to resident's needs is the cornerstone of this service area. Preparing rooms, maintaining a clean environment, providing linens and caring for resident's clothing are essential to operating a quality health care facility.

Reducing Preventable Hospitalizations

According to data released by the Centers for Medicare & Medicaid Services and the Administration on Aging, one in every four Residents admitted to a skilled nursing facility are being re-admitted to the hospital within 30 days at a cost of $4.3 billion annually.[2]

[2] See CMS and AoA *Transitions and Long-Term Care: Reducing Preventable Hospital Readmissions Among Nursing Facility Residents.*

FutureCare tracks and analyzes unplanned transfers to the hospitals with the goal of reducing the unnecessary transfers. This had led FutureCare to make significant improvements in its care.

Full time nurse practitioner presence including coverage on weekends in many facilities contributes to Futurecare's ability to manage more challenged clinical residents. The nurse practitioner's promptassessment and medication/treatment plan reconciliation on all new admissions also significantly reduces the medical risk associated with the residents. To further enhance the medical care programs, FutureCare employs a full-time board certified gerontologist as corporate medical director and chief medical officer. The corporate medical director's duty is to provide oversight and management to the facility medical directors, physicians and mid-level practitioners.

FutureCare also employs an enhanced physician communication system, E-Medicall, which allows for instantaneous, recorded physician communication to promptly address Residents' changes in condition. E-Medicall utilizes internet-based protocols and physician smart phones to communicate with nursing staff.

Most recently,, FutureCare has partnered with University of Maryland Medical System in a grant program partially funded by CareFirst Maryland, to provide telemedicine within the Homewood site. Utilizing mobile diagnostic medical devices, and video, patient information and status can be reviewed by Emergency trained physicians prior to transfer to an Emergency Room. The benefit of such a capability is quicker diagnosis, rapid treatment implementation, and possible avoidance of re-hospitalizations.

To further FutureCare's goal of reducing preventable readmissions to the hospital, FutureCare has increased the skill set and knowledge of our core clinical staff. This has been achieved through several efforts. FutureCare started with the facility mid-level nurse managers by transitioning to an all RN management model. FutureCare has added clinical expertise certifications to career ladders, such as, certifications for nurse assessment coordinators, wound certification for our Wound and Skin Care Coordinators and Nurse Practitioners, Peripheral Intravenous and Peripherally-Inserted Central Catheter certifications for all licensed nursing staff. FutureCare also has a robust continuing educational program with two state of the art regional education centers and led by a master's prepared educator, ,who is ANCC board certified in Gerontology..

All of FutureCare's facilities now have the capability of providing intravenous services 24 hours a day, seven days a week. We have the capability to place a peripherally inserted central catheter at bedside within four hours of it being ordered. We also have the capability to confirm proper placement at the bedside without the use of x-rays using Vasanova technology (in Residents free of atrial fibrillation). This allows immediate administration of the ordered medication. Avoiding unnecessary delays

reduces the likelihood of re-hospitalization.

FutureCare has an affiliated Respiratory Services Company, with the ability to staff full-time respiratory therapists 24/7. This allows it the capability to provide better quality care. FutureCare has significantly added physical, speech, and occupational therapy staff throughout the facilities which has allowed us to expand our weekend coverage so that Residents are being treated more promptly, minimizing the risk of complications from recovering illnesses or surgery.

Another one of FutureCare's unique and important clinical programs is called "STOP" ("Suitable Transfers Only Program") This program targets all newly admitted/readmitted Residents for the first thirty days of their stay and has been proven to reduce the number of preventable hospital returns. This program is specifically designed to properly identify, assess and manage Residents' changes in condition before they become acutely ill. Nurses will perform a targeted assessment protocol which includes a head-to-toe assessment of every newly-admitted Resident at least every shift (CMS requires at least daily charting) or more often as clinically indicated. Senior facility clinical management staff will be involved in every hospital transfer before they occur, Residents condition/time permitting.

FutureCare will continue to improve its quality through enhanced electronic information gathering and comparisons to national data. The American Health Care Association (AHCA), the national skilled nursing facility association, along with many other national organizations, have developed a national campaign to improve the quality of care in nursing homes. All of FutureCare's facilities have joined this effort.

Additionally, FutureCare has partnered with University of Maryland Medical System in a grant program partially funded by CareFirst Maryland, to provide telemedicine within the Homewood site. Utilizing mobile diagnostic medical devices, and video, patient information and status can be reviewed by Emergency trained physicians prior to transfer to an Emergency Room. The benefit of such a capability is quicker diagnosis, rapid treatment implementation, and possible avoidance of re-hospitalizations.

FutureCare has developed new health offerings into its array of health services, and branded these new offerings as VitalStrong by FutureCare. The new offerings fall into four categories, known as:

HeartStrong
BreatheStrong
WalkStrong
CampStrong

VitalStrong by FutureCare has been developed to provide state of the art clinical and rehabilitation services utilizing progressive technology, with clinical oversight by a physician, nurse practitioner, and physiatrist – a doctor of physical medicine and

rehabilitation. A Care navigator will guide patients through their treatment process from admission to discharge and will update the primary care physician when ready to return home.

FutureCare Homewood is the legacy operator of 2700 North Charles building, which was built in three phases dating back to the 1890's. The original core structure was built as a hospital, and no longer houses patients. Later additions occurred with a two story building built in the 1960's and a 7 story structure erected in the early 1980's. Although the structure in its various states went through different name changes, the most prominently known name was North Charles General Hospital, an independent operation which closed in 1985. The facility was subsequently acquired by John Hopkins Hospital but closed in the late 1980's. Subsequently, the facility was purchased in the early 1990's by a nursing home chain known as Mariner Health, and operated as a sub-acute facility. By the mid 1990's Mariner sold the building and operation to the current owner which has maintained it as a comprehensive nursing facility since then.

Currently, the first floor is used as a dialysis site by an outside company and some office space usage for the landlord of the rental company that occupies the building. Under the renovation project, this portion of the building will act as the new entrance and pathway to access the proposed second floor non-patient areas that may remain. In this manner, outside parties that are not involved in the nursing home operation will not traverse the patient care operations of the second floor.

The next stage of the hospital was built in the 1960's, and consists of two floors. It houses a ventilator unit on the first floor, and is recognized as a distinct part unit by Office of Health Care Quality for residents with respiratory conditions of a severe nature. The second floor of this structure is currently utilized for outside tenants, but whose best integrated usage would be for the provision of health care, consistent with the intended purpose of the building. Within that framework of utilizing the building as a health care setting, the creation of a distinct Rehabilitation Unit for cardiac and orthopedic patients, would dovetail with a state of the art Rehabilitation Gym which is already in place on the third floor of the 1980's tower.

The 1980's tower contains 7 stories (basement, and six floors.). The third floor houses the state of the art Rehabilitation Gym referenced above. The 4th, 5th and 6th floors are patient room areas. The 5th floor houses more of a skilled care population, and the 4th and 6th floor are primarily long term care units. One obstacle of operation is that while the 5th floor has short term clients, it contains residents with a broad spectrum of needs. Residents with cardiac, orthopedic, wound care, digestive disorders, neurologic diseases, pulmonary and infectious diseases, reside on the unit. By creating a separate unit on the second floor, equipment, care and services can be better delineated to create optimal private space for these patients to rehab and recover. At the same time, it will enable the fifth floor to better deal with those other types of skilled short term care admissions. Education of staff can be better tailored to deal with specific disease processes and achieve higher degree of operational

attentiveness to the challenges that these patients face in the recovery process.

2. The Project

The Project envisions adding 30 single private rooms with full bath, inclusive of showers in the second floor of the building. Currently this space, is partially occupied by a commercial tenant and partially unoccupied. Prior to its current use, this space housed the surgical floor for what was the North Charles General Hospital. The additional 30 bed wing is targeted to service the needs of two VitalStrong patient populations in particular:

WalkStrong – The WalkStrong program at FutureCare is designed to meet the clinical and short-stay rehabilitation needs of those who have undergone an orthopedic procedure for joint replacement, fracture, shoulder, neck or spine surgery, and would benefit from a short stay rehabilitation program. These new rooms located on a short-stay-rehabilitation unit, assure the skilled orthopedic team is always close by. The rehabilitation specialist, physicians, and treatment team will develop a customized treatment plan, which includes: physical, occupational and/or speech therapy; surgical site care; pain management; consulting physiatrist service (Physical medicine and rehabilitation); nutritional services; and education are all part of this patient specific program. These services will be available seven days per week and the goals to be achieved include reduce likelihood of hospital readmission, improve functional abilities and greater independence, improved quality of life and reduction of symptoms. Educational teaching deal with topics such as weight bearing restrictions following surgery, exercise guidelines, pain management, medication management, wound healing, nutrition, anxiety and stress relief.

HeartStrong – The HeartStrong Program at FutureCare is designed to meet the clinical and short stay rehabilitation needs of those who have been diagnosed with cardiac illnesses such as Coronary Artery Disease (CAD), Congestive Heart Failure (CHF, Myocardial Infarction (MI) or other cardiac diagnoses. In addition, we provide care for patients who require short stay rehabilitation and therapy, following these procedures and treatments:

Cardiac Stenting
Clinical Care Post Pacemaker
Implanted Defibrillator (ICD)
Life Vest Monitoring
Valve Replacements
Complications from Cardiac Catheterization
Coronary Artery Bypass Grafting (CABG)

Creating these new rooms on a short stay rehabilitation unit, assures that the skilled cardiac team is always in close proximity. A consulting cardiologist and rehabilitation specialist will develop a customized treatment plan. The benefit to patients include: reduce likelihood of a hospital readmission; improved functional abilities, and

greater independence; improved quality of life, reduction of symptoms, access to cardiac support materials. Additionally, the unit will be stocked with an EKG and Automated external defibrillator (AED) along with specialize trained nurses. Respiratory therapy services are also available in the building on a 24-7 basis.

One of the most important components of this program, will be patient education and training, in preparation of the patient's return to the community and managing with their cardiac status. Educational focus will include: recognition of signs and symptoms of cardiac issues and what to do if they occur; exercise guidelines and restrictions specific to cardiac patients; work simplification/energy conservation; medication management; anxiety/stress relief, nutritional counseling, equipment utilization, oxygen safety, benefits of smoking cessation, emotional support and mental health counseling.

As noted above, FutureCare Homewood is an existing skilled nursing facility, located at 2700 North Charles Street in Baltimore City. The building, which was originally constructed as a 2-story hospital and which has undergone several renovations and expansions over the years, consists of the original 2-story concrete-block and steel-joist structure from the mid-1960's, a 6-story concrete-frame expansion from the early 1980's (plus basement), and a 5-story 19th-century wood-frame townhouse.

The 30 bed proposed expansion unit will be located in the original 2-story concrete-block and steel-joist structure. It entails renovating approximately fifty percent of the Second Floor, to a new 30-bed skilled nursing unit. The Project also involves renovating a small portion of the First Floor, for the purpose of providing a separate building entrance for the remaining Second Floor office tenants.

The Project will be designed to comply with current building and life-safety codes, as well as the requirements of the Americans with Disabilities Act Accessibility Guidelines and COMAR 10.07.02 (Comprehensive Care Facilities). The Project will incorporate standard "green building" strategies to comply with the International Green Construction Code (IGCC) as required in Baltimore City.

The upgrades to the existing building include:

- Replacement Of Six Elevators
- Replace The Existing Air Handling Control System
- Replace The Existing Fire Alarm System
- Building Modernization
    - 1st floor (Ventilator Unit) upgrade of 16 rooms housing 31 beds and hallway.
    - 4th floor (Long Term Care Unit) upgrade 20 rooms housing 39 beds.
    - 5th floor (Short Term Care Unit) upgrade Hallway
    - 6th floor (Long Term Care Unit) upgrade 20 rooms housing 39 beds and hallway.

These are explained in more detail under COMAR 10.24.08.05(7) (Facility and Unit Design).

12. Complete Table A of the CON Table Package for Nursing Home (CCF) Applications

Please see Exhibit 2, which includes the entire CON Application Table Package.

13. Identify any community based services that are or will be offered at the facility and explain how each one will be affected by the project.

None of FCH's community based services will be affected by this project.

14. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: 1.693 acres

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

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

(1) Owned by: FutureCare Homewood Properties, LLC

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

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

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

(5) Other: _____
Explain and provide legal documents as an attachment.

15. PROJECT SCHEDULE

In completing this section, please note applicable performance requirements time frames set forth in Commission regulations, COMAR 10.24.01.12. Ensure that the information presented in the following table reflects information presented in Application Item 11 (Project Description).

	Proposed Project Timeline	
Obligation of 51% of capital expenditure from approval date	18	months
Initiation of Construction within 4 months of the effective date of a binding construction contract	4	months
Time to Completion of Construction from date of capital	18	months

obligation		

16. PROJECT DRAWINGS

Projects involving new construction and/or renovations should include scalable schematic drawings of the facility at least a 1/16” scale. Drawings should be 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 bath rooms, 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.

Please see Exhibit 3.

17. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete the Construction and Renovation Square Footage worksheet in the CON Table Package (Table B)

Please see Exhibit 2, which includes the entire CON Application Table Package.

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project and identify the provider of each utility. Specify the steps that will be necessary to obtain utilities.

All utilities are already available on-site.

PART II - PROJECT BUDGET

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

Note: Applicant should include a list of all assumptions and specify what is included in each budget line, as well the source of cost estimates and the manner in which all cost estimates are derived. Explain how the budgeted amount for contingencies was determined and why the amount budgeted is adequate for the project given the nature of the project and the current stage of design (i.e., schematic, working drawings, etc.)

Please see Exhibit 2, which includes the entire CON Application Table Package.

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. **List names and addresses of all owners and individuals responsible for the proposed project and its implementation.**

Gary L. Attman and Leonard J. Attman
c/o FutureCare Health and Management Corporation
8028 Ritchie Highway, Suite 118
Pasadena, MD 21122

2. **Are the applicant, owners, or the responsible persons listed in response to Part 1, questions 2, 3, 4, 7, and 9 above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.**

Mr. Gary L. Attman and Mr. Leonard J. Attman have ownership interests in, and Future Care Health and Management Corporation is involved in the management of each of the following health care facilities:

FutureCare Cherrywood
12020 Reisterstown Road
Reisterstown, Md 21136

FutureCare Chesapeake
305 College Parkway
Arnold, Md 21012

FutureCare Courtland
7920 Scotts Level Rd
Baltimore, MD 21208

FutureCare Old Court
5412 Old Court Road
Randallstown, Md 21133

FutureCare Canton Harbor
1300 S. Ellwood Avenue
Baltimore, Md 21224

FutureCare Irvington
22 South Athol Avenue
Baltimore, Md 21229

FutureCare Charles Village
2327 N. Charles St
Baltimore, Md 21218

FutureCare Coldspring

4700 Harford Road
Baltimore, Md. 21214

FutureCare Homewood
2700 N. Charles St
Baltimore, Md 21218

FutureCare Pineview
9106 Pineview Lane
Clinton, Md 20735

FutureCare Sandtown/Winchester
1000 N. Gilmore Street
Baltimore, Md 21217

FutureCare Lochearn
4800 Seton Drive
Baltimore, Md 21215

FutureCare Northpoint
1046 Old Northpoint Road
Baltimore, Md 21224

FutureCare at Good Samaritan
1601 East Belvedere Avenue
Baltimore, Md 21239

Leonard J. Attman and Gary L. Attman also have ownership interests in HomeCare Maryland, LLC, a home health agency and PLMD, LLC, d/b/a Pulse Medical Transport, an ambulance company, and three dialysis clinics.

Leonard J. Attman and Gary L. Attman have ownership interests in Prince George's Post-Acute through another entity, which was granted a CON for the development of a new CCF project by the MHCC) currently under development.

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Question 2, above, been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owners or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

Each of the above listed facilities is a Comprehensive Care Facility ("CCF") licensed by the Maryland Office of Healthcare Quality ("OHCQ") and each has continually maintained licensure. These facilities are also certified for participation in the federal Medicare and Medicaid programs. The OHCQ regularly surveys these facilities for licensure purposes as well as for compliance with the Medicare and Medicaid requirements of participation. In general, CCFs are subject to annual surveys by the OHCQ as well as periodic complaint surveys conducted in

response to facility self-reported issues and concerns raised by residents or their advocates.

The Medicare and Medicaid certification process has, since the mid-1990's, become more formalized in mandating certain actions based on findings of non-compliance within a 180-day survey cycle. Based on the level of deficiency cited and the period of non-compliance, such actions can require the imposition of civil money penalties, denials of payment for new Medicare and Medicaid admissions (which are not outright bans on admissions nor do they prohibit readmissions of Medicare and Medicaid beneficiaries) and termination of the Medicare and Medicaid provider agreement, as well as related state law sanctions. The above facilities have been subject to this licensing, certification and survey process. While one or more of the facilities identified above may have at some point in the past five years been subject to an imposition of a civil money penalty, none of the facilities have ever been subject to termination, a restriction on licensure or a ban on admissions. FutureCare at Good Samaritan, acquired by FutureCare ownership on 7/1/16, was subject to a Civil Money Penalty levied prior to its acquisition, but while under a management agreement with Med-Star Good Samaritan Hospital.

4. **Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) received inquiries in last from 10 years from any federal or state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with any state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.**

   The above listed facilities are fully licensed and certified.

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5. **Have the applicant, owners or responsible individuals listed in response to Part 1, questions 2, 3, 4, 7, and 9, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).**

   No.

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

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

4/5/2017
Date

Signature of Owner or Board-designated Official

Member
Position/Title

Gary L. Altman
Printed Name

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

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

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

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

10.24.01.08G(3)(a). <u>The State Health Plan</u>.

Every Comprehensive Care Facility ("CCF" -- more commonly known as a nursing home) applicant must address each applicable standard from **COMAR 10.24.08: State Health Plan for Facilities and Services -- Nursing Home and Home Health Services.**[3] Those standards follow immediately under ***10.24.08.05 Nursing Home Standards*.**

Please provide a direct, concise response explaining the project's consistency with each standard. <u>In cases where demonstrating compliance with a standard requires the provision of specific documentation, please include the documentation as a part of the application.</u>

10.24.08.05 Nursing Home Standards.

A. General Standards. The Commission will use the following standards for review of all nursing home projects.

(1) Bed Need. **The bed need in effect when the Commission receives a letter of intent for the application will be the need projection applicable to the review.**

The most recent MHCC Comprehensive Care Bed Need Projections for Baltimore City were for target year 2016 and were published by the MHCC in the *Maryland Register* on 4/16/2016.

(2)Medical Assistance Participation.

(a) **Except for short-stay, hospital-based skilled nursing facilities required to meet .06B of this Chapter, the Commission may approve a Certificate of Need for a nursing home only for an applicant that participates, or proposes to**

[3] [1] Copies of all applicable State Health Plan chapters are available from the Commission and are available on the Commission's web site here:http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp

participate, in the Medical Assistance Program, and only if the applicant submits documentation or agrees to submit documentation of a written Memorandum of Understanding with Medicaid to maintain the proportion of Medicaid patient days required by .05A 2(b) of this Chapter.

(b) **Each applicant shall agree to serve a proportion of Medicaid patient days that is at least equal to the proportion of Medicaid patient days in all other nursing homes in the jurisdiction or region, whichever is lower, calculated as the weighted mean minus 15.5% based on the most recent Maryland Long Term Care Survey data and Medicaid Cost Reports available to the Commission as shown in the *Supplement to COMAR 10.24.08: Statistical Data Tables*, or in subsequent updates published in the *Maryland Register*.**

(c) **An applicant shall agree to continue to admit Medicaid residents to maintain its required level of participation when attained and have a written policy to this effect.**

(d) **Prior to licensure, an applicant shall execute a written Memorandum of Understanding with the Medical Assistance Program of the Department of Health and Mental Hygiene to:**

(i) Achieve or maintain the level of participation required by .05A 2(b) of this Chapter; and

(ii) Admit residents whose primary source of payment on admission is Medicaid.

(iii) An applicant may show evidence why this rule should not apply.

FCH participates in the Medical Assistance Program. FCH will sign the MOU prior to licensure of the additional beds. The most recently published Medicaid percentage requirement (*Maryland Register*, 2/5/2016, p. 303) is 47.3 percent. In FY 2016, FCH's Medicaid percentage was 68.79%.

(3) Community-Based Services. **An applicant shall demonstrate commitment to providing community-based services and to minimizing the length of stay as appropriate for each resident by:**

(a) Providing information to every prospective resident about the existence of alternative community-based services, including, but not limited to, Medicaid home and community-based waiver programs and other initiatives to promote care in the most appropriate settings;

(b) Initiating discharge planning on admission; and

(c) Permitting access to the facility for all "Olmstead" efforts approved by the Department of Health and Mental Hygiene and the Department of Disabilities to provide education and outreach for residents and their families regarding

home and community-based alternatives.

FCH provides information to all prospective residents about the existence of alternative community-based services, including but not limited to Medicaid home and community-based waiver programs, home care, medical day care, assisted living, and other initiatives to promote care in the most appropriate settings. Please see Exhibit 4 for examples of such material distributed to prospective residents at FCH.

FCH initiates discharge planning on admission as part of its development of the Resident Care Plan. Please see Exhibit 5, which includes FutureCare's Discharge Planning Policy.

FCH permits access to the facility for all Olmstead efforts approved by the Department of Health and Mental Hygiene to provide education and outreach for residents and their families.

(4) Nonelderly Residents. **An applicant shall address the needs of its nonelderly (<65 year old) residents by:**

(a) **Training in the psychosocial problems facing nonelderly disabled residents; and**

(b) **Initiating discharge planning immediately following admission with the goal of limiting each nonelderly resident's stay to 90 days or less, whenever feasible, and voluntary transfer to a more appropriate setting.**

FCH addresses the needs of its non-elderly residents by, among other things, implementing a policy of placing non-elderly Residents near each other to the extent feasible. FCH provides in-service education for staff and utilize local hospitals and social service agencies on a consulting basis to develop its inservice programs relating to non-elderly Residents. FCH's social worker maintains contact with appropriate government agencies relating to career and technical education in order to facilitate vocational rehabilitation services for non-elderly Residents. FCH also provides wireless Internet access to allow interconnectivity to community news and opportunities.

FCH also initiates discharge planning with the goal of limiting each nonelderly resident's stay to 90 days or less, whenever feasible, and voluntary transfer to a more appropriate setting.

An initial care plan is developed for each resident immediately following admission. During the care plan session, discharge planning will be discussed. Discharge potential will be documented on all care plan notes for the resident. FCH also develops specialized programs for social activities for the non-elderly as part of the facility's overall activities and recreational programs.

***(5) Appropriate Living Environment*. An applicant shall provide to each resident an appropriate living environment, including, but not limited to:**

(a) In a new construction project:

(i) Develop rooms with no more than two beds for each patient room;

(ii) Provide individual temperature controls for each patient room; and

(iii) Assure that no more than two residents share a toilet.

(b) In a renovation project:

(i) Reduce the number of patient rooms with more than two residents per room;

(ii) Provide individual temperature controls in renovated rooms; and

(iii) Reduce the number of patient rooms where more than two residents share a toilet.

(c) An applicant may show evidence as to why this standard should not be applied to the applicant.

FCH will not have any rooms with more than two beds. Each room will have individual temperature controls. No more than two residents will share a toilet.

***(6) Public Water*. Unless otherwise approved by the Commission and the Office of Health Care Quality in accordance with COMAR 10.07.02.26, an applicant for a nursing home shall demonstrate that its facility is, or will be, served by a public water system.**

FCH is already served by a public water system.

***(7) Facility and Unit Design*. An applicant must identify the special care needs of the resident population it serves or intends to serve and demonstrate that its proposed facility and unit design features will best meet the needs of that population. This includes, but is not limited to:**

(a) Identification of the types of residents it proposes to serve and their diagnostic groups;

(b) Citation from the long term care literature, if available, on what types of design

features have been shown to best serve those types of residents;

(c) An applicant may show evidence as to how its proposed model, which is not otherwise documented in the literature, will best serve the needs of the proposed resident population.

FutureCare Homewood is an existing comprehensive care facility, located at 2700 North Charles Street in Baltimore City. The building, which was originally constructed as a 2-story hospital and which has undergone several renovations and expansions over the years, consists of the original 2-story concrete-block and steel-joist structure from the mid-1960's, a 6-story concrete-frame expansion from the early 1980's, and a 5-story 19th-century wood-frame townhouse.

The Project is located in the original 2-story concrete-block and steel-joist structure. It entails renovating approximately sixty percent of the Second Floor, for the purpose of converting existing unrelated tenant office space to a new 30-bed comprehensive care unit for resident requiring rehabilitation services. The Project also involves renovating a small portion of the First Floor, for the purpose of providing a separate building entrance for the remaining office tenants.

The Project will be designed to comply with current building and life-safety codes, as well as the requirements of the Americans with Disabilities Act Accessibility Guidelines and COMAR 10.07.02 (Comprehensive Care Facilities) and the life safety codes required by the Centers for Medicare and Medicaid Services Requirements of Participation for long term care facilities under 42 CR, Part 483. The Project will incorporate standard "green building" strategies to comply with the International Green Construction Code (IGCC) as required in Baltimore City.

The thirty bed unit will be focused on short term rehabilitation patients, with the design the project being tailored to meet their care needs:

PROJECT CHARACTERISTICS

RESIDENT ROOMS

- All of the Resident Rooms are single-occupancy.
- All of the Resident Rooms have full bathrooms with showers.
- All of the Resident Bathrooms are fully-accessible in keeping with the most current ADA guidelines.

NURSING UNITS

- In addition to the Nurses Station, there is a separate Charting Area, so that staff is distributed throughout the Unit.
- The Unit includes 2 Clean Utility Rooms, 2 Soiled Utility Rooms, 2 Janitor's Closets and 2 Nourishment Centers, to ensure that all support spaces are conveniently located for the staff.

- In addition to the private showers in the Resident Rooms, the Unit includes a Spa with space to accommodate a shower gurney.

TREATMENT SPACES

- Physician's Office
  A Physician's Office, with a private Exam Room, is located on the Unit.

- Rehabilitation Services Center
  A recently-renovated Rehab Center is located on the Third Floor and includes the following:
  - Speech Therapy Room
  - Treatment Room
  - Training Kitchen and Laundry
  - Training Bathroom
  - State-of-the-Art Rehab Equipment

- Dialysis Center

A 12-seat Dialysis Center is located on the First Floor. US Renal is the current operator under a lease rental agreement for the space. The lease includes provisions for priority status of Future Care Homewood residents to the dialysis center.

ACTIVITY SPACES

- The Unit has its own Dining/Activity Room, dedicated for sole use by the residents of this Unit.
- The Dining/Activity Room has a full-service Café to be staffed by food service professionals, where food will be prepared and served.
- The Unit has a separate Library/Media Room, to provide a quiet space for the residents' use.
- There is also a Family Room, which can be used for smaller family gatherings and staff meetings.

FULL FACILITY UPGRADES:

REPLACEMENT OF SIX ELEVATORS

- The facility has six elevators which all require modernization. While the elevators have been maintained consistently, and updated with new equipment as required, all six are coming to the end of their life cycle, as determined by a consultant report commissioned by FutureCare (ALLSAFE Elevator Inspections report). An elevator replacement plan is proposed which:

1) Replace(s) 2 3500lbs.@350fpm servicing 7 floors in the 1980's wing

2) Replace(s) 2 6000lbs@350fpm servicing 7 floors in the 1980's wing

3) Replace 1 3500lbs.@75fpm servicing 2 floors in the 1960's wing

4) Replace 1 4000lbs.@100fpm servicing 3 floors in the 1890 wing which accesses the second floor area where rehab unit is proposed.

5) Modernize all equipment associated with the machine room

REPLACE THE EXISTING CONTROL SYSTEM

- Install a new system of Direct Digital Controls for Air Handler units 1 and 2 which will provide significant operational, monitoring, and alarm notification enhancements over the original pneumatic controls.

  1. The upgrade will provide global transmission to all controller of QA Temperature, Humidity and Enthalpy (calculated)

  2. Provide full operational control via connected points to various inputs and outputs

- The impact of this replacement project should be to significantly improve efficient operation of the physical cooling and heating plant of the building.

REPLACE THE EXISTING FIRE ALARM SYSTEM

- Replace the existing fire alarm system with a new fire panel and associated devices to include, batter back up; LCD lighting, modules, power supply, smoke detectors, heat detectors, base, pull stations, monitor modules, relays and duct detectors.

- The last significant upgrade to the system occurred the 1980s and although the system is well maintained are now 30 years old and in need of updating. Project will enhance the safety monitoring in the building.

BUILDING MODERNIZATION

- 1st floor (Ventilator Unit) upgrade of 16 rooms housing 31 beds and hallway.

  1. Hallway improvements consist of wall protection, handrails, new ceiling tile and grids.

  2. Room upgrades include new flooring in bedrooms and bathrooms, new overbed lights, new televisions, wall protection, vanity lights, wardrobes, chairs; nights stands, window treatments, ceiling tiles and grid, sinks and faucets, sheetrock of block walls, and paint and install new headwall protection.

- 4th floor (Long Term Care Unit) upgrade 20 rooms housing 39 beds.

1. Hallway improvements include new bump rails, handrails, painting, handrails, and flooring, ceiling grid and tile, new nursing station, security cameras, room signage.

2. Room improvements include painting, wall protection, sinks and faucets, vanity lights, overbed lights, privacy curtains, chairs, night stands, televisions, window treatments and flooring.

- 5th floor (Short Term Care Unit) upgrade Hallway

    1. New handrails, wall protection and door protection, new flooring, painting, installing ceiling tile and grid, add security cameras, new Nurse Station, Med Room and Nourishment area.

- 6th floor (Long Term Care Unit) upgrade 20 rooms housing 39 beds and hallway.

    1. Hallway improvements to include, handrails, bump rails, door protection, painting, new flooring, ceiling tile and grid, security cameras, nurse station, med room and nourishment area.

    2. Room improvements to include painting, wall protection, sinks and faucets, vanity lights, overbed lights, window treatments, chairs, night stands, and flooring.

FCH is proposing to establish 30 beds in a private setting, on a separate floor and unit for its cardiac and orthopedic short term patients. The long-term care industry is undergoing rapid change as a result of changes in reimbursement for acute care hospital, that put an emphasis on global budgets and transitioning in the near future to community based budgets. Length of stays are shorter, and rehab opportunities are often conducted in comprehensive care facilities with short term stay units, outpatient therapy units or home health settings. For those rehabilitation and treatment needs that are best met by short term stay units, the traditional roommate semi-private room is no longer considered optimal. While the traditional medical model remains important, just as important are quality of life considerations. Private rooms provide greater autonomy, dignity and privacy. Patients are making the choice to request private room for their rehab stay, and are by-passing facilities that don't accommodate this need. Physicians too, are looking to partner with those facilities that can best provide a quality of life improved stay as well as quality of care.

The primary factors that influence opting for a private accommodation appear to be privacy (for self and when conversing with others), lack of control over life-style and environment, and feeling uncomfortable being forced to be an unwilling observer to others.

In clinical terms, the evidence is strong on iatrogenic outcomes, especially related to nosocomial infections. Also, sleep which is an important life function and its

associated restive benefit is much more likely to succeed when a patient is not disrupted by their roommate, or caregivers coming in to tend to their roommate. Someone, who has just come off of a surgery, require all the tools at hand to avoid infection and receive rest as part of the rehabilitative process.

Another potential issue with sharing a room is the possibility of sharing with someone whose cognitive functioning is not on a level with their roommate. This can lead to the roommate trying to help or look out for their roommate, at a time when they need to be convalescing themselves. While staff is there it take care of all residents, it is only a natural human condition for patients to want to be good neighbors and watch out for someone they perceive as less capable or functional. Additionally, if housed with someone not at their functional level, they may begin to feel depressed if they have a roommate who cannot interact with them at their level.

When partnering and establishing programs at FutureCare Homewood, the management has had to convert on a case by case basis, semi-private rooms to private accommodations. The result has been to voluntarily restrict opportunities for admission, as the numbers of beds available for intake are reduced. In establishing rooms that are designed and built to accommodate single users, the facility will be able to leave its semi-private rooms in play, creating greater availability and choice for those seeking admission.

The new unit being proposed in the CON, is designed for enhancing quality of life as well as quality of care. It will house innovative concepts, such as tele-medicine devices, nearby access to rehab, dialysis and respiratory services. FutureCare Homewood residents have access to in-house medical professionals and a close association with nearby Med-Star and University Hospital systems. Indeed these health systems look to FutureCare Homewood to partner with them in extending their care, and keep costs of the health system down. By providing a quality of life environment mixed with this well respected historical CMS 4/5 star facility, the building will update itself and remain a strong presence in the Baltimore City health care community.

(8) Disclosure. **An applicant shall disclose whether any of its principals have ever pled guilty to, or been convicted of, a criminal offense in any way connected with the ownership, development, or management of a health care facility.**

None of FCH's nor FutureCare's principals have ever pled guilty to, or been convicted of, a criminal offense in any way connected with the ownership, development, or management of a health care facility.

(9) Collaborative Relationships. **An applicant shall demonstrate that it has established collaborative relationships with other types of long term care providers to assure that each resident has access to the entire long term care continuum.**

FutureCare Homewood has a long history of engagement with other long term care providers to ensure access to the entire long term care continuum. Inclusive of these relationships and types of services offered:

Hospitals: Transfer Agreements in place with Med-Star Union Memorial and University Midtown Centers.

Hospital Tele-Medicine: Homewood works with the Emergency Room of University Hospital in a tele-medicine program to help better manage care in house, avoiding possible re-hospitalizations.

RE-Location Plan: FutureCare Homewood has agreements with other comprehensive care facilities should patients require relocation due to emergency situations.

Insurance Carriers: formal agreements in place with a host of commercial, third party governmental and managed care companies. Among the most utilized insured products are Medicare, Medical Assistance, CIGNA, United, Veterans Administration, Riverside, Med-Star, and John Hopkins Family Plans. The participation allows full access to almost all seeking entrance to the facility.

Hospice Care: corporate agreements in place with Seasons Hospice and Stella Maris Hospice. Individual hospice agreements on a single case agreement accepted.

Dialysis Care: an agreement with US Renal to provide on-site care to both internal in-patients and out-patients in the community.

Ventilator Care: on site ventilator unit run through an in-house unit.

Home Health: agreements with HomeCare Maryland, VNA, and Amedisys.

Assisted Living: FutureCare Homewood only discharges to licensed assisted living homes in the region, primarily Baltimore City. In addition, staff visits each center before allowing an assisted living to be part of its referral listing. Every patient receives a follow up call within 2 days after discharge, and again at the 30 day mark.

Day Care: Patients referred to adult day care center when appropriate at time of discharge.

Adult Protective Services: referrals to Baltimore City Agency when patients are identified to be at risk upon discharge.

Network Referrals: Alcohol Anonymous, Narcotic Addiction Recovery Centers, Methadone Clinics are some of the organizations with which FutureCare Homewood collaborates with to see that residents receive follow up care during discharge hand-off where appropriate.

Pharmacy Delivery: cooperate with Walgreens in a home delivery service for discharged patients unable to get out of their house.

B. New Construction or Expansion of Beds or Services. The Commission will review proposals involving new construction or expansion of comprehensive care facility beds, including replacement of an existing facility or existing beds, if new outside walls are proposed, using the following standards in addition to .05A(1)-(9):

(1) Bed Need.

(a) **An applicant for a facility involving new construction or expansion of beds or services, using beds currently in the Commission's inventory, must address in detail the need for the beds to be developed in the proposed project by submitting data including, but not limited to: demographic changes in the target population; utilization trends for the past five years and expected changes in the next five years; and demonstrated unmet needs of the target population.**

(b) **For a relocation of existing comprehensive care facility beds, an applicant must demonstrate need for the beds at the new site, including, but not limited to: demonstrated unmet needs; utilization trends for the past five years and expected changes in the next five years; and how access to, and/or quality of, needed services will be improved.**

The most recent MHCC Comprehensive Care Bed Need Projections for Baltimore City published by the MHCC (*Maryland Register*, 4/16/2016, p. 572) shows:

Gross Bed Need:	4,048
Total Bed Inventory:	3,878
Unadjusted Net Bed Need:	170
Community Based Services Adjustment:	380
2016 Net Bed Need	0

As stated above, FCH is not seeking to add new nursing home capacity in Baltimore City. Furthermore, the projections are out of date, as they are for 2016.

As the bed need projections are out of date, FCH has extended the projection of bed need in Baltimore City to the year 2020 using the MHCC's methodology as described on pages 24-25 of the Nursing Home Services section of the State Health Plan. FCH's consultant, Andrew Solberg, had the base year 2008 data because they were provided to him by Commission staff in an earlier nursing home review.

FCH downloaded the most recent "2014 Household Population Projections for Non-Hispanic White and All Other by Age, Sex and Race (7/8/14)" from the Maryland Department of Planning website. We then aggregated the 2020 date for each jurisdiction for the age cohorts 0-64, 65-74, 75-84, and 85+, which are the cohorts used in the methodology.

Population
2020
By Jurisdiction

Jurisdiction	0-64	65-74	75-84	85+
ALLEGANY	59,871	8,273	4,913	2,091
ANNE ARUNDEL	488,054	56,050	26,262	9,632
BALT/CO	697,720	85,592	40,507	23,180
CALVERT	80,123	9,482	4,346	1,650
CAROLINE	30,136	3,629	1,630	655
CARROLL	143,662	19,473	9,131	3,632
CECIL	91,028	10,802	4,895	1,871
CHARLES	151,634	14,398	6,330	1,989
DORCHESTER	27,717	4,127	2,105	849
FREDERICK	223,315	24,434	12,025	5,876
GARRETT	24,014	3,808	2,035	738
HARFORD	214,207	25,971	12,279	6,191
HOWARD	282,207	30,513	14,750	4,783
KENT	15,515	3,311	1,754	819
MONTGOMERY	898,802	98,009	47,778	22,412
PR GEORGES	790,688	77,281	34,222	12,304
QUEEN ANNES	43,127	6,081	3,325	1,066
ST MARYS	108,517	9,749	5,064	1,818
SOMERSET	23,331	2,647	1,288	481
TALBOT	28,701	6,680	3,971	1,495
WASHINGTON	132,873	15,532	8,161	3,734
WICOMICO	90,967	10,590	5,186	2,455
WORCESTER	41,157	8,305	4,864	1,774
BALT/CITY	552,808	49,379	22,194	9,711

Source: Maryland Department of Planning, (http://www.mdp.state.md.us/msdc/S3_Projection.shtml), Accessed 3/7/17.

The methodology follows the following steps.

1. *Calculate the base year patient days by age group, area of origin, and jurisdiction of care.*

This step was already performed by MHCC staff in the data provided to Mr. Solberg.

2. *Calculate the base year use rate by age group by applying the following rules:*

    a. *Calculate the use rate for the most recent year, by age group and jurisdiction of origin, by dividing the base year patient days, by age group and Maryland jurisdiction of origin, by the base year population,*

by age group and jurisdiction of origin, and multiplying the result by .1.000.

b. Calculate an adjusted base year use rate by reducing the base year use rate calculated in Paragraph (a) above by 5 percent.

This step also was already performed by MHCC staff in the data provided to Mr. Solberg.

3. Calculate the target year patient days for each age group for each Maryland jurisdiction of residence by multiplying the adjusted base year use rate for a given age group in the jurisdiction of residence by the target year projected population for the same age group in the jurisdiction, and dividing the result by 1,000.

FCH made this calculation by multiplying the appropriate use rate times the appropriate population in each jurisdiction.

4. Calculate the migration-adjusted target year patient days for each jurisdiction of care by using the following rules:

(a) When the jurisdiction of residence is the same as the jurisdiction of care, and the retention rate is less than 80 percent, and the base year use rate for the 65+ population is greater than the 33rd percentile, add the base year patient days for a given age group, receiving care in the same jurisdiction of residence, to one half of the base year patient days for a given age group receiving care outside the jurisdiction of residence; divide the result by the base year patient days for the age group and jurisdiction of residence; multiply by the target year patient days for the age group and jurisdiction of residence; and sum the result over all jurisdictions of residence in Maryland;

(b) When the jurisdiction of residence in Maryland is not the same as the jurisdiction of care, and the retention rate is less than 80 percent, and the base year use rate for the 65+ population is greater than the 33rd percentile, divide the base year patient days for a given age group, a given jurisdiction of residence, and a given jurisdiction of care by twice the base year patient days for the age group and the jurisdiction of residence; multiply the result by the target year patient days for the age group and jurisdiction of residence; and sum the result over all jurisdictions of residence;

(c) When the retention rate is greater than 80 percent, or the base year use rate for the 65+ population is less than the 33rd percentile, the target year patient days are equal to the patient days for each jurisdiction of residence as calculated in step 4(a); sum the result over all jurisdictions of residence;

(d) When the jurisdiction of residence is an adjacent state, sum the base year patient days for each age group and jurisdiction of residence for a given jurisdiction of care, multiply the base year patient days for each age group by the population growth rate in that age group, and sum the result over all

jurisdictions of residence for a given jurisdiction of care.

The data provided to Mr. Solberg identified which Step 4 rules applied to each age cohort from each jurisdiction of residence and each jurisdiction of care. FCH applied the appropriate step as identified by the MHCC.

However, for persons who received care in Baltimore City from Out of State, FCH simply used the 2008 volumes and assumed no growth.

5. *Calculate the total target year patient days for each jurisdiction of care by summing the target year patient days for each age group in the jurisdiction of care over all age groups,*

FCH calculated that the total number of patient days that would be experienced in Baltimore City in 2020 is 1,461,651.

6. *Calculate the gross bed need for each jurisdiction of care by dividing the target year patient days for the jurisdiction by the product of365 and 0.95.*

Total Patient Days 2020	1,461,651
ADC	4,005
Occupancy	95%
Gross Bed Need	4,215.29

7. *Calculate the net bed need for each jurisdiction of care by subtracting the inventory of beds obtained using the rules in .07H (1) and (2) of this Chapter from the gross bed need for the jurisdiction.*

On 3/13/17, Kevin McDonald, Chief - Certificate of Need Division at the MHCC provided FCH with an updated nursing home bed inventory, showing that there are 5,465 licensed, waiver, and temporarily de-licensed beds in Baltimore City.

Needed Beds, 2020	4,215
Total Beds	3,882
Net Need	333

8. *Calculate the number of nursing home beds for which community based services (CBS) will substitute in each jurisdiction of care.*
   (a) *Calculate the proportion of total nursing home patient days represented by the patients appropriate for CBS by dividing the CBS days by the total patient days for each jurisdiction of care in the base year.*
   (b) *Calculate the number of target year patient days appropriate for CBS by multiplying the target year patient days by the proportion of total nursing home patient days calculated in Step 8(a).*

(c) Calculate the number of nursing home beds for which CBS will substitute for nursing home beds in each jurisdiction of care by dividing the target year patient days appropriate for CBS by the result of the product of365 and 0.95.

According to the data that the MHCC had provided to Mr. Solberg, the CBS percentage for Baltimore City used in the current projections was 9.4%.

CBS Adj.	9.40%
Total 2020 Patient Days	1,461,651
CBS Pt. Days	137,371
ADC	376
Occupancy	0.95
CBS Bed Adjustment	396

9. Calculate the adjusted net bed need for each jurisdiction of care by subtracting the number of nursing horne beds for which CBS will substitute from the net bed need for each jurisdiction of care.

Needed Beds, 2020	4,215
Total Beds	3,882
Net Need	333
CBS Bed Adjustment	396
Total 2020 Need	-63

Very importantly, we are not proposing a new facility. Additionally, these beds are already in inventory. The beds are needed for existing short term rehabilitation patients in collaboration with the hospitals. Currently, while the 5th floor has short term clients, it contains residents with a broad spectrum of needs. Residents with cardiac, orthopedic, wound care, digestive disorders, neurologic diseases, pulmonary and infectious diseases, all currently stay on the unit. By creating a separate unit on the second floor, equipment, care and services can be better delineated to create optimal private space for these patients to rehab and recover. At the same time, it will enable the fifth floor to better deal with those other types of skilled short term care admissions. Furthermore, this addition will help to fund the additional needed renovations to FCH.

(2) Facility Occupancy.

(a) The Commission may approve a nursing home for expansion only if all of its beds are licensed and available for use, and it has been operating at 90 percent or higher, average occupancy for the most recent consecutive 24 months.

(b) An applicant may show evidence why this rule should not apply.

Table ___ shows the occupancy for FCH for the last two years. If one only looks at the facility wide occupancy rate, one will see that it was 88.6% in 2015 and 89.7% in 2016. However, in both 2015 and 2016, FCH was renovating the Unit 5 Short Term Care unit and had to close beds for a period of time in both years. In 2015, FCH closed five semi-private rooms (10 beds) for cardiac patients for three months (90 days each) while they were being renovated. Hence, FCH lost the ability to use 900 potential patient days during that period. In 2016, FCH renovated other areas of that unit, closing beds on a rotating schedule. FCH lost only 420 potential patient days during 2016. When these lost potential days are subtracted from the total potential days, FCH's occupancy rate is above 90% for both years.

Table 4
Occupancy Rate
By Unit
FCH
2015, 2016

Unit	Bed Count	Actual Days	Potential Days	% Occupancy	Lost Days Due to Renovation	Adj. Potential Days	Adj. % Occupancy
2015							
I (Respiratory)	31	10,090	11,315	89.2%		11,315	89.2%
4 (LTC)	39	13,489	14,235	94.8%		14,235	94.8%
5 (STC)	39	11,101	14,235	77.9%	900	13,335	83.1%
6 (LTC)	39	13,208	14,235	92.8%		14,235	92.8%
Total	148	47,888	54,020	88.6%	900	53,120	90.1%
2016							
I (Respiratory)	31	10,164	11,346	89.6%		11,346	89.6%
4 (LTC)	39	13,531	14,274	94.8%		14,274	94.8%
5 (STC)	39	11,563	14,274	81.0%	420	13,854	83.5%
6 (LTC)	39	13,337	14,274	93.4%		14,274	93.4%
Total	148	48,595	54,168	89.7%	420	53,748	90.4%
Total 24 Months	148	96,466	108,188	89.2%	1,320	106,868	90.3%

(3) Jurisdictional Occupancy.

(a) The Commission may approve a CON application for a new nursing home only if the average jurisdictional occupancy for all nursing homes in that jurisdiction equals or exceeds a 90 percent occupancy level for at least the

most recent 12 month period, as shown in the Medicaid Cost Reports for the latest fiscal year, or the latest Maryland Long Term Care Survey, if no Medicaid Cost Report is filed. Each December, the Commission will issue a report on nursing home occupancy.

(b) An applicant may show evidence why this rule should not apply.

Not applicable. FCH is not proposing a new nursing home.

(4) Medical Assistance Program Participation.

(a) An applicant for a new nursing home must agree in writing to serve a proportion of Medicaid residents consistent with .05A 2(b) of this Chapter.

Not Applicable.

(b) An applicant for new comprehensive care facility beds has three years during which to achieve the applicable proportion of Medicaid participation from the time the facility is licensed, and must show a good faith effort and reasonable progress toward achieving this goal in years one and two of its operation.

Not Applicable.

(c) An applicant for nursing home expansion must demonstrate either that it has a current Memorandum of Understanding (MOU) with the Medical Assistance Program or that it will sign an MOU as a condition of its Certificate of Need.

FCH participates in the Medical Assistance Program. FCH will sign the MOU prior to licensure of the additional bed. The most recently published Medicaid percentage requirement (*Maryland Register*, 2/5/2016, p. 303) is 47.3 percent. In FY 2016, FCH's Medicaid percentage was 68.79%.

(d) An applicant for nursing home expansion or replacement of an existing facility must modify its MOU upon expansion or replacement of its facility to encompass all of the nursing home beds in the expanded facility, and to include a Medicaid percentage that reflects the most recent Medicaid participation rate.

See (c), above.

(e) An applicant may show evidence as to why this standard should not be applied to the applicant.

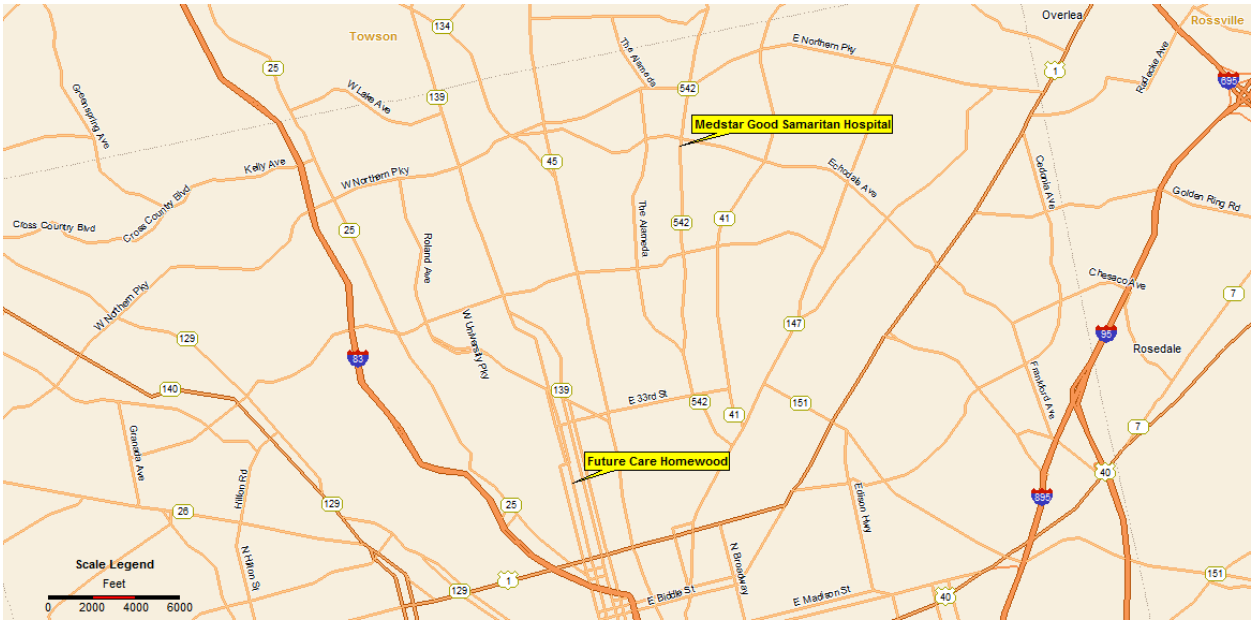
Not applicable.

(5) Quality. **An applicant for expansion of an existing facility must demonstrate that it has no outstanding Level G or higher deficiencies, and that it maintains a demonstrated program of quality assurance.**

FCH has no outstanding Level G or higher deficiencies. FCH maintains a demonstrated program of quality assurance. Exhibit 6 includes FCH's Quality Assurance Policy.

(6) Location. **An applicant for the relocation of a facility shall quantitatively demonstrate how the new site will allow the applicant to better serve residents than its present location.**

Not applicable. FCH is not proposing to relocate its facility. However, FCH acknowledges that the beds will be relocating from MedStar Good Samaritan Hospital to FCH. The two facilities are relatively close to each other, a distance of only 3.1 miles (3.6 miles, 14 minutes, driving distance and time). The effects of the relocation on the population served are not expected to be material.



C. Renovation of Facility. The Commission will review projects involving renovation of comprehensive care facilities using the following standards in addition to .05A(1)-(9).

(1) Bed Status. **The number of beds authorized to the facility is the current number of beds shown in the Commission's inventory as authorized to the facility, provided:**

(a) That the right to operate the facility, or the beds authorized to the facility, remains in good standing; and

MedStar Good Samaritan Hospital has the the right to sell the beds, which are temporarily de-licensed and remain in good standing. Future Care has the right to operate FCH and the beds authorized to the facility and remains in good standing.

(b) That the facility provides documentation that it has no outstanding Level G or higher deficiency reported by the Office of Health Care Quality.

FCH has no outstanding Level G or higher deficiency reported by the Office of Health Care Quality.

(2) Medical Assistance Program Participation. **An applicant for a Certificate of Need for renovation of an existing facility:**

(a) Shall participate in the Medicaid Program;

(b) May show evidence as to why its level of participation should be lower than that required in .05A2(b) of this Chapter because the facility has programs that focus on discharging residents to community-based programs or an innovative nursing home model of care;

(c) Shall present a plan that details how the facility will increase its level of participation if its current and proposed levels of participation are below those required in .05A2(b) of this Chapter; and

(d) Shall agree to accept residents who are Medicaid-eligible upon admission

.

FCH participates in the Medical Assistance Program. FCH will sign the MOU prior to licensure of the additional beds. The most recently published Medicaid percentage requirement (*Maryland Register*, 2/5/2016, p. 303) is 47.3 percent. In FY 2016, FCH's Medicaid percentage was 68.79%.

(3) Physical Plant. **An applicant must demonstrate how the renovation of the facility will improve the quality of care for residents in the renovated facility, and, if applicable will eliminate or reduce life safety code waivers from the Office of Health Care Quality and the State Fire Marshall's Office.**

As stated previously, the FutureCare Homewood building was built in three phases dating back to the 1890's. The original core structure was built as a hospital, and no longer houses patients. Later additions occurred with a two story building built in the 1960's and a 7 story structure erected in the early 1980's. Although the structure in its various states went through different name changes, the most prominently known name was North Charles General Hospital, an independent operation which closed in 1985. The facility was subsequently acquired by John Hopkins Hospital but closed in the late 1980's. Subsequently, the facility was purchased in the early 1990's by a nursing home chain known as Mariner Health, and operated as a sub-acute facility. By the mid 1990's Mariner sold the building and operation to FutureCare Health and

Management, who have operated it as a comprehensive nursing facility since that point in time.

Currently, the first floor is used as a dialysis site and some office space usage for the landlord of the rental company that occupies the building. Under the renovation project, this portion of the building will act as the new entrance and pathway to access the proposed second floor non-patient areas that may remain. In this manner, outside parties that are not involved in the nursing home operation will not traverse the patient care operations of the second floor.

The next stage of the hospital was built in the 1960's, and consists of two floors. It houses a ventilator unit on the first floor. The second floor of this structure is currently utilized for outside tenants, but whose best integrated use would be for the provision of health care, consistent with the intended purpose of the building. This is the area that will be re-purposed as the 30 bed Rehab Unit for cardiac and orthopedic patients.

The 1980's tower contains 7 stories (basement, and six floors.). The third floor houses the state of the art Rehab Gym referenced above. The 4th, 5th and 6th floors are patient room areas. The 5th floor houses more of a skilled care population, and the 4th and 6th floor are primarily long term care units. One obstacle of operation is that while the 5th floor has short term clients, it contains residents with a broad spectrum of needs. Residents with cardiac, orthopedic, wound care, digestive disorders, neurologic diseases, pulmonary and infectious diseases, all currently stay on the unit. By creating a separate unit on the second floor, equipment, care and services can be better delineated to create optimal private space for these patients to rehab and recover. At the same time, it will enable the fifth floor to better deal with those other types of skilled short term care admissions.

The facility has six elevators which all require modernization. While the elevators have been maintained consistently, and updated with new equipment as required, all six are coming to the end of their life cycle, as determined by a consultant report commissioned by FutureCare (ALLSAFE Elevator Inspections report).

A building (or set of buildings) as old as FCH has inefficient air handling systems. FCH proposes to install a new system of Direct Digital Controls for Air Handler units 1 and 2 which will provide significant operational, monitoring, and alarm notification enhancements over the original pneumatic controls. The upgrade will provide global transmission to all controller of QA Temperature, Humidity and Enthalpy (calculated). It will also provide full operational control via connected points to various inputs and outputs.

The last significant upgrade to the fire alarm system occurred the 1980s and, although the system is well maintained, is now 30 years old and in need of updating. Project will enhance the safety monitoring in the building. This project will replace the existing fire alarm system with a new fire panel and associated devices to include, batter back up; LCD lighting, modules, power supply, smoke detectors, heat detectors,

base, pull stations, monitor modules, relays and duct detectors.

This project also includes other components of building modernization.

- 1st floor (Ventilator Unit) upgrade of 16 rooms housing 31 beds and hallway.
  - Hallway improvements consist of wall protection, handrails, new ceiling tile and grids.
  - Room upgrades include new flooring in bedrooms and bathrooms, new overbed lights, new televisions, wall protection, vanity lights, wardrobes, chairs; nights stands, window treatments, ceiling tiles and grid, sinks and faucets, sheetrock of block walls, and paint and install new headwall protection.
- 4th floor (Long Term Care Unit) upgrade 20 rooms housing 39 beds.
  - Hallway improvements include new bump rails, handrails, painting, handrails, and flooring, ceiling grid and tile, new nursing station, security cameras, room signage.
  - Room improvements include painting, wall protection, sinks and faucets, vanity lights, overbed lights, privacy curtains, chairs, night stands, televisions, window treatments and flooring.
- 5th floor (Short Term Care Unit) upgrade Hallway
  - New handrails, wall protection and door protection, new flooring, painting, installing ceiling tile and grid, add security cameras, new Nurse Station, Med Room and Nourishment area.
- 6th floor (Long Term Care Unit) upgrade 20 rooms housing 39 beds and hallway.
  - Hallway improvements to include, handrails, bump rails, door protection, painting, new flooring, ceiling tile and grid, security cameras, nurse station, med room and nourishment area.
  - Room improvements to include painting, wall protection, sinks and faucets, vanity lights, overbed lights, window treatments, chairs, night stands, and flooring.

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

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

INSTRUCTIONS: Fully address the way in which the proposed project is consistent with any specific applicable need standard or need projection methodology in the State Health Plan. If the current bed need projection published by the MHCC based on the need formula in the State Health Plan does not project a need for all of the beds proposed, the applicant should identify the need that will be addressed by the proposed project by quantifying the need for all facility and service capacity proposed for development,

relocation or renovation in the project.

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

Please assure that all sources of information used in the need analysis are identified and identify all the assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), and the relevant population considered in the analysis with information that supports the validity of these assumptions. The existing and/or intended service area population of the applicant should be clearly defined.

Complete the Statistical Projection (Tables D and E, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Table D must be completed if the applicant is an existing facility. Table E must be completed if the application is for a new facility or service or if it is requested by MHCC staff.

The response to Nursing Home Standard COMAR 10.24.08.05B(1) is hereby incorporated into this response.

The addition of 30 private rooms at FutureCare Homewood will meet the growing need for private accommodations once a person discharges from the acute setting to the subacute setting for rehabilitation. MedStar Health and Mercy Hospital, the closest hospital systems to Homewood, have created private rooms for all of their acute patients, complete with private bath, and state-of-the-art conveniences. Once a patient is stable for discharge to a subacute facility, the expectation is that they will have a private room with private bath. Orthopedic and Cardiac patients in particular tend to be younger, more demanding of private accommodations. This alert, oriented, patient also expects services such as Wi-Fi, cable and phone, as well as selective dining options, all of which will be available in the newly created 30 bed unit.

MHCC Public Use data for 2014 show that the transitional care unit at Good Samaritan Hospital (from which these beds are bring purchased and which this unit will effectively replace) operated at 90.8% occupancy.

Beds	Beds x 365	Patient Days	% Occupancy
30	10,950	9,946	90.8%

Data from Avalere – Vantage Care (a data source) for Q3 2015 through Q2 of 2016 at MedStar Good Samaritan Hospital and MedStar Union Memorial Hospital show a total of 1,559 new SNF placements, with 436 of those going to the TCU at MedStar

Good Samaritan Hospital. That equates to over 430 patients needing placement each year in Baltimore City with the TCU beds no longer in service. In addition, the average Length of Stay ("ALOS") in the hospital has decreased, as the shift in healthcare to discharge patients sooner, or not admit at all had had a direct impact on hospital ALOS. Direct admits from the ER or Observation Units to the SNF are increasing, as hospitals look for more cost effective ways to care for patients.

Through the VitalStrong Rehabilitation Programs at FutureCare, the applicant has developed a collaborative relationship with MedStar Health to develop the HeartStrong 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. This collaborative effort with the hospital cardiac and orthopedic teams has resulted in clinical pathways for Cardiac patients needing short stay rehab, as well as orthopedic post-surgical recovery. Ongoing feedback from the hospital physicians is that private rooms are needed to provide a smooth transition from the hospital setting to rehab, and provide the best accommodations for healing and recovery. The 30 new private room unit will cater specifically to this population, featuring HeartStrong and WalkStrong, allowing the current 5th floor unit of semi-private rooms to treat more of the medically complex or longer staying rehab patients such as stroke, trach, and dialysis.

10.24.01.08G(3)(c). <u>Availability of More Cost-Effective Alternatives</u>.

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 project. It should also identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including the alternative of the services being provided by existing facilities.

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 cost 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 goal and objective achievement or the most effective solution to the identified

problem(s) for the level of cost required to implement the project, when compared to the effectiveness and cost of alternatives including the alternative 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.

FutureCare Homewood considered two alternatives to adding these beds, adding them at FutureCare Irvington and FutureCare Homewood:

Adding the beds at FutureCare Irvington:

1. Like FutureCare Homewood, FutureCare Irvington is comprised of different attached building constructed in different decades. However, unlike FutureCare Homewood, adding the beds at FutureCare Irvington could only have been accomplished by putting them in a wing that is remote from any core or support service areas making it operationally untenable.

2. FutureCare Irvington already has 48 private rooms to service residents,.

3. The anticipated cost of constructing at FutureCare Irvington would have been greater, as the remote part of the building would have required new electrical, plumbing, HVAC, structural and other upgrades far beyond the plant at Homewood.

4. Thirty private rooms unlikely to fit onto one floor of this old building space, and the need is to create private room's not semi-private accommodations.

Adding the beds at FutureCare Homewood:

1. Much closer proximity to the campus of MedStar Good Samaritan Hospital which is the original site of the purchased beds.

2. The physical space currently allows for 30 private rooms. Currently the entire building holds only 4 private rooms, all on different floors.

3. Currently residents with cardiac, orthopedic, wound care, digestive disorders, neurologic diseases, pulmonary and infectious diseases, all stay on the same unit. By creating a separate unit on the second floor, equipment, care and services can be better delineated as a distinct short-stay orthopedic and cardiac rehabilitation unit. Advanced training of staff, an educational resource area, and amenities such as private rooms with bath, help to provide a seamless transition from the hospital to rehabilitation.

4. The development of the second floor as a VitalStrong Rehabilitation Unit for orthopedic and cardiac rehab will enable the fifth floor to better meet the needs of a more clinically complex skilled short term patient. Not only does FutureCare Homewood admit patients from all Baltimore area hospitals

requiring skilled nursing and rehabilitation onto the fifth floor, but patients that have been weaned from the ventilator unit on the first floor are often able to be transferred to the fifth floor for continued nursing and rehabilitation care if there is a bed available.

5. As FutureCare Homewood requires substantial additional upgrades and renovation, the addition of the 30 beds serves to underwrite the costs of the upgrades.

FutureCare Homewood also considered renovating the second floor and creating a 30 bed all private room unit, without adding 30 beds. However, this had several deficiencies.

1. Given FutureCare Homewood's high occupancy, it would not allow FutureCare Homewood to be able to accommodate the admissions which are referred to it by local hospitals since the temporary delicensure of the MedStar Good Samaritan TCU.

2. It would not allow FutureCare Homewood to separate the short stay patients into appropriate clinical or rehabilitation units as described above.

3. It would not help to support the additional upgrades and renovations needed by FutureCare Homewood.

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

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

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

- **Complete applicable Revenue & Expense Tables and the Workforce and Bedside Care Staffing worksheets in the CON Table Package, as required (Tables H and I for all applicants and Table F for existing facilities and/or Table G, for new facilities, new services, and when requested by MHCC staff). Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item. Instructions are provided in the cover sheet of the CON package and on each worksheet. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if**

applicable. If the projections are based on Medicare percentages above the median for the jurisdiction in which the nursing home exists or is proposed, explain why the projected Medicare percentages are reasonable.

- **Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an <u>independent</u> Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.**

- **If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.**

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

- **Identify the performance requirements applicable to the proposed project (see Part I question 15) and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).**

We expect the facility current lender, PNC, to finance this project through a construction loan which will be combined with the existing mortgage loan and ultimately convert to a permanent loan at the end of 2020. Terms are assumed to be interest only (prime rate 4%) through the construction period and then converting to a permanent loan with a 25 year amortization (also at prime rate). All debt service is paid by the operator to the owner and is incorporated in the rent expense line item, which you will note increases annually during this project. The current mortgage on the property is approximately 2.2 million. This project anticipates adding an additional 6.250 million in debt over a 3 year period, culminating in a 8.250 million permanent loan. This approximates only a 35% loan to value (LTV) ratio which is extremely low. Due to this extremely low LTV, we are projecting a $0 equity requirement for this project.

As the CON Application Table Package shows, FCH is financially viable and will remain so after it implements this project.

FCH does not have audited financial statements. Exhibit 7 includes unaudited financial reports for the most recent two years.

Exhibit 8 includes a letter expressing interest in working with FCH to obtain financing.

Exhibit 9 includes letters of support. As more are received, FCH will forward them to the MHCC.

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

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

INSTRUCTIONS: List all of the Maryland Certificates of Need that have been issued to the project applicant, its parent, or its affiliates or subsidiaries over the prior 15 years, including their terms and conditions, and any changes to approved Certificates that needed to be obtained. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

This applicant has no Certificates of Need within the last fifteen years.

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

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

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:

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

b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant for a new nursing home claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer.

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

d) On costs to the health care delivery system.

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

This project should not have any impact on other facilities, as it is effectively replacing the transitional care unit at MedStar Good Samaritan Hospital, which operated at over 90 percent occupancy.

The additional 30 beds will impact the payor mix to the extent that it will increase the overall Medicare percentage and, to a lesser extent, increase the private insurance percentage. The Medicaid percentage will decline a small amount, but will still be higher than the 47.3 percent to which FCH will commit in the signed MOU. (While the Medicaid percentage is expected to decline, the number of Medicaid admissions and patient days is not expected to decline.) In FY 2016, FCH's Medicaid percentage was 68.79%.

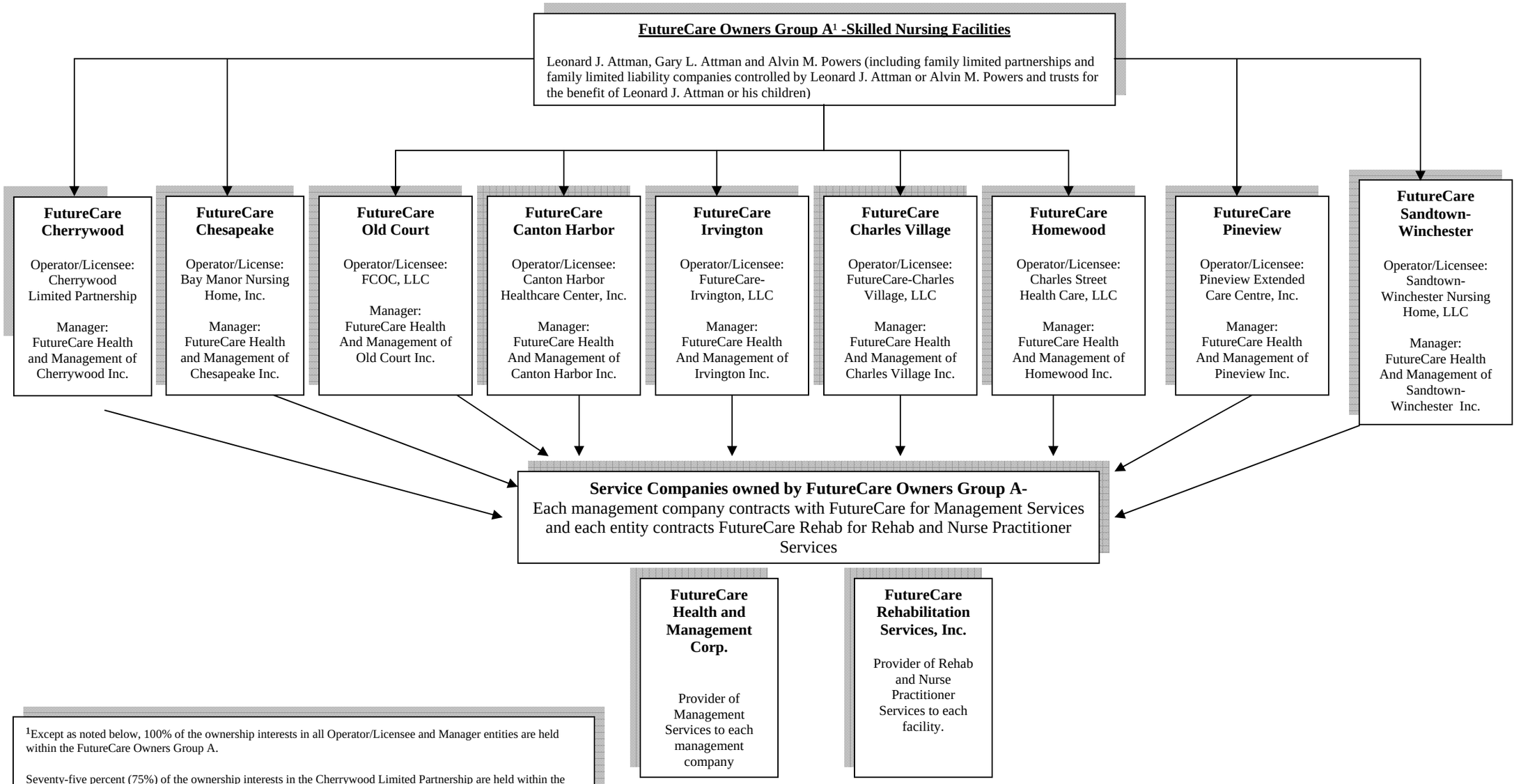
The Table of Assumptions which explain the bases for the cost and revenue assumptions is included in Exhibit 10.

Exhibits

1. Organizational Chart
2. CON Application Table Package
3. Project Drawings
4. Material Distributed To Prospective Residents
5. FutureCare's Discharge Planning Policy
6. Quality Assurance Policy
7. Financial Statements
8. Letter Regarding Financing
9. Letters of Support
10. Table of Assumptions
11. Affirmations

EXHIBIT 1

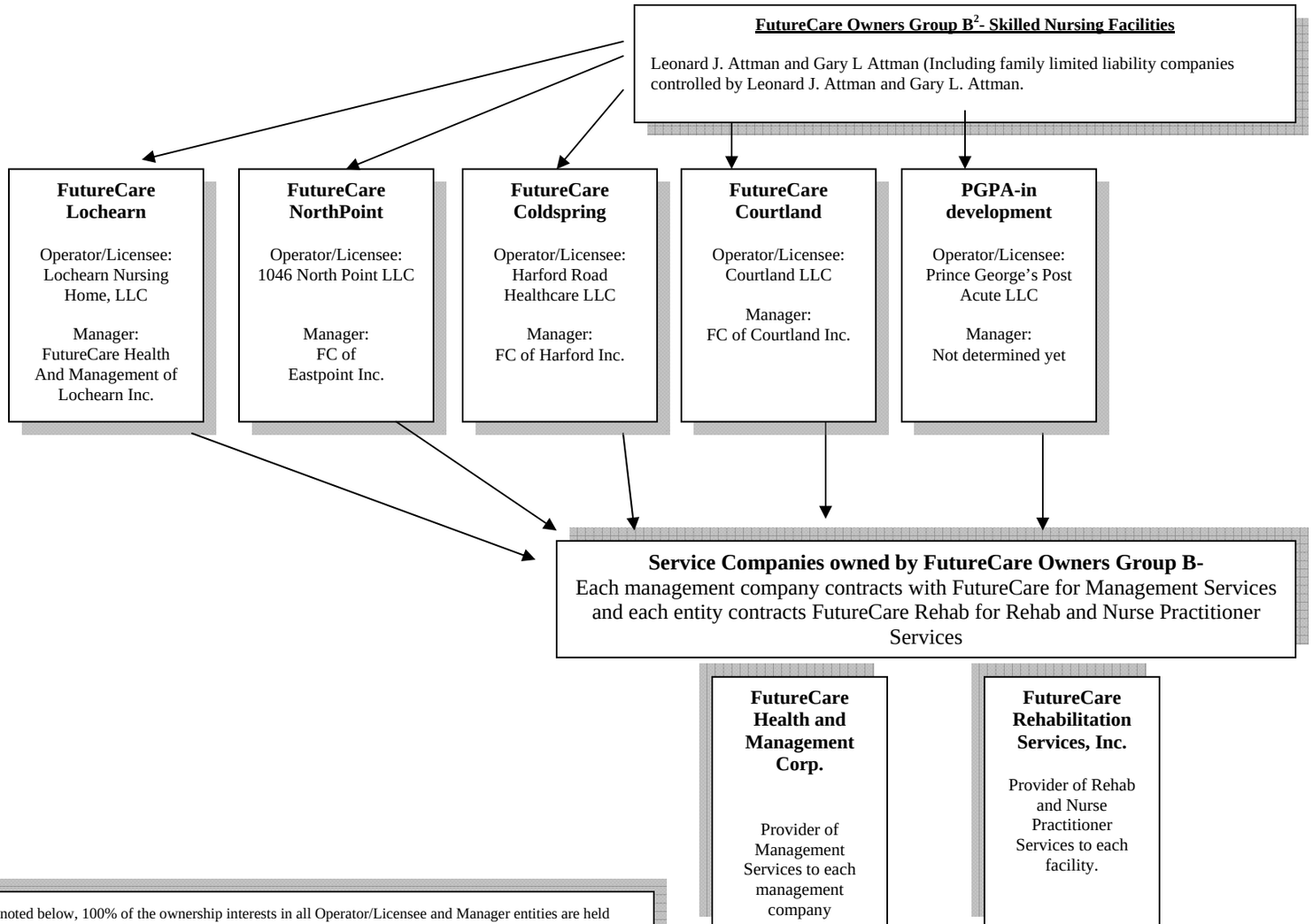
FUTURECARE ORGANIZATION CHART



[1]Except as noted below, 100% of the ownership interests in all Operator/Licensee and Manager entities are held within the FutureCare Owners Group A.

Seventy-five percent (75%) of the ownership interests in the Cherrywood Limited Partnership are held within the FutureCare Owners Group A.
Sixty percent (60%) of the ownership interests in FCOC, LLC are held within the FutureCare Owners Group A

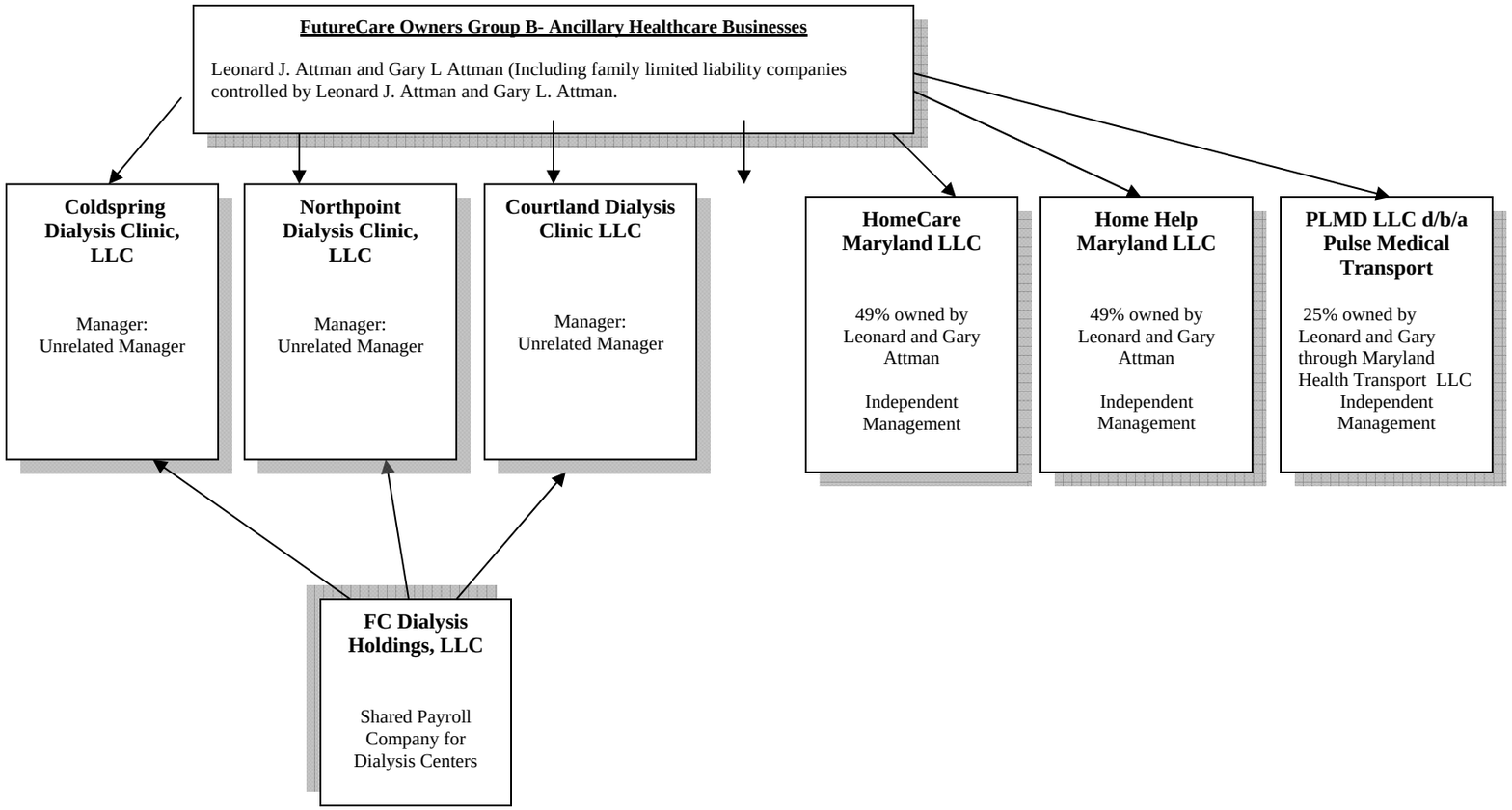
FUTURECARE ORGANIZATION CHART

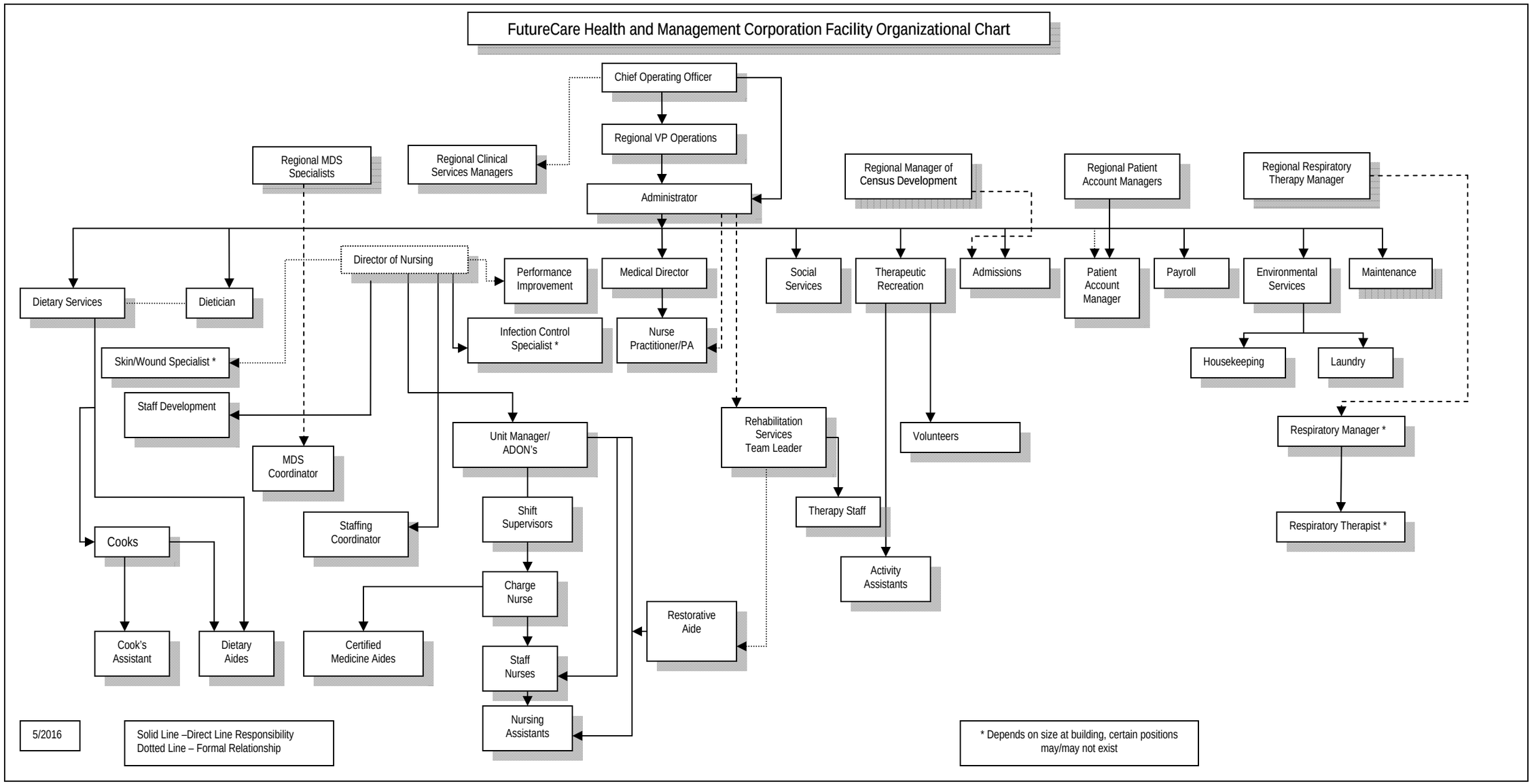


[2]Except as noted below, 100% of the ownership interests in all Operator/Licensee and Manager entities are held within the FutureCare Owners Group B.

[2]Ninty percent (90%) of the ownership interests in Lochearn Nursing Home, LLC are held within the FutureCare Owners Group B.
Fifty one percent (51%) of the ownership interests in Courtland, LLC are held within the FutureCare Owners Group B

FUTURECARE ORGANIZATION CHART




FutureCare Health and Management Corporation Facility Organizational Chart
Chief Operating Officer
Regional VP Operations
Regional MDS Specialists
Regional Clinical Services Managers
Regional Manager of Census Development
Regional Patient Account Managers
Regional Respiratory Therapy Manager
Administrator
Director of Nursing
Performance Improvement
Medical Director
Social Services
Therapeutic Recreation
Admissions
Patient Account Manager
Payroll
Environmental Services
Maintenance
Dietary Services
Dietician
Infection Control Specialist *
Nurse Practitioner/PA
Skin/Wound Specialist *
Housekeeping
Laundry
Staff Development
Rehabilitation Services Team Leader
Volunteers
Unit Manager/ ADON's
Respiratory Manager *
MDS Coordinator
Shift Supervisors
Therapy Staff
Cooks
Staffing Coordinator
Respiratory Therapist *
Charge Nurse
Activity Assistants
Restorative Aide
Cook's Assistant
Dietary Aides
Certified Medicine Aides
Staff Nurses
Nursing Assistants
5/2016
Solid Line –Direct Line Responsibility
Dotted Line – Formal Relationship
* Depends on size at building, certain positions may/may not exist

FutureCare Health and Management Corporation
Operations Organizational Chart

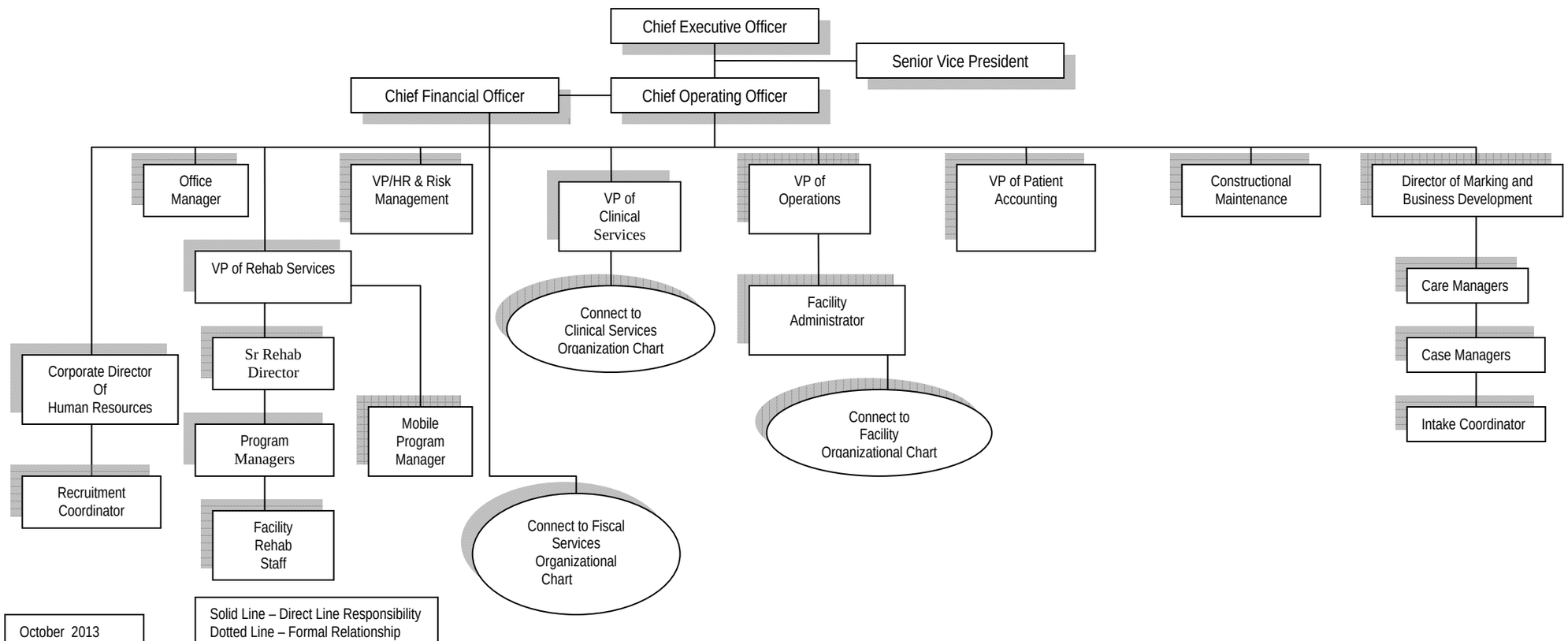


EXHIBIT 2

TABLE A. BED CAPACITY BY FLOOR AND NURSING UNIT BEFORE AND AFTER PROJECT

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

Before the Project						After Project Completion				
		Based on Physical Capacity				Based on Physical Capacity				
		Room Count					Room Count			
Service Location (Floor/Wing)	Current Licensed Beds	Private	Semi-Private	Total Rooms	Physical Bed Capacity	Service Location (Floor/Wing)	Private	Semi-Private	Total Rooms	Physical Bed Capacity
COMPREHENSIVE CARE						**COMPREHENSIVE CARE**				
First Floor Unit	31	1	15	16	31	**First Floor Unit**	1	15	16	31
						Second Floor Unit	30		30	30
Fourth Floor Unit	39	1	19	20	39	**Fourth Floor Unit**	1	19	20	39
Fifth Floor Unit	39	1	19	20	39	**Fifth Floor Unit**	1	19	20	39
Sixth Floor Unit	39	1	19	20	39	**Sixth Floor Unit**	1	19	20	39
SUBTOTAL Comprehensive Care	**148**	**4**	**72**	**76**	**148**	**SUBTOTAL**	**34**	**72**	**106**	**178**
ASSISTED LIVING						**ASSISTED LIVING**				
TOTAL ASSISTED LIVING						**TOTAL ASSISTED LIVING**				
Other *(Specify/add rows as needed)*				0	0	**Other** *(Specify/add rows as needed)*			0	0
TOTAL OTHER						**TOTAL OTHER**				
FACILITY TOTAL	**148**	**4**	**72**	**76**	**148**	**FACILITY TOTAL**	**34**	**72**	**106**	**178**

TABLE B. PROPOSED NEW CONSTRUCTION AND RENOVATION SQUARE FOOTAGE

INSTRUCTION: Account for all existing and proposed square footage by floor. Further breakdown by nursing unit and building wing are at Applicants discretion and should be used by applicants if it adds valuable information to the description of the existing and proposed facilities. Add or delete rows if necessary. See additional instruction in the column to the right of the table.

Gross Square Footage by Floor/Nursing Unit/Wing	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Basement	**22,255**	**0**	**0**	**22,255**	**22,255**
First Floor	**42,356**	**0**	**10,044**	**32,312**	**42,356**
Second Floor	**42,636**	**0**	**21,591**	**21,045**	**42,636**
Third Floor	**16,292**	**0**	**0**	**16,292**	**16,292**
Fourth Floor	**13,780**	**0**	**7,436**	**6,344**	**13,780**
Fifth Floor	**13,780**	**0**	**3,282**	**10,498**	**13,780**
Sixth Floor	**11,920**	**0**	**7,590**	**4,330**	**11,920**
Penthouse	2,204	0	0	2,204	**2,204**
					0
					0
					0
					0
					0
					0
					0
					0
Total	**165,223**	**0**	**49,943**	**115,280**	**165,223**

TABLE C. PROJECT BUDGET

INSTRUCTION: Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application. If the project involves services other than CCF such as assisted living explain the allocation of costs between the CCF and the other service(s). See additional instruction in the column to the right of the table. NOTE: Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.a as a use of funds and on line B.8 as a source of funds

			CCF Nursing Home	Other Service Areas	Total
A.	**USE OF FUNDS**				
1.	**CAPITAL COSTS**				
	a.	**New Construction**			
	(1)	Building			$0
	(2)	Fixed Equipment			$0
	(3)	Site and Infrastructure			$0
	(4)	Architect/Engineering Fees			$0
	(5)	Permits (Building, Utilities, Etc.)			$0
		SUBTOTAL New Construction	**$0**	**$0**	**$0**
	b.	**Renovations**			
	(1)	Building	$5,076,735		$5,076,735
	(2)	Fixed Equipment (not included in construction)			$0
	(3)	Architect/Engineering Fees	$335,575		$335,575
	(4)	Permits (Building, Utilities, Etc.)	$50,000		$50,000
		SUBTOTAL Renovations	**$5,462,310**	**$0**	**$5,462,310**
	c.	**Other Capital Costs**			
	(1)	Movable Equipment	$225,000		$225,000
	(2)	Contingency Allowance	$183,632		$183,632
	(3)	Gross interest during construction period	$151,285		$151,285
	(4)	Other *(Specify/add rows if needed)*	$320,000		$320,000
		SUBTOTAL Other Capital Costs	**$879,917**	**$0**	**$879,917**
		TOTAL CURRENT CAPITAL COSTS	**$6,342,227**	**$0**	**$6,342,227**
	d.	Land Purchased/Donated			
	e.	Inflation Allowance	$206,255		$206,255
		TOTAL CAPITAL COSTS	**$6,548,482**	**$0**	**$6,548,482**
2.	**Financing Cost and Other Cash Requirements**				
	a.	Loan Placement Fees	$200,700		$200,700
	b.	Bond Discount			$0
	c.	Legal Fees CON)	$25,000		$25,000
	d.	Legal Fees (Other)			$0
	e.	Non-Legal Consultant Fees (CON application related - specify what it is and why it is needed for the CON	$25,000		$25,000
	f.	Non-Legal Consultant Fees			
	g.	Liquidation of Existing Debt			$0
	h.	Debt Service Reserve Fund			$0
	i.	Other *(Specify/add rows if needed)*			$0
		SUBTOTAL	**$250,700**	**$0**	**$250,700**
3.	**Working Capital Startup Costs**				$0
		TOTAL USES OF FUNDS	**$6,799,182**	**$0**	**$6,799,182**
B.	**Sources of Funds**				
1.	**Cash**				$0
2.	**Philanthropy (to date and expected)**				$0
3.	**Authorized Bonds**				$0
4.	**Interest Income from bond proceeds listed in #3**				$0
5.	**Mortgage/Loan**		**$6,799,182**		$6,799,182
6.	**Working Capital Loans**				$0
7.	**Grants or Appropriations**				
	a.	**Federal**			$0
	b.	**State**			$0
	c.	**Local**			$0
8.	**Other *(Specify/add rows if needed)***				$0

TOTAL SOURCES OF FUNDS	**$6,799,182**		**$6,799,182**
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

TABLE 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. 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. ADMISSIONS										
a. Comprehensive Care (public)	401	429	482	503	526	608	866			
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care	**401**	**429**	**482**	**503**	**526**	**608**	**866**	**0**	**0**	**0**
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL ADMISSIONS	***401***	***429***	***482***	***503***	***526***	***608***	***866***			
2. PATIENT DAYS										
a. Comprehensive Care (public)	47,888	48,595	49,640	49,640	49,640	51,508	59,495			
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care	**47,888**	**48,595**	**49,640**	**49,640**	**49,640**	**51,508**	**59,495**	**0**	**0**	**0**
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	***47,888***	***48,595***	***49,640***	***49,640***	***49,640***	***51,508***	***59,495***			
3. NUMBER OF BEDS										
a. Comprehensive Care (public)	148	148	148	148	148	156	178			
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care Beds	**148**	**148**	**148**	**148**	**148**	**156**	**178**	**0**	**0**	**0**
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL BEDS	***148***	***148***	***148***	***148***	***148***	***156***	***178***	***0***	***0***	***0***

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. 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**			
4. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. Comprehensive Care (public)	88.6%	89.7%	91.9%	91.9%	91.9%	90.5%	91.6%	#DIV/0!	#DIV/0!	#DIV/0!
b. Comprehensive Care (CCRC Restricted)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Comprehensive Care Beds	**88.6%**	**90.0%**	**91.9%**	**91.9%**	**91.9%**	**90.5%**	**91.6%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Assisted Living	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**88.6%**	**90.0%**	**91.9%**	**91.9%**	**91.9%**	**90.5%**	**91.6%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
5. OUTPATIENT (specify units used for charging and recording revenues)										
a. Adult Day Care										
b. Other (Specify/add rows of needed)										
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***

TABLE E. UTILIZATION PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (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 proposed 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 with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY	**2020 3 months**	**2021**					
1. ADMISSIONS							
a. Comprehensive Care (public)	59	277					
b. Comprehensive Care (CCRC Restricted)							
Total Comprehensive Care	**59**	**277**	**0**	**0**	**0**	**0**	**0**
c. Assisted Living							
d. Other (Specify/add rows of needed)							
TOTAL ADMISSIONS							
2. PATIENT DAYS							
a. Comprehensive Care (public)	1,868	9,855					
b. Comprehensive Care (CCRC Restricted)							
Total Comprehensive Care	**1,868**	**9,855**	**0**	**0**	**0**	**0**	**0**
c. Assisted Living							
TOTAL PATIENT DAYS	***1,868***	***9,855***	***0***	***0***	***0***	***0***	***0***
3. NUMBER OF BEDS							
a. Comprehensive Care (public)	30	30					
b. Comprehensive Care (CCRC Restricted)							
Total Comprehensive Care Beds	**30**	**30**	**0**	**0**	**0**	**0**	**0**
c. Assisted Living							
d. Other (Specify/add rows of needed)							
TOTAL BEDS	***30***	***30***	***0***	***0***	***0***	***0***	***0***
4. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. Comprehensive Care (public)	67.7%	90.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. Comprehensive Care (CCRC Restricted)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Comprehensive Care Beds	**67.7%**	**90.0%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Assisted Living	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**67.7%**	**90.0%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
5. OUTPATIENT (specify units used for charging and recording revenues)							
a. Adult Day Care							
b. Other (Specify/add rows of needed)							
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***

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	23,060,620	26,737,333			
b. Outpatient Services										
Gross Patient Service Revenues	***$ 21,203,993***	***$ 21,541,035***	***$ 22,148,468***	***$ 22,148,468***	***$ 22,148,468***	***$ 23,060,620***	***$ 26,737,333***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 244,025	$ 331,725	$ 377,081	$ 377,081	$ 377,081	$ 392,590	$ 455,104			
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***	***$ 22,668,030***	***$ 26,282,229***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 32,484	$ 30,683	$ 56,089	$ 56,089	$ 56,089	$ 56,495	$ 58,784			
NET OPERATING REVENUE	***$ 20,992,452***	***$ 21,239,992***	***$ 21,827,476***	***$ 21,827,476***	***$ 21,827,476***	***$ 22,724,525***	***$ 26,341,013***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 9,873,882	$ 10,242,322	$ 10,670,441	$ 10,670,441	$ 10,670,441	$ 11,216,841	$ 12,818,096			
b. Contractual Services	$ 2,116,025	$ 2,258,780	$ 2,205,416	$ 2,205,416	$ 2,205,416	$ 2,364,713	$ 2,961,664			
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	$ 954,210	$ 1,093,225			
j. Other Expenses (Specify/add rows if needed)	$ -	$ -	$ -	$ -	$ -	$ -	$ -			
Pharmacy	$ 683,785	$ 718,634	$ 765,084	$ 765,084	$ 765,084	$ 832,931	$ 1,085,456			
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	$ 263,738	$ 289,443			
Food	$ 365,374	$ 371,680	$ 357,904	$ 357,904	$ 357,904	$ 371,373	$ 428,959			
Utilities	$ 10,631	$ 325	$ 993	$ 993	$ 993	$ 1,030	$ 1,190			

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**			
Taxes/Property/ Insurance	$ 1,025,728	$ 1,087,292	$ 1,123,659	$ 1,123,659	$ 1,123,659	$ 1,147,696	$ 1,255,527			
Rental of Facility	$ 1,040,000	$ 1,187,217	$ 1,212,000	$ 1,267,128	$ 1,440,288	$ 1,572,444	$ 1,795,752			
Equipment rental/Repairs & Maint	$ 190,788	$ 379,281	$ 378,118	$ 378,118	$ 378,118	$ 387,472	$ 426,450			
Transportation Services	$ 135,634	$ 148,456	$ 124,538	$ 124,538	$ 124,538	$ 128,157	$ 141,806			
TOTAL OPERATING EXPENSES	**$ 18,524,936**	**$ 19,790,576**	**$ 20,322,034**	**$ 20,377,162**	**$ 20,550,322**	**$ 21,545,703**	**$ 24,602,666**	**$ -**	**$ -**	**$ -**

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**			
3. INCOME										
a. Income From Operation	**$ 2,467,516**	**$ 1,449,417**	**$ 1,505,442**	**$ 1,450,314**	**$ 1,277,154**	**$ 1,178,822**	**$ 1,738,347**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income										
SUBTOTAL	***$ 2,467,516***	***$ 1,449,417***	***$ 1,505,442***	***$ 1,450,314***	***$ 1,277,154***	***$ 1,178,822***	***$ 1,738,347***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 2,467,516***	***$ 1,449,417***	***$ 1,505,442***	***$ 1,450,314***	***$ 1,277,154***	***$ 1,178,822***	***$ 1,738,347***	***$ -***	***$ -***	***$ -***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	26.4%	30.3%	32.1%	32.1%	32.1%	33.8%	38.7%			
2) Medicaid	64.2%	61.1%	60.9%	60.9%	60.9%	59.0%	53.7%			
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%	6.1%			
5) Self-pay	1.7%	1.1%	0.5%	0.5%	0.5%	0.5%	0.4%			
6) Other	1.1%	1.3%	1.3%	1.3%	1.3%	1.2%	1.0%			
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%	25.1%	29.4%			
2) Medicaid	71.4%	68.8%	69.1%	69.1%	69.1%	67.4%	62.6%			
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%	5.4%	6.1%			
5) Self-pay	1.9%	1.4%	0.7%	0.7%	0.7%	0.7%	0.6%			
6) Other	1.3%	1.6%	1.5%	1.5%	1.5%	1.4%	1.2%			
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE G. 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). This table should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the utilization projections in Table E and with the Workforce costs 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 projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Revenue should be projected based on actual charges with detailed calculation by payer in the attachment. The contractual allowance should not be reported if it is a positive adjustment to gross revenue. Specify the sources of non-operating income. See additional instructions in the column to right of the table.

	Projected Years (ending five years after completion) Add columns of needed.						
Indicate CY or FY	**2020 3 months**	**2021**					
1. REVENUE							
a. Inpatient Services	$ 912,152	4,588,865					
b. Outpatient Services							
Gross Patient Service Revenues	***$ 912,152***	***$ 4,588,865***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 15,509	$ 78,023					
d. Contractual Allowance							
e. Charity Care							
Net Patient Services Revenue	***$ 896,643***	***$ 4,510,842***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify)	$ 406	$ 2,695					
NET OPERATING REVENUE	***$ 897,049***	***$ 4,513,537***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 546,400	$ 2,147,656					
b. Contractual Services	$ 159,296	$ 756,247					
c. Interest on Current Debt	$ 20,299	$ 20,299					
d. Interest on Project Debt	$ -	$ -					
e. Current Depreciation	$ -	$ -					
f. Project Depreciation	$ -	$ -					
g. Current Amortization	$ -	$ -					
h. Project Amortization	$ -	$ -					
i. Supplies	$ 32,894	$ 171,908					
j. Other Expenses (Specify)	$ -	$ -					
Pharmacy	$ 67,847	$ 320,372					
Management Fee	$ -	$ -					
Other Administration	$ (14,027)	$ 11,678					
Food	$ 13,468	$ 71,055					
Utilities	$ 37	$ 197					
Taxes/Property/ Insurance	$ 24,037	$ 131,868					
Rental of Facility	$ 121,632	$ 344,940					
Equipment rental/Repairs & Maint	$ 9,353	$ 48,332					
Transportation Services	$ 3,619	$ 17,268					
TOTAL OPERATING EXPENSES	***$ 984,856***	***$ 4,041,820***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ (87,807)**	**$ 471,717**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (87,807)***	***$ 471,717***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ (87,807)***	***$ 471,717***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	74.8%	70.4%					
2) Medicaid	13.2%	18.9%					
3) Blue Cross	0.0%	0.0%					
4) Commercial Insurance	12.0%	10.6%					

TABLE G. 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). This table should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the utilization projections in Table E and with the Workforce costs 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 projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Revenue should be projected based on actual charges with detailed calculation by payer in the attachment. The contractual allowance should not be reported if it is a positive adjustment to gross revenue. Specify the sources of non-operating income. See additional instructions in the column to right of the table.

	Projected Years (ending five years after completion) Add columns of needed.						
Indicate CY or FY	**2020 3 months**	**2021**					
5) Self-pay	0.0%	0.0%					
6) Other	0.0%	0.0%					
TOTAL	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Inpatient Days							
1) Medicare	65.5%	14.7%					
2) Medicaid	21.4%	78.9%					
3) Blue Cross	0.0%	0.0%					
4) Commercial Insurance	13.1%	3.7%					
5) Self-pay	0.0%	0.9%					
6) Other	0.0%	1.8%					
TOTAL	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE H. 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. See additional instruction in the column to the right of the table.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT	
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)*											
Assistant Administrator	0.918	36.06	$68,818							0.918	$68,818
Admissions	0.918	34.38	$65,617							0.918	$65,617
Clerical	0.554	16.16	$18,602	0.369	$16.16	$12,401				0.923	$31,003
Quality Assurance	0.918	39.76	$75,887							0.918	$75,887
Central Supply	0.918	17.49	$33,376							0.918	$33,376
Reception	2.005	14.02	$58,497							2.005	$58,497
Business Office	1.765	25.78	$94,652							1.765	$94,652
Medical Records	0.889	24.98	$46,190							0.889	$46,190
Inservice Training	0.459	40.09	$38,252							0.459	$38,252
Payroll/Personnel	0.918	27.13	$51,776							0.918	$51,776
Staffing Coordinator	0.918	16.91	$32,276							0.918	$32,276
Total Administration	11.2		$583,942	0.4		$12,401			$0	11.5	$596,343
Direct Care Staff *(List general categories, add rows if needed)*											
DON	0.918	58.62	$111,880							0.918	$111,880
Asst DON	0.918	48.89	$93,298							0.918	$93,298
Shift Supervisor	3.209	40.94	$273,271							3.209	$273,271
Unit Manager	3.670	43.61	$332,933	0.918	$43.61	$83,233				4.588	$416,167
RN	24.693	37.66	$1,934,395	9.827	$37.97	$776,120				34.520	$2,710,515
LPN	13.477	29.75	$833,999	1.404	$29.75	$86,875				14.881	$920,874
GNA	52.697	15.54	$1,702,902	11.240	$15.54	$363,206				63.936	$2,066,109
Respiratory	12.289	35.95	$919,018	0.000						12.289	$919,018
Restorative Aide	2.166	16.40	$73,870	0.902	$16.40	$30,779				3.068	$104,650

TABLE H. WORKFORCE INFORMATION

Unit Secretaries	1.835	14.54	$55,511	0.918	$14.54	$27,756				2.753	$83,267
MDS Coordinator	1.925	40.50	$162,175	0.963	$40.50	$81,087				2.888	$243,262
Total Direct Care	117.8		$6,493,253	26.2		$1,449,057				144.0	$7,942,310
Support Staff *(List general categories, add rows if needed)*											
Activities	3.498	$15.82	$115,081	0.860	$11.26	$20,145				4.358	$135,226
Dietary	7.323	$30.28	$461,214	2.501	$30.41	$158,196				9.824	$619,410
Housekeeping	14.460	$13.39	$402,597	2.580	$11.62	$62,358				17.040	$464,954
Laundry	4.054	$10.81	$91,121	0.921	$10.81	$20,709				4.975	$111,830
Maintenance	3.527	$25.28	$185,477							3.527	$185,477
Social Service	2.803	$23.42	$136,507	0.471	$19.43	$19,049				3.274	$155,556
Total Support	35.7		$1,391,998	7.3		$280,457			$0	43.0	$1,672,455
REGULAR EMPLOYEES TOTAL	164.6		$8,469,192	33.9		$1,741,915			$0	198.5	$10,211,107

TABLE H. WORKFORCE INFORMATION

2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
Administrator			$210,979			$0			$0	0.0	$210,979
						$0			$0	0.0	$0
						$0			$0	0.0	$0
						$0			$0	0.0	$0
Total Administration			$210,979			$0			$0	0.0	$210,979
Direct Care Staff *(List general categories, add rows if needed)*											
Contract Nursing and Respiratory			$176,676								$176,676
Nurse Practitioner			$62,550								$62,550
Physical Therapy			$640,758			$306,316					$947,075
Occupational Therapy			$625,857			$299,192					$925,050
Speech Therapy			$223,520			$106,854					$330,375
Laboratory			$72,501			$34,061					$106,562
Radiology			$18,983			$9,035					$28,018
Total Direct Care Staff			$1,820,846			$755,459			$0	0.0	$2,576,305
Support Staff *(List general categories, add rows if needed)*											
Social Service			$993			$197			$0	0.0	$1,190
Medical Director			$100,356			$0			$0	0.0	$100,356
Dentist			$16,800			$0			$0	0.0	$16,800
Barber and Beauty			$2,978			$591			$0	0.0	$3,570
Security			$52,464			$0					
Total Support Staff			$173,591			$788			$0	0.0	$174,380
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 I. Scheduled Staff for Typical Work Week

INSTRUCTION: Quantify the staff that will provide bedside care that would be counted toward the current minimum staffing as required by COMAR 10.07.02.12

	Weekday Hours Per Day					Weekend Hours Per Day			
Staff Category	**Day**	**Evening**	**Night**	**Total**		**Day**	**Evening**	**Night**	**Total**
Registered Nurses	91.2	80	56	227.2		75.2	80	56	211.2
L. P. N. s	36.8	32	16	84.8		36.8	32	16	84.8
Aides				0					0
C. N. A.s	202.5	120	82.5	405		150	120	82.5	352.5
Medicine Aides									
Total	330.5	232	154.5	717		262	232	154.5	648.5
Licensed Beds at Project Completion				178		**Licensed Beds at Project Completion**			**178**
Hours of Bedside Care per Licensed Bed per Day				4.03		**Hours of Bedside Care per Licensed Bed Per Day**			3.64

	Weekday Hours Per Day					Weekend Hours Per Day			
Staff Category	**Day**	**Evening**	**Night**	**Total**		**Day**	**Evening**	**Night**	**Total**
Ward Clerks (bedside care time calculated at 50%	24			24					0
Total Including 50% of Ward Clerks Time				12					0
Total Hours of Bedside Care per Licensed Bed Per Day				4.16		**Total Hours of Bedside Care per Licensed Bed Per Day**			3.64

TABLE J. CONSTRUCTION CHARACTERISTICS

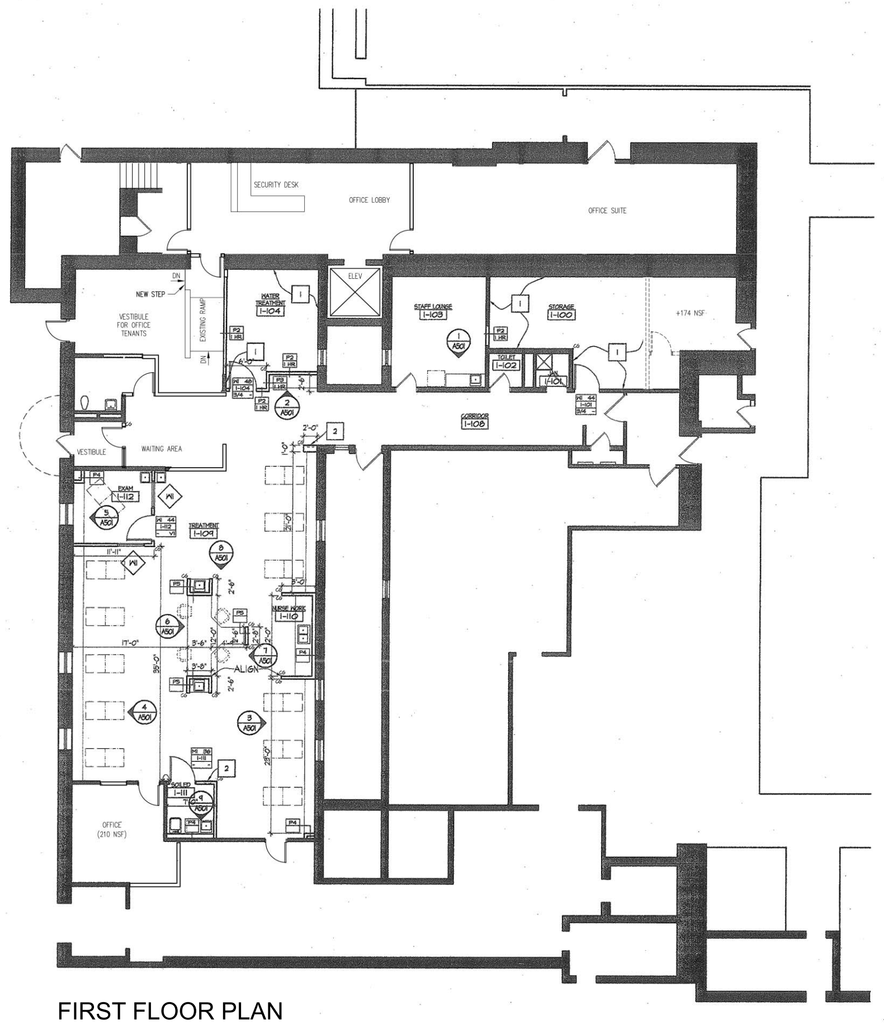
INSTRUCTION : If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☐	☐
Class B (6-story section)(*)	☐	☑
Class C (2-story section)(*)	☐	☑
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☐	☑
Excellent	☐	☐
Number of Stories		(*) Sections of the building were constructed at different times and vary in height from 2 to 6 stories. The new 30-bed Rehab Unit will be located in the 2-story section.

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement		
First Floor		10,044
Second Floor		21,591
Third Floor		
Fourth Floor		7,436
Fifth Floor		3,282
Sixth Floor		7,590
Total Square Feet		**49,943**
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor		1,183
Second Floor		841
Third Floor		
Fourth Floor		357
Fifth Floor		370
Sixth Floor		376
Total Linear Feet		**3,127**
Average Linear Feet		
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor		14' - 10-1/2"
Second Floor		14' - 10-1/2"
Third Floor		
Fourth Floor		12' - 0"
Fifth Floor		12' - 0"
Sixth Floor		12' - 0"
Average Wall Height		

EXHIBIT 3



FIRST FLOOR PLAN

0 8' 16' 32'

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

SECOND FLOOR PLAN

0 8' 16' 32'

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

FUTURE CARE HOMEWOOD
30-BED NURSING UNIT
AUGUST 16, 2016

KANN PARTNERS

EXHIBIT 4

If you want to go home, there may be a way!

Get long term services and supports in the community!

If Medical Assistance pays for any part of your nursing home care, you may be able to get care and services in your own community home instead of in a nursing home.

In the last few years, hundreds of people have moved out of nursing homes to receive services in the community. There are several programs that provide services in the community. We can help you decide which one may be right for you and help you apply. **Just let us know**.

If you would like to learn more about services that may help you move back to the community, ask a social worker at your nursing home, or contact one of the places listed on the back of this page.

This document is produced by the Maryland Department of Health and Mental Hygiene. By law, nursing homes must give this information to every nursing home resident who indicates a preference to return to the community.
Revised 12/23/14

State Government	
Maryland Department of Disabilities	800-637-4113
Maryland Department of Health and Mental Hygiene Community First Choice/Community Options Waiver MFP Nursing Facility Transition Program	 877-463-3464 or 410-767-1739 410-767-7242 (MFP)
Maryland Department on Aging	1-800-AGE-DIAL (1-800-243-3425)
Maryland Access Point	1-844 MAP-LINK (844-627-5465) www.marylandaccesspoint.info
Adult Evaluation and Review Services (AERS)	877-463-3464 or 410-767-7479
Developmental Disabilities Administration	Central MD 410-234-8200 Western MD 301-791-4670 Southern MD 301-362-5100 Eastern Shore 410-572-5920

Advocacy	
Independence Now (PG & Montgomery Counties)	301-277-2839
Southern MD CIL (Calvert, Charles, St. Mary's Counties)	301-884-4498
The Freedom Center (Frederick & Carroll Counties)	301-846-7811
Resources for Independence (Western Maryland)	800-371-1986
Bay Area CIL (BACIL) (Cecil Co. and the Eastern Shore)	443-260-0822 or 877-511-0744
The IMAGE Center (Baltimore City/Co. & Harford)	410-982-6311
Accessible Resources for Independence (Howard & Anne Arundel Counties)	410-636-2274
Brain Injury Association of Maryland	410-448-2924 or 800-221-6443
Maryland Statewide Independent Living Council	240-638-0074
Mental Health Association of Maryland	443-901-1550

Legal Resources	
Legal Aid Bureau LTC Assistance Program & MD Senior Legal Hotline1-866-635-2948 www.mdlab.org The Assisted Living/Nursing Home Program provides legal assistance to financially eligible nursing home residents anywhere in Maryland.	Maryland Disability Law Center (MDLC) 1-800-233-7201, TDD number: 410-727-6387 www.mdlclaw.org MDLC is a non-profit legal services established by federal and state law to advocate for the rights of persons with disabilities in Maryland.

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Revised 12/23/14

EXHIBIT 5

FutureCare Health and Management Corporation
Administrative Manual

Discharge Planning/Notification

Purpose:

To evaluate resident health status and formulate the best plan of discharge for each resident.

Policy:

1. The Social Services department conducts a discharge evaluation upon the resident's admission to the facility and documents it in the Social Services section of the medical record. Discharge goals and notes are reviewed at subsequent interdisciplinary meetings (Resident Care Plan and weekly Rehabilitation Rounds). Additional discharge planning reviews are completed as necessary.
2. The interdisciplinary team contributes to the final discharge plan in the following manner:

   A. Attending physician - provides instructions regarding discharges or transfers

   B. Nursing - assesses the resident's nursing and health needs, remains alert to post discharge care and provides appropriate education and instructions to the resident, responsible party and/or caregiver.

   C. Social Services - identifies and requests assistance from community health and social service agencies and other community resources when indicated.
      - Home Health Services, Hospice Services, DME Services
        - Social Services will initially ask the resident/responsible party if there is a specific community based provider/vendor they would like to utilize.
        - If the resident/responsible party does not identify a preferred provider/vendor, social services will provide the resident/responsible party with a list of providers/vendors routinely referred to by the facility.
        - If the resident/responsible party requests the social services department to choose a provider/vendor on their behalf, the social services department will co-ordinate a community provider/vendor based on the provider/vendor's ability to provide the required services and availability.

   D. Dietitian - provides dietary instruction and direction and/or consultation to the resident and/or caregiver when a special diet is indicated,

E. Rehabilitation Therapist - recommends a post-discharge plan of care, provides instructions and directions regarding therapy.

3. Residents, families and responsible parties are included in the discharge planning process.

   When indicated, the Social Services department facilitates Resident/Family Discharge Planning Meetings. Upon discharge, residents, families or caregivers are provided with information on the following (partial list):
   - Medications
   - Physician's orders for care
   - Home health services
   - Therapy services
   - Follow-up appointments for care.

4. Upon discharge from the facility, preferably within 72 hours the Director of Social Services will make a follow-up telephone call to the resident/responsible to ascertain satisfaction with living arrangements, community referrals and home health services. Documentation of this contact will be made on the Social Services Post-Discharge follow-up Form.

EXHIBIT 6

FutureCare Health and Management Corporation

Performance Improvement Program

Preface

The Performance Improvement (PI) Program for FutureCare Health and Management Company measures the efforts of the FutureCare facilities in achieving their goal of the provision of service that consistently meets or exceeds the organization's mission, professional standards, and customer expectations. The purpose of the Performance Improvement program is to ensure that the resident care provided is optimal within available resources and is consistent with the mission and values of FutureCare. The identification of customer expectations continued monitoring and development and implementation of plans of action are vital to the improvement of quality services.

Objectives

The Performance Improvement Program shall work toward the following objectives:

- Establish, maintain, support, and document evidence of an ongoing PI program that includes effective mechanisms for monitoring and evaluating resident care and for appropriate response to findings.
- Identify and delineate the authority, responsibilities and accountability relationships of organizational components responsible for facility PI functions to ensure communication in PI matters.
- Assist individual departments at FutureCare facilities in continuously improving care and services by identifying opportunities to improve care and services and resolve problems through the use of monitoring and evaluation activities.
- Evaluate the results of actions taken by the FutureCare facilities and maximize the efficient use of resources available within the facilities and the community
- Provide a coordinated, comprehensive program for the communication and dissemination of relevant information, findings, recommendations and follow-up to the FutureCare Board of Directors, corporate staff, and departments within the FutureCare facilities.

Authority

The FutureCare Health and Management Board of Directors is ultimately responsible for the establishment, maintenance and support of an effective performance improvement program. The Board, through its President and Chief Executive Officer, delegates this responsibility and the necessary authority to take action to each FutureCare Administrator. The Administrator shall assure that the PI program is compatible with federal, state and local regulations, accrediting organizations, and the requirements of third party payers.

Organization

The organizational chart delineates the lines of authority and reporting for the implementation of the PI program. This chart is intended to show the departments and

committees that normally impact on the provision of resident care and/or assure resident, employee, and visitor safety.

Scope

Within each FutureCare facility performance improvement activities are integrated and coordinated among departments and committees that have an impact on resident care. PI activities are designed to minimize the duplication of effort. Each department that has an impact on resident care will be included in the program and share responsibility and accountability for PI activities.

Confidentiality

All performance improvement information and activities will remain confidential, except where prohibited by law.

Process

Performance Improvement begins with the establishment of facility objectives. Once established, issues that currently or potentially have a negative effect on the optimal performance of the facility are identified. Performance measurement is at the core of all PI activities. Once the existing level of performance is known, facilities can make informed judgments about the stability of existing processes, identify opportunities for improvements in process, identify the need to redesign processes, and decide if improvements or redesign of processes met objectives.

Performance improvement activities throughout all FutureCare facilities shall include, but not be limited to concurrent review, ongoing monitoring, resident complaint resolution, accident/injury review, and the prevention of abuse and neglect.

Concurrent Review

Daily, each resident is observed and appraised for a change in their physical or mental status by a nurse. Documentation of such review occurs in the Treatment Administration Record. When a change is noted, the nurse identifying the change performs an evaluation, which includes the following parameters:

- Medications
- Laboratory values
- Intake and output
- Skin breakdown
- Weights
- Appetite
- Injuries resulting from accidents/incidents
- Other parameters related to change

Documentation of the evaluation is done on a flow sheet that becomes a part of the resident's medical record.

The Performance Improvement Manger assures compliance with concurrent review and changes in condition. Patterns and trends, when identified are reported at the PI committee.

See "Concurrent Review" in the Nursing Practice manual for additional information

Ongoing Monitoring

The ongoing monitoring process includes the monitoring and evaluation of important aspects of care/services, inclusive of processes important to the health and safety of residents.
Solicitation and evaluation of customer's needs and expectations to improve delivery systems and performance patterns are also included.

Teams of staff who have direct knowledge of the problem or the system to be evaluated will carry out performance improvement projects. Team members will be the staff members who are affected by the project.

See "Performance Improvement Process for FutureCare Facilities" in PI manual for additional information.

Complaint/Concern Process

Any resident, family member, visitor or staff member has the right to make a complaint about resident care and services without fear of retribution in any form.
Complaints/concerns are received at the facility or the FutureCare Customer Care Line.
The administrator reports on complaints/concerns at the PI committee.

See "Concerns and Complaints" policy in the Administrative Manual for additional information.

Accidents and Injuries

An accident or injury is defined as any occurrence that constitutes major or minor injury to the resident, visitor, or staff. All accident and injuries are to be reported through the appropriate channels for necessary action and follow-up without fear of retribution in any form.

The PI manager tracks and trends accidents and injuries. Accidents and injuries are reviewed at the facility's safety committee. Recommendations from the committee are forwarded to the appropriate Department Head for follow-up. A summary of findings is reported at the PI meeting.

See "Incident and Accident: Management" in the Administrative Manual for additional information.

Abuse and Neglect

All FutureCare facilities take measures to protect the resident's right to be free from mental, verbal, or physical abuse. All cases of suspected or witnessed abuse are fully investigated by the facility and reviewed by the regional nurse. The Administrator, Director of Nursing, and PI Manager also review the findings and when indicated findings are reported to the PI committee.

See "Abuse of Residents" and "Incident/Accident Management" in the Administrative Manual for further information.

Follow Up Assessment

The Performance Improvement committee members will complete an annual evaluation of the facility's performance improvement plan to determine whether or not the plan was successful. To reach and maintain an improved level of care and service, the completed evaluations will be reviewed by the Chairman of the Performance Improvement committee and the Performance Improvement Manager.
Copies of the evaluations will be forwarded to the corporate office for additional review.

Annual Review

The Performance Improvement program will be reviewed annually by the members of the facility's Performance Improvement committee members for necessary revisions and approval. Recommendations for revisions are to be submitted to the corporate office. After review and any approved revisions, the Performance Improvement Manual will be approved annually by the Administrator and one other committee member.
The review and approval of the manual will be reflected in the Performance Improvement Meeting minutes.

FutureCare Health and Management Corporation
Administrative Manual

Organizational Plan for the Provision of Resident Care

I. GENERAL DESCRIPTION

The Facility is a comprehensive care facility. The Facility offers a range of services including rehabilitation, respiratory, complex medical services, intravenous therapy, wound care, and nursing home care as needed.

A. Facility Vision

FutureCare Health and Management corporation strives to be a leader in the provision of comprehensive care and rehabilitative services to the frail elderly, temporarily disabled, or catastrophically ill. We achieve this vision through the rendering of compassionate, professional, proficient, and respectful treatment of residents and their loved ones. We recognize that we care not only for the body, but also for the soul.

B. Facility Mission

FutureCare Health and Management Corporation will be the community healthcare facility of choice through excellence of services and care.

C. Leadership Values

The Facility recognizes these values and their role in fulfilling our mission and vision:

- To set a positive example in all that we do.
- To respect all employees, promoting unity, trust, pride, and teamwork.
- To accept and promote positive chance, take risks, accept responsibility and be accountable for our actions.
- To achieve a high quality of work life through effective communication and through the involvement of all employees in an environment of openness and fairness in which everyone is treated with dignity, honesty, and respect.

- To promote a dedication to the Facility's commitment of achieving excellence in services rendered to all its customers.

- To create a culture which emphasizes constant learning and development.

II. PHILOSOPHY OF RESIDENT CARE SERVICES

Consistent with the mission and vision of the facility commitment to our Standard of Excellence in Care is the foundation for our philosophy of resident care services. In collaboration with the community, the facility will provide health care services through:

- Mission, vision, and leadership statements which serve as the foundation for planning, implementing, and evaluating coals and objectives.

- Long-range strategic planning with Facility leadership to determine the services to be provided.

- Establishing annual departmental goals and objectives that are consistent with the Facility's mission and vision, and which are based on a collaborative assessment of needs.

- Provision of services that are appropriate to the scope and level of care required by the residents to be served.

- Ongoing evaluation of services provided through formalized processes; i.e., performance assessment and improvement activities, budgeting, and

- Integration of services through a variety of mechanisms; i.e., multidisciplinary committees and task forces; performance assessment and improvement activities; communications through leadership forum, and special forums.

- Leadership and employee education and development.

III. LEADERSHIP RESPONSIBILITIES

The facility leadership is defined as the Administrator. Medical Director, Director of Nursing and other Department Heads.

- The facility leadership will be responsible for providing a framework for planning health care services provided by the organization based on the Facility's mission and vision, and for developing and implementing an effective planning process that allows for defining timely and clear goals. The planning process includes a collaborative assessment of our customer and community needs, defining a long-range strategic plan, developing operational plans, establishing annual operating budgets and monitoring compliance, establishing annual operating budgets and monitoring compliance, establishing annual capital budgets, monitoring and establishing resource allocation and policies, and ongoing evaluation of the plans implementation and success. The planning process minimally addresses both resident care functions and organizational support functions.
- The facility leadership is responsible to design services to be provided by the facility that are appropriate to the scope and level of care required by the residents we serve.
- The facility leadership will ensure communication of the Facility's mission. goals, objectives, and strategic plans across the Facility.
- The facility leadership is responsible for approving the performance assessment and improvement plan which is designed to enable the prioritization of areas for improvement and reprioritize in response to untoward and unexpected events.
- The facility leadership ensures uniform delivery of resident care services provided throughout the Facility.
- The facility leadership provides appropriate job enrichment, employee development, and continuing education opportunities which serve to promote retention of staff and to foster excellence in care delivery and support services.
- The facility leadership ensures appropriate direction, management, and leadership of all services and/or departments.
- The facility leadership ensures staffing resources are available to appropriately meet the needs of the residents served.
- The facility leadership strives to ensure that systems are in place which promote the integration of services w1iich support the resident's continuum of care needs.
- The facility leadership appoints appropriate committees, task forces, and other forums to ensure interdepartmental collaboration on issues of mutual concern and requiring multidisciplinary input.

- The facility leadership involves department managers in evaluating, planning, and recommending annual expense and capital objectives, and operating budgets based on the expected resource needs of their departments.
- Department managers are held accountable for managing and justifying their budgets and resource utilization. This includes, but is not limited to identifying, investigating, and budgeting for new technologies which can be expected to improve the delivery of resident care services.
- The facility leadership is responsible for taking action on recommendations generated through performance improvement activities and regulatory bodies.

IV. PERFORMANCE IMPROVEMENT

The facility Staff will design, implement and evaluate systems and services facility wide to facilitate delivery of the same level of resident care. The Performance Improvement Program will measure performance of the delivery of resident care in order to assure the efficacy and appropriateness of procedures, treatments, interventions and care provided. Efficacy and appropriateness will be demonstrated based on resident assessments/reassessments, state-of-the-art practice and desired outcomes, with respect for resident rights and confidentiality.

Design, implementation and evaluation of systems and services for the delivery of resident care will be consistent with our philosophy that resident care can be delivered:

- with compassion respect and dignity for each individual resident
- in a mariner that best meets the individualized needs of our residents
- in timely manner that meets the individualized needs of our residents
- coordinated through multidisciplinary team collaboration, to ensure continuity in delivery of care to the greatest extent possible.
- in a mariner that maximizes the efficient use of our financial and human resources by streamlining of processes, enhanced communication. continuing staff education and technological advancements.

An departments will be responsible for following the facility's plan for Performance Improvement, initiating activities designed to follow-upon unusual occurrences or specific concerns/issues which may include formal total quality management elements, following policies and procedures for ensuring staff competency, and

follow-up as appropriate on resident/family complaints and resident satisfaction results. Input from residents, staff and physicians guide the improvement process.

V. RESIDENT CARE SERVICES

Resident care services are organized and designed to provide safe, effective, timely and compassionate, preventive, diagnostic, therapeutic, and supportive care throughout the resident's stay. The provision of these services requires specialized knowledge and skill derived from the biopsychosocial sciences, customarily associated with professional education and licenser. Therefore, resident care services are prescribed, coordinated, delegated, supervised, and evaluated by professional health care providers. Through assessment of each resident's unique physical, psychosocial and spiritual needs, these professionals apply their specialized knowledge to the process of planning the care and treatment of each resident. With the goal of achieving positive resident outcomes, the medical, nursing, and allied health staff work collaboratively and interdependently, with each discipline contributing its unique perspective and skill set.

Resident care service departments include those whose practitioners have direct, hands-on contact with residents or those whose work have direct and significant impact on the care and treatment of residents. These departments include:

- Activities
- Dental Services
- Infection Control
- Laboratory
- Medical Staff Services
- Nursing Services
- Nutritional Services
- Pharmacy
- Podiatry Services
- Psychological Services
- Radiology/diagnostic Services
- Rehabilitation Services
- Respiratory
- Social Services

- **ACTIVITIES PROGRAM:** All residents of the facility have the opportunity to participate in the meaningful activities geared towards improving their functional ability. The activities department provides a structured program of activities designed to enhance the quality of life of our residents by allowing them to participate at and improve their level of functioning.

The Activities Director has the responsibility for the design and implementation of a recreation and activity program which is both therapeutic in nature and individualized to an extent, that it will offer the benefit of improving functional ability to all residents.

Participation in all activities will be voluntary and left up to the discretion of the resident at the time of the event. Participation levels are recorded and are included in the interdisciplinary care plan process.

An initial activity assessment is done by the activities department on all residents. An appropriate care plan is developed utilizing this assessment.

The facility provides adequate space, supplies, and equipment to carry out the program. Program contents and scheduling is maintained by the department and posted in the facility to insure easy access to all residents, staff, and visitors.

- **DENTAL SERVICES:** A consultant dentist is retained by the facility and is responsible for:
    - Performing or supervising and annual dental re-evaluation for each resident.
    - Providing consultation to physicians and other services on oral health matters.
    - Providing staff in-service education
    - Assuring that emergency dental services are available 24 hours a day.
    - Provides necessary information on residents to appropriate staff and care planning conferences.
    - Each resident receives an oral assessment prior to or within 14 days admission and annually. The assessment is done by the dentist or a registered nurse (after competency through a dentist has been obtained.
    - The facility assists, if needed, with arrangements for transportation to the dentist's office.
- **INFECTION CONTROL:** A primary directive of the Infection Control program is to ensure that the clinical community has the information to protect residents and staff from the acquisition of nosocomial infection or illness. The scope of services represents a dichotomy of activities at the direct resident care level which are inclusive of both clinical and support functions, and activities that support the organization's plan for the Environment of Care. Although the surveillance, control, and prevention of infection is an organizational function of the facility, the overall management rests with the Infection Control Practitioner.

- **LABORATORY:** See Laboratory Services agreement.

- **MEDICAL STAFF:** AD departments providing resident care have established lines of communication with the Physician staff.

- **Scope of Care:** Scope of care of each practicing and licensed member of the Medical Staff is delineated through the credentialing process. A physician is on site or available by phone to meet resident care needs 24 hours a day, 7 days a week.

- **NURSING SERVICES:** Nursing care provided throughout the facility is provided under the direction of the Director of Nursing. The Director of Nursing is vested with the authority and responsibility for:

  - Developing organization-wide resident care programs, policies, and procedures that describe how residents' nursing care needs are assessed, evaluated, and met.
  - Developing and implementing the organization's plan for providing nursing care.
  - Participating with leaders from the governing body, management, medical staff, and clinical areas in the organization's decision-making structures and processes.
  - Implementing an effective, ongoing program to measure, assess, and improve the quality of nursing care delivered to residents.

  Definition of Nursing Care: In accord with the Maryland Nurse Practice Act, the practice of registered nursing at the facility means:

  > "..... the performance of acts requiring specialized knowledge, judgment and skill based on the biological, physiological behavioral and sociological sciences as the basis for assessment, nursing diagnosis, planning, implementation and evaluation of the practice of nursing in order to:
  >
  > - Maintain health,
  > - Prevent illness or
  > - Care for or rehabilitate the ill injured, or infirm.

  For these purposes, "practice registered nursing" includes:

  - Administration;
  - Teaching;
  - Counseling;
  - Supervision, delegation and evaluation of nursing practice;
  - Execution of therapeutic regimen- including the administration of medication and treatment,
  - Independent nursing, functions and delegated medical functions; and

- Performance of additional acts authorized by the Board under ¶7-205 of this title."

> Also in accord with the Maryland Nurse Practice Act 2 the practice of licensed practical nursing at the facility means:
>
> > "to perform in a team relationship an act that requires specialized knowledge, judgment, and skill based on principles of biological, physiological behavioral, or sociological science to:"
> >
> > - Administer treatment or medication to an individual;
> > - Aid in the rehabilitation of an individual
> > - Promote preventive measures in community health;
> > - Give counsel to an individual
> > - Safeguard life and health
> > - Teach and supervise
>
> In concert with the Maryland Nurse Practice Act, the nursing process is the central theme in our nursing care delivery system. Nursing care is delivered by RN's, LPN's, and unlicensed personnel. The nursing process is the basis for:
>
> > - Orientation and continuing education.
> > - The development of policies and standards of practice and care.
> > - The nursing documentation system.
> > - Monitoring, evaluating, and improving the quality of nursing care.
> > - Evaluating staff performance.
>
> Organizational structure is consistent with and designed to support the variety of resident services offered and the scope of nursing car-, activities in all these units/areas. The Department of Nursing exists to provide individualized, safe, appropriate, and therapeutically effective nursing care to all residents served by the facility. The department provides the organizational infrastructure necessary to support and facilitate the work of individual nursing units.
>
> The Nursing Department is organized to meet the nursing care needs of residents throughout the facility, to establish and maintain nursing care policies and procedures and to continuously improve the nursing care provided throughout the facility. Regardless of the unit in which nursing care is provided, the maintenance and application of nursing care policies and procedures for residents with the same nursing care needs ensures that our residents receive the same level of nursing care

throughout the facility. Expected outcomes of care are the same for residents' locations, because nursing care standards addressing specific resident care needs, problems or nursing diagnoses, are universally applicable.

Nursing care needs on each unit are identified through nursing assessment, evaluation of care provided, and re-assessment. In order for nursing care to be given the resident must

be assessed in the physical, psychological and cognitive domains, both on entry into our
system on and ongoing basis. Assessment includes both data collection and analysis of information for the purpose of identifying resident care needs, problems, or nursing diagnoses. This in turn facilitates the selection of an appropriate plan of care. Such plans of care are implemented, documented, and evaluated. This evaluation of nursing care plans determines the effectiveness of the care given and thus, of the nursing process, for
each resident. This cyclical process leads back to assessment and re-execution of the entire process, or to achievement of desired outcomes by the resident.

Nursing staff operate both independently and interdependently with other health care disciplines. Collaboration commonly occurs through screening and referral by Nursing for the need for further discipline-specific assessment; through interdisciplinary dialogue and conferences to establish common goals and treatment plans; through execution of interdisciplinary plans of care and resident education.

Practitioners/Competency: The Department of Nursing consists of staff personnel who deliver direct nursing care to residents; unit managers, who are responsible for supporting and directing the work of the staff-, a nurse educator who coordinates orientation and staff education clerical personnel, who provide clerical support to the staff. The Nursing Practice Manual contains a complete description of the levels of personnel who provide nursing care, as well as the system to ensure competency, including license verification.

Staff Plan: The mechanisms utilized to match resident care needs with the amount and type of nursing personnel required are delineated in the Plan for Nursing Staffing in the Nursing Practice Manual.

The appropriateness of this plan and the Plan for Nursing Staffing is reviewed annually as part of the annual budgetary process, usually beginning in October; and whenever warranted by changes in resident care needs or outcomes of the facility and its medical and other staff, and in consideration of legal and regulatory requirements. Examples of changes which would indicate the need for such interim reviews are: changes in occupancy rates, census, changes in intensity of nursing care services required, changes in technology impacting on nursing workload and

changes in types of services provided; As part of the review process, the allocation of financial and other resources is assessed to determine whether nursing care is provided safely, appropriately, efficiently, and effectively.

The staffing plan ensures that a Registered Nurse is on duty 7 days a week.

- **NUTRITIONAL SERVICES:** The Nutritional Services Department provides the following care and services for residents.

    1. Assess and provide for the nutritional status of residents.

    2. Develop, recommend, and evaluate nutritional care plans.

    3. Provide nutritional consultations and diet instruction that were ordered or requested from physicians, nurses, and other health care personnel. These services are provided in cooperation with the residents, families, physicians, pharmacists, social workers, speech pathologist, nursing personnel, and other health care personnel.

    Skill Level of Personnel Involved in Resident Care: A Registered dietitian is licensed by the state of Maryland, and has completed an undergraduate degree with a course of study approved by the American Dietetic Association.

    Hours of Operation: The department is staffed for resident services from 6:00 a.m. to 8:00 p.m. At all other times, the nursing supervisor has the ability to access supplies to meet the nutritional needs of the residents.

    Staffing Plan for Resident Care Services: See department policy for operational schedule.

- **PHARMACEUTICAL SERVICES:**

    Scope of Care: Pharmaceutical Services (a contractual service) provides efficient, safe, and effective drug therapy, as well as IV therapy nursing services.

    Major services provided by Pharmacy include: physician medication order review, verification and unit dose dispensing, IV compounding, drug delivery. maintenance of a pharmacy profile, and drug information. Improvement of organizational performance is an important aspect of pharmaceutical care.

Monitoring of proper medication use by assisting the medical staff with formulary maintenance, monitoring for drug-drug, drug-disease, and drug-food interactions, and adverse drug reactions are activities in this department. Pharmaceutical services are provided 7 days a week.

The IV Therapy nursing team provides service, if needed, 24 hours a day. The IV team is called when the facility staff are unable to initiates parenterel therapy.

Skill Level of Personnel: Pharmacists must be licensed in accordance with regulation of the Maryland State Board of Pharmacy. Technical staff meet basic educational requirements, and are trained to assist the pharmacist in distribution activities. Registered nurses licensed in the State of Maryland function on the IV Therapy team.

- **PODIATRY SERVICES:** A consultant podiatrist is retained by the facility. The podiatrist visits when deemed necessary by the attending physician.

- **PSYCHOLOGICAL SERVICES:** See contractual agreement

- **RADIOLOGY SERVICES:** See contractual agreement

- **REHABILITATION SERVICES:** Rehabilitation Services (a contractual service) include physical therapy, occupational therapy, speech-language therapy. Residents are treated in a timely manner, according to needs as their condition warrants and the referring physician

  desires, with consideration given to the resident's desires and convenience. Every attempt is made to address each new referral within 24 hours of receipt of the referral.

- Physical therapists provide assessment and treatment to individuals with orthopedic. neurological, vascular, and a variety of medical diagnoses resulting in pain abnormality of body structure, or functional limitations as consequences of the acute or chronic disease. They provide direct care, education, and training to the resident, family, or care givers, and consult with other interdisciplinary team members in reference to appropriate treatment programs and discharge planning.

- Occupational therapists provide assessment and treatment of individuals with orthopedic, neurological, and a variety of medical diagnoses resulting in pain, abnormality of body structure, or functional limitations as consequences of the acute or chronic disease. They provide direct care, education, and training to the resident,

- Significant others, or caregivers, and consult with other interdisciplinary team members in reference to appropriate treatment programs and discharge planning.

- Speech language pathologists provide identification assessment, speech pathology diagnosis, and treatment intervention to individuals with neurogenic communication and/or swallowing disorders.
  They provide direct care, education, and counseling to individuals with disorders of communication/swallowing, as well as to their family members or appropriate care givers.

- They consult with other interdisciplinary treatment team members in reference to appropriate treatment programs and discharge planning.

  Staff Skill Level: All physical therapists, occupational therapists, and speech pathologists have graduated from accredited schools and maintain current Maryland State licenser.

  Timely Service: Services are available as follows:

  Physical Therapy: Monday through Saturday, 6:30 a.m. - 5:30 p.m.

  Occupational Therapy: Monday through Friday 7:00 a.m. – 5:00 p.m. and Saturday 8:00 a.m. – 4:00 p.m.

  Speech-Language Pathology: Monday through Friday 7:30 a.m. – 5:30 p.m. and Saturday 8:00 a.m. – 1:00 p.m.

  Staffing Plans: Departmental staffing and equipment, are determined by resident volume, needs of the population served, the work to be accomplished, as well as the amount of time required by each resident to provide quality care as set forth by the established plan of care. See department plan for further information.

- **RESPIRATORY SERVICES**: See contractual agreement.

- **SOCIAL SERVICES:**

  Scope of Care: Social Work services are provided to all residents.

  Services include resident assessment, resident advocacy, and discharge planning coordination which includes coordination of home health services, referrals to agencies to arrange for appropriate support services, counseling services which include crisis intervention, adjustment to illness, community resource information and liaison activities between the facility and community agencies.

Each resident receives an admission assessment. Other needs are identified in a timely manner through an open referral system.

Skill Level of Personnel: Social Workers are Maryland Licensed Master of Social Work, Bachelor of Social Work prepared staff or are qualified by experience.

Staffing Plan: A social worker is available Monday - Friday from 8:00 am - 4:30 p.m.

VI. RESIDENT SUPPORT SERVICES AND INTEGRATION WITH RESIDENT CARE SERVICES

Resident support services facilitate the comfort and safety of the resident and help to ensure the continuing availability and efficiency of resident care services. Acknowledgment of every discipline's and department's unique knowledge, judgment and skills serves as the foundation for integration of services. Each segment of the facility community has important contributions to make to the well-being of residents and is capable of supporting the contributions of others. This fosters a spirit of interdisciplinary teamwork.

To provide efficient and effective care on a continuing basis, open fine of communication among disciplines, resident care service departments, resident support service departments, and appropriate community agencies are encouraged vertically and horizontally. Associates from resident care services and support departments are expected to communicate openly and freely within and among departments and disciplines, to facilitate continuity of care, to maintain a safe and pleasant resident environment, and to promote positive resident outcomes. Problem-solving is encouraged at the lowest possible levels within the organization. In the interest of effective interdepartmental relationships, staff is expected to be responsive to one another’s concerns and to seek mutually acceptable solutions. Managers possess the authority and are charged with the responsibility of resolving problems appropriate to their span of control, utilizing a resident oriented approach as a foundation for decision making. Options available to managers in resolving interdepartmental ad hoc committees or task forces; addressing issues with respective leadership; and referring concerns to appropriate existing committees.

Resident support services are fisted and described below. For each department, the description includes at least its major activities and functions and how the support service relates to and is integrated with resident care service departments.

- Administration
- Admissions
- Business Office
- Education
- Environmental Service/Maintenance
- Human Resources
- Medical Records

- **ADMINISTRATION:** The role of Administration is to ensure that the facility provides services consistent with the mission and vision of the facility. The Administrator is the highest administrative officer. In his absence, the Director of Nursing acts in his stead. The administrator is available via a pager 24 hours a day.

- **ADMISSIONS:** Admissions, in conjunction with nursing, assigns rooms for all residents and in-house transfers. When problems arise concerning room assignment, the administrator will be made aware of the situation in order to help find a resolution.

- **BUSINESS OFFICE:** The business Office is responsible for the timely billing and collection of resident charges. Questions in regard to billing concerns from residents and
third-party payers are addressed by the Business Office personnel. Confirmation of resident demographic and financial information and verification of insurance benefits is performed to expedite the resident admission.

- **FACILITY EDUCATION:** The educational foundation for the facility encompasses principles of teaching and learning and principle of adult education. The ultimate goal is the provision of quality resident care by providing educational programs and services that assist the staff in acquiring, maintaining and improving competence, and by facilitating the implementation of policy and process standards.

  The primary purpose is to provide orientation for new staff; to establish education programs for all staff; establish mechanisms to determine competence of all staff to perform their assigned duties; to promote professional development and job enrichment; and to develop processes that assess, maintain demonstrate, and improve the overall performance of the staff. The second purpose is to provide health prevention and wellness education to the community and to resident and family through educational activities.
- **ENVIRONMENTAL SERVICES:** The function of the Environmental Services Department is to provide environmental and linen services.

Environmental Services consist of routinely cleaning resident care and nonresident care areas of the internal facility environment in accordance with schedules appropriate to each area; cleaning resident rooms after residents have been discharged, and preparing them for the admission of new residents; responding to requests for unscheduled housekeeping services that are needed for reasons of health, safety, or resident care; and checking resident rooms and other resident care and nonresident care areas for environmental repair needs, e.g., broken floor tiles, chipped paint or plaster, etc., and reports same to the Maintenance Department.

The linen services include the following functions: Routinely providing clean linen to all resident care areas through exchange cart system on a daily basis; providing additional supplementary linens on request to all resident care areas 24 hours a day, 7 days a week; collecting soiled linen from all resident care areas on a daily basis; and additional supplementary soiled linen pickup from all resident care areas upon request 24 hours a day, 7 days a week.

- **MAINTENANCE DEPARTMENT:** The major function of the Maintenance Department is the preventive maintenance and repair of the building systems and equipment as well as the medical equipment within the facility. Through ongoing repair and maintenance, the staff work to maintain an attractive, comfortable and therapeutic resident care environment.

- **HUMAN RESOURCES:** The Human Resources Department develops and administers fair and consistent personnel policies and procedures.

  The Human Resources Department works with departmental managers to help assure that:

  1. Adequate numbers of competent staff and licensed independent practitioners are available when and where needed. The department also has developed a monitoring system to ensure that all appropriate individuals maintain up-to-date licenses to practice.

  2. Employee performance is assessed on a regular basis, supporting continuing education and skill development as appropriate. The Human Resources Department maintains the confidential personnel files and records of each employee, and advises managers and administrators regarding the status of employee performance evaluations.

     All final warnings or discharge of any personnel is consistent with facility policy as stated in the Personnel Policy Manual. The department serves as a resource for managers and staff with benefit questions.

- **MEDICAL RECORDS:** The medical record is maintained to serve the resident. health care providers, and the institution in accordance with legal, accrediting, and regulatory agency requirements. Medical records are available at all times for resident care, and the department has established procedures to facilitate this process.

  The Medical Record Department handles and coordinates requests by outside agencies/persons for copies of records. Confidentiality policies and procedures are established by the Medical Record Department. Coding and abstracting of diagnoses is performed retrospectively by the Medical Record Department for the management of care, administrative planning, external regulatory needs, and timely reimbursement.

  The facility utilizes a medical record consultant to provide expertise and audit functions in matters pertaining to the effective maintenance, operation, and confidentiality of medical records.

EXHIBIT 7

Charles Street Healthcare, LLC
T/A FutureCare - Homewood

Financial Statements

For The Years Ended
December 31, 2014 And 2013

HERTZBACH
certified public accountants · consultants

Charles Street Healthcare, LLC
T/A FutureCare - Homewood

Table Of Contents

For The Years Ended December 31, 2014 And 2013

HERTZBACH
certified public accountants · consultants

Independent Accountant's Review Report

To The Members
Charles Street Healthcare, LLC
T/A FutureCare - Homewood
8028 Ritchie Highway
Pasadena, Maryland 21122

We have reviewed the accompanying balance sheets of Charles Street Healthcare, LLC T/A FutureCare - Homewood as of December 31, 2014 and 2013, and the related statements of operations, changes in members' equity, and cash flows for the years then ended. A review includes primarily applying analytical procedures to management's financial data and making inquiries of Company management. A review is substantially less in scope than an audit, the objective of which is the expression of an opinion regarding the financial statements as a whole. Accordingly, we do not express such an opinion.

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America and for designing, implementing, and maintaining internal control relevant to the preparation and fair presentation of the financial statements.

Our responsibility is to conduct the reviews in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants. Those standards require us to perform procedures to obtain limited assurance that there are no material modifications that should be made to the financial statements. We believe that the results of our procedures provide a reasonable basis for our report.

Based on our reviews, we are not aware of any material modifications that should be made to the accompanying financial statements in order for them to be in conformity with accounting principles generally accepted in the United States of America.

Hertzbach & Company, P.A.

Owings Mills, Maryland
April 11, 2015

F I N A N C I A L

S T A T E M E N T S

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Balance Sheets

December 31,	2014	2013
ASSETS		
CURRENT ASSETS		
Cash	$ 2,675,681	$ 1,550,160
Accounts Receivable, Patient Care, Net	2,697,910	2,147,306
Prepaid Expenses And Other Current Assets	132,816	498,058
Due From Third-Party Payers	173,121	156,314
Total Current Assets	5,679,528	4,351,838
PROPERTY AND EQUIPMENT, Net	690,103	643,899
OTHER ASSETS		
Deferred Costs, Net	5,054	5,894
TOTAL ASSETS	$ 6,374,685	$ 5,001,631
LIABILITIES AND MEMBERS' EQUITY		
CURRENT LIABILITIES		
Accounts Payable And Accrued Expenses	$ 1,252,633	$ 1,235,859
Revolving Credit Note	-	122,155
Due To Third-Party Payers	3,394,546	2,149,547
Total Liabilities	4,647,179	3,507,561
MEMBERS' EQUITY	1,727,506	1,494,070
TOTAL LIABILITIES AND MEMBERS' EQUITY	$ 6,374,685	$ 5,001,631

See Accompanying Notes And Independent Accountant's Review Report

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Statements Of Operations

For The Years Ended December 31,	2014	2013
Revenue:		
Net Patient Services	$ 19,225,409	$ 17,788,063
Operating Expenses:		
Nursing Care Services	7,986,998	7,655,924
Other Patient Care Services	1,027,857	990,376
Routine Services	1,716,882	1,633,092
Administrative Services	2,659,791	2,347,827
Capital/Property Services	942,470	937,136
Other Operating Expenses, Net	322,308	275,789
Ancillary Services	2,111,323	1,902,624
Total Operating Expenses	16,767,629	15,742,768
Operating Income	2,457,780	2,045,295
Other Expenses:		
Rent	1,087,000	1,172,111
Depreciation And Amortization	167,344	152,454
Total Other Expenses	1,254,344	1,324,565
NET INCOME	$ 1,203,436	$ 720,730

See Accompanying Notes And Independent Accountant's Review Report

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Statements Of Changes In Members' Equity

For The Years Ended December 31,	2014	2013
Members' Equity, Beginning Of Year	$ 1,494,070	$ 1,323,340
Members' Distributions	(970,000)	(550,000)
Net Income	1,203,436	720,730
Members' Equity, End Of Year	$ 1,727,506	$ 1,494,070

See Accompanying Notes And Independent Accountant's Review Report

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Statements Of Cash Flows

For The Years Ended December 31,	2014	2013
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net Income	$ 1,203,436	$ 720,730
Adjustments To Reconcile Net Income To Net Cash Provided By Operating Activities:		
Depreciation And Amortization	167,344	152,454
Provisions For Bad Debt, Net Of Recoveries	298,531	265,629
(Increase) Decrease In Operating Assets:		
Accounts Receivable, Patient Care	(849,135)	191,741
Prepaid Expenses And Other Current Assets	365,242	(5,057)
Due From Third-Party Payers	(16,807)	105,508
Increase (Decrease) In Operating Liabilities:		
Accounts Payable And Accrued Expenses	16,774	26,795
Due To Third-Party Payers	1,244,999	1,198,037
Net Cash Provided By Operating Activities	2,430,384	2,655,837
CASH FLOWS FROM INVESTING ACTIVITIES:		
Acquistions Of Property And Equipment	(212,708)	(355,789)
Net Cash Used In Investing Activities	(212,708)	(355,789)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payments On Revolving Credit Note, Net	(122,155)	(364,389)
Members' Distributions	(970,000)	(550,000)
Net Cash Used In Financing Activties	(1,092,155)	(914,389)
NET INCREASE IN CASH	1,125,521	1,385,659
CASH, BEGINNING OF YEAR	1,550,160	164,501
CASH, END OF YEAR	$ 2,675,681	$ 1,550,160
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash Paid During The Year For Interest	$ 1,868	$ 4,153

See Accompanying Notes And Independent Accountant's Review Report

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Notes To Financial Statements

For The Years Ended December 31, 2014 And 2013

1. NATURE OF BUSINESS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

NATURE OF BUSINESS – Charles Street Health Care, LLC T/A FutureCare - Homewood (the Company) was created under Maryland law pursuant to its Articles of Organization effective on October 25, 1995, and commenced operations on January 1, 1996. The Company currently operates a nursing facility consisting of 148 comprehensive care beds located in Baltimore, Maryland.

PERSONAL ASSETS AND LIABILITIES AND MEMBERS' SALARIES – In accordance with the generally accepted method of presenting limited liability company financial statements, the financial statements do not include the personal assets and liabilities of the members, including their obligation for income taxes on their distributive shares of the net income of the Company or their rights to refunds on its net loss, nor any provision for income tax expense or an income tax refund. The expenses shown in the statements of income do not include any salaries to the members.

METHOD OF ACCOUNTING – The financial statements of the Company are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America.

CASH AND CASH EQUIVALENTS **–** For purposes of the statements of cash flows, the Company considers all unrestricted highly liquid investments with an initial maturity of three months or less when purchased to be cash equivalents.

USE OF ESTIMATES **–** The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

PROVISION FOR DOUBTFUL ACCOUNTS – The Company provides for estimated losses on accounts receivable based on an analysis of specific accounts, collection history, and industry experience.

REVENUE RECOGNITION – Patient service revenue is reported at established billing rates or at the amount realizable under the agreement with the third-party payer. Revenue under the third-party payer's agreement is subject to examination and retroactive adjustments. A provision for estimated third-party payer settlements is provided in the period the related services are rendered. Differences between the amounts accrued and subsequent settlements are recorded in revenue in the year of settlement.

PROPERTY AND EQUIPMENT **–** Property and equipment are recorded at cost. Depreciation is provided for on the straight-line method computed over the estimated useful lives of the assets. Maintenance and repairs are charged to expense as incurred; major renewals and betterments are capitalized.

ADVERTISING **–** Advertising (including help wanted and promotional costs) is charged to operations when incurred. The Company has no significant direct-response advertising. Advertising expense for the years ended December 31, 2014 and 2013, totaled $15,919 and $21,314, respectively, and is included in administrative services in the statements of operations.

DEFERRED COSTS – Loan acquisition costs have been capitalized and are amortized over the life of the loan using the straight-line method.

INCOME TAXES – No provision or benefit for income taxes has been included in these financial statements since taxable income or loss passes through to, and is reportable by, the members individually.

1. NATURE OF BUSINESS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

INCOME TAXES (CONTINUED) – In accordance with FASB Accounting Standards Codification (ASC) 740, *Income Taxes*, which clarifies the accounting for uncertainty in income taxes, the Company recognizes the tax benefit from uncertain tax positions only if it is more likely than not the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position.

Based on its evaluation, the Company has concluded that there are no significant uncertain tax positions requiring recognition in the financial statements. No interest or penalties have been recorded as a result of tax uncertainties. The tax years ended December 31, 2011 through December 31, 2014 remain open to examination by tax jurisdictions to which the Company is subject.

COMPENSATED ABSENCES – Employees of the Company are entitled to paid vacation and personal days depending on job classification, length of service, and other factors. The Company has accrued $205,392 and $221,070 for vacation and personal days as of December 31, 2014 and 2013, respectively, which is included in accounts payable and accrued expenses on the balance sheets.

IMPAIRMENT OF LONG-LIVED ASSETS – Long-lived assets are evaluated for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. If such assets are deemed to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the fair value. There were no impairment losses for the years ended December 31, 2014 and 2013.

2. PATIENT ACCOUNTS RECEIVABLE

Patient accounts receivable as of December 31, 2014 and 2013 is comprised of the following:

	2014		2013	
Medicaid	$ 1,389,138	42%	$ 1,336,709	50%
Private	692,670	21%	440,552	17%
Managed Care, Hospice, And Other Insurance	296,802	9%	256,638	10%
Medicare Part A	837,735	26%	545,385	21%
Medicare Part B And Enteral Feeding	17,450	1%	29,080	1%
Veteran Administration	26,088	1%	28,142	1%
	3,259,883	100%	2,636,506	100%
Less: Provison For Doubtful Accounts	561,973		489,200	
	$ 2,697,910		$ 2,147,306	

3. DUE FROM/TO THIRD-PARTY PAYERS

Due from/to third-party payers represents the estimated settlement amounts due from/to the Medicaid and Medicare programs for cost reports in which a final settlement has not yet been issued. The cost reports are subject to verification, leading to final settlement. The due to Medicaid, Working Capital Fund represents an interest free working capital advance from the Medicaid program. Payment on this advance is due on May 1, 2015. Management believes this advance will be extended for another year. The balances as of December 31, 2014 and 2013 consisted of the following:

	2014	2013
Due From Third-Party Payers		
Due From Medicare, Coinsurance	$ 173,121	$ 156,314
Due To Third-Party Payers		
Due To Medicaid - 2014	1,641,874	-
Due To Medicaid - 2013	1,572,687	1,572,687
Due To Medicaid - 2012	-	432,688
Due To Medicaid - 2010	4,957	4,957
Due To Medicaid, Working Capital Fund	175,028	139,215
	$ 3,394,546	$ 2,149,547

4. DEFERRED COSTS

Deferred costs as of December 31, 2014 and 2013 consisted of the following:

	2014	2013
Loan Acquistion Costs	$ 21,014	$ 21,014
Less: Accumulated Amortization	15,960	15,120
	$ 5,054	$ 5,894

Amortization expense was $840 for each of the years ended December 31, 2014 and 2013. Estimated aggregate amortization expense for amortizable deferred costs for each of the next five years is $840 per year.

5. PROPERTY AND EQUIPMENT

Property and equipment as of December 31, 2014 and 2013 consisted of the following:

	2014	2013
Furniture And Fixtures	$ 1,505,001	$ 1,402,773
Leasehold Improvements	697,874	587,394
	2,202,875	1,990,167
Less: Accumulated Depreciation And Amortization	1,512,772	1,346,268
	$ 690,103	$ 643,899

Depreciation and amortization expense on the property and equipment for the years ended December 31, 2014 and 2013 was $166,504 and $151,614, respectively.

6. REVOLVING CREDIT NOTE

The Company has a revolving credit note agreement with PNC Bank. The balance on the note was $0 and $122,155 as of December 31, 2014 and 2013, respectively. Terms of the note are as follows:

Maximum Borrowing Amount:	Lesser of $2,200,000 or 85% of eligible receivables as defined in the note agreement.
Interest Rate:	London Interbank Offered Rate (LIBOR) plus 2.50% (2.67% at December 31, 2014 and 2013).
Maturity:	Entire balance is due September 30, 2015.
Collateral:	Secured by all of the assets of the Company.
Guarantors:	None.
Covenants:	The note is subject to certain financial and nonfinancial covenants.

7. RELATED PARTY TRANSACTIONS

LEASE OF FACILITY – Certain members of the Company are members of FutureCare – Homewood Properties, LLC (Homewood), which owns the land, building, and certain furniture and equipment of the facility. The Company entered into an operating lease to rent the facility from Homewood which expires on April 30, 2019. The agreement with Homewood includes rent, property taxes, property insurance, and utilities. Rent expense was $1,087,000 and $1,172,111 for the years ended December 31, 2014 and 2013, respectively.

The estimated minimum annual rental payments due under the current operating lease agreement are as follows:

Years Ending December 31,	Amount
2015	$ 1,140,000
2016	1,140,000
2017	1,140,000
2018	1,140,000
2019	380,000
	$ 4,940,000

MANAGEMENT SERVICES – Certain members of the Company are stockholders of FutureCare Health and Management of Homewood, Inc. (FutureCare). The Company entered into a management agreement with FutureCare to receive management services as defined in an agreement dated January 1, 2005, which auto renewed on December 31, 2014 for an additional five years expiring on December 31, 2019.

The annual management fee is equal to approximately 7% and 6% for the years ended December 31, 2014 and 2013, respectively, of the Company's gross revenues from operations and may be adjusted as mutually agreed upon. In no event, however, may the annual fee exceed 9% of the Company's gross revenues. Management fee expense for the years ended December 31, 2014 and 2013 was $1,365,000 and $1,104,000, respectively, and is included in administrative services in the statements of operations.

7. RELATED PARTY TRANSACTIONS (CONTINUED)

THERAPY SERVICES – Certain members of the Company are stockholders of FutureCare Rehabilitation, Inc. (FutureCare Rehab). The Company entered into an agreement with FutureCare Rehab to provide therapy services to the Company's patients. Fees incurred to FutureCare Rehab for those services for the years ended December 31, 2014 and 2013 totaled $1,260,293 and $1,120,011, respectively, and are included in ancillary services in the statements of operations.

8. PROFIT SHARING PLAN

The Company has adopted a qualified 401(k) profit sharing plan covering all employees with at least one year and 1,000 hours of service. The Company provides a matching contribution of 25% of the participant's contribution up to a maximum of 4% of eligible wages. The contributions for the years ended December 31, 2014 and 2013 were $16,792 and $11,337, respectively.

9. CERTAIN SIGNIFICANT RISKS AND UNCERTAINTIES

The health care industry is subject to numerous laws and regulations by federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for resident services, and Medicare and Medicaid fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management is not aware of any violations of these laws and regulations.

10. CONCENTRATIONS

CONCENTRATION OF CREDIT RISK – The Company maintains cash balances at multiple financial institutions and, at times, balances may exceed federally insured limits. The Company has never experienced any losses related to these balances. At December 31, 2014, the Company had cash balances on deposit that exceeded federally insured amounts by $2,441,084.

ACCOUNTS RECEIVABLE AND PATIENT SERVICE REVENUE – The Company grants credit without collateral to its residents, most of who are insured under third-party payer arrangements. See Note 2 for detail of the concentration of gross accounts receivable for services to patients. Approximately 92% and 91% of patient service revenue was derived under Federal and State third-party reimbursement programs for the years ended December 31, 2014 and 2013, respectively.

11. COMMITMENTS AND CONTINGENCIES

WORKERS' COMPENSATION – The Company, together with 14 related entities, maintains a high deductible workers' compensation plan which covers its employees. The plan calls for the Company to reimburse the plan administrator for the sum of the claim charges attributable to the Company. The expenses of the Company cannot exceed $300,000 per claim with a pooled policy aggregate for all entities covered under the plan as defined by the policy. Additional losses incurred above the claim maximums, if any, would be funded through a reinsurance policy maintained by the plan.

The Company records provisions for expenses for workers' compensation liability claims based on the amount of paid losses together with a provision for case reserves established by the plan's third-party claim adjusters as well as the plan administrator's and management's review of the individual claim facts, historical claim development factors, and industry experience.

11. COMMITMENTS AND CONTINGENCIES (CONTINUED)

WORKERS' COMPENSATION (CONTINUED) – While management believes that the provision for claims on workers' compensation is adequate, the ultimate liability may be in excess of or less than the amounts recorded. To the extent that the Company has paid to the plan administrator an amount in excess of future claims, those amounts are included in prepaid expenses and other current assets on the balance sheets. The Company's prepaid asset balance for workers' compensation was $0 and $381,086 as of December 31, 2014 and 2013, respectively.

12. SUBSEQUENT EVENTS

Management has evaluated subsequent events and transactions for potential recognition or disclosure through the independent accountant's review report date, the date the financial statements were available to be issued. There were no events that required recognition or disclosure in the financial statements.

S U P P L E M E N T A R Y

I N F O R M A T I O N

HERTZBACH
certified public accountants · consultants

Independent Accountant's Review Report On Supplementary Information

To The Members
Charles Street Healthcare, LLC
T/A FutureCare - Homewood
8028 Ritchie Highway
Pasadena, Maryland 21122

Our report on our reviews of the basic financial statements of Charles Street Healthcare, LLC T/A FutureCare - Homewood appears on page 1. Those reviews were made primarily for the purpose of expressing a conclusion that there are no material modifications that should be made to the financial statements in order for them to be in conformity with accounting principles generally accepted in the United States of America. The supplementary information included in the accompanying schedules on pages 13-19 is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information has been subjected to the inquiry and analytical procedures applied in the reviews of the basic financial statements, and we did not become aware of any material modifications that should be made to such information.

Hertzbach & Company, P.A.

Owings Mills, Maryland
April 11, 2015

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Schedules Of Nursing Care Services

For The Years Ended December 31,	2014	2013
Salaries And Wages	$ 5,805,670	$ 5,574,581
Employee Benefits	1,529,834	1,434,974
Supplies	602,555	579,721
Contracted Respiratory	27,126	(5,047)
Contracted Services	21,813	71,695
Total Nursing Care Services	$ 7,986,998	$ 7,655,924

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Schedules Of Other Patient Care Services

For The Years Ended December 31,	2014	2013
Food	$ 367,963	$ 355,145
Medical Director:		
Contracted Services	99,150	97,950
Nurse Practitioner And Dental Services:		
Contracted Services	109,215	115,053
Psychiatric Contracted Services	-	750
	109,215	115,803
Pharmacy Expense:		
Over-The-Counter Drugs	38,266	41,316
Contracted Services	10,278	8,699
	48,544	50,015
Recreational And Social Service Expense:		
Salaries And Wages	241,105	230,019
Supplies	86,086	74,931
Contracted Services	8,052	3,483
	335,243	308,433
Barber And Beauty Shop	4,384	3,905
Employee Benefits	63,358	59,125
Total Other Patient Care Services	$ 1,027,857	$ 990,376

See Independent Accountant's Review Report On The Supplementary Information

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Schedules Of Routine Services

For The Years Ended December 31,	2014	2013
Dietary:		
Salaries And Wages	$ 418,787	$ 392,694
Contracted Services	12,708	26,356
Supplies	58,977	58,688
	490,472	477,738
Laundry:		
Linen Replacement	94,435	76,773
Salaries And Wages	100,300	103,613
Supplies	24,471	16,004
	219,206	196,390
Housekeeping:		
Salaries And Wages	300,643	293,603
Supplies	75,963	65,394
	376,606	358,997
Operation And Maintenance Facility:		
Salaries And Wages	175,229	154,394
Repairs And Maintenance	119,519	149,977
Utilities	9,929	4,656
Minor Equipment	52,958	45,208
Contracted Services	9,633	2,549
	367,268	356,784
Employee Benefits	263,330	243,183
Total Routine Services	$ 1,716,882	$ 1,633,092

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Schedules Of Administrative Services

For The Years Ended December 31,	2014	2013
Administrative Expenses:		
Management Fee	$ 1,365,000	$ 1,104,000
Salaries And Wages:		
Office	418,611	420,195
Administration	226,219	183,630
Insurance	137,948	105,166
Legal And Consulting	44,986	67,241
Security Contracted Services	49,960	50,762
Supplies	40,358	49,722
Telephone	36,774	36,402
Data Processing	33,014	26,749
Dues And Subscriptions	24,433	25,452
Advertising	15,919	21,314
Accounting	17,220	17,000
Bank Charges	13,316	11,277
Meetings And Seminars	6,460	6,636
Taxes And Licenses	8,369	930
Contract Services- Quality Assurance	(181)	-
Travel- Reimbursable	1,243	-
Auto	874	496
	2,440,523	2,126,972
Medical Record Expenses:		
Salaries And Wages	43,518	45,232
Supplies	6,497	4,946
Contracted Services	-	(1,202)
	50,015	48,976
Training:		
Salaries And Wages And Contracted Services	34,366	35,585
Interest	1,868	4,153
Employee Benefits	133,019	132,141
Total Administrative Services	$ 2,659,791	$ 2,347,827

See Independent Accountant's Review Report On The Supplementary Information

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Schedules Of Capital/Property Services

For The Years Ended December 31,	2014	2013
Recurring Capital/Property Services:		
Taxes	$ 21,777	$ 21,625
Provider Assessment	920,482	915,298
Insurance	211	213
Total Capital/Property Services	$ 942,470	$ 937,136

See Independent Accountant's Review Report On The Supplementary Information

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Schedules Of Other Operating Revenue And Expenses

For The Years Ended December 31,	2014	2013
Other Operating Revenue:		
Employee And Guest Meals And Other	$ 4,094	$ 7,927
Vending Machines	3,185	4,449
Telephone And Cable	25,800	26,760
Beauty And Barber Shop	4,147	3,369
Total Other Operating Revenue	37,226	42,505
Other Operating Expenses:		
Provisions For Bad Debt, Net Of Recoveries	298,531	265,629
Equipment Rental	37,499	34,637
Marketing And Community Outreach	20,754	14,028
Contributions	2,750	4,000
Total Other Operating Expenses	359,534	318,294
Total Other Operating Expenses, Net	$ 322,308	$ 275,789

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Schedules Of Ancillary Services

For The Years Ended December 31,	2014	2013
Contracted Services	$ 1,260,293	$ 1,120,011
Prescription Drugs	584,633	510,708
Specialized Medical Equipment Rental	38,031	51,724
X-Ray, Laboratory, And Consolidated Billing	95,690	88,300
Transportation	132,426	128,504
Supplies	250	3,377
Total Ancillary Services	$ 2,111,323	$ 1,902,624

Charles Street Healthcare, LLC
T/A FutureCare - Homewood

Financial Statements

For The Years Ended
December 31, 2015 And 2014

HERTZBACH
certified public accountants · consultants

Charles Street Healthcare, LLC
T/A FutureCare - Homewood

Table Of Contents

For The Years Ended December 31, 2015 And 2014

HERTZBACH
certified public accountants · consultants

Independent Accountant's Review Report

To the Members
Charles Street Healthcare, LLC
T/A FutureCare - Homewood

8028 Ritchie Highway
Pasadena, Maryland 21122

We have reviewed the accompanying financial statements of Charles Street Healthcare, LLC T/A FutureCare - Homewood, which comprise the balance sheets as of December 31, 2015 and 2014, and the related statements of operations, changes in members' equity, and cash flows for the years then ended, and the related notes to the financial statements. A review includes primarily applying analytical procedures to management's financial data and making inquiries of company management. A review is substantially less in scope than an audit, the objective of which is the expression of an opinion regarding the financial statements as a whole. Accordingly, we do not express such an opinion.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatements whether due to fraud or error.

Accountant's Responsibility

Our responsibility is to conduct the review engagements in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the AICPA. Those standards require us to perform procedures to obtain limited assurance as a basis for reporting whether we are aware of any material modifications that should be made to the financial statements for them to be in accordance with accounting principles generally accepted in the United States of America. We believe that the results of our procedures provide a reasonable basis for our conclusion.

Accountant's Conclusion

Based on our reviews, we are not aware of any material modifications that should be made to the accompanying financial statements in order for them to be in accordance with accounting principles generally accepted in the United States of America.

Supplementary Information

The supplementary information included on pages 13-19 is presented for purposes of additional analysis and is not a required part of the basic financial statements. The information is the representation of management. We have reviewed the information and, based on our reviews, we are not aware of any material modifications that should be made to the information in order for it to be in accordance with accounting principles generally accepted in the United States of America. We have not audited the information and, accordingly, do not express an opinion on such information.

Hertzbach & Company, P.A.

Owings Mills, Maryland
April 26, 2016

F I N A N C I A L

S T A T E M E N T S

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Balance Sheets

December 31,	2015	2014
ASSETS		
CURRENT ASSETS		
Cash	$ 248,780	$ 2,675,681
Accounts Receivable, Patient Care, Net	2,470,220	2,697,910
Prepaid Expenses And Other Current Assets	248,231	132,816
Due From Third-Party Payers	203,494	173,121
Total Current Assets	3,170,725	5,679,528
PROPERTY AND EQUIPMENT, Net	748,367	690,103
OTHER ASSETS		
Deferred Costs, Net	4,214	5,054
Project Costs	40,876	-
Total Other Assets	45,090	5,054
TOTAL ASSETS	$ 3,964,182	$ 6,374,685
LIABILITIES AND MEMBERS' EQUITY		
CURRENT LIABILITIES		
Accounts Payable And Accrued Expenses	$ 1,272,966	$ 1,252,633
Due To Third-Party Payers	1,771,194	3,394,546
Total Liabilities	3,044,160	4,647,179
MEMBERS' EQUITY	920,022	1,727,506
TOTAL LIABILITIES AND MEMBERS' EQUITY	$ 3,964,182	$ 6,374,685

See Independent Accountant's Review Report And Accompanying Notes To Financial Statements

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Statements Of Operations

For The Years Ended December 31,	2015	2014
Revenue:		
Net Patient Services	$ 21,203,993	$ 19,225,409
Operating Expenses:		
Nursing Care Services	8,254,309	7,986,998
Other Patient Care Services	1,032,889	1,027,857
Routine Services	1,822,091	1,716,882
Administrative Services	2,933,256	2,659,791
Capital/Property Services	921,777	942,470
Other Operating Expenses, Net	275,967	322,308
Ancillary Services	2,266,824	2,111,323
Total Operating Expenses	17,507,113	16,767,629
Operating Income	3,696,880	2,457,780
Other Expenses:		
Rent	1,040,000	1,087,000
Depreciation And Amortization	189,364	167,344
Total Other Expenses	1,229,364	1,254,344
NET INCOME	$ 2,467,516	$ 1,203,436

See Independent Accountant's Review Report And Accompanying Notes To Financial Statements

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Statements Of Changes In Members' Equity

For The Years Ended December 31,	2015	2014
Members' Equity, Beginning Of Year	$ 1,727,506	$ 1,494,070
Members' Distributions	(3,275,000)	(970,000)
Net Income	2,467,516	1,203,436
Members' Equity, End Of Year	$ 920,022	$ 1,727,506

See Independent Accountant's Review Report And Accompanying Notes To Financial Statements

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Statements Of Cash Flows

For The Years Ended December 31,	2015	2014
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net Income	$ 2,467,516	$ 1,203,436
Adjustments To Reconcile Net Income To Net Cash		
Provided By Operating Activities:		
Depreciation And Amortization	189,364	167,344
Provisions For Bad Debt, Net Of Recoveries	244,025	298,531
(Increase) Decrease In Operating Assets:		
Accounts Receivable, Patient Care	(16,335)	(849,135)
Prepaid Expenses And Other Current Assets	(115,415)	365,242
Due From Third-Party Payers	(30,373)	(16,807)
Increase (Decrease) In Operating Liabilities:		
Accounts Payable And Accrued Expenses	20,333	16,774
Due To Third-Party Payers	(1,623,352)	1,244,999
Net Cash Provided By Operating Activities	1,135,763	2,430,384
CASH FLOWS FROM INVESTING ACTIVITIES:		
Acquisitions Of Property And Equipment	(246,788)	(212,708)
Acquisitions Of Project Costs	(40,876)	-
Net Cash Used In Investing Activities	(287,664)	(212,708)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payments On Revolving Credit Note, Net	-	(122,155)
Members' Distributions	(3,275,000)	(970,000)
Net Cash Used In Financing Activties	(3,275,000)	(1,092,155)
NET (DECREASE) INCREASE IN CASH	(2,426,901)	1,125,521
CASH, BEGINNING OF YEAR	2,675,681	1,550,160
CASH, END OF YEAR	$ 248,780	$ 2,675,681
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash Paid During The Year For Interest	$ 463	$ 1,868

See Independent Accountant's Review Report And Accompanying Notes To Financial Statements

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Notes To Financial Statements

For The Years Ended December 31, 2015 And 2014

1. NATURE OF BUSINESS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

NATURE OF BUSINESS – Charles Street Health Care, LLC T/A FutureCare - Homewood (the Company) was created under Maryland law pursuant to its Articles of Organization effective on October 25, 1995, and commenced operations on January 1, 1996. The Company currently operates a nursing facility consisting of 148 comprehensive care beds located in Baltimore, Maryland.

PERSONAL ASSETS AND LIABILITIES AND MEMBERS' SALARIES – In accordance with the generally accepted method of presenting limited liability company financial statements, the financial statements do not include the personal assets and liabilities of the members, including their obligation for income taxes on their distributive shares of the net income of the Company or their rights to refunds on its net loss, nor any provision for income tax expense or an income tax refund. The expenses shown in the statements of income do not include any salaries to the members.

METHOD OF ACCOUNTING – The financial statements of the Company are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America.

CASH AND CASH EQUIVALENTS – The Company considers all unrestricted highly liquid investments with an initial maturity of three months or less when purchased to be cash equivalents.

USE OF ESTIMATES – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

PROVISION FOR DOUBTFUL ACCOUNTS – The Company provides for estimated losses on accounts receivable based on an analysis of specific accounts, collection history, and industry experience.

PATIENT SERVICE REVENUE – Patient service revenue is reported at established billing rates or at the amount realizable under the agreement with the third-party payer. Revenue under the third-party payer's agreement was subject to examination and retroactive adjustments for the year ended December 31, 2014 and prior years. A provision for estimated third-party payer settlements is provided in the period the related services are rendered for those years. Differences between the amounts accrued and subsequent settlements are recorded in revenue in the year of settlement.

PROPERTY AND EQUIPMENT – Property and equipment are recorded at cost. Depreciation and amortization is provided for on the straight-line method computed over the estimated useful lives of the assets. Maintenance and repairs are charged to expense as incurred; major renewals and betterments are capitalized.

ADVERTISING – Advertising (including help wanted and promotional costs) is charged to operations when incurred. The Company has no significant direct-response advertising. Advertising expense for the years ended December 31, 2015 and 2014, totaled $15,401 and $15,919, respectively, and is included in administrative services in the statements of operations.

DEFERRED COSTS – Loan acquisition costs have been capitalized and are amortized over the life of the loan using the straight-line method.

INCOME TAXES – No provision or benefit for income taxes has been included in these financial statements since taxable income or loss passes through to, and is reportable by, the members individually.

1. NATURE OF BUSINESS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

COMPENSATED ABSENCES – Employees of the Company are entitled to paid vacation and personal days depending on job classification, length of service, and other factors. The Company has accrued $202,933 and $205,392 for vacation and personal days as of December 31, 2015 and 2014, respectively, which is included in accounts payable and accrued expenses on the balance sheets.

IMPAIRMENT OF LONG-LIVED ASSETS – Long-lived assets are evaluated for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. If such assets are deemed to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the fair value. There were no impairment losses for the years ended December 31, 2015 and 2014.

2. PATIENT ACCOUNTS RECEIVABLE

Patient accounts receivable as of December 31, 2015 and 2014 is comprised of the following:

	2015		2014	
Medicaid	$ 1,192,878	41%	$ 1,389,138	42%
Private	373,905	12%	692,670	21%
Managed Care, Hospice, And Other Insurance	419,144	14%	296,802	9%
Medicare Part A	863,977	29%	837,735	26%
Medicare Part B	49,219	2%	17,450	1%
Veteran Administration	45,107	2%	26,088	1%
	2,944,230	100%	3,259,883	100%
Less: Provison For Doubtful Accounts	474,010		561,973	
	$ 2,470,220		$ 2,697,910	

3. DUE FROM/TO THIRD-PARTY PAYERS

Due from/to third-party payers represents the estimated settlement amounts due from/to the Medicaid and Medicare programs for cost reports in which a final settlement has not yet been issued. The Medicaid program no longer provides for retroactive settlements for years beginning after December 31, 2014. The 2014 and prior cost reports are subject to verification, leading to final settlement. The due to Medicaid, Working Capital Fund represents an interest free working capital advance from the Medicaid program. Payment on this advance is due on May 1, 2016. Management believes this advance will be extended for another year. The balances as of December 31, 2015 and 2014 consisted of the following:

	2015	2014
Due From Third-Party Payers		
Due From Medicare, Coinsurance	$ 203,494	$ 173,121
Due To Third-Party Payers		
Due To Medicaid - 2014	$ 1,575,086	$ 1,641,874
Due To Medicaid - 2013	-	1,572,687
Due To Medicaid - 2010	-	4,957
Due To Medicaid, Working Capital Fund	196,108	175,028
	$ 1,771,194	$ 3,394,546

4. DEFERRED COSTS

Deferred costs as of December 31, 2015 and 2014 consisted of the following:

	2015	2014
Loan Acquistion Costs	$ 21,014	$ 21,014
Less: Accumulated Amortization	16,800	15,960
	$ 4,214	$ 5,054

Amortization expense was $840 for each of the years ended December 31, 2015 and 2014. Estimated aggregate amortization expense for amortizable deferred costs for each of the next five years is $840 per year.

5. PROPERTY AND EQUIPMENT

Property and equipment as of December 31, 2015 and 2014 consisted of the following:

	2015	2014
Furniture And Fixtures	$ 1,658,426	$ 1,505,001
Leasehold Improvements	791,237	697,874
	2,449,663	2,202,875
Less: Accumulated Depreciation And Amortization	1,701,296	1,512,772
	$ 748,367	$ 690,103

Depreciation and amortization expense on the property and equipment for the years ended December 31, 2015 and 2014 was $188,524 and $166,504, respectively.

6. REVOLVING CREDIT NOTE

The Company has a revolving credit note agreement with PNC Bank. The balance on the note was $0 for each of the years ended December 31, 2015 and 2014. Terms of the note are as follows:

Maximum Borrowing Amount:	Lesser of $1,700,000 or 85% of eligible receivables as defined in the note agreement.
Interest Rate:	London Interbank Offered Rate (LIBOR) plus 2.50% (2.74% and 2.67% at December 31, 2015 and 2014, respectively).
Maturity:	Entire balance is due September 30, 2016.
Collateral:	Secured by all of the assets of the Company.
Guarantors:	None.
Covenants:	The note is subject to certain financial and nonfinancial covenants.

7. RELATED PARTY TRANSACTIONS

LEASE OF FACILITY – Certain members of the Company are members of FutureCare – Homewood Properties, LLC (Homewood), which owns the land, building, and certain furniture and equipment of the facility. The Company entered into an operating lease to rent the facility from Homewood which expires on April 30, 2019. The agreement with Homewood includes rent, property taxes, property insurance, and utilities. Rent expense was $1,040,000 and $1,087,000 for the years ended December 31, 2015 and 2014, respectively.

7. RELATED PARTY TRANSACTIONS (CONTINUED)

LEASE OF FACILITY (CONTINUED) – The estimated minimum annual rental payments due under the current operating lease agreement are as follows:

Years Ending December 31,	Amount
2016	$ 1,212,000
2017	1,212,000
2018	1,212,000
2019	404,000
	$ 4,040,000

MANAGEMENT SERVICES – Certain members of the Company are stockholders of FutureCare Health and Management of Homewood, Inc. (FutureCare). The Company entered into a management agreement with FutureCare to receive management services as defined in an agreement dated January 1, 2005, and expiring on December 31, 2019.

The annual management fee is equal to approximately 8% and 7% for the years ended December 31, 2015 and 2014, respectively, of the Company's gross revenues from operations and may be adjusted as mutually agreed upon. In no event, however, may the annual fee exceed 9% of the Company's gross revenues. Management fee expense for the years ended December 31, 2015 and 2014 was $1,644,000 and $1,365,000, respectively, and is included in administrative services in the statements of operations.

THERAPY SERVICES – Certain members of the Company are stockholders of FutureCare Rehabilitation, Inc. (FutureCare Rehab). The Company entered into an agreement with FutureCare Rehab to provide therapy services to the Company's patients. Fees incurred to FutureCare Rehab for those services for the years ended December 31, 2015 and 2014 totaled $1,340,875 and $1,260,293, respectively, and are included in ancillary services in the statements of operations.

8. PROFIT SHARING PLAN

The Company has adopted a qualified 401(k) profit sharing plan covering all employees with at least one year and 1,000 hours of service. The Company provides a matching contribution of 25% of the participant's contribution up to a maximum of 4% of eligible wages. The contributions for the years ended December 31, 2015 and 2014 were $19,131 and $16,792, respectively.

9. CERTAIN SIGNIFICANT RISKS AND UNCERTAINTIES

The health care industry is subject to numerous laws and regulations by federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for resident services, and Medicare and Medicaid fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management is not aware of any violations of these laws and regulations.

10. CONCENTRATIONS

CONCENTRATION OF CREDIT RISK – The Company maintains cash balances at multiple financial institutions and, at times, balances may exceed federally insured limits. The Company has never experienced any losses related to these balances. At December 31, 2015, the Company had cash balances on deposit that exceeded federally insured amounts by $139,516.

ACCOUNTS RECEIVABLE AND PATIENT SERVICE REVENUE – The Company grants credit without collateral to its residents, most of who are insured under third-party payer arrangements. See Note 2 for detail of the concentration of gross accounts receivable for services to patients. Approximately 90% and 92% of patient service revenue was derived under Federal and State third-party reimbursement programs for the years ended December 31, 2015 and 2014, respectively.

11. COMMITMENTS AND CONTINGENCIES

WORKERS' COMPENSATION – The Company, together with 14 related entities, maintains a high deductible workers' compensation plan which covers its employees. The plan calls for the Company to reimburse the plan administrator for the sum of the claim charges attributable to the Company. The expenses of the Company cannot exceed $300,000 per claim with a pooled policy aggregate for all entities covered under the plan, as defined by the policy. Additional losses incurred above the claim maximums, if any, would be funded through a reinsurance policy maintained by the plan.

The Company records provisions for expenses for workers' compensation liability claims based on the amount of paid losses together with a provision for case reserves established by the plan's third-party claim adjusters as well as the plan administrator's and management's review of the individual claim facts, historical claim development factors, and industry experience.

While management believes that the provision for claims on workers' compensation is adequate, the ultimate liability may be in excess of or less than the amounts recorded. To the extent that the Company has paid to the plan administrator an amount in excess of future claims, those amounts are included in prepaid expenses and other current assets on the balance sheets. The Company's prepaid asset balance for workers' compensation was $38,484 and $0 as of December 31, 2015 and 2014, respectively.

12. SUBSEQUENT EVENTS

Management has evaluated events and transactions subsequent to the balance sheet date for potential recognition or disclosure through April 26, 2016, the date the financial statements were available to be issued. There were no events that required recognition or disclosure in the financial statements.

S U P P L E M E N T A R Y

I N F O R M A T I O N

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Schedules Of Nursing Care Services

For The Years Ended December 31,	2015	2014
Salaries And Wages	$ 6,050,678	$ 5,805,670
Employee Benefits	1,520,318	1,529,834
Supplies	547,519	602,555
Contracted Respiratory	46,387	27,126
Contracted Services	89,407	21,813
Total Nursing Care Services	$ 8,254,309	$ 7,986,998

See Independent Accountant's Review Report

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Schedules Of Other Patient Care Services

For The Years Ended December 31,	2015	2014
Food	$ 365,374	$ 367,963
Medical Director:		
Contracted Services	99,150	99,150
Nurse Practitioner And Dental Services:		
Contracted Services	120,093	109,215
Pharmacy Expense:		
Over-The-Counter Drugs	40,043	38,266
Contracted Services	10,310	10,278
	50,353	48,544
Recreational And Social Service Expense:		
Salaries And Wages	238,974	241,105
Supplies	83,004	86,086
Contracted Services	12,310	8,052
	334,288	335,243
Barber And Beauty Shop	3,579	4,384
Employee Benefits	60,052	63,358
Total Other Patient Care Services	$ 1,032,889	$ 1,027,857

See Independent Accountant's Review Report

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Schedules Of Routine Services

For The Years Ended December 31,	2015	2014
Dietary:		
Salaries And Wages	$ 479,692	$ 418,787
Contracted Services	2,166	12,708
Supplies	57,131	58,977
	538,989	490,472
Laundry:		
Linen Replacement	77,454	94,435
Salaries And Wages	97,560	99,800
Supplies	26,620	24,471
Contracted Services	-	500
	201,634	219,206
Housekeeping:		
Salaries And Wages	346,446	300,643
Supplies	78,323	75,963
	424,769	376,606
Operation And Maintenance Facility:		
Salaries And Wages	175,005	175,229
Repairs And Maintenance	118,824	119,519
Utilities	10,631	9,929
Minor Equipment	58,332	52,958
Contracted Services	17,814	9,633
	380,606	367,268
Employee Benefits	276,093	263,330
Total Routine Services	$ 1,822,091	$ 1,716,882

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Schedules Of Administrative Services

For The Years Ended December 31,	2015	2014
Administrative Expenses:		
Management Fee	$ 1,644,000	$ 1,365,000
Salaries And Wages:		
Office	423,471	418,611
Administration	244,420	226,219
Insurance	102,731	137,948
Supplies	50,583	40,358
Security Contracted Services	49,824	49,960
Legal And Consulting	45,596	44,986
Telephone	37,702	36,774
Data Processing	31,711	33,014
Dues And Subscriptions	26,721	24,433
Accounting	17,628	17,220
Advertising	15,401	15,919
Bank Charges	15,070	13,316
Education And Training	11,177	5,261
Meetings And Seminars	2,269	1,199
Auto	1,422	874
Taxes And Licenses	1,220	8,369
Travel- Reimbursable	109	1,243
Contract Services- Quality Assurance	-	(181)
	2,721,055	2,440,523
Medical Record Expenses:		
Salaries And Wages	47,960	43,518
Supplies	5,395	6,497
	53,355	50,015
Training:		
Salaries And Wages And Contracted Services	29,202	34,366
Supplies	750	-
	29,952	34,366
Interest	463	1,868
Employee Benefits	128,431	133,019
Total Administrative Services	$ 2,933,256	$ 2,659,791

See Independent Accountant's Review Report

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Schedules Of Capital/Property Services

For The Years Ended December 31,	2015	2014
Recurring Capital/Property Services:		
Taxes	$ 26,726	$ 21,777
Provider Assessment	894,781	920,482
Insurance	270	211
Total Capital/Property Services	$ 921,777	$ 942,470

See Independent Accountant's Review Report

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Schedules Of Other Operating Revenue And Expenses

For The Years Ended December 31,	2015	2014
Other Operating Revenue:		
Employee And Guest Meals And Other	$ 10,093	$ 4,094
Vending Machines	3,662	3,185
Telephone And Cable	15,090	25,800
Beauty And Barber Shop	3,639	4,147
Total Other Operating Revenue	32,484	37,226
Other Operating Expenses:		
Provisions For Bad Debt, Net Of Recoveries	244,025	298,531
Equipment Rental	23,746	37,499
Marketing And Community Outreach	33,080	20,754
Contributions	7,600	2,750
Total Other Operating Expenses	308,451	359,534
Total Other Operating Expenses, Net	$ 275,967	$ 322,308

See Independent Accountant's Review Report

Charles Street Healthcare, LLC
T/A FutureCare - Homewood
Schedules Of Ancillary Services

For The Years Ended December 31,	2015	2014
Contracted Services	$ 1,340,875	$ 1,260,293
Prescription Drugs	633,432	584,633
Specialized Medical Equipment Rental	48,218	38,031
X-Ray, Laboratory, And Consolidated Billing	105,878	95,690
Transportation	135,634	132,426
Supplies	2,787	250
Total Ancillary Services	$ 2,266,824	$ 2,111,323

EXHIBIT 8

PNC HEALTHCARE

April 4, 2017

Gary Attman
President & CEO
Futurecare Health and Management
8028 Rithcie Hwy
Suite 118
Pasadena, MD 21122

Dear Gary,

We are excited to hear about your CON application to expand and modernize FutureCare Homewood. PNC is proud to have been your bank for this facility for the past 10 years, and we look forward to continuing this relationship well into the future. PNC would be interested to consider and evaluate a formal financing request from Futurecare to finance the proposed 30 bed expansion as well as other modernization of the plant infrastructure and patient areas.

Sincerely,

Joe Tavarez
Vice President, Relationship Manager
PNC Healthcare

EXHIBIT 9

MedStar Health

Bradley S. Chambers
President, MedStar Good Samaritan Hospital
President, MedStar Union Memorial Hospital
Senior Vice President, MedStar Health

MedStar Good Samaritan Hospital
5601 Loch Raven Blvd.
Baltimore, MD 21239
443-444-3902 **PHONE**
MedStarGoodSam.org

MedStar Union Memorial Hospital
201 E. University Pkwy.
Baltimore, MD 21218
410-554-2227 **PHONE**
MedStarUnionMemorial.org

March 17, 2017

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

Re: Certificate of Need Application for FutureCare Homewood

Dear Mr. Steffen:

MedStar Union Memorial Hospital (MUMH) is the closest hospital to FutureCare Homewood (FCH) and has partnered with this building in a number of ways that are relevant to FutureCare's application to modernize and expand by 30 private rooms. Specifically:

- MUMH, MedStar Good Samaritan Hospital and MedStar Harbor Hospital are in the process of consolidating inpatient orthopaedic surgery at MUMH - elective and trauma related. Thus MUMH's orthopaedic program is growing and with it, referrals for sub-acute rehabilitative care.

- MUMH is the central source for cardiac intervention and surgery for the four MedStar North hospitals as well numerous non-MedStar referral sources. This service line is also growing.

- Many of the orthopaedic and cardiac patients served by MUMH live in Baltimore City. So having a sub-acute facility close to home and near where they received their acute care is an important aspect of their care continuum. This proximity and close working relationship between the two institutions also serves the patients' best interest when urgent care may be needed once the patient is at FCH.

- The MUMH cardiac and orthopaedic inpatient nursing units are all private rooms, a decision in response to patient preference and staffing efficiencies where gender and co-morbidity factors work against optimal semi-private room utilization. We have seen where transferring a patient from a private room setting to one that is semi-private is a hard sell and ultimately, reduces patient satisfaction. Private rooms at FCH would certainly harmonize the transition from MUMH to a nearby, high quality sub-acute facility.

For these and other reasons, MUMH supports this CON application by FutureCare. We appreciate this opportunity to address the MHCC and its willingness to consider our support of this project.

Sincerely,

Bradley S. Chambers
President

MedStar Union
Memorial Hospital

201 East University Parkway
Baltimore, MD 21218
410-554-4444 x1 PHONE
410-554-4464 FAX
unionmemorial.org

Lisa Hayen, BSN, RN
Patient Care Coordination Manager

MedStar Orthopedics

March 20, 2017

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

Re: Certificate of Need Application for FutureCare Homewood

Dear Mr. Steffen:

I am writing to express my support for the Certificate of Need application filed by FutureCare Homewood to add private rooms. Homewood is a high quality life care community, and its semi-private rooms for rehabilitation patients are not appealing to many patients we refer there. More of the patients we refer to Homewood would choose it for their rehabilitation due to its unique orthopedic WalkStrong program if it had private rooms. It needs this project in order to keep residents of Baltimore City healthy. Homewood must have a "state of the art" nursing facility in order to continue meeting the growing needs of our residents in this new century.

Homewood requires new patient rooms in order to meet our population's needs. It has proven itself to be a responsible provider which is cost conscious and fiscally responsible. Our patients look to Homewood for information, prevention, and treatment services. It must be able to meet these needs.

I support this project and hope that the Commission approves Homewood's CON application.

Sincerely,

Lisa Hayen, BSN, RN

Lisa Hayen, BSN, RN
Patient Care Coordination Manager
Orthopedics at MUMH

cc: Les Goldschmidt

Mercy
MEDICAL CENTER

A University Affiliated Center Conducted by the Sisters of Mercy

3/15/2017

Ms. Snyder

It is my understanding that one of your facilities may be extending with the addition of private rooms. While some of our patients do not mind semi private rooms. There are a large portion of our patients who prefer private rooms for several reasons. Privacy is very important as well as not having to share facilities with other people. Other reasons for requesting private rooms are to decrease exposure to other illness, better sleeping - which is critical to healing, reduced noise levels and controllable lighting and temperatures. Also private rooms are more accessible for family members to stay. I believe that having more private rooms would be very beneficial to the patients.

Sincerely,

Jane Stahm RN

Jane Stahm RN
Director Case Management
Mercy Medical Center
Phone: 410-783-5872
Fax: 410-332-9015

EXHIBIT 10

Fiscal years 2015 and 2016- Volumes, Revenues and Expenses for these two fiscal years were the actual amounts incurred.

Year 2017 – Volumes, Revenues, and Expenses for 2017 are based upon the facility budget which reflect the current facility staffing, wages, benefits, and expected other costs as well as expected payor mix and payor rates. Rent paid by the facility to the owner is inclusive of the cost of gas and electric, water, real estate taxes and principal and interest on the facility mortgage debt.

Years 2018, 2019 - All assumptions remained static with the current 2017 budget. In accordance with the instructions, no inflation was applied to either revenue or expenses. The only change reflected in these two years, relates to the rental expense line item. The increase in rent expense relates to interest on the borrowings related to the facility modernization as well as additional rent required due to the loss of the commercial tenant during 2019 in preparation of construction.

Year 2020- All assumptions remained static for the first 9 months with the exception of the continued increase in the rent as described above. We assume that the 30 beds will open for admissions on 10/1/2020 and the facility will reach an occupancy of 27 additional residents by 12/31/2020. Of the 27 additional average daily census due to the additional beds, it is assumed that there will be 19 additional short term residents in the facility and 8 additional long term residents in the facility. Staffing of the new unit begins 30 days prior to opening and increases over the 3 month fill. Other facility costs are assumed to increase on a PPD basis or % of revenue basis as appropriate.

Year 2021- This year is assumed to be a stable year post 30 bed addition. All costs and staffing are stable for the entire year for a 178 bed facility. The rent was increased to reflect the change related to principal and interest on a permanent loan of 8,710,000 amortized over 25 years at 4%. This year is reflective of all future years post 30 bed addition (not adjusted for inflation)

Specific revenue rate assumptions are as follows:
The standard room rate is $330.00 per day for private pay patients.

The average rate for Medicare Part A is assumed to be $576.66 per patient day. The Medicare rate is slightly reduced in 2021 to $570.25 due to the addition of non-ventilator rehab residents.

The average Medicaid rate (net of contractual allowances) is assumed to be 392.44 per patient day using current rates, expected case mix indices (CMI), and mix of Medicaid ventilator residents (assumed to be approx. 19). The Medicaid ventilator rate is $778.42. Other revenue assumptions include additional Medicare part B revenue from providing various therapy services in the amounts of $370,000 per year. The average Medicaid rate in 2021 reduces to 385.98 due to the addition of 8 non-ventilator residents to the mix.

Managed care rates are assumed to be $451.00 per patient day

Hospice rate is assumed to be $343.00 per patient day

VA Rate is assumed to be $332.00 per patient day

EXHIBIT 11

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

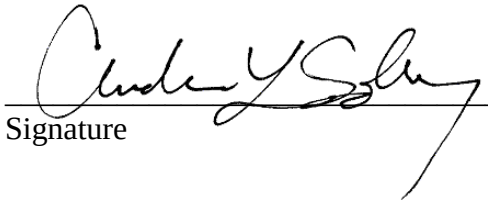
Signature _____ Date 4/5/2017

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

Lesa D. Goldschmidt
Signature

4/6/17
Date

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



Signature

4/5//2017

Date