CERTIFICATE OF NEED APPLICATION

COMPREHENSIVE CARE FACILITY (NURSING HOME)

BRINTON WOODS HEALTH CARE CENTER, LLC

APRIL 6, 2018

BRINTON WOODS
HEALTH & REHABILITATION CENTER AT WINFIELD
A LifeBridge Health Partner

LIFEBRIDGE HEALTH

CARROLL HOSPITAL
a LifeBridge Health center

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Exhibits

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

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: Brinton Woods Health and Rehabilitation at Winfield[2]

Address:

1442 Buckhorn Road	Sykesville	21784	Carroll
Street	City	Zip	County

2. Name of Owner Brinton Woods Health Care Center, 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.

Please refer to **Exhibit 1** for the ownership structure of Brinton Woods Health Care Center, LLC.

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): Brinton Woods Health Care Center, LLC

Address:

9515 Deereco Road, Suite 407 Street	Timonium City	21093 Zip	MD State	Balto. County
Telephone: 410-795-2737				

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

SAME

[2] This is the name of the facility at its current location, but the name of the facility may be changed after it is relocated to the Carroll Hospital campus.

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. Lead or primary contact:

Name and Title: Teresa Fletcher, Assistant Vice President

Company Name LifeBridge Health

Mailing Address:

200 Memorial Avenue	**Westminster MD**	**21157**
Street	City	Zip

Telephone: 410-469-5220
E-mail Address (required): teresaf@carrollhospitalcenter.org

Fax: 410-601-9516

If company name is different than applicant briefly describe the relationship	LifeBridge Health is the majority owner of the Applicant. Please refer to **Exhibit 1** for the delineation of the ownership structure of the Applicant.

B. Additional or alternate contact:

Name and Title: Marta Harting

Company Name Venable LLP

Mailing Address:

750 E. Pratt Street	**Baltimore**	**MD**	**21202**
Street	City	Zip	State

Telephone: 410-244-7400

E-mail Address (required): mdharting@venable.com

Fax: 410-244-7442

If company name is different than applicant briefly describe the relationship	Legal Counsel

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

Carroll Hospital Center

Address:

200 Memorial Avenue	**Westminster**	**21157**	**MD**	**Carroll**
Street	City	Zip	State	County

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 in the real property and any related parent entities. Attach a chart that completely

delineates this ownership structure.

Applicant Response: Please see **Exhibit 4** for the delineation of the LBH ownership structure that includes Carroll Hospital Center, the owner of the real property to which BW-W would be relocated with this project. Brinton Woods Senior Living, LLC is the owner of the real estate on which BW-W is currently operating. LBH is a majority (55%) owner of Brinton Woods Senior Living, LLC. The ownership structure of Brinton Woods Senior Living, LLC., is delineated in **Exhibit 2**.

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

Brinton Woods Health Care Center, 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:

Street	City	Zip	State	County

Telephone: _____

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.

Brinton Woods Management Company, LLC currently provides management services for BW-W, but may or may not provide management services for BW-W after it is relocated to the Carroll Hospital campus. LBH does not have an ownership interest in Brinton Woods Management Company, LLC. That entity is wholly owned by three of the individual minority owners of the Applicant.

Address:

Street	City	Zip	State	County
9515 Deereco Road, Suite 407	Timonium	21093	MD	Baltimore

Telephone: 410-560-4925

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

APPLICANT RESPONSE:

(1) Brief Description of Project. Brinton Woods Health and Rehabilitation at Winfield (BW-W) is a long-term and subacute care facility located in Carroll County. Rated as a five-star facility by the Centers for Medicare and Medicaid, BW-W has been providing health and rehabilitation services for short-term rehabilitation and long-term skilled nursing care in Carroll County for more than 12 years. It has a total of 60 beds, six are private and the remaining 54 are semi-private.

In November 2017, LifeBridge Health (LBH) acquired a majority (55%) ownership interest, in the Applicant.[3] Please refer to **Exhibit 1** for the delineation of the ownership structure of the Applicant. This transaction was accompanied by plans to rebuild and relocate the aging BW-W facility to the campus of Carroll Hospital, an LBH partner.

Originally built in 1959, and acquired by the Applicant in 2006, BW-W is not only an aging facility, but is unable to expand or improve its current facility to better meet Life Safety Requirements. Because of the current site's property typography and the design of the current structure, at its current location BW-W cannot undergo the significant improvements and modernization that are required in order to meet the needs and expectations of patients and their families. .

The Applicant is not seeking additional bed capacity. Rather, it is requesting approval for capital spending and the replacement and relocation of the existing facility. The relocation and

[3] The transaction documents require LBH to purchase the remaining 45% interest in the Applicant and Brinton Woods Senior Living, LLC, in the future under certain circumstances.

new facility are expected to strengthen the continuity of care for both current and future BW-W patients and improve the quality of care for those patients by improving their access to clinical resources. By doing so, the project will support LBH's success under the Maryland Demonstration Model and focus on the Triple Aim: improve the patient experience of care, improve clinical outcomes, and potentially reduce the total costs of care.

Through this new facility, the Applicant plans to breathe new life into the care offered at BW-W by combining the latest trends from residential, medical and hospitality models with an advanced technological infrastructure.

(2) Rationale for the Project. Key objectives and rationale for the project include:

- By investing in this facility now, the Applicant will be better prepared to meet the projected increase in demand for quality nursing home beds. The elderly population in Carroll County is growing by more than 3% annually (see Table 2 below**).** In addition, nursing home use rates are expected to increase in response to the Maryland Demonstration Model, other risk contracting, the expected waiver of the 3-day rule, and the upgrading of nursing home services. Although the Applicant is not requesting additional bed capacity with this project, the new facility will be in a position to expand in the future to accommodate additional beds, whereas the existing facility cannot be expanded.

- BW-W's physical plant requires significant capital upgrades and investment, and it cannot be modernized adequately to meet community needs in its current location. Its small "footprint" will not accommodate additional private rooms and its current plant cannot be modified for patient-oriented, progressively designed features. Additionally, its somewhat remote location remains a weakness. Rebuilding the nursing home on another site will provide a higher ratio of private rooms to reduce infection risks, improve functional outcomes, and respond directly to the short supply of private rooms in Carroll County.

- There are a limited number of private nursing home beds in Carroll County. Just 20% of nursing home beds in Carroll County and only 6.5% of the nursing home beds in Westminster are private. Additionally, nearly 30% of Carroll County nursing home beds are in 3- or 4-bed rooms. (See Table 1). Having three to four residents in one room does not provide suitable living conditions for any person, especially for patients who are in most cases elderly, frail and suffering from comorbidities that limit their mobility and ability to perform daily living activities. The new BW-W facility will have 40 private and 10 semi-private rooms, providing a very high ratio of private rooms with private baths (67%) compared to the current private room complement at BW-W of 10%.

Table 1

Beds by Room Type - Carroll County Nursing Homes

Nursing Home	Semi-Private Beds	Triple Room Beds	Quad Room Beds	Private Room Beds	Total Beds	Private Room %
Brinton Woods Nursing and Rehabilitation Center	54	0	0	6	60	10%
Carroll Lutheran Village Healthcare Center	94	0	0	9	103	9%
Golden Living Center	56	78	16	8	158	5%
Integrace Copper Ridge Nursing Home	16	0	0	50	66	76%
Integrace Fairhaven, Inc.	12	0	0	67	79	85%
Long View Healthcare Center, LLC	80	0	0	28	108	26%
Lorien - Taneytown	60	0	0	3	63	5%
Lorien Mt. Airy	58	0	0	4	62	6%
Pleasant View Nursing Home of Mt. Airy	0	0	104	0	104	0%
Transitions Healthcare at Sykesville	44	21	48	5	118	4%
Totals	**474**	**99**	**168**	**180**	**921**	**20%**

- Quality: Despite its physical plant limitations, BW-W is one of only four, CMS 5-Star rated facilities in Carroll County. The average rating of the other six facilities in Carroll County is 2.2 Stars. Additionally, in its last two inspections by the Department of Health, BW-W received only a total of three deficiencies, outperforming every nursing home in the county with the exception of two. BW-W also compares very favorably to State and national averages, making it one of the highest ranking facilities in the County according to the Maryland Healthcare Commission's long term care health ratings. The average number of deficiencies in the two most recent surveys of the remaining 9 facilities in Carroll County is 12, which exceeds both the State and national averages.

- Telemedicine and ancillary support services are in short supply in Carroll County nursing homes, resulting in access barriers. The Applicant plans to build a state-of-the-art facility that will be technologically advanced to enhance access to clinical specialists through telemedicine and interaction with family by providing easy to use, communication capabilities.

- By having a nursing home on the Carroll Hospital campus, for patients choosing the new Brinton Woods facility, the Applicant will be able to reduce patient placement delays tied to transfer and information exchange, and minimize the costs and difficulty of ambulance transports.

- The new location also will provide patients with much easier access to consultations by skilled clinical providers and specialized services including, outpatient dialysis, imaging, wound care and hyperbaric medicine, and full range of other services located on Carroll Hospital's campus.

- Patients choosing the new BW-W also will be able to have their complex and chronic conditions followed more closely and will have access to nurse and social work

navigators from Carroll Hospital to help coordinate care management of patients and mobilize the local community resources for support after discharge.

- By better managing patients and providing quality resources and support through LBH, the Applicant anticipates a potential reduction in the overall cost of care by decreasing potentially avoidable utilization, especially Emergency Room visits and readmissions.

- With a location on the Carroll campus, the community also will be able to clearly identify BW-W's partnership with Carroll Hospital and LifeBridge Health which will further enhance its reputation for quality care

(3) Cost:

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.

Applicant Response: The project will relocate BW-W to the Carroll Hospital campus from its current location, maintaining the same number of beds (60 beds), but substantially increasing the number of private rooms to 40 private and 10 semi-private rooms. The two-story building will be built on an approximately five acre parcel of land on the Carroll Hospital campus. The land currently has three residential houses that will be razed. The Nursing Home will be steel construction with brick and vinyl siding and a pitched shingled roof. The lower level measures 12,460 square feet and will provide support space for the kitchen, laundry, staff locker rooms, supply and storage area, staff training area, staff lounge and offices.

The upper level measures 34,925 square feet and will consist of forty private and ten semi-private patient rooms. The private rooms will be 295 square feet and the semi-private rooms will be 360 square feet. The patient rooms will each have their own bathroom and shower. On this floor there will be two sitting rooms, two day rooms, a living room, and a large centrally located dining/activity room with access to an exterior patio. The upper level will also house the administrative offices and physical/occupational therapy unit.

Please refer to **Exhibit 3** for the drawings and project schedule.

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

APPLICANT RESPONSE: See CON Table A.

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.

Applicant Response: No community based services will be affected by the project. Please refer to the response to Standard .05A(3) for additional information about community based services.

14. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: ___5___ 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_____ NO __X___ (If NO, describe below the current status and timetable for receiving each of the necessary approvals.)

Applicant Response: All State, county and city permits for the project will be applied for as required and in accordance with the project timeline.

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

(1) Owned by: Carroll Hospital Center

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

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

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

(5) Other: N/A
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	12	months
Initiation of Construction within 4 months of the effective date of a binding construction contract	2	months
Time to Completion of Construction from date of capital obligation	19	months

16. PROJECT DRAWINGS

Projects involving new construction and/or renovations should include scalable schematic drawings of the facility at 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".

Applicant Response: See Exhibit 3.

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.

Applicant Response: See Exhibit 3.

C. Specify dimensions and square footage of patient rooms.

Applicant Response: Each private patient room will be 295 square feet. Each semi-private room will be 360 square feet. **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)

Applicant Response: See CON Table B.

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.

Applicant Response: The new facility will have adequate access to utilities. Being located on the hospital campus, the facility will have access to the same utilities as the hospital, including electric, water and sewage.

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.)

Applicant Response: See CON Table C.

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.

Response:

Brinton Woods Health Care Center, LLC
9414 Deereco Road, Suite 407
Timonium MD 21093

LifeBridge Health
Carroll Hospital Center, Business Development
200 Memorial Avenue
Westminster, MD 21157

The ownership structure of Brinton Woods Health Care Center LLC is shown in **Exhibit 1**. The organizational structure of LifeBridge Health is shown in **Exhibit 4.**

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.

Applicant Response:

Brinton Woods at Arlington West
3939 Penhurst Avenue
Baltimore, MD 21215
Acquired in 2008

Brinton Woods at Pikesville
7 Sudbrook Lane
Pikesville, MD 21208
Acquired in 2017

Brinton Woods Post-Acute Care
5009 Frankford Avenue
Baltimore, MD 21206
Acquired in 2007

Brinton Woods at Dupont Circle
2131 O Street NW
Washington, DC 20037
Acquired in 2012

Brinton Woods of Denton 420 Colonial Drive
Denton, MD 21629
Acquired in 2017

Please refer to **Exhibit 4** for the health care facilities in the LifeBridge Health system.

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.

   Applicant Response: Brinton Woods Management and its affiliates have had a successful history of operating comprehensive care facilities, otherwise disclosed in this application. It has never had a facility lose its license, had a license suspended, or had its Medicare and Medicaid certification terminated. Such facilities are heavily regulated by the Office of Health Care Quality of the Maryland Department of Health and the federal Centers for Medicare and Medicaid Services. None of its historically operated facilities have had a level G or above survey deficiency in the past 5 years. In July, 2017 Brinton Woods took over two facilities formerly operated by a different, unrelated company that had survey challenges. In the less than a year since it took over, Brinton Woods has invested substantially in staff, systems, equipment, electronic medical records and capital improvements. One of these facilities, Brinton Woods Pikesville, was cited by OHCQ with a J level deficiency commencing while the former operator was in control. Brinton Woods Pikesville successfully implemented a corrective action plan and is in substantial compliance.

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.

   Applicant Response: Like virtually all health care facilities, these facilities have received citations as part of their regular licensure and accreditation surveys, but none of these citations have resulted in probation, significant penalties, or revocation of licensure or accreditation.

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).

   Applicant Response: No.

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.

04/05/2018
Date


Signature of Owner or Board-designated Official

President, Carroll Hospital & Executive Vice President, LifeBridge Health
Position/Title

Leslie Simmons, RN, FACHE
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). The State Health Plan.

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.**[4] 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. In cases where demonstrating compliance with a standard requires the provision of specific documentation, please include the documentation as a part of the application.

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.

Applicant Response: This project will not increase the number of beds at BW-W.

(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 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

[4] [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

Chapter.

Applicant Response: The Applicant will continue to participate in the Medical Assistance Program. The Applicant has a Memorandum of Understanding with Medicaid, which will remain in effect until the new facility is relocated, at which time the Applicant will enter into a new MOU to reflect the current participation rate

(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*.

Applicant Response: The Applicant agrees to continue to meet this standard.

(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.

Applicant Response: The Applicant agrees to continue to meet this standard.

(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.

Applicant Response: The Applicant will continue to operate under its current MOU with the Medical Assistance Program of the Department of Health. Once the new facility is approved and relocated, the Applicant agrees to enter into a new MOU to reflect the then-current participation rate

(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;

Applicant Response: The Applicant offers newly-admitted residents and/or their responsible party information on community services, including but not limited to Medicaid home and community-based waiver programs if available, home care, medical day care, assisted living and other initiatives to promote care in the most appropriate settings. See **Exhibit 5.**

(b) Initiating discharge planning on admission; and

Applicant Response: The Applicant currently initiates discharge planning upon admission for all patients and will continue to do so once the facility is relocated.

(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.

Applicant Response: The Applicant currently complies with this standard and will continue to permit access to the facility for agencies that provide education and outreach to residents and their families regarding community based alternatives.

(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.

Applicant Response: The Applicant addresses the need of its residents (including non-elderly residents) based on individual medical and psychosocial needs, regardless of age or disability. Services include: a licensed social worker, RNs, LPNs and GNAs; therapeutic recreations; an RN certified in wound care; and an RN certified in infection control. As previously stated, the Applicant currently initiates the discharge planning on admission for all patients, regardless of age or physical status, and will continue to do so once the facility is relocated.

(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;

Applicant Response: The new facility will offer all private and semi-private rooms, with no more than two beds in any patient room.

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

Applicant Response: The new facility will provide individual temperature controls in each patient room.

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

Applicant Response: In the new facility, no more than two residents will share a toilet.

(b) In a **renovation** project:

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

Applicant Response: Not applicable.

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

Applicant Response: Not applicable.

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

Applicant Response: Not applicable.

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

Applicant Response: Not applicable.

(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.

Applicant Response: The new facility will be served by the same public water system that serves Carroll Hospital.

(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;

Applicant Response: The Applicant cares for residents with a wide variety of diagnosis, including Chronic Obstructive Pulmonary Disease (COPD), Congestive

Heart Failure (CHF), diabetes, hypertension, muscle weakness, dementia, and other age-related, chronic conditions that inhibit patients' ability to perform daily living activities. (See **Exhibit 6** for a full listing of diagnoses for current patients.) The Applicant will continue to care for the same types of residents in its new facility.

(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;

Applicant Response:

THE KORTE COMPANY (Exhibit 7)

The Korte Company has delivered more than 2,000 senior living projects Nationwide and developed the Design-Build method. Its 2018 publication, *Delivering World-Class Care and Quality of Life, The Owners Guide to Senior Living Design and Construction*, includes several recommendations that will be incorporated into the project, including:

- *Moving towards the dual-purpose model of efficient care and quality lifestyle through incorporating the best design elements of hospitals, hotels and homes.*

- *Using interior design elements of the traditional home, the biggest of which is privacy, to allow seniors progressing from living on their own to receiving daily care in a nursing home to maintain dignity and personal space, including providing private rooms, private bathrooms and individual showers or baths.*

- *Utilizing a modern architectural model that maximizes individual spaces while making every element of the building disability-friendly.*

- *Designing a senior living facility that goes beyond complying with the standards of the Americans with Disabilities Act (ADA) to enable seniors to do as much as they can for themselves.*

- *Creating an environment with nurturing colors, green spaces and inviting decorations to generate a positive impact on outcomes and care.*

SKILLED NURSING NEWS (Exhibit 8)

Research has long supported the theory that private rooms reduce infection rates and the spread of viruses throughout health care settings. In this article, Skilled Nursing highlights the industry trend toward more private settings. The initial increases capital costs are offset in the long run by the benefit to residents, their families and staff and the decrease in the overall cost of care.

Costly Design Features Can Pay Off for Skilled Nursing, Alex Spanko, July 4, 2017, https://skillednursingnews.com/2017/07/costly-design-features-can-pay-off-skilled-nursing

"Not only do private rooms minimize residents' exposure to others in large group settings, but they also allow single-user bathrooms, greatly reducing the chances of bacteria spreading."

THE ADVISORY BOARD (Exhibit 9)

Telemedicine is moving to the forefront of healthcare. The study by Triple Care has proven, that in the skilled nursing area in particular, its efficacy can drive positive outcomes for patients and reduce avoidable utilization in the acute care setting.

Virtual Physician Coverage Provides on-Demand Consultation, Care Continuity, 2017, Service Line Strategy/Advisor Interviews, research and analysis; advisory.com

"The service provided by Triple Care, a telemedicine group serving over 60 skilled nursing facilities across eleven states, has been shown to improve clinical, operational, and financial performance for their partner sites, particularly through avoided hospital readmissions. In a single study the platform accrued over $1.5M in savings for total cost of care."

As described above, the Applicant plans to build a state of the art facility that will be technologically advanced to enhance access to clinical specialists through telemedicine and interaction with family by providing easy to use communication capabilities.

(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.

Applicant Response: Not applicable.

(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.

Applicant Response: The owners have never 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.

Applicant Response: The Applicant has established multiple collaborative relationships with other service providers to ensure that a wide variety of needs can be accommodated at the nursing facility including those for, Hospice; IV Therapy, Radiology, Laboratory, Respiratory Therapy, Pharmacy and Physical, Occupational and Speech Therapy. See **Exhibit 10.**

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.

Applicant Response:

The most recent MHCC Comprehensive Care Bed Need Projections for Carroll County (April 29, 2016 Maryland Register) shows:

Gross Bed Need:	750
Total Bed Inventory:	931
Unadjusted Net Bed Need:	181
Community Based Services Adjustment:	45
2016 Net Bed Need:	0

The Applicant is not seeking to add additional beds as part of this project.

The beds at the existing BW-W facility are projected to operate at 90% capacity in FY18. The Applicant projects a modest growth from its estimated CY18 budget of 350 to 440 admissions between 2018 and 2023. Although BW-W is a 5-Star rated facility and currently operates at 90% capacity, as described in detail in "Rationale for the Project" (Part 1, Question 11(a)(2)) above and in response to 10.24.01.08G(3)(b) (Need) below, in its current location, BW-W cannot accommodate additional private rooms and its current plant cannot be modified for more spacious, patient-oriented, progressively designed features. Further, BW-W is unable to expand and long-term will be challenged to continue to effectively meet the increasing needs of Carroll County's aging residents. Its small "footprint" will As further described in "Rationale for the Project" (Part 1, Question 11(a)(2)) above and in response to 10.24.01.08G(3)(b) (Need) below, relocating BW-W to the Carroll Hospital campus will address these unmet needs, and improve both access to and quality of the services provided by BW-W.

As shown in Table 2, the elderly population in Carroll County is growing. It is projected to grow by over 17% between 2017 and 2022, from 15% of the total population to 20%.

Table 2

Populatin Growth by Age Cohort
Carroll County
2018-2023

County Age Detail- Total Male and Female								
Age	**2010 Census**	**2015 Estimate**	**2016 Estimate**	**2017 Estimate**	**2018 Estimate**	**2023 Projection**	**2018-2023 Estimated Growth**	**% change**
Age 0 - 4	9,031	8,210	8,224	8,212	8,193	8,388	195	2%
Age 5 - 9	11,433	9,426	9,289	9,087	8,906	8,265	(641)	-7%
Age 10 - 14	12,600	11,467	11,235	10,927	10,633	9,007	(1,626)	-15%
Age 15 - 17	8,173	7,652	7,551	7,389	7,247	6,759	(488)	-7%
Age 18 - 20	6,553	7,475	7,403	7,266	7,162	7,092	(70)	-1%
Age 21 - 24	7,362	9,075	9,151	9,062	8,978	9,801	823	9%
Age 25 - 34	15,417	17,008	17,756	18,298	18,691	20,482	1,791	10%
Age 35 - 44	23,658	18,980	18,508	18,230	18,222	17,950	(272)	-1%
Age 45 - 54	29,805	28,680	27,854	26,864	25,840	20,949	(4,891)	-19%
Age 55 - 64	21,293	24,027	24,438	24,792	25,260	27,773	2,513	10%
Sub-Total 0-64	**145,325**	**142,000**	**141,409**	**140,127**	**139,132**	**136,466**	**(2,666)**	**-2%**
Age 65 - 74	11,895	15,179	15,791	16,476	17,178	20,889	3,711	22%
Age 75 - 84	6,894	7,304	7,608	7,740	7,979	8,926	947	12%
Age 85+	3,020	3,359	3,406	3,414	3,440	3,534	94	3%
Sub-Total 65+	**21,809**	**25,842**	**26,805**	**27,630**	**28,597**	**33,349**	**4,752**	**17%**
Carroll County Total	**167,134**	**167,842**	**168,214**	**167,757**	**167,729**	**169,815**	**2,086**	**1%**

-Information obtained from Nielsen and Spotlight Demographics

Additionally, as shown in Table 3 nursing home utilization by Carroll County residents has increased over the last five years. After declining by 20% between 2012 and 2013, it increased by 12% between 2014 and 2015 and by 14% between 2015 and 2016, an overall increase of 6% between 2012 and 2016.

Table 3

NURSING HOME UTILIZATION, CARROLL COUNTY RESIDENTS
2012-2016

	2012	2013	2014	2015	2016
Discharges, Age 0-64	171	206	165	178	261
Discharges Age 65+	1,717	1,678	1,364	1,562	1,756
Discharges, All Ages	1,888	1,570	1,529	1,740	2,017
% Change Annual		-20%	-3%	12%	14%
% Change 2011-2016					6%

As reflected in Table 4, growth in Carroll County's population alone can be expected to generate more than 300 additional nursing home admissions by the year 2022.

Table 4

Comprehensive Care Admissions - Carroll County
Projected Incremental Population-Based Growth
2018 - 2023
At Stable Use Rates (CY16)

Age Cohort		Estimated CY2017	CY2018	CY2019	CY2020	CY2021	CY2022	TOTAL
0 - 64	Population	140,127	139,132	138,599	138,066	137,533	137,000	
	Use Rate/1,000	2.0	2.0	2.0	2.0	2.0	2.0	
ESTIMATED ADMISSIONS		280	279	278.2	277	276	275	**1,666**
65 +	Population	27,630	28,597	29,570	30,543	31,516	32,489	
	Use Rate/1,000	69.5	69.5	69.5	69.5	69.5	69.5	
ESTIMATED ADMISSIONS		1,918	1,988	2,050	2,120	2,189	2,252	**12,517**
TOTAL	Population	167,757	167,729	168,169	168,609	169,049	169,489	
	Use Rate	13.11	13.11	13.11	13.11	13.11	13.11	
ESTIMATED ADMISSIONS		**2,198**	**2,267**	**2,328**	**2,397**	**2,465**	**2,527**	**14,183**
INCREMENTAL ADMISSIONS			**69**	**62**	**69**	**69**	**62**	**329**

[1] Population: Nielson-Claritas
[2] Use Rates: Maryland Long Term Care Survey, 2016

Additionally, as shown in Table 5, 20 percent of Carroll County residents (500 patients in 2015) received skilled nursing care outside of the county.

Table 5
Carroll County Residents
Distribution of Nursing Home Admissions
By County Where Facility is Located
CY2015

	CY2015	
Location of Nursing Home	**Admissions**	**% of Admissions**
Carroll County	1,884	80%
Baltimore County	217	9%
Frederick County	77	3%
Baltimore City	63	3%
Howard County	45	2%
Anne Arundel County	17	1%
All Other	59	2%
Total	**2,362**	**100%**

Source: Minimum Dataset provided through the Maryland Heath Care Commission

The outmigration of skilled nursing patients is likely due in part to the lack or limited offering of services at Carroll County nursing homes including:

- Private rooms
- Dialysis care
- Chronic disease management for patients with COPD and other patients with complex comorbidities
- Weekend admissions

The proposed Project will improve access to these services and amenities for Carroll County residents, alleviating the need for some to be placed further from their homes and support systems.

Please refer to "Rationale for the Project" (Part 1, Question 11(a)(2)) above and 10.24.01.08G(3)(b) (Need) for a further discussion of how the Project will improve access to needed services in Carroll County.

(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.

Applicant Response: Not applicable.

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

Applicant Response: Not applicable.

(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.

Applicant Response: Not applicable.

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

Applicant Response: Not applicable.

(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.

Applicant Response: 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.

Applicant Response: 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.

Applicant Response: Not applicable.

(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.

Applicant Response: Once the new facility is approved and relocated, the Applicant commits to entering into a new MOU to reflect the then-current Medicaid participation rate.

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

Applicant Response: 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.

Applicant Response: Not applicable.

(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.

Applicant Response: The new site on the Carroll Hospital campus will allow the Applicant to better serve its residents than its present location. In 2017, of BW-W's 252 total admissions, Carroll Hospital Center was the discharge source for 113 of them (45%), the single largest source of discharges to BW-W by far. BW-W is located approximately 12 miles away from Carroll Hospital currently. When BW-W residents need to be transported to physician offices or to receive specialty services including dialysis or cancer treatment, it involves at least a 15 to 20 minute ride. These trips are difficult for many frailer patients, and take a toll on the more cognitively-impaired patients who often become disoriented by ambulance trips and the time away from familiar settings. Additionally, the further the patient needs to be transported, the more the total costs of care increases. With the new facility located on the Carroll Hospital campus, residents will have much easier, less stressful and less costly access to outpatient treatment settings and primary and specialty providers.

Transfers from Carroll Hospital Center to post-acute facilities typically entail a half day to a full day's time attributed to either (a) delays in transport (b) delays in the information exchange across sites and/or (c) refusal of area nursing home to admit patients on weekends. Acute care stays are routinely extended unnecessarily. Once BW-W operates on the same campus as Carroll Hospital, patient information will be shared much more easily through a shared electronic medical record. As a result, for patients choosing BW-W, nursing home admission will be completed more quickly. Additionally, the transportation of patients will be much less involved and therefore timelier as well.

Please refer to **Exhibit 11** for a map showing the current location of BW-W and other nursing homes in Carroll County.

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

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

Applicant Response: Not applicable.

(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

Applicant Response: Not applicable.

(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.

Applicant Response: Not applicable.

10.24.01.08G(3)(b). Need.

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.

APPLICANT RESPONSE:

The following section describes the facility constraints at Brinton Woods and the service gaps that exist more broadly across Carroll County, and describes how the proposed plan for replacing and relocating Brinton Woods will respond directly to these needs. The Applicant is not requesting an increase in its bed capacity in this project. Please refer to the Applicant's response to Standard .05B(1) for additional information regarding need. Tables D and E of the CON Table Package are attached.

The capital investment required for a replacement facility is being made together with the strategic relocation of BW-W to the Carroll Hospital campus in order to better serve patients requiring a skilled nursing stay and maximize use of the post-acute setting. The close proximity to the hospital will improve quality of care, strengthen continuity of care, and expand the types of patients who can be served in the jurisdiction by BW-W. For patients who select BW-W, the Applicant is confident that it will be able to minimize transportation delays, reduce ER utilization and the total cost of care, while effectuating positive changes in the care management of its patients and residents.

A. Facility Needs at Brinton Woods

Need: Aging plant

- As explained previously, BW-W has an aging plant that is unable to be expanded or further renovated to meet "construction type" standards and certain Life Safety Codes in the older part of the facility. Approximately 25% of the current BW-W site would need to be completely rebuilt. That section of the facility houses its six private rooms, the boiler room, laundry services and well water system. That being the case, the entire facility would need to be shut down to renovate that section.

Need: Lack of private rooms:

- Only a limited number of private rooms are available across nursing homes in Carroll County. Some facilities have up to four beds to a room. BW-W currently operates with only six (6) private rooms; the balance of its 52 rooms are semi-private. See Table 6.

    - Research has long supported the use of private rooms in the delivery of health care, both in hospital settings and those in skilled nursing and rehabilitation facilities. Semi-private rooms increase the risk of infection and denies patients the privacy and dignity of a patient-oriented care model. This runs counter to the Triple Aim goals of improving patient experience and improving quality of care. In fact, evidence exists to show that nursing home care in private rooms is correlated with improved outcomes (see response to COMAR 10.24.08.05 A.7 (b)).

      The new facility will be designed with a majority (40 rooms/67%) of private rooms, consistent with the evidence that demonstrates that private rooms are correlated with improved outcomes. Having no more than two patients in any room or sharing a bathroom will help to minimize infection rates and provide patient privacy and dignity to promote well-being and independence to further support improved outcomes

    - Small, semi-private rooms have complicated efforts at BW-W to introduce some of the latest technology for telemedicine, social media and remote communications with family/friends. Features that could further improve quality of care and resident quality of life.

      The new, spacious, better equipped rooms will better accommodate telemedicine equipment for physician consultation. Drawing on the strength of LBH's IT infrastructure, the use of telemedicine is expected to reduce ER utilization, readmissions and transports to specialty providers. Communications technology will be provided that will enhance our residents' experience and interaction with their friends and family.

    - Just 20% of nursing home beds in Carroll County and only 6.5% of nursing home beds in Westminster are private. Additionally, nearly 30% of Carroll County nursing home beds are triple or quad rooms. See Table 6. As a result, patients from Carroll County who seek a private room for skilled nursing care often must look to an out-of-County facility. This typically entails longer patient transfer delays, involves longer transport time, disrupts the continuity of care and poses challenges for family members

Table 6

Beds by Room Type - Carroll County Nursing Homes

Nursing Home	Semi-Private Beds	Triple Room Beds	Quad Room Beds	Private Room Beds	Total Beds	Private Room %
Brinton Woods Nursing and Rehabilitation Center	54	0	0	6	60	10%
Carroll Lutheran Village Healthcare Center	94	0	0	9	103	9%
Golden Living Center	56	78	16	8	158	5%
Integrace Copper Ridge Nursing Home	16	0	0	50	66	76%
Integrace Fairhaven, Inc.	12	0	0	67	79	85%
Long View Healthcare Center, LLC	80	0	0	28	108	26%
Lorien - Taneytown	60	0	0	3	63	5%
Lorien Mt. Airy	58	0	0	4	62	6%
Pleasant View Nursing Home of Mt. Airy	0	0	104	0	104	0%
Transitions Healthcare at Sykesville	44	21	48	5	118	4%
Totals	**474**	**99**	**168**	**180**	**921**	**20%**

Source: 2015 Maryland Long Term Care Survey

Need: Inadequate physical plant to meet growing patient needs and proposed State Regulations:

- Because a two-story section of the BW-W facility was originally a residential building, that two-story portion (which accounts for approximately 25% of the facility) does not meet current Life Safety Code for Fire Safety "Construction Type" requirements. As a result, BW-W is required to conduct an annual Fire Safety Evaluation (FSFE). While BW-W has received a waiver for, and meets all requirements annually for Fire Safety, it cannot resolve the problem without major construction and financial hardship to the facility, being that the facility would need to be shut down entirely to reconstruct that section of the building.

- Currently at BW-W, up to four patients share one bathroom, and the bathroom lacks adequate size and the latest equipment and fixtures.

- Other limitations of the facility include:

  - Narrow rooms pose challenges for bariatric patients, wheelchairs and lifting equipment.

  - Floor and window space and lighting are insufficient.

  - Hallways, day rooms and multi-purpose areas lack the space for accommodating simultaneous functions including, resident transport, rehabilitation, social activities and other activities associated with overall daily resident care.

  - The new BW-W facility will not only greatly enhance resident comfort, privacy and outcomes, but through new collaborative relationships also will

improve the quality of care and patient/family satisfaction while potentially reducing avoidable utilization. Quality of care improvements will support BW-W's success under the Maryland Demonstration Model continuing to identify it as a high quality, 5-star, post-acute provider for CMS sponsored initiatives.

B. Remote location

Need: Patient transports

- Currently, BW-W is approximately 12 miles away from Carroll Hospital's campus. For BW-W residents who need to be transported to physician offices or to receive specialty services including dialysis or cancer treatment. These trips can be difficult for many frailer patients and their families, and take a toll on the more cognitively-impaired patients who often become disoriented by ambulance trips and the time away from familiar settings.

- Additionally, the further the patient needs to be transported, the more the total costs of care increases.

- With the new facility located on the Carroll Hospital campus, residents will have much easier, less stressful and less costly access to outpatient treatment settings and primary and specialty providers.

Need: Delays in transferring patients from hospital to nursing home

- Transfers from Carroll Hospital Center to post-acute facilities typically entail a half day to a full day's time attributed to either (a) delays in transport (b) delays in the information exchange across sites and/or (c) refusal of area nursing home to admit patients on weekends. Acute care stays are routinely extended unnecessarily. Once BW-W operates on the same campus as Carroll Hospital, patient information will be shared much more easily through a shared electronic medical record. As a result, for patients choosing BW-W, nursing home admission will be completed more quickly. Additionally, the transportation of patients will be much less involved, and therefore accomplished in a more timely manner.

- Like at its current location, the Applicant will continue accept patients over the weekend at the new location, which will continue to help reduce the acute care length of stay and associated costs for patients and families choosing BW-W. By continuing to eliminate weekend placement delays and speeding the patient's access to rehabilitation and skilled nursing care, the Applicant hopes to improve the overall continuity and quality of care for Carroll Hospital patients.

Need: Recruitment Efforts

- By relocating BW-W to a more central location with improved access to labor resources, it is expected that the facility will be better positioned to recruit and retain clinical and support staff.

C. Clinical Services Needs at Brinton Woods

Need: Access to Dialysis Services

- Currently, there are no nursing home facilities in Carroll County that provide on-site dialysis. Accordingly, most nursing home patients who require dialysis upon discharge must be placed outside Carroll County, which is difficult for patients and their families, or placed locally and transported up to three times per week, by ambulance, to an outpatient facility.

- Arranging placement for patients who require dialysis care is challenging financially for facilities who are often responsible for covering the additional transport costs for these patients. Carroll Hospital reports that placement of dialysis patients to post-acute care (more than 20 patients per year) is associated with placement delays ranging between 2-6 days per patient.

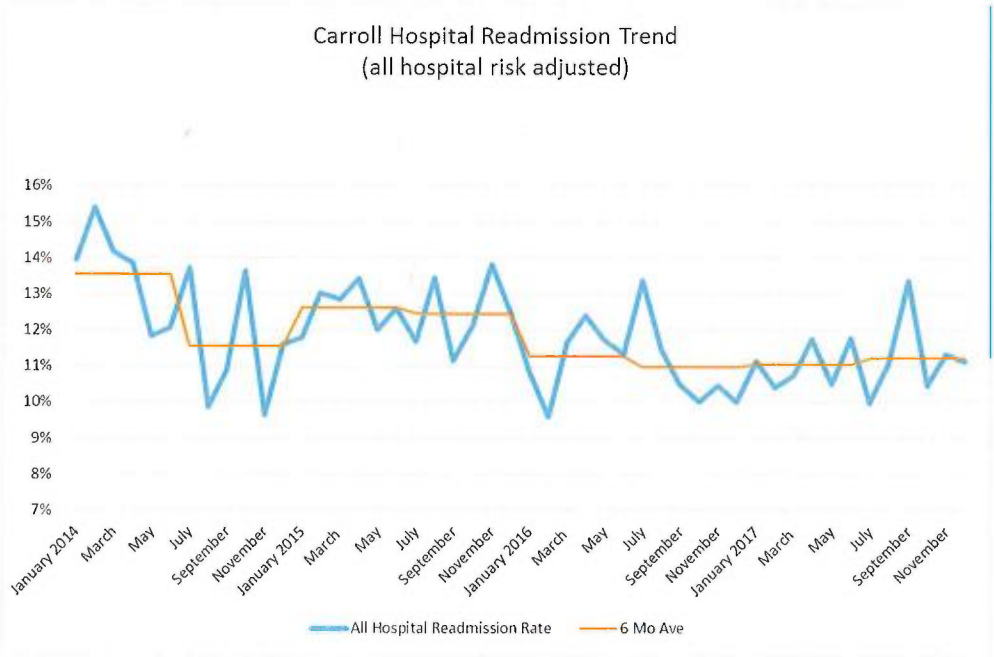
- Relocation of BW-W to the Carroll Hospital campus will improve access to dialysis services for BW-W's residents. With dialysis services on the hospital campus, just one block from the new BW-W location, accessing dialysis services will be quick, easy and much safer for patients.

Need: Readmissions: Enhanced Medical Management

- In 2015 (the most recent data published by Medicare Standard Claims File), 15 residents who were receiving care under Medicare fee-for-service at BW-W had 17 ED visits to Carroll Hospital. Another 26 residents were readmitted to Carroll Hospital, resulting in 37 inpatient stays totaling 231 days. Together, these ED visits and readmissions resulted in $608,366 in costs. See **Exhibit 12.**

- While BW-W has personalized, detailed care plans for each resident and has implemented programs that target residents with chronic diseases (like its new pulmonary program), by being located on the Carroll Hospital campus, BW-W would be better able to proactively manage complex patients by being closer to Carroll Hospital's full range of primary and specialty providers and its services and programs designed to proactively manage patients with complex, chronic comorbidities. Carroll Hospital's clinical and support teams will collaborate with BW-W staff to enhance its current services by helping to provide innovative care management solutions that will benefit residents with Chronic Obstructive Pulmonary Disease (COPD), Chronic Heart Failure (CHF) and other medical conditions. This would not only improve patient comfort and outcomes but is expected to potentially reduce utilization in the acute care setting, reducing the overall cost of care.

- As reflected in the graph above, over time, and through collaboration with community-based providers and significant investments in clinical navigation and healthcare integration, Carroll Hospital has been able to reduce readmissions. While there is still much work to do, Carroll Hospital and LifeBridge Health continue focus on creating new resources for patients and developing innovative solutions to help patients and long term care and assisted living communities proactively manage patients/residents, and this project will support that effort.



Source: Carroll Hospital, Trended Readmission Reporting, Quality and Healthcare Redesign Department

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

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

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the 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.

APPLICANT RESPONSE:

The partnership of LifeBridge Health and Brinton Woods was accompanied by the overarching goals to (a) modernize the BW-W aging facility, (b) support further quality improvements at BW-W, (c) respond to distinct community needs for post-acute care, and (d) effectively integrate BW-W with Carroll Hospital Center. Three options were evaluated to achieve these goals:

Option 1: Maintain the current aging facility and position additional clinical resources at this site.

BW-W could continue to provide services in its current facility but it would continue to be unale to meet current and pending Life Safety Fire Safety requirements and would be challenged to meet increasingly stringent guidelines from other state and federal agencies. BW-W also would be unable to expand or make further improvements without incurring significant cost and a total disruption to the services being provided.

Additionally, and most importantly, because of its location, BW-W would continue to have limited access to the vast clinical and non-clinical resources of Carroll Hospital and the LifeBridge Health System and its range of health care providers.

At the current site, BW-W would not be able to achieve the improvements in the overall living environment and well-being of its residents that this project would create.

Option 2: Rebuild BW-W on its current site and position additional clinical resources at this site.

There is not adequate land to further expand or renovate the current site without closing the entire facility. As explained previously, BW-W operates in an aging plant and due to the property's typography and the limitations of the physical structure, it is unable to be expanded or further renovated to offer more private rooms and baths or meet "construction type" standards and certain Life Safety Codes in the older part of the facility. Approximately 25% of the current BW site would need to be completely rebuilt. That section of the facility houses its six private rooms, the boiler room, laundry services and well water system. That being the case, the entire facility would need to be shut down to renovate that section. Therefore, expanding in place is not a viable option.

Option 3: Build a replacement facility and relocated BW-W to the campus of Carroll Hospital Center

This option – the project proposed in this application -- involves the strategic relocation of BW-W to the Carroll Hospital campus where BW-W can be modernized to better serve patients requiring a skilled nursing stay, and use of the post-acute setting, improve quality of care, strengthen continuity of care, and expand the types of patients who can be served in the County by BW-W. In a new, centrally located facility designed with the latest amenities for long-term care patients and supported by the strength of Carroll Hospital and LifeBridge Health, BW-W will be on the forefront of care redesign and be much better able serve its residents and their families.

These three options were evaluated relative to the extent to which community needs could be met and the "return on investment" could be achieved, with return on investment assessed in

terms of access to care, quality of care, costs of care, and continuity of care. This analysis demonstrates that the relocation of BW-W to the Carroll Hospital campus is the most cost effective alternative available to achieve the objectives of this project.

Feature	**Option 1** Maintain current plant	**Option 2** Rebuild on current site	**Option 3** Rebuild on Carroll Hospital campus
Create more private rooms		n/a	✓
Reduce the overall cost of care through a shared infrastructure and integrative health care system			✓
Increase the number patients served; timeliness of placement and reduce the inconvenience of outmigration for patients and families		n/a	✓
Strengthen continuity of care by utilizing Carroll and LBH resources for medical management	✓ partial	n/a	✓
More readily facilitate specialty consults		n/a	✓
Reduce transfer time from the acute care setting	✓	n/a	✓
Operate single clinical information system for information exchange	✓	n/a	✓
Support employee recruitment by operating in a more centralized location		n/a	✓
Effectively communicate to the community the partnership of Carroll Hospital Center and Brinton Woods to further enhance its reputation for quality care		n/a	✓
Provide opportunity for expansion to accommodate more outpatient/community services		n/a	✓

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. Ellen- Letters of support?

- 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).

  Applicant Response: Please refer to the CON Tables attached to this Application. **Exhibit 13** contains LBH's audited financial statements for the last two years (FY2016

and FY2017) and demonstrate the availability of the equity contribution for this project being made by LBH. **Exhibit 14** contains the Applicant's financial statements for the last two years. While the Applicant's financial statements are not audited, they contain an independent accountant's review report. No grant funding is proposed. There is community support for this project and the Applicant is in the process of collecting letters of support that will be provided to the Commission. Please refer to **Exhibit 3** for the details of the project timeline and construction documents.

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.

Applicant Response: The Applicant has not obtained any CONs in the past. A list of the CONs issued to other LBH system members in the last 15 years is provided in **Exhibit 15**.

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;

Applicant Response: The Applicant is not adding bed capacity as part of this project, and the plan for replacement and relocation of BW-W is not expected to significantly alter local referral patterns. Instead, this project is intended to (a) minimize the need for patients to go out of County for care and (b) better maintain continuity of care—on campus—for "Complex and Chronic Care patients."

In total, the Applicant projects a modest growth from its CY18 projected budget of 350 to 440 admissions over four years. It is presumed that this incremental growth of 90

admissions will not adversely affect any single provider in Carroll County, as illustrated in the presentations which follow.

TABLE 7

Brinton Woods Volume Projections
FY2018- FY2021

	Estimated	Projected			
	Current Facility CY18	Year 1 CY19	Year 2 CY20	Year 3 CY21	Year 4 CY21
Admissions	350	350	370	405	440
Average Length of Stay	56.3	56.3	53.2	48.6	44.8
Patient Days	19,710	19,710	19,710	19,710	19,710
Average Daily Census	54	54	54	54	54
Occupancy - 60 Beds	90%	90%	90%	90%	90%

The Maryland Long Term Care Survey documents admissions for the ten comprehensive care facilities in Carroll County. The market share figures indicate market volume (Carroll County residents served) across these ten nursing homes in Carroll County.[5]

Table 8
2015
Admissions to Carroll County Nursing Homes

Nursing Home	2015 Admissions	% of Total Admissions
Brinton Woods Nursing and Rehabilitation Center	275	12.2%
Carroll Lutheran Village Healthcare Center	184	8.2%
Golden Living Center	287	12.7%
Integrace Copper Ridge Nursing Home	194	8.6%
Integrace Fairhaven, Inc.	357	15.8%
Long View Healthcare Center, LLC	147	6.5%
Lorien – Taneytown	213	9.4%
Lorien Mt. Airy	215	9.5%
Pleasant View Nursing Home of Mt. Airy	121	5.4%
Transitions Healthcare at Sykesville	263	11.7%
Total	**2,256**	**100%**

Source: Maryland Long-Term Survey - Comprehensive Care

[5] Market share percentages represent market share of total facility volume, and are not limited to Carroll County residents

In FY2017, Carroll Hospital arranged placement for a total of 1,333 patients at skilled nursing facilities (SNF).[6] These SNF referrals were distributed across 30 different facilities, but more than 75% of these patients were concentrated in seven local area nursing homes, including BW-W. See Table 9.

Table 9

SNF Placements from Carroll Hospital Center

FY2017

	FY2017	
	# SNF Placements	% of SNF Placements
Brinton Woods	110	8%
6 other local area nursing homes	925	69%
All other facilities	298	22%
Total SNF Placements from CHC	**1,333**	**100%**

Source: Carroll Hospital Center

Placements in 2017 show that only 8% of Carroll Hospital Center's total SNF referrals were transferred to BW-W, reflecting the limitations at the current facility, which include the overall design and feel of its living spaces; the lack of private rooms which makes patient gender and acuity matching challenging; its relatively remote location which is not preferred by families; and the limited clinical resources available to accommodate patients requiring more specialized services including those for chronic disease management and renal failure. Although only 8% of Carroll Hospital's total SNF referrals were transferred to BW-W, Carroll Hospital is the largest referral source to BW-W, accounting for nearly 45% of its total admissions.

By building a new facility on the Carroll Hospital campus, the Applicant expects more patients and families to opt for the new, centrally located, state-of-the-art facility.

CHC projects that patients/families opting for BW-W will increase based on:

- The proximity of Brinton Woods to Carroll Hospital
  - Continuity of care with their services and physicians
  - Easy access to treatments, dialysis, and specialty consults
- Expanded medical management capabilities
  - Enhanced medical management
  - Relationship with CHC navigators, who help ensure all patients are utilizing

[6] Figures represent skilled nursing placements, only; an additional 132 placements were made for long-term care, but these patients were generally long-term residents of nursing homes and returning to the nursing home after an acute care episode.

available resources to the fullest extent

- Timely weekend admissions

- Amenities
  - A new, well-appointed facility
  - All private and semi-private rooms

The impact on other providers in Carroll County will be minimal given the following:

- The majority of volume will represent patients who are now transferred to out-of-County facilities.

- Most of the incremental volume to BW-W will originate from Carroll Hospital Center, which utilizes six other local area nursing homes. Even if all 90 incremental cases were to shift from local area nursing homes to BW-W, the Applicant would expect that shift to be proportionate to current market share, resulting in no significant impact to any one facility.

- Any potential impact to existing providers also will be offset by the estimated population-driven growth in nursing home volume across Carroll County. This growth should help to maintain volume/grow volume across all nursing homes in Carroll County. Between CY2018-2022, Carroll County's elderly population is projected to grow by 17%; over 3% per year. This will drive a volume increases in total nursing home discharges in Carroll County, even at stable use rates. See Table 10.

Table 10

Population Growth by Age Cohort
Carroll County
2018-2023

County Age Detail- Total Male and Female								
Age	2010 Census	2015 Estimate	2016 Estimate	2017 Estimate	2018 Estimate	2023 Projection	2018-2023 Estimated Growth	% change
Sub-Total 0-64	145,325	142,000	141,409	140,127	139,132	136,466	(2,666)	-2%
Sub-Total 65+	21,809	25,842	26,805	27,630	28,597	33,349	4,752	17%
Carroll County Total	167,134	167,842	168,214	167,757	167,729	169,815	2,086	1%

-Information obtained from Nielsen and Spotlight Demographics

- Population-based estimate: As reflected in Table 11, Carroll County's population alone can be expected to generate more than 300 additional nursing home discharges by the

year 2022. Therefore, as BW-W grows its admissions, nursing homes across the County should experience proportionate growth as well.

Table 11

Comprehensive Care Admissions - Carroll County
Projected Incremental Population-Based Growth
2018 - 2023
At Stable Use Rates (CY16)

Age Cohort		Estimated CY2017	CY2018	CY2019	CY2020	CY2021	CY2022	TOTAL
0 - 64	Population	140,127	139,132	138,599	138,066	137,533	137,000	
	Use Rate/1,000	2.0	2.0	2.0	2.0	2.0	2.0	
ESTIMATED ADMISSIONS		280	279	278.2	277	276	275	1,666
65 +	Population	27,630	28,597	29,570	30,543	31,516	32,489	
	Use Rate/1,000	69.5	69.5	69.5	69.5	69.5	69.5	
ESTIMATED ADMISSIONS		1,918	1,988	2,050	2,120	2,189	2,252	12,517
TOTAL	Population	167,757	167,729	168,169	168,609	169,049	169,489	
	Use Rate	13.11	13.11	13.11	13.11	13.11	13.11	
ESTIMATED ADMISSIONS		**2,198**	**2,267**	**2,328**	**2,397**	**2,465**	**2,527**	**14,183**
INCREMENTAL ADMISSIONS			**69**	**62**	**69**	**69**	**62**	**329**

[1] Population: Nielson-Claritas
[2] Use Rates: Maryland Long Term Care Survey, 2016

- Facility-based estimate: We have applied the allocation of the additional population-based growth, based on market share for Carroll County nursing homes presented in CY2015 Maryland Long Term Survey data. It is estimated by applying estimated population growth to overall nursing home market share at Carroll County facilities; no assumption about increased use rate or decreased outmigration is applied here.

Table 12

Carroll County Nursing Home Admissions
Population-Based Growth Estimates
Projected Volumes Based on Elderly Population Growth and Stable Use Rate
CY2017-2022

	CY2015 Market Share	CY17 - CY22 Incremental Growth
Brinton Woods	**12.2%**	**40**
Carroll Lutheran	8.2%	27
Golden Living Center	12.7%	42
Intergrace Copper Ridge	8.6%	28
Intergrace Fairhaven	15.8%	52
Long View Healthcare	6.5%	21
Lorien Mt. Airy	9.4%	31
Lorien-Taneytown	9.5%	31
Pleasant View Nursing Home, Mt. Airy	5.4%	18
Transitions Healthcare at Sykesville	11.7%	38
TOTAL DISCHARGES	**100%**	**329**

Sources
[1] Population: Nielson-Claritas
[2] Market Share based on Nursing home admissions:
Maryland Long Term Care Survey-Comprehensive Care

In summary, the overall growth in nursing home volume for Carroll County will produce sufficient volume to support growth at nursing homes across Carroll County, even as BW-W grows its volume. At a stable use rate, virtually all of the nursing homes in Carroll County can be expected to maintain volume or see slight volume growth as a function of the demographic growth in the County.

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.

Applicant Response: The Applicant projects no significant impact on payer mix of other providers in Carroll County as a result of the projected modest growth in BW-W's admissions.

As shown in CON Table F, the Applicant projects a small shift in BW-W's Medicare/ Medicaid ratio. The Applicant, believes that the state-of-the-art, mostly private-room facility located on the campus of the only hospital in the County will attract more patients, resulting in an increased number of Medicare patients and their families selecting the new BW-W facility than select BW-W at its current location.

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);

Applicant Response: The project will improve access to health care services by the population being served by offering:

- More private rooms
- On campus dialysis care
- Accommodations/medical monitoring for TPN
- Chronic disease management for residents with COPD and other residents with complex comorbidities
- Weekend admissions

While reliable data does not exist as to the reason for nursing home selection, with 20% of Carroll County residents (500 patients) opting for out-of-County placement, we assume that the limited access to the above referenced services, is often a factor. If a person resides in the county, it is likely that his or her support system also is local, whether that be family, friends, spiritual or other community-based support. That being the case, there is a very good probability that many of the patients who currently find long term and rehabilitative care outside of Carroll County, would prefer to stay closer to home and their support systems.

Clearly, not all of the 500 patients would be expected to choose in-County nursing homes. However, case managers at Carroll Hospital Center report that its patient base and their families are very reluctant to go out-of-County for care and often struggle with the decision for transfer to facilities located outside of Carroll County.

Table 13

Carroll County Residents

Distribution of Nursing Home Admissions

By County Where Facility is Located

CY2015

	CY2015	
Location of Nursing Home	**Admissions**	**% of Admissions**
Carroll County	1,884	80%
Baltimore County	217	9%
Frederick County	77	3%
Baltimore City	63	3%
Howard County	45	2%
Anne Arundel County	17	1%
All Other	59	2%
Total	**2,362**	**100%**

Source: Minimum Dataset provided through the Maryland Heath Care Commission

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.

Applicant Response: Medicare and Medicaid (with fixed levels of reimbursement) represent the overwhelming majority of BW-W's current and projected payor mix so the project will have no impact on charges to these programs. Likewise, private insurance reimbursement is negotiated with the payor, so no impact on charges to commercial insurers will result from the project.

Between projected CY2018 and projected CY2022, total expenses are estimated to increase approximately $785,000 or 12%. The majority of the increase ($500,000) is attributable to "New Project Depreciation." The remainder of material increases are reflected in "Contracted Services" and attributed to projected increases in the cost of therapy-related services.

AFFIRMATIONS

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Application for Certificate of Need: Comprehensive Care Facility (Nursing Home), filed by Brinton Woods Health Care Center, LLC are true and correct to the best of my knowledge, information and belief.

Dated: April 4, 2018

Name: Cris Coleman,
Title: AVP, Finance
Carroll Hospital

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Application for Certificate of Need: Comprehensive Care Facility (Nursing Home), filed by Brinton Woods Health Care Center, LLC, are true and correct to the best of my knowledge, information and belief.

Dated: April 4, 2018

Daren Cortese

Name: Daren Cortese

Title: President, Brinton Woods

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Application for Certificate of Need: Comprehensive Care Facility (Nursing Home), filed by Brinton Woods Health Care Center, LLC are true and correct to the best of my knowledge, information and belief.

Dated: April 4, 2018

Name: Teresa A. Fletcher

Title: AVP, Business Development
LifeBridge Health

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Application for Certificate of Need: Comprehensive Care Facility (Nursing Home), filed by Brinton Woods Health Care Center, LLC, are true and correct to the best of my knowledge, information and belief.

Dated: April 4, 2018

Maurice Spielman

Name: Maurice Spielman

Title: Corp. Dir. Design & Construction

LifeBridge Health

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Application for Certificate of Need: Comprehensive Care Facility (Nursing Home), filed by Brinton Woods Health Care Center, LLC, are true and correct to the best of my knowledge, information and belief.

Dated: April 4, 2018

Name: Miriam Suldan

Title: Senior Managing Consultant, BRG

CON TABLES

Summary of Key Financial Assumptions

Census:

Total average daily census is projected at 54 patients (90% occupancy) which is consistent with normalized historic trends. Medicare census is projected to increase from a historic level of 14 to 22 average daily patients – accounting for 41% of total census days by CY 2022 (the 2nd full year of operations on the Carroll Hospital campus). The location of the proposed new facility in the center Carroll County's largest population area is primarily responsible for this expected increase. Medicaid percent of total patient days (approximately 46%) is projected to remain in compliance with the existing Memorandum of Understanding throughout the projection period.

Gross Patient Revenue:

Revenue is projected by payor type at per day rates currently in effect. The Private Pay rate is the presently advertised rate while the Medicare and Medicaid rates are based on current rates set by each program and current facility acuity levels. Detail gross patient revenue by payor and year is provided with the supplemental schedules included with the application.

Bad Debt:

Bad debt expense is projected at historic levels which is set as a reserve based on accounts receivable aging.

Salaries and Wages:

Salaries and wages are based on budgeted staffing patterns necessary for current patient acuity and administrative and patient care support functions. Additional details regarding estimated workforce requirements and staffing levels per shift are located on Schedule H and I.

Contracted Services:

Expense items included in this category are those where a 3rd party contractor is utilized to staff certain areas of the operation. This would include all therapy services, respiratory therapy, Medical Director, Pharmacist, lab services, radiology services, patient transport, licensed social work, and certain maintenance projects. Most of these expenses are variable costs that will increase on a projected per day basis with census, particularly Medicare census. An itemization of contracted services by category and year is provided with the supplemental schedules included with the application.

Supply Expense:

Items included in this category are medical supplies, oxygen, tube feeding, activities, food, dietary supplies, laundry supplies, housekeeping supplies, briefs and disposables, maintenance supplies, office supplies and pharmacy prescriptions and over the counter medications. These expenses are based on

historical levels and only the pharmacy items are variable in proportion to Medicare census. An itemization of supply expense by category and year is provided with the supplemental schedules included with the application.

Other Expense:

Other expenses include all expenses not included in the above categories. This would include items such as cable TV, repairs and maintenance, gas and electric, trash removal, data processing, insurances (except workers comp), management fees, real estate taxes, provider tax, and equipment rentals. These expenses are estimated based on historic levels and are fixed expenses except for management fees that are based on 5% of total revenue. Incremental expenses associated with the proposed location and enhanced facilities (primarily utilities/water and real estate taxes/property insurance) have been included. An itemization of other expenses by category and year is provided with the supplemental schedules included with the application.

Current Depreciation:

Based on historic levels and assumes funded depreciation for new capital improvements of existing building.

Current Interest:

The existing building has a mortgage balance of approximately $1.7 million at 5% interest.

Project Depreciation:

Project depreciation is projected to come on-line beginning in CY 2020 (1/2 year convention) – the estimated opening of the new location. Annual depreciation expense of $684k is based on total project costs of approximately $14.8 million. Depreciation periods range from 7 years for furnishings and equipment to 40 years for exterior shell.

TABLE F. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

Detailed of Revenue by Payor Type

	Actual CY 2017	Projected CY 2018	Projected CY 2019	Projected CY 2020	Projected CY 2021	Projected CY 2022	Projected CY 2023
PRIVATE	$ 921,714	$ 817,600	$ 817,600	$ 817,600	$ 817,600	$ 584,000	$ 584,000
MARYLAND MEDICAID	2,628,670	2,748,922	2,748,922	2,650,747	2,454,395	2,454,395	2,454,395
MANAGED CARE	271,476	292,000	292,000	292,000	292,000	292,000	292,000
MEDICARE PART A	2,444,007	3,118,820	3,118,820	3,304,970	3,677,270	4,049,570	4,049,570
MEDICARE PART B	115,369	113,174	113,174	113,174	113,174	113,174	113,174
TOTALS	**$ 6,381,236**	**$ 7,090,517**	**$ 7,090,517**	**$ 7,178,491**	**$ 7,354,440**	**$ 7,493,140**	**$ 7,493,140**

TABLE F. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

Detailed of Contracted Services Expense

	Actual CY 2017	Projected CY 2018	Projected CY 2019	Projected CY 2020	Projected CY 2021	Projected CY 2022	Projected CY 2023
NURSING	$ 15,549	$ -	$ -	$ -	$ -	$ -	$ -
IV THERAPY	12,695	-	-	-	-	-	-
RESPIRATORY	40,673	24,638	24,638	24,468	24,638	24,638	24,638
MEDICAL DIRECTOR	33,600	33,600	33,600	33,600	33,600	33,600	33,600
PT, OT, SPEECH THERAPY	646,738	766,423	766,423	802,426	874,434	946,442	946,442
PHARMICIST	12,482	11,605	11,605	11,605	11,605	11,605	11,605
LAB	32,076	35,511	35,511	37,380	41,118	44,856	44,856
RADIOLOGY	23,236	30,456	30,456	32,059	35,265	38,471	38,471
AMBULANCE/PATIENT TRANSPORT	20,655	19,775	19,775	20,816	22,898	24,979	24,979
SOCIAL WORK	2,892	3,110	3,110	3,110	3,110	3,110	3,110
MAINTENANCE	27,720	27,068	27,068	27,068	27,068	27,068	27,068
ACTIVITIES	2,390	2,676	2,676	2,676	2,676	2,676	2,676
BARBER & BEAUTY	4,235	4,373	4,373	4,373	4,373	4,373	4,373
TOTALS	**$ 874,941**	**$ 959,235**	**$ 959,235**	**$ 999,581**	**$ 1,080,785**	**$ 1,161,818**	**$ 1,161,818**

TABLE F. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

Detailed of Supply Expense

	Actual CY 2017	Projected CY 2018	Projected CY 2019	Projected CY 2020	Projected CY 2021	Projected CY 2022	Projected CY 2023
NURSING SUPPLIES	$ 89,874	$ 84,162	$ 84,162	$ 84,162	$ 84,162	$ 84,162	$ 84,162
OXYGEN	4,827	4,928	4,928	4,928	4,928	4,928	4,928
TUBE FEEDING	1,930	2,365	2,365	2,365	2,365	2,365	2,365
ACTIVITIES	4,723	4,788	4,788	4,788	4,788	4,788	4,788
FOOD	141,391	128,115	128,115	128,115	128,115	128,115	128,115
DIETARY	16,133	17,478	17,478	17,478	17,478	17,478	17,478
LAUNDRY	4,891	5,869	5,869	5,869	5,869	5,869	5,869
BRIEFS & DISPOSABLES	31,574	31,872	31,872	31,872	31,872	31,872	31,872
HOUSEKEEPING	14,235	14,563	14,563	14,563	14,563	14,563	14,563
MAINTENANCE	19,938	20,249	20,249	20,249	20,249	20,249	20,249
OFFICE	24,620	24,394	24,394	24,394	24,394	24,394	24,394
PHARMACY	245,928	299,362	299,362	313,111	340,607	368,569	368,569
TOTALS	**$ 600,064**	**$ 638,145**	**$ 638,145**	**$ 651,894**	**$ 679,390**	**$ 707,352**	**$ 707,352**

TABLE F. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

Detailed of Other Expenses

	Actual CY 2017	Projected CY 2018	Projected CY 2019	Projected CY 2020	Projected CY 2021	Projected CY 2022	Projected CY 2023
CABLE TV	$ 8,846	$ 8,834	$ 8,834	$ 8,834	$ 8,834	$ 8,834	$ 8,834
PERSONAL HYGIENE	4,780	4,586	4,586	4,586	4,586	4,586	4,586
REPAIRS & MAINTENANCE	25,100	19,296	19,296	19,296	19,296	19,296	19,296
GAS & ELECTRIC	50,988	52,420	52,420	53,354	56,156	56,156	56,156
WATER & SEWER	-	-	-	8,500	34,000	34,000	34,000
TRASH	5,343	5,515	5,515	5,618	5,929	5,929	5,929
HEATING/COOKING FUEL	21,552	17,172	17,172	17,559	18,719	18,719	18,719
DATA PROCESSING	75,091	64,442	64,442	64,442	64,442	64,802	64,802
ADVERTISING-PROMOTIONAL	3,330	6,000	6,000	6,000	6,000	6,000	6,000
DUES & SUBSCRIPTIONS	13,115	12,096	12,096	12,096	12,096	12,096	12,096
MILEAGE REIMBURSEMENT	3,371	3,361	3,361	3,361	3,361	3,361	3,361
INSURANCE - NON PROPERTY	35,818	35,573	35,573	35,573	35,573	35,573	35,573
EMPLOYEE BACKGROUND	4,514	5,119	5,119	5,119	5,119	5,119	5,119
TELEPHONE	14,640	14,659	14,659	14,659	14,659	14,659	14,659
SEMINARS & TRAINING	6,540	7,741	7,741	7,741	7,741	7,741	7,741
MANAGEMENT FEES	321,934	354,000	354,000	360,000	366,000	372,000	372,000
REAL PROPERTY TAXES	24,305	24,221	24,221	49,166	124,221	124,221	124,221
INSURANCE	17,538	18,894	18,894	22,647	28,579	28,579	28,579
PROVIDER TAX	342,179	344,378	344,378	335,070	316,455	297,840	297,840
OTHER NURSING RENTAL	17,888	18,829	18,829	18,829	18,829	18,829	18,829
EQUIPMENT LEASES	12,754	12,700	12,700	12,700	12,700	12,700	12,700
MISCELLANEOUS	34,381	41,409	41,409	40,963	21,376	16,554	16,554
TOTALS	**$ 1,044,007**	**$ 1,071,245**	**$ 1,071,245**	**$ 1,106,113**	**$ 1,184,671**	**$ 1,167,594**	**$ 1,167,594**

CON TABLE PACKAGE FOR NURSING HOME (CCFs) APPLICATIONS

Name of Applicant: Brinton Woods Health Care Center, LLC

Date of Submission: 4/6/2018

Applicants should follow additional instructions included at the top of each of the following worksheets. Please ensure all green fields (see above) are filled.

Table	Table Title	Instructions
Table A	Bed and Room Inventory	All Comprehensive Care facility applicants must complete Table A regardless of the project type and scope.
Table B	Construction and Renovation Square Footage	All applicants proposing new construction or renovation must complete Table B.
Table C	Project Budget	All applicants, regardless of project type or scope, must complete Table C.
Table D	Utilization - Entire Facility	Existing facility applicants must complete Table D. All applicants who complete this table must also complete Table F.
Table E	Utilization - New Facility or Service	Applicants who propose to: establish a new facility; a new service; or are directed by MHCC staff must complete Table E. All applicants who complete this table must also complete Table G.
Table F	Revenues & Expenses, Uninflated - Entire Facility	Existing facility applicants must complete Table F. The projected revenues and expenses in Table F should be consistent with the volume projections in Table D.
Table G	Revenues & Expenses, Uninflated - New Facility or Service	Applicants who propose to: establish a new facility; a new service and any other applicant who completes a Table D must complete Table G. The projected revenues and expenses in Table G should be consistent with the volume projections in Table E.
Table H	Workforce	All applicants, regardless of project type or scope, must complete Table H.
Table I	Bedside Care Staffing	All applicants, regardless of project type or scope, must complete Table I.

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.

Before the Project						After Project Completion				
		Based on Physical Capacity					Based on Physical Capacity			
		Room Count					Room Count			
Service (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				
Ground Floor	10		5	5	10	First Floor			50	60
1st Floor	50	6	22	28	50				0	0
				0	0				0	0
				0	0				0	0
				0	0				0	0
SUBTOTAL Comprehensive Care	60	6	27	33	60	SUBTOTAL			50	60
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	60	6	27	33	60	FACILITY TOTAL	0	0	50	60

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.

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
Ground Floor		12,460 SQ. FT.			12,460
First Floor		34,925 SQ. FT.			34,925
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
Total	0	0	0	0	47,385

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). 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.d 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	$11,312,375		$11,312,375
(2) Fixed Equipment			$0
(3) Site and Infrastructure	$899,500		$899,500
(4) Architect/Engineering Fees	$1,300,000		$1,300,000
(5) Permits (Building, Utilities, Etc.)	$100,000		$100,000
SUBTOTAL New Construction	**$13,611,875**	**$0**	**$13,611,875**
b. Renovations			
(1) Building			$0
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees			$0
(4) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL Renovations	$0	$0	$0
c. Other Capital Costs			
(1) Movable Equipment	$1,000,000		$1,000,000
(2) Contingency Allowance	$225,625		$225,625
(3) Gross interest during construction period			$0
(4) Other *(Specify/add rows if needed)*			$0
SUBTOTAL Other Capital Costs	***$1,225,625***	***$0***	**$1,225,625**
TOTAL CURRENT CAPITAL COSTS	**$14,837,500**	$0	**$14,837,500**
d. Land Purchased/Donated			
e. Inflation Allowance			
TOTAL CAPITAL COSTS	**$14,837,500**	$0	**$14,837,500**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c CON Application Assistance			
c1. Legal Fees			$0
c2. Other (Specify/add rows if needed)			
d. Non-CON Consulting Fees			$0
d1. Legal Fees			
d2. Other (Specify/add rows if needed)			$0
e. Debt Service Reserve Fund			$0
f. Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$0***	***$0***	**$0**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	*$14,837,500*	*$0*	***$14,837,500***
B. Sources of Funds			
1. Cash	$14,837,500		$14,837,500
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
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			**$0**
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.

	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	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
1. ADMISSIONS								
a. Comprehensive Care (public)	292	252	350	350	370	405	440	440
b. Comprehensive Care (CCRC Restricted)								
Total Comprehensive Care	**292**	**252**	**350**	**350**	**370**	**405**	**440**	**440**
c. Assisted Living								
d. Other (Specify/add rows of needed)								
TOTAL ADMISSIONS	***292***	***252***	***350***	***350***	***370***	***405***	***440***	***440***
2. PATIENT DAYS								
a. Comprehensive Care (public)	19,030	18,770	19,710	19,710	19,710	19,710	19,710	19,710
b. Comprehensive Care (CCRC Restricted)								
Total Comprehensive Care	**19,030**	**18,770**	**19,710**	**19,710**	**19,710**	**19,710**	**19,710**	**19,710**
c. Assisted Living								
d. Other (Specify/add rows of needed)								
TOTAL PATIENT DAYS	***19,030***	***18,770***	***19,710***	***19,710***	***19,710***	***19,710***	***19,710***	***19,710***
3. NUMBER OF BEDS								
a. Comprehensive Care (public)	60	60	60	60	60	60	60	60
b. Comprehensive Care (CCRC Restricted)								
Total Comprehensive Care Beds	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**
c. Assisted Living								
d. Other (Specify/add rows of needed)								
TOTAL BEDS	***60***	***60***	***60***	***60***	***60***	***60***	***60***	***60***
4. OCCUPANCY PERCENTAGE **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.*								
a. Comprehensive Care (public)	86.9%	85.7%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
b. Comprehensive Care (CCRC Restricted)								
Total Comprehensive Care Beds	**86.9%**	**85.7%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**
c. Assisted Living								
d. Other (Specify/add rows of needed)								
TOTAL OCCUPANCY %	**86.9%**	**85.7%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**
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***

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	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**
1. ADMISSIONS					
a. Comprehensive Care (public)	0	20	55	90	90
b. Comprehensive Care (CCRC Restricted)					
Total Comprehensive Care	**0**	**20**	**55**	**90**	**90**
c. Assisted Living					
d. Other (Specify/add rows of needed)					
TOTAL ADMISSIONS	***0***	***20***	***55***	***90***	***90***
2. PATIENT DAYS					
a. Comprehensive Care (public)	0	0	0	0	0
b. Comprehensive Care (CCRC Restricted)					
Total Comprehensive Care	**0**	**0**	**0**	**0**	**0**
c. Assisted Living					
TOTAL PATIENT DAYS	***0***	***0***	***0***	***0***	***0***
3. NUMBER OF BEDS					
a. Comprehensive Care (public)	60	60	60	60	60
b. Comprehensive Care (CCRC Restricted)					
Total Comprehensive Care Beds	**60**	**60**	**60**	**60**	**60**
c. Assisted Living					
d. Other (Specify/add rows of needed)					
TOTAL BEDS	***60***	***60***	***60***	***60***	***60***
4. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per					
a. Comprehensive Care (public)	90.0%	90.0%	90.0%	90.0%	90.0%
b. Comprehensive Care (CCRC Restricted)					
Total Comprehensive Care Beds	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**
c. Assisted Living					
d. Other (Specify/add rows of needed)					
TOTAL OCCUPANCY %	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**
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***

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.

	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	**CY 2016**	**CY 2017**	**CY 2018**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**
1. REVENUE								
a. Inpatient Services	$ 6,238,789	$ 6,381,236	$ 7,090,517	$ 7,090,517	$ 7,178,491	$ 7,354,440	$ 7,493,140	$ 7,493,140
b. Outpatient Services								
Gross Patient Service Revenues	***$ 6,238,789***	***$ 6,381,236***	***$ 7,090,517***	***$ 7,090,517***	***$ 7,178,491***	***$ 7,354,440***	***$ 7,493,140***	***$ 7,493,140***
c. Allowance For Bad Debt	$ 83,245	$ 136,199	$ 94,309	$ 94,309	$ 96,709	$ 100,309	$ 102,000	$ 102,000
d. Contractual Allowance								
e. Charity Care								
Net Patient Services Revenue	***$ 6,155,544***	***$ 6,245,037***	***$ 6,996,208***	***$ 6,996,208***	***$ 7,081,782***	***$ 7,254,131***	***$ 7,391,140***	***$ 7,391,140***
f. Other Operating Revenues (Specify/add rows if needed)	$ 53,613	$ 6,909	$ 4,319	$ 4,319	$ 4,319	$ 4,319	$ 4,319	$ 4,319
NET OPERATING REVENUE	***$ 6,209,157***	***$ 6,251,946***	***$ 7,000,527***	***$ 7,000,527***	***$ 7,086,101***	***$ 7,258,450***	***$ 7,395,459***	***$ 7,395,459***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 3,276,124	$ 3,383,223	$ 3,526,303	$ 3,526,303	$ 3,526,303	$ 3,526,303	$ 3,558,250	$ 3,558,250
b. Contractual Services	$ 837,241	$ 874,941	$ 959,235	$ 959,235	$ 999,581	$ 1,080,785	$ 1,161,818	$ 1,161,818
c. Interest on Current Debt	$ 87,378	$ 82,641	$ 77,604	$ 71,000	$ 49,500			
d. Interest on Project Debt								
e. Current Depreciation	$ 141,246	$ 182,822	$ 181,224	$ 181,224	$ 135,918	$ -	$ -	$ -
f. Project Depreciation					$ 342,000	$ 684,000	$ 684,000	$ 684,000
g. Current Amortization	*$ 40,197*	*$ 40,197*	*$ 40,197*	*$ 40,197*	*$ 30,148*			
h. Project Amortization								
i. Supplies	$ 533,509	$ 600,264	$ 638,145	$ 638,145	$ 651,894	$ 679,390	$ 707,352	$ 707,352
j. Other Expenses (Specify/add rows if needed)	$ 950,837	$ 1,044,007	$ 1,071,245	$ 1,071,245	$ 1,106,112	$ 1,184,671	$ 1,167,594	$ 1,167,594
TOTAL OPERATING EXPENSES	***$ 5,866,532***	***$ 6,208,095***	***$ 6,493,953***	***$ 6,487,349***	***$ 6,841,456***	***$ 7,155,149***	***$ 7,279,014***	***$ 7,279,014***
3. INCOME								
a. Income From Operation	**$ 342,625**	**$ 43,851**	**$ 506,574**	**$ 513,178**	**$ 244,645**	**$ 103,301**	**$ 116,445**	**$ 116,445**
b. Non-Operating Income	$ -	$ -						
SUBTOTAL	***$ 342,625***	***$ 43,851***	***$ 506,574***	***$ 513,178***	***$ 244,645***	***$ 103,301***	***$ 116,445***	***$ 116,445***
c. Income Taxes								
NET INCOME (LOSS)	***$ 342,625***	***$ 43,851***	***$ 506,574***	***$ 513,178***	***$ 244,645***	***$ 103,301***	***$ 116,445***	***$ 116,445***
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	43.1%	40.1%	45.6%	45.6%	47.6%	51.5%	55.3%	55.3%
2) Medicaid	44.3%	41.2%	38.8%	38.8%	36.9%	33.4%	30.0%	30.0%
3) Blue Cross	0.0%							
4) Commercial Insurance	2.0%	4.3%	4.1%	4.1%	4.1%	4.0%	3.9%	3.9%
5) Self-pay	10.6%	14.4%	11.5%	11.5%	11.4%	11.1%	10.9%	10.9%
6) Other	0.0%							
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Inpatient Days								
1) Medicare	28.08%	27.02%	31.48%	31.48%	33.33%	37.04%	40.74%	40.74%
2) Medicaid	58.59%	52.98%	51.85%	51.85%	50.00%	46.30%	46.30%	46.30%
3) Blue Cross	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
4) Commercial Insurance	1.66%	3.66%	3.70%	3.70%	3.70%	3.70%	3.70%	3.70%
5) Self-pay	11.67%	16.34%	12.96%	12.96%	13.00%	12.96%	9.26%	9.26%
6) Other	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

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.

	Projected Years (ending five years after completion) Add columns of				
Indicate CY or FY	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**
1. REVENUE					
a. Inpatient Services	$ -	$ 87,974	$ 263,923	$ 402,623	$ 402,623
b. Outpatient Services	$ -	$ -	$ -	$ -	$ -
Gross Patient Service Revenues	***$ -***	***$ 87,974***	***$ 263,923***	***$ 402,623***	***$ 402,623***
c. Allowance For Bad Debt	$ -	$ 2,400	$ 6,000	$ 7,691	$ 7,691
d. Contractual Allowance	$ -	$ -	$ -	$ -	$ -
e. Charity Care	$ -	$ -	$ -	$ -	$ -
Net Patient Services Revenue	***$ -***	***$ 85,574***	***$ 257,923***	***$ 394,932***	***$ 394,932***
f. Other Operating Revenues (Specify)	$ -	$ -	$ -	$ -	$ -
NET OPERATING REVENUE	***$ -***	***$ 85,574***	***$ 257,923***	***$ 394,932***	***$ 394,932***
2. EXPENSES					
a. Salaries & Wages (including benefits)	$ -	$ -	$ -	$ 31,947	$ 31,947
b. Contractual Services	$ -	$ 40,346	$ 121,550	$ 202,583	$ 202,583
c. Interest on Current Debt	$ (6,604)	$ (28,104)	$ (77,604)	$ (77,604)	$ (77,604)
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -
e. Current Depreciation	$ -	$ (45,306)	$ (181,224)	$ (181,224)	$ (181,224)
f. Project Depreciation	$ -	$ 342,000	$ 684,000	$ 684,000	$ 684,000
g. Current Amortization	$ -	$ (10,049)	$ (40,197)	$ (40,197)	$ (40,197)
h. Project Amortization	$ -	$ -	$ -	$ -	$ -
i. Supplies	$ -	$ 13,749	$ 41,245	$ 69,207	$ 69,207
j. Other Expenses (Specify)	$ -	$ 34,867	$ 113,426	$ 96,349	$ 96,349
TOTAL OPERATING EXPENSES	**$ (6,604)**	**$ 347,503**	**$ 661,196**	**$ 785,061**	**$ 785,061**
3. INCOME					
a. Income From Operation	**$ 6,604**	**$ (261,929)**	**$ (403,273)**	**$ (390,129)**	**$ (390,129)**
b. Non-Operating Income					
SUBTOTAL	***$ 6,604***	***$ (261,929)***	***$ (403,273)***	***$ (390,129)***	***$ (390,129)***
c. Income Taxes					
NET INCOME (LOSS)	***$ 6,604***	***$ (261,929)***	***$ (403,273)***	***$ (390,129)***	***$ (390,129)***
4. PATIENT MIX					
a. Percent of Total Revenue					
1) Medicare	0.0%	2.0%	6.0%	9.7%	9.7%
2) Medicaid	0.0%	-1.8%	-5.4%	-8.8%	-8.8%
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%
4) Commercial Insurance	0.0%	-0.1%	-0.1%	-0.2%	-0.2%
5) Self-pay	0.0%	-0.1%	-0.4%	-0.7%	-0.7%
6) Other	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Inpatient Days					
1) Medicare	0.0%	1.9%	5.6%	9.3%	9.3%
2) Medicaid	0.0%	-1.9%	-5.5%	-5.5%	-5.5%
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%
4) Commercial Insurance	0.0%	0.0%	0.0%	0.0%	0.0%
5) Self-pay	0.0%	0.0%	0.0%	-3.7%	-3.7%
6) Other	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL	***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.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost (should be consistent with projections in Table 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)*											
Administrator	1.0	$96,078	$96,078							1.0	$96,078
Admissions	1.5	$49,669	$74,504							1.5	$74,504
Human Resource Director	0.6	$37,985	$22,791							0.6	$22,791
Receptionist	1.8	$28,710	$51,104							1.8	$51,104
Business Office Manager	1.0	$59,038	$59,038							1.0	$59,038
Total Administration	5.9	$51,618	$303,514							5.9	$303,514
Direct Care Staff *(List general categories, add rows if needed)*											
RNs	5.6	$72,121	$403,906							5.6	$403,906
LPNs	6.5	$56,041	$362,137							6.5	$362,137
CMAs	2.2	$44,190	$95,185							2.2	$95,185
GNAs	24.1	$37,880	$913,763							24.1	$913,763
Total Direct Care	38.3	$46,297	$1,774,991							38.3	$1,774,991
Support Staff *(List general categories, add rows if needed)*											
Director of Nursing	1.0	$98,713	$98,713							1.0	$98,713
Nursing Administration	4.0	$49,721	$198,884							4.0	$198,884
Activities	2.4	$31,275	$75,060							2.4	$75,060
Social Worker	1.0	$56,845	$56,845	0.5	$56,845	$28,423				1.5	$85,268
Dietary	7.3	$35,885	$261,961							7.3	$261,961
Houskeeping	4.0	$25,493	$101,971							4.0	$101,971
Laundry	2.2	$24,974	$53,694							2.2	$53,694
Maintenance	2.0	$50,773	$101,546							2.0	$101,546
Total Support	23.9	$39,777	$948,674	0.5	$56,845	$28,423				24.4	$977,096
REGULAR EMPLOYEES TOTAL	***68.1***	***$44,472***	**$3,027,179**	***0.5***	***$56,845***	**$28,423**				**68.6**	**$3,055,602**
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
										0.0	$0
										0.0	$0
										0.0	$0
										0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
										0.0	$0
										0.0	$0
										0.0	$0
										0.0	$0
Total Direct Care Staff			$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*											
										0.0	$0
										0.0	$0
										0.0	$0
										0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below)*:			$499,124			$3,524					$502,648
Based on historical % of salaries (includes payroll taxes, workers comp, group insurance and other misc. employee benefits											
TOTAL COST	***68.1***		***$3,526,303***	***0.5***		***$31,947***	***0.0***		***$0***		***$3,558,250***

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	8	16	8	32	8	8	8	24
L. P. N. s	16	8	8	32	16	16	8	40
Aides	48	48	32	128	48	48	32	128
C. N. A.s				0				0
Medicine Aides	8	8	0	16	8	8	0	16
Total	80	80	48	208	80	80	48	208
Licensed Beds at Project Completion				60	**Licensed Beds at Project Completion**			**60**
Hours of Bedside Care per Licensed Bed per Day				3.47	**Hours of Bedside Care per Licensed Bed Per Day**			3.47

	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%	4	0	0	4	0	0	0	0
Total Including 50% of Ward Clerks Time								
Total Hours of Bedside Care per Licensed Bed Per Day				212	**Total Hours of Bedside Care per Licensed Bed Per Day**			208

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	☐	☐
Class C	☑	☐
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☑	☐
Excellent	☐	☐
Number of Stories	2	

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement	12,460	
First Floor	34,925	
Second Floor		
Third Floor		
Fourth Floor		
Average Square Feet		
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Total Linear Feet		
Average Linear Feet		
Wall Height (floor to eaves)	**Feet**	
Basement	14	
First Floor	14	
Second Floor		
Third Floor		
Fourth Floor		
Average Wall Height	**14**	
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger	1	
Freight		
Sprinklers	**Square Feet Covered**	
Wet System	45,780	
Dry System	1,605	
Other		
Type of HVAC System for proposed project	Warm and Cool Air Zoned	
Type of Exterior Walls for proposed project	Brick/Vinyl Siding	

TABLE K. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS

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

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation	$112,000	
Utilities from Structure to Lot Line	$37,500	
Subtotal included in Marshall Valuation Costs	**$149,500**	
Site Demolition Costs	**$95,000**	
Storm Drains	**$115,000**	
Rough Grading	**$150,000**	
Hillside Foundation	**$97,500**	
Paving	**$105,000**	
Exterior Signs	**$20,000**	
Landscaping	$45,000	
Walls	$85,000	
Yard Lighting	$37,500	
Other *(Specify/add rows if needed)*		
Subtotal On-Site excluded from Marshall Valuation Costs	**$750,000**	
OFFSITE COSTS		
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs		
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$750,000**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$899,500**	**$0**

*The combined total site and offsite cost included and excluded from Marshall Valuation Service should typically equal the estimated site preparation cost reported in Application Part II, Project Budget (see Table E. Project Budget). If these numbers are not equal, please reconcile the numbers in an explanation in an attachment to the application.

EXHIBITS

EXHIBIT 1

Post-Transaction Organization of Brinton Woods Health Care Center, LLC

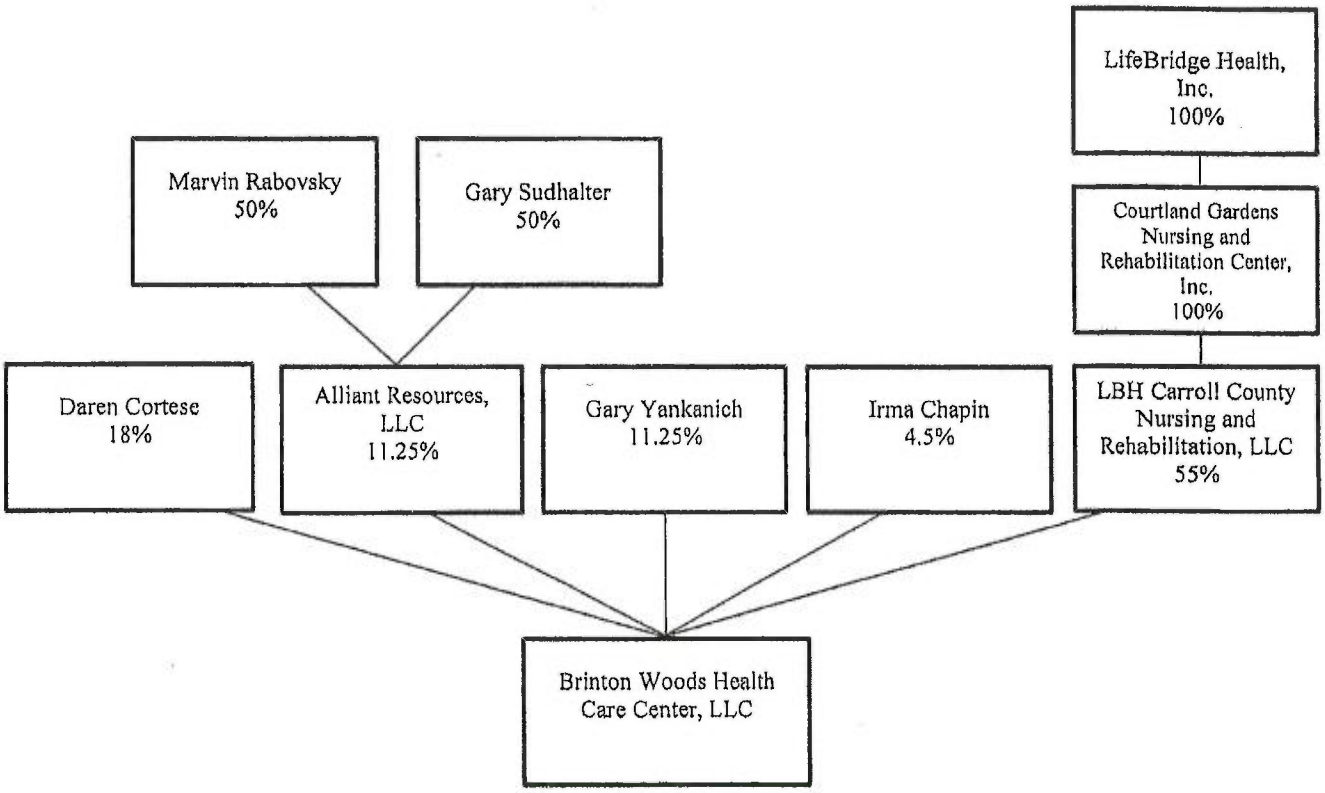


EXHIBIT 2

Post-Transaction Organization of Brinton Woods Senior Living, LLC

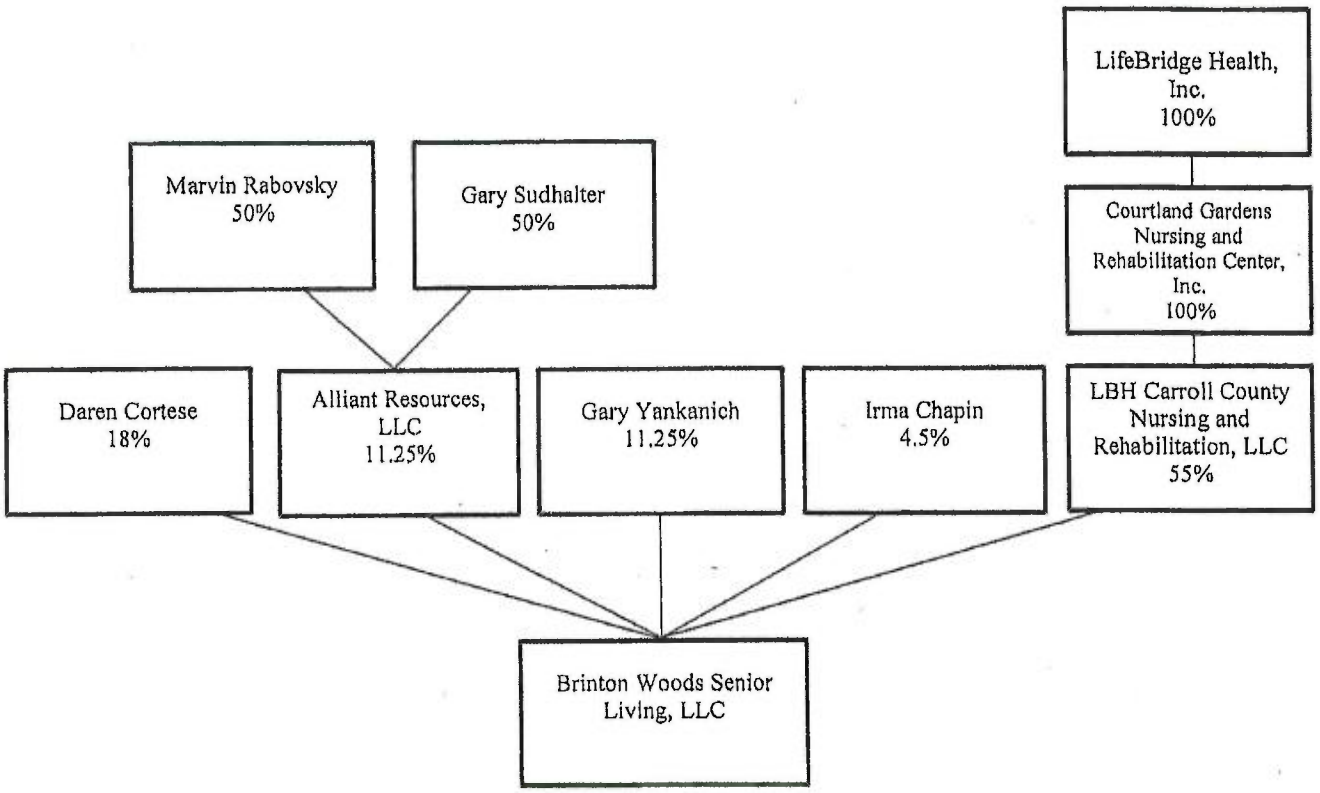
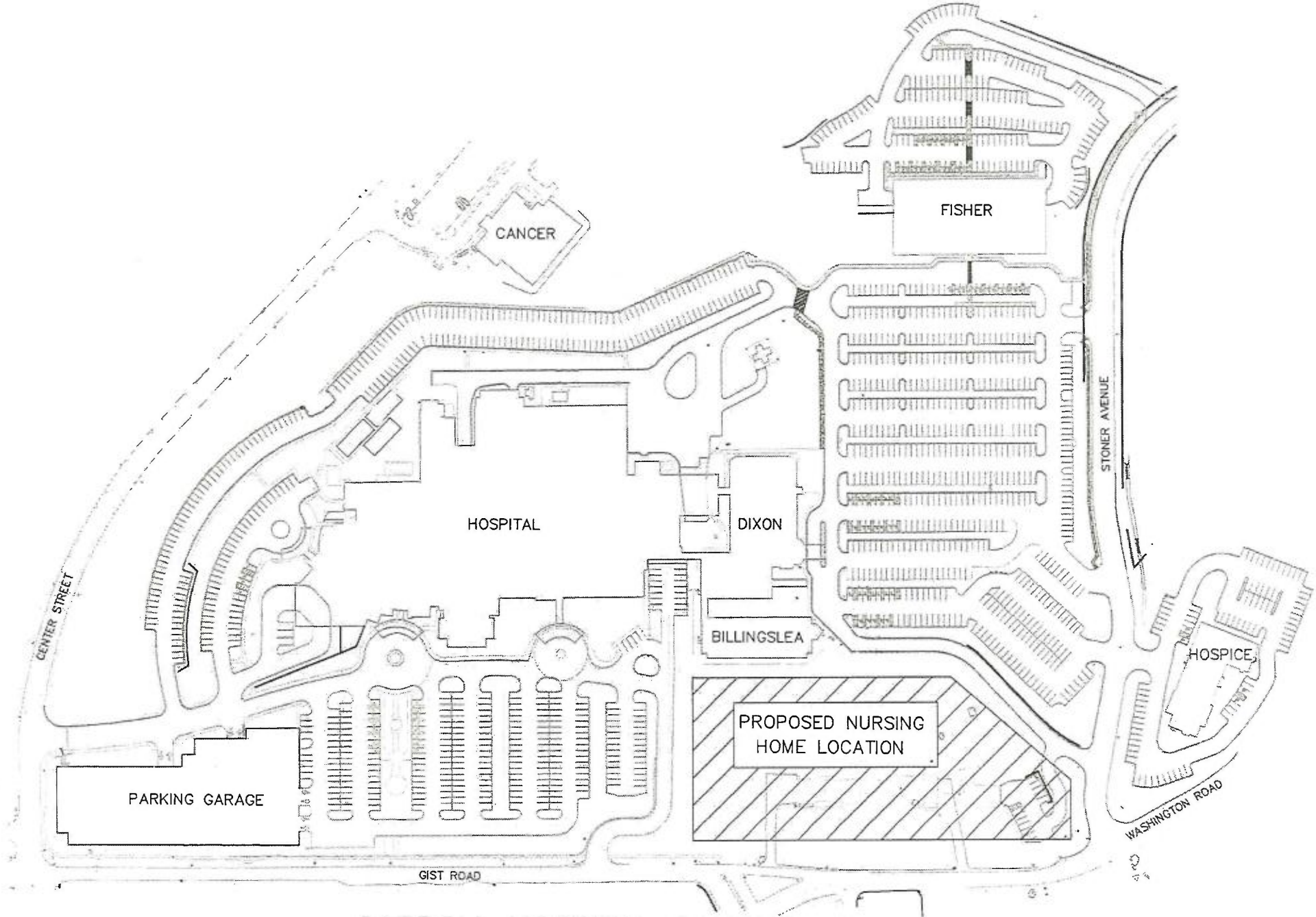
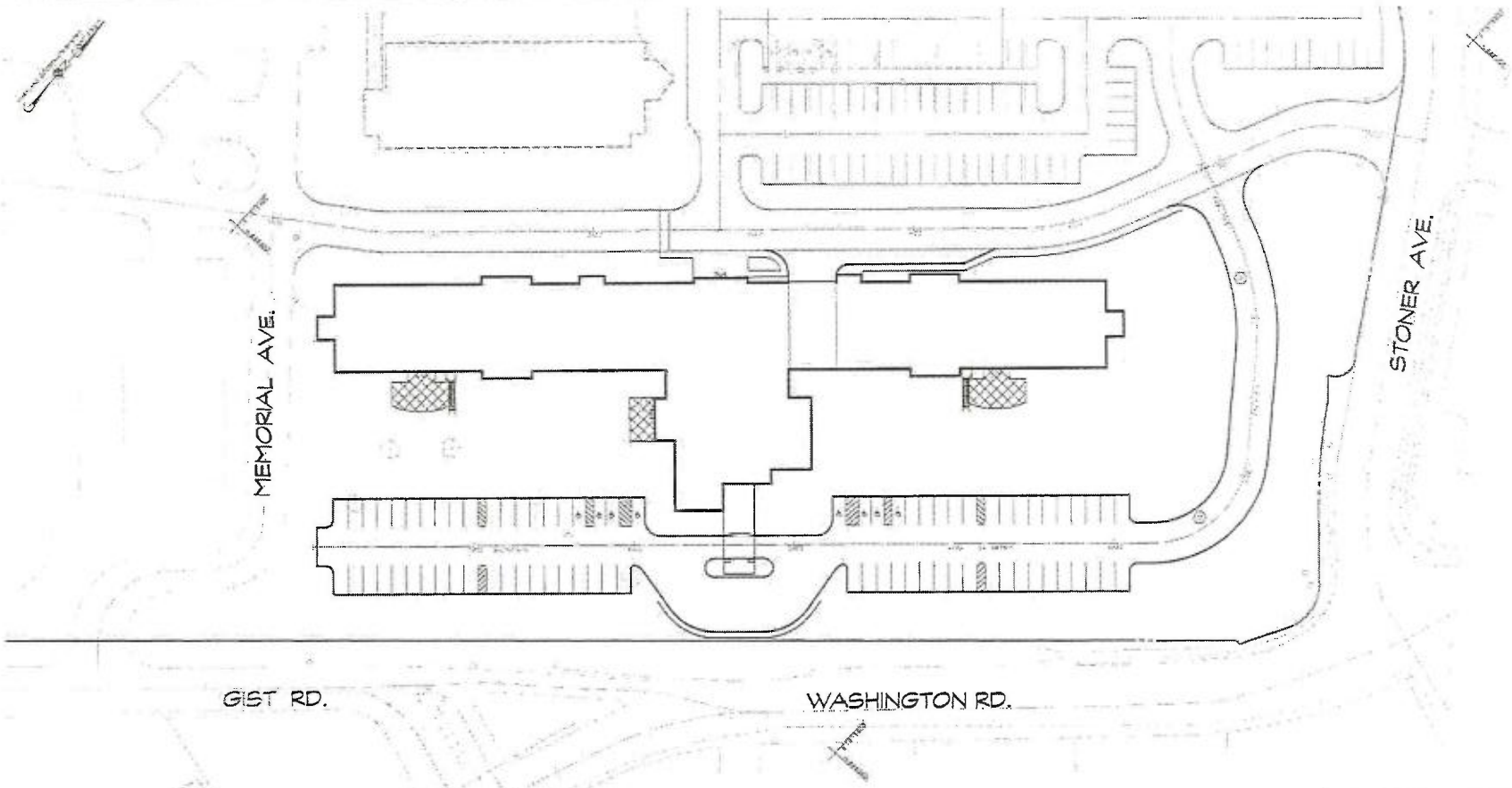


EXHIBIT 3



CARROLL HOSPITAL CAMPUS



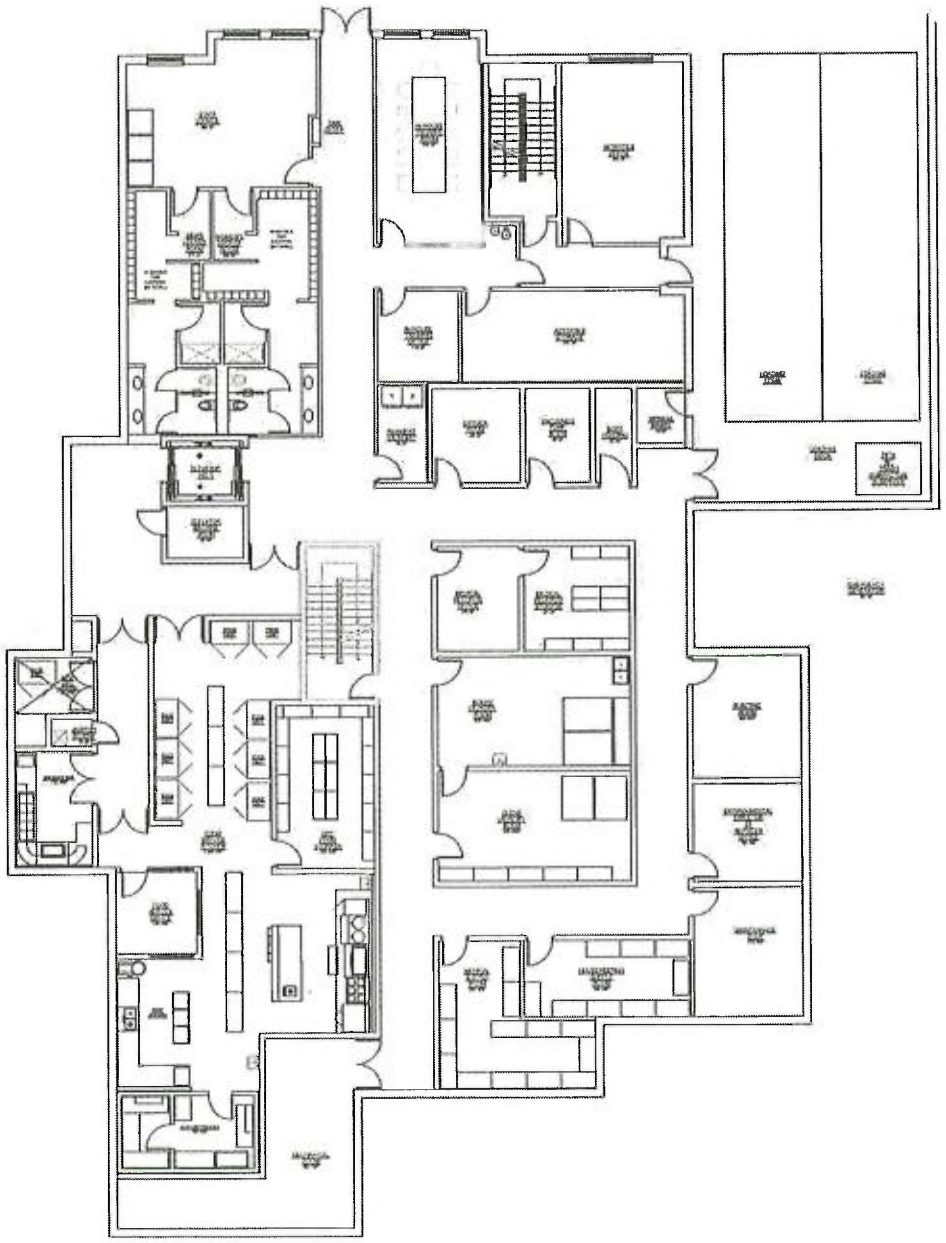
CENTERLINE CURVE DATA

LAYOUT PLAN
for
Carroll Hospital Center
NURSING HOME FACILITY

TH ELECTION DISTRICT CARROLL COUNTY, MD

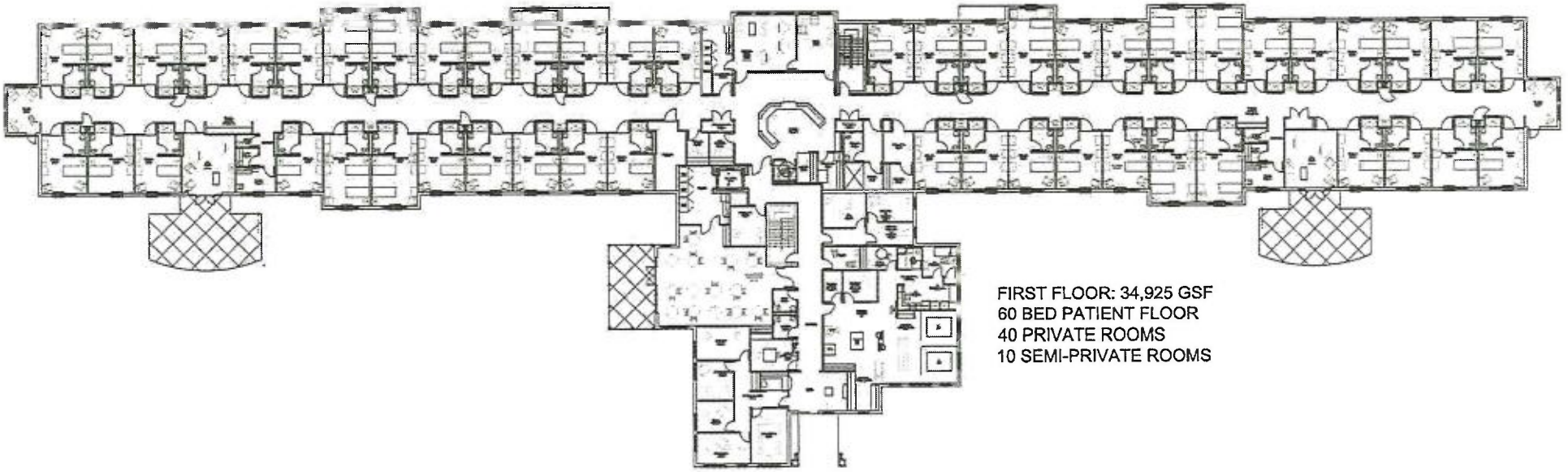
CLSI

OWNER / DEVELOPER
CARROLL HOSPITAL CENTER INC.
200 MEMORIAL AVE.
WESTMINSTER MD, 21157
(410) 876-3000



LOWER LEVEL SUPPORT SPACE: 10,855 GSF

LOWER LEVEL STRUCTURED LOADING DOCK: 1,605 SF

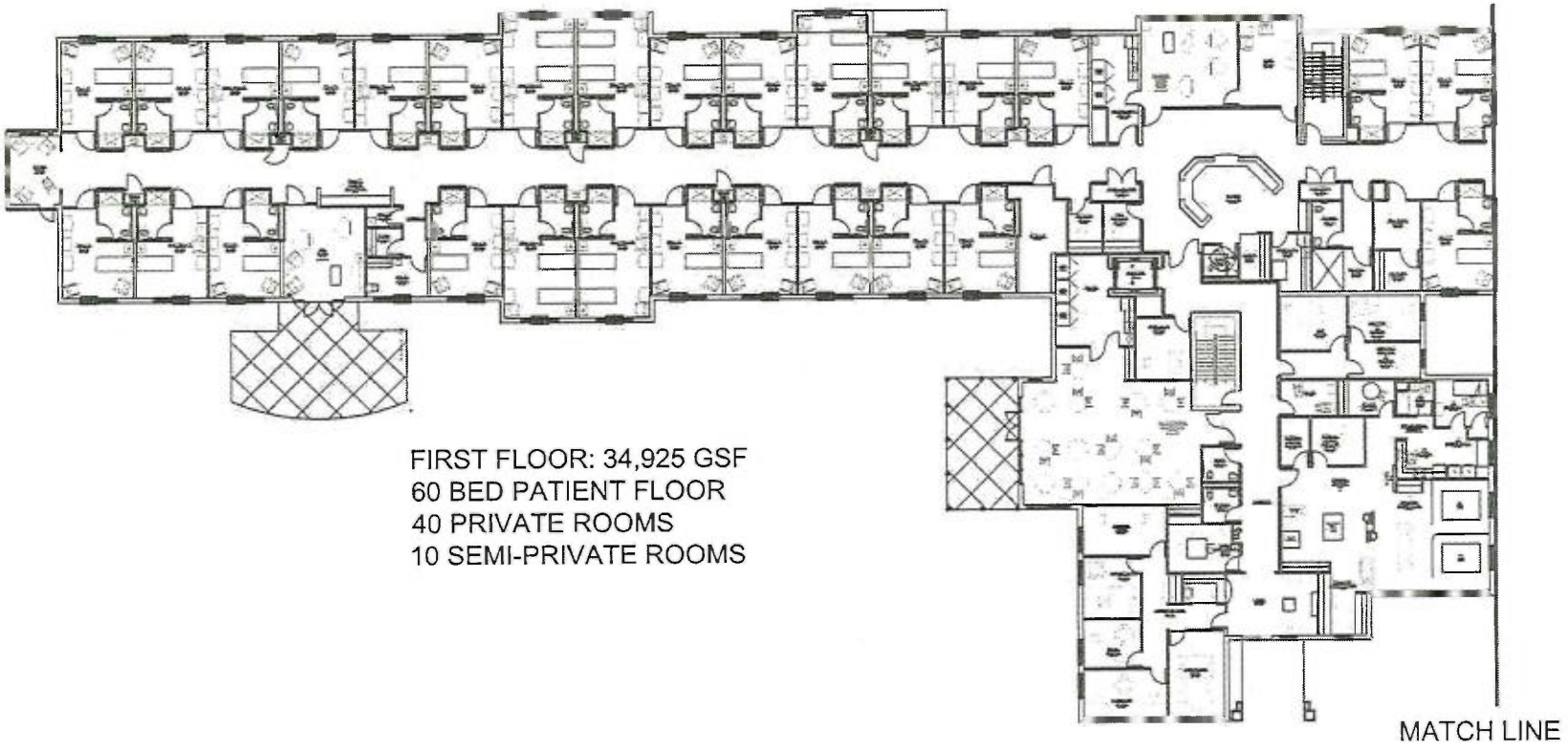


FIRST FLOOR: 34,925 GSF
60 BED PATIENT FLOOR
40 PRIVATE ROOMS
10 SEMI-PRIVATE ROOMS

MATCH LINE

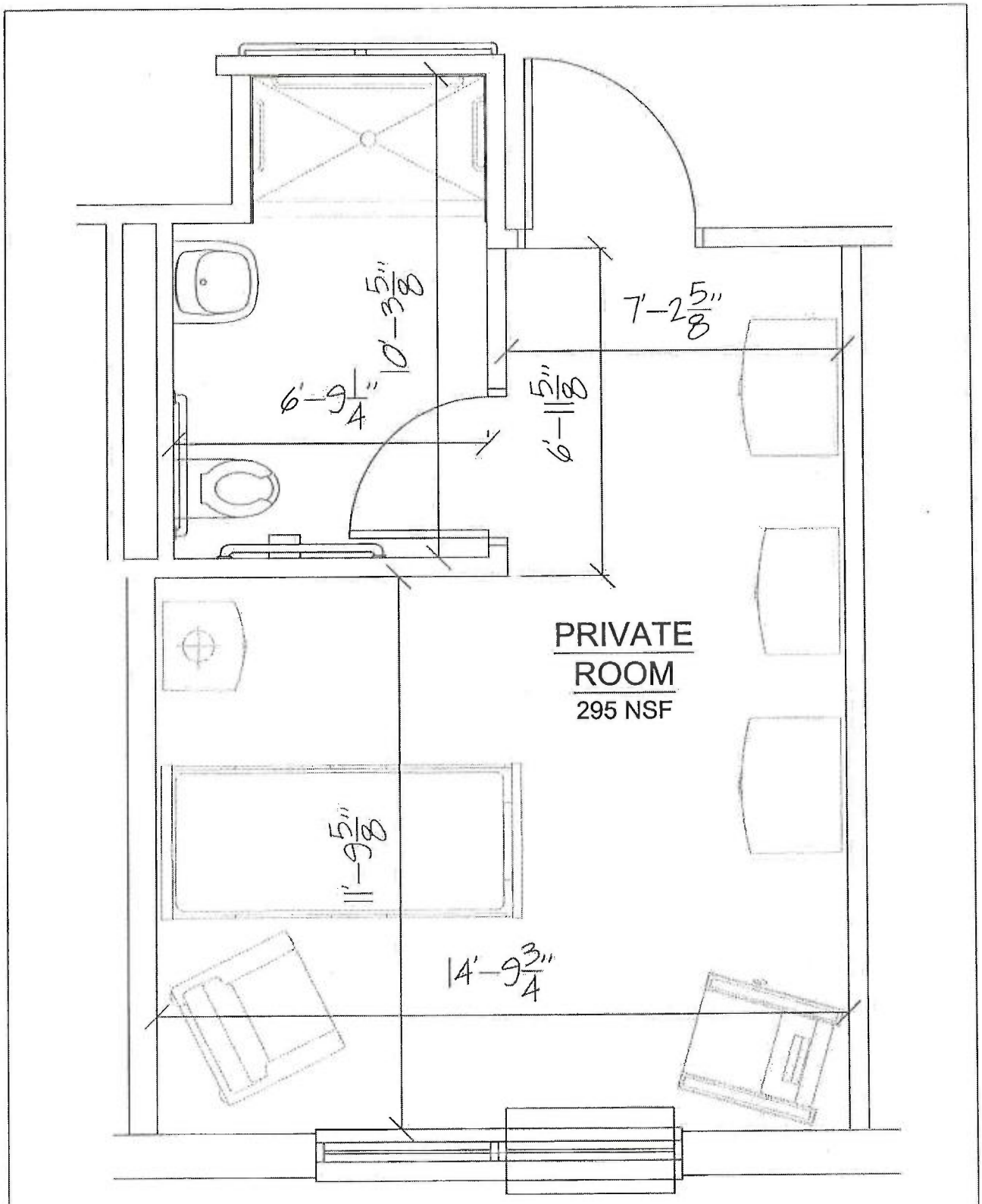
MATCH LINE

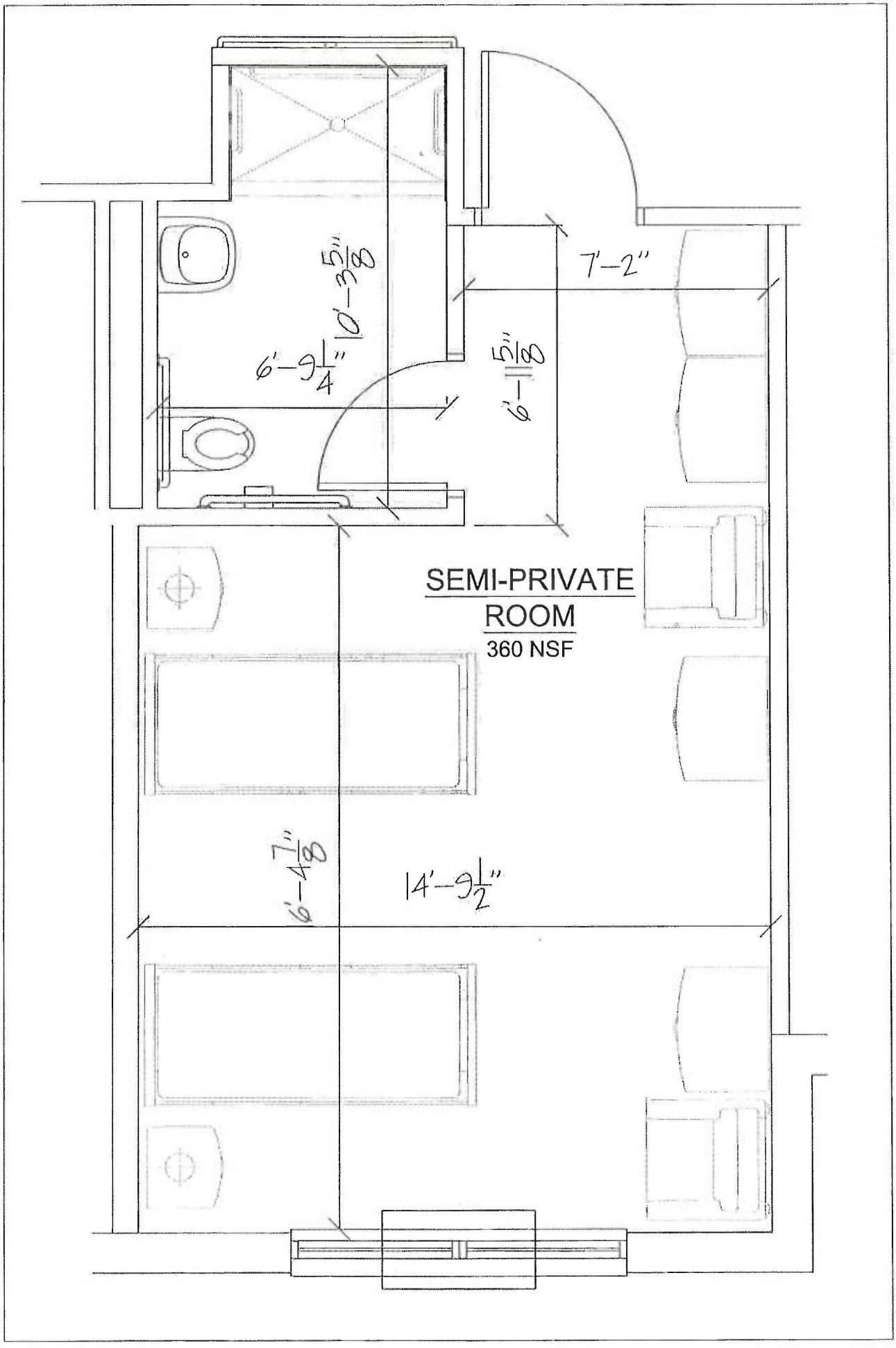
MATCH LINE



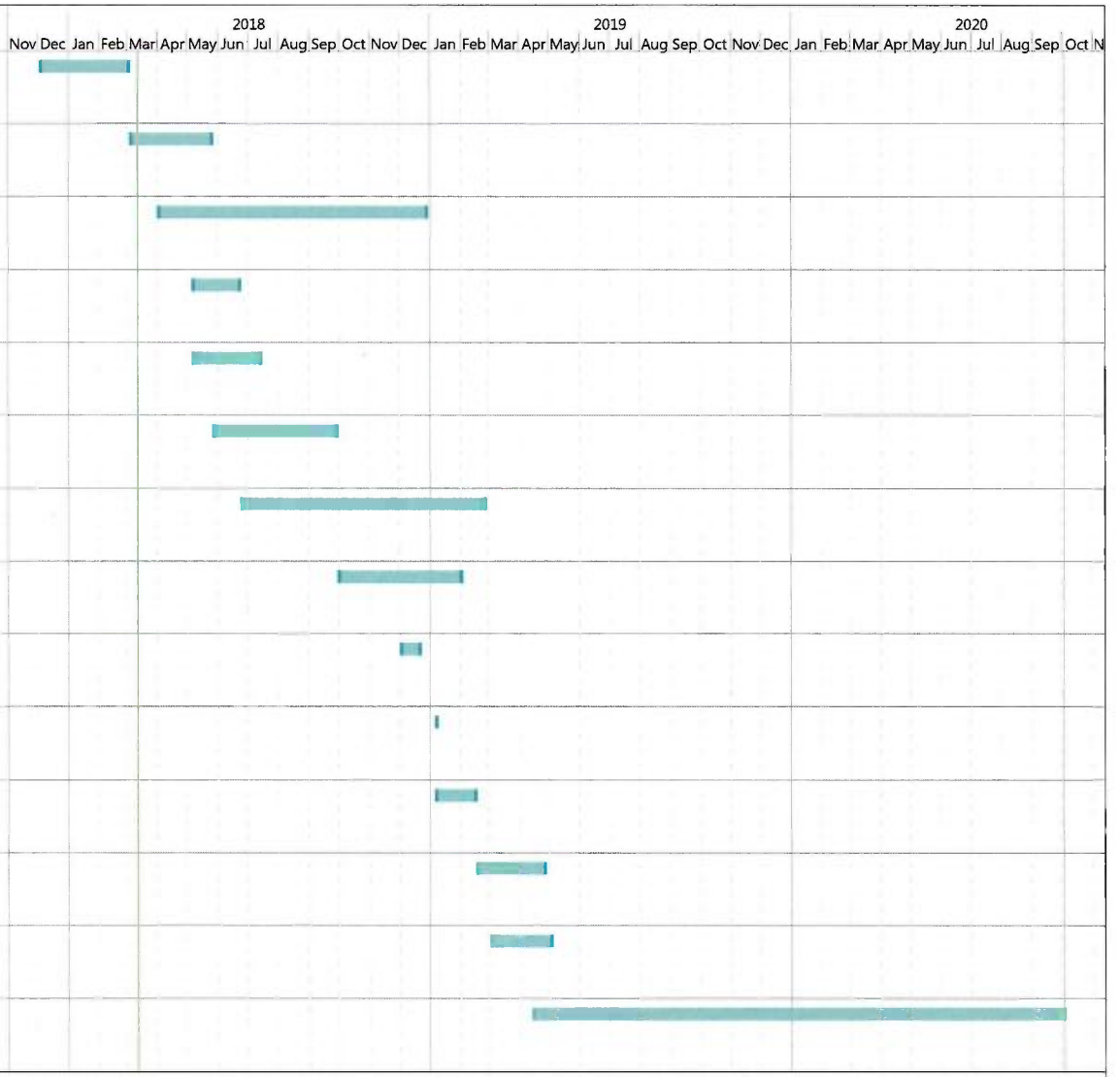
MATCH LINE

FIRST FLOOR: 34,925 GSF
60 BED PATIENT FLOOR
40 PRIVATE ROOMS
10 SEMI-PRIVATE ROOMS


10'-3 5/8"
6'-9 1/4"
7'-2 5/8"
6'-5 1/8"
PRIVATE
ROOM
295 NSF
11'-9 5/8"
14'-9 3/4"


7'-2"
10'-3 5/8"
6'-9 1/4"
5 1/8"
6'-
SEMI-PRIVATE
ROOM
360 NSF
7 1/8"
6'-
14'-9 1/2"

ID	Task Name	Duration	Start	Finish
1	Concept Plan	65 days	Mon 12/4/17	Fri 3/2/18
2	Design Development	60 days	Mon 3/5/18	Fri 5/25/18
3	Certificate of Need	195 days	Mon 4/2/18	Fri 12/28/18
4	Planning Commission Part :	35 days	Mon 5/7/18	Fri 6/22/18
5	Zoning Approval	50 days	Mon 5/7/18	Fri 7/13/18
6	Construction Documents	90 days	Mon 5/28/18	Fri 9/28/18
7	Planning Commission Part :	176 days	Mon 6/25/18	Mon 2/25/19
8	Building Permit Approval Process	90 days	Mon 10/1/18	Fri 2/1/19
9	Project Bidding	15 days	Mon 12/3/18	Fri 12/21/18
10	Award Project	1 day	Mon 1/7/19	Mon 1/7/19
11	Early Grading Permit	30 days	Mon 1/7/19	Fri 2/15/19
12	Site Improvements	50 days	Mon 2/18/19	Fri 4/26/19
13	Public Works Agreement	45 days	Mon 3/4/19	Fri 5/3/19
14	Construction	385 days	Mon 4/15/19	Fri 10/2/20



Project: Carroll Hospital Nursing Home
Date: Mon 3/12/18

Task	Inactive Summary	External Tasks
Split	Manual Task	External Milestone
Milestone	Duration-only	Deadline
Summary	Manual Summary Rollup	Progress
Project Summary	Manual Summary	Manual Progress
Inactive Task	Start-only	
Inactive Milestone	Finish-only	

Marshall Valuation Service Calculation
CARROLL NURSING HOME
New Construction

I. The Marshall Valuation Service Estimate

			MVS Page #
a	Type	Nursing Home	Section 15-26
b	Construction Quality / Class	Good / C	
c	Stories	2	
d	Perimeter		800 for use in perimeter adj.
e	Height	14'	
f	Square Feet	47,385	
f.1	Average Floor Area		25,000 for use in perimeter adj.
	A. Base Costs		
g	Basic Structure	$191.00	Section 15-26
h	Elimination of HVAC Cost for Adjustment	$0.00	Section 15-26
i	HVAC Add-on for Mild Climates	$0.00	Section 15-26
j	HVAC Add-on for Extreme Climates	$0.00	Section 15-26
k	**Total Base**	$191.00	
	B. Additions		
l	Elevators (if not in base)	$4.04	Section 15-26
m	Sprinkler Amount	$3.38	Section 15-37
n	**Subtotal**	$7.42	
o	**Total**	$198.42	
	C. Multipliers		
p	Perimeter Multiplier		Section 15-38
q	Product		
r	Height Multiplier	1.046	Section 15-38
s	Product		
t	Multi-story Multiplier (0.5% / story above 3)	NA	Section 15-26
u	Product		
	D. Update / Location Multipliers		
v	Update Multiplier	1.00	Section 99-3
w	Product		
x	Location Multiplier	1.02	Section 99-8
y	Product	$210.87	

Final MVS Square Foot Cost Estimate

II. The Project

A. Base Calculations	**Actual**	**Per Sq. Ft.**
New Construction	$11,538,000	$243.49
Site Preparation	$899,500	$18.98
Architectural Fees	$1,300,000	$13.75
Permits	$100,000	$2.20
	$13,837,500	$278.42

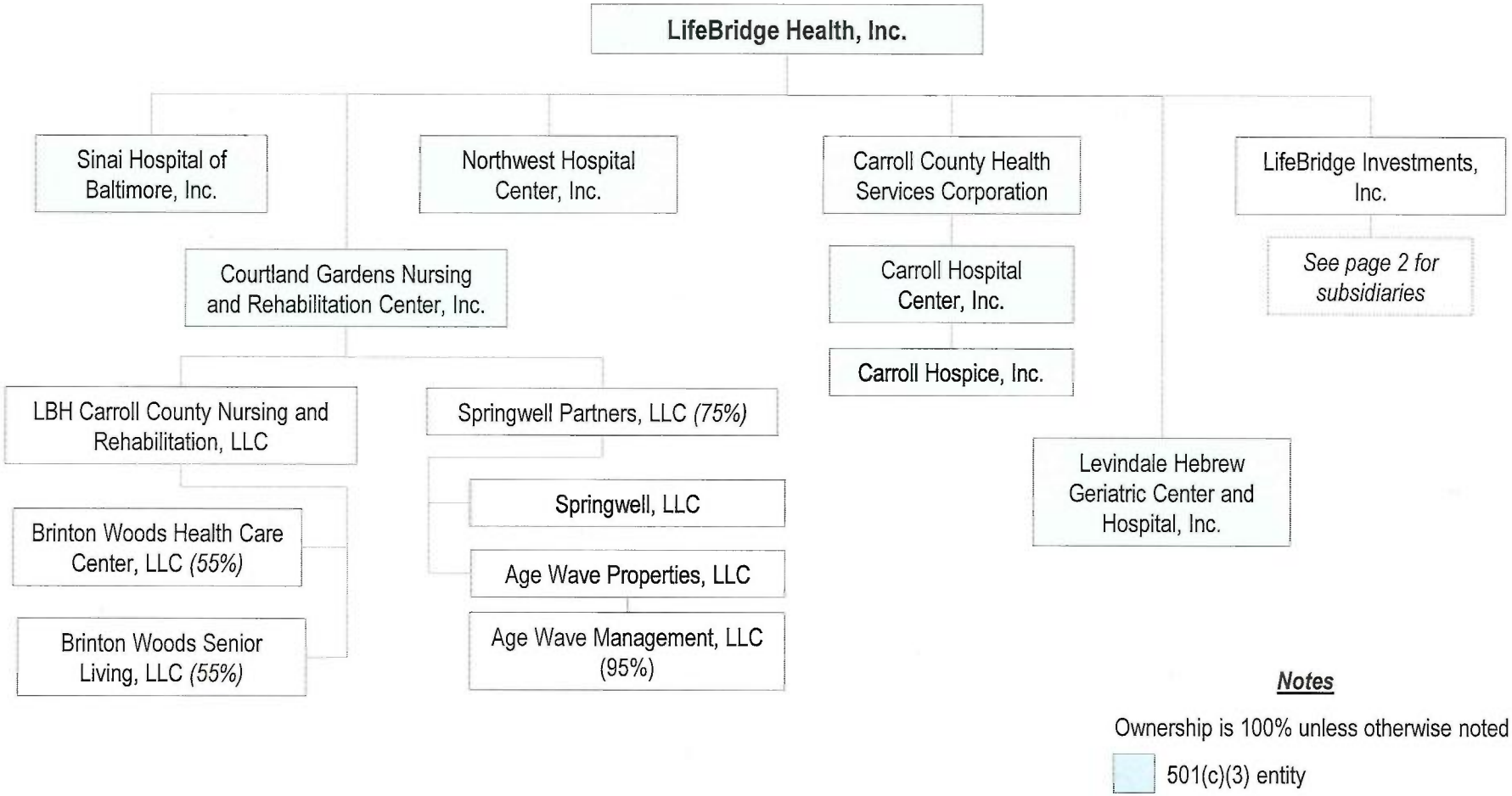
3/12/2018

EXHIBIT 4

LifeBridge Health, Inc.

Organizational Chart – Selected Entities

April 5, 2018



LifeBridge Health, Inc.

Organizational Chart – Selected Entities

April 5, 2018

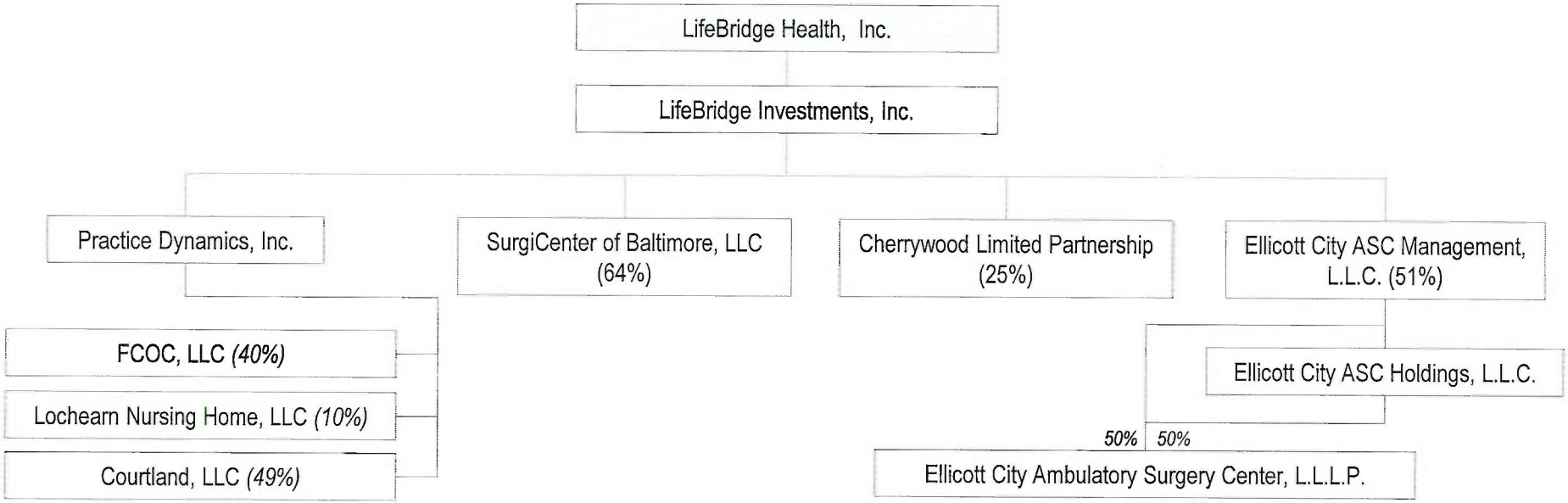
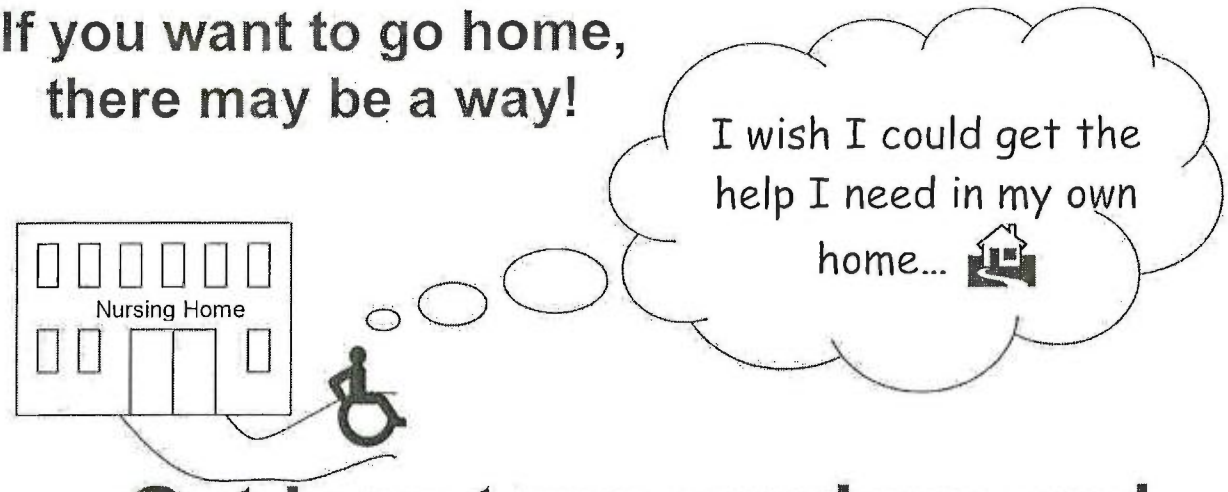


EXHIBIT 5

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

Brinton Woods
Health & Rehabilitation Center
at Arlington West

LONG TERM CARE SERVICES IN THE COMMUNITY

Please sign on the line below to certify that you have received the one-page information sheet on long term care services in the community.

Resident Name: _____

_____ _____
Signature Date

_____
Print Name

_____
Facility Representative

(This form must be kept in the resident's medical record.)

EXHIBIT 6

Brinton Woods Health Care Center, LLC
Diagnosis Report - Current Residents

Resident: All | Physician: All | Status: Current | Unit: All | Floor: All

Diagnosis	Number of Residents
(IDIOPATHIC) NORMAL PRESSURE HYDROCEPHALUS (G91.2)	1
ABNORMAL POSTURE (R29.3)	11
ABNORMAL POSTURE (R29.3)	1
ABNORMAL WEIGHT LOSS (R63.4)	4
ACQUIRED ABSENCE OF RIGHT LEG ABOVE KNEE (Z89.611)	1
ACTINIC KERATOSIS (L57.0)	1
ACUTE AND CHRONIC RESPIRATORY FAILURE, UNSPECIFIED WHETHER WITH HYPOXIA OR HYPERCAPNIA (J96.20)	1
ACUTE BRONCHOSPASM (J98.01)	1
ACUTE CYSTITIS WITH HEMATURIA (N30.01)	1
ACUTE EMBOLISM AND THROMBOSIS OF DEEP VEINS OF UNSPECIFIED UPPER EXTREMITY (I82.629)	1
ACUTE EMBOLISM AND THROMBOSIS OF LEFT FEMORAL VEIN (I82.412)	1
ACUTE KIDNEY FAILURE, UNSPECIFIED (N17.9)	1
ACUTE RESPIRATORY FAILURE WITH HYPOXIA (J96.01)	2
ACUTE RESPIRATORY FAILURE, UNSPECIFIED WHETHER WITH HYPOXIA OR HYPERCAPNIA (J96.00)	1
ACUTE STRESS REACTION (F43.0)	1
ACUTE UPPER RESPIRATORY INFECTION, UNSPECIFIED (J06.9)	1
ACUTE VAGINITIS (N76.0)	1
ADJUSTMENT DISORDER WITH ANXIETY (F43.22)	1
ADJUSTMENT DISORDER WITH DEPRESSED MOOD (F43.21)	1
ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD (F43.23)	2
ADULT FAILURE TO THRIVE (R62.7)	1
AGE-RELATED NUCLEAR CATARACT, LEFT EYE (H25.12)	1
AGE-RELATED NUCLEAR CATARACT, RIGHT EYE (H25.11)	1
AGE-RELATED NUCLEAR CATARACT, UNSPECIFIED EYE (H25.10)	1
AGE-RELATED OSTEOPOROSIS WITH CURRENT PATHOLOGICAL FRACTURE, RIGHT FEMUR, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING (M80.051D)	1
AGE-RELATED OSTEOPOROSIS WITHOUT CURRENT PATHOLOGICAL FRACTURE (M81.0)	3
AGE-RELATED OSTEOPOROSIS WITHOUT CURRENT PATHOLOGICAL FRACTURE (M81.0)	3
ALTERED MENTAL STATUS, UNSPECIFIED (R41.82)	1
ALZHEIMER'S DISEASE, UNSPECIFIED (G30.9)	1
ALZHEIMER'S DISEASE, UNSPECIFIED (G30.9)	2
ANEMIA IN CHRONIC KIDNEY DISEASE (D63.1)	1
ANEMIA IN OTHER CHRONIC DISEASES CLASSIFIED ELSEWHERE (D63.8)	1
ANEMIA IN OTHER CHRONIC DISEASES CLASSIFIED ELSEWHERE (D63.8)	2
ANEMIA, UNSPECIFIED (D64.9)	17
ANEMIA, UNSPECIFIED (D64.9)	5
ANISOMETROPIA (H52.31)	1
ANXIETY DISORDER, UNSPECIFIED (F41.9)	18
ANXIETY DISORDER, UNSPECIFIED (F41.9)	5
APHASIA (R47.01)	2
APHASIA FOLLOWING NONTRAUMATIC INTRACEREBRAL HEMORRHAGE (I69.120)	1
ATHEROSCLEROSIS OF AORTA (I70.0)	1
ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS (I25.10)	7
ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS (I25.10)	3
ATTENTION AND CONCENTRATION DEFICIT (R41.840)	2
BACTEREMIA (R78.81)	1
BACTEREMIA (R78.81)	1
BENIGN NEOPLASM OF CEREBRAL MENINGES (D32.0)	1
BENIGN NEOPLASM OF MENINGES, UNSPECIFIED (D32.9)	1
BENIGN PROSTATIC HYPERPLASIA WITH LOWER URINARY TRACT SYMPTOMS (N40.1)	1
BENIGN PROSTATIC HYPERPLASIA WITHOUT LOWER URINARY TRACT SYMPTOMS (N40.0)	5
BENIGN PROSTATIC HYPERPLASIA WITHOUT LOWER URINARY TRACT SYMPTOMS (N40.0)	1
BIPOLAR DISORDER, CURRENT EPISODE DEPRESSED, SEVERE, WITHOUT PSYCHOTIC FEATURES (F31.4)	1
BIPOLAR DISORDER, UNSPECIFIED (F31.9)	1
BLADDER DISORDER, UNSPECIFIED (N32.9)	1
BRADYCARDIA, UNSPECIFIED (R00.1)	1
CACHEXIA (R64)	1
CALCULUS OF KIDNEY (N20.0)	2
CANDIDAL STOMATITIS (B37.0)	1
CANDIDIASIS, UNSPECIFIED (B37.9)	1
CARDIAC MURMUR, UNSPECIFIED (R01.1)	1
CARDIAC MURMUR, UNSPECIFIED (R01.1)	1
CEREBRAL INFARCTION DUE TO UNSPECIFIED OCCLUSION OR STENOSIS OF UNSPECIFIED CEREBRAL ARTERY (I63.50)	1
CEREBRAL INFARCTION, UNSPECIFIED (I63.9)	12
CEREBROVASCULAR DISEASE, UNSPECIFIED (I67.9)	1
CHRONIC ATRIAL FIBRILLATION (I48.2)	2
CHRONIC CLUSTER HEADACHE, INTRACTABLE (G44.021)	1

Resident: All | Physician: All | Status: Current | Unit: All | Floor: All

Diagnosis	Number of Residents
CHRONIC KIDNEY DISEASE, STAGE 2 (MILD) (N18.2)	1
CHRONIC KIDNEY DISEASE, STAGE 3 (MODERATE) (N18.3)	3
CHRONIC KIDNEY DISEASE, STAGE 4 (SEVERE) (N18.4)	1
CHRONIC KIDNEY DISEASE, UNSPECIFIED (N18.9)	7
CHRONIC MYELOMONOCYTIC LEUKEMIA (C93.1)	1
CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED (J44.9)	11
CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED (J44.9)	1
CHRONIC PAIN SYNDROME (G89.4)	2
CHRONIC RESPIRATORY FAILURE WITH HYPOXIA (J96.11)	1
CHRONIC RESPIRATORY FAILURE, UNSPECIFIED WHETHER WITH HYPOXIA OR HYPERCAPNIA (J96.10)	1
CHRONIC SUPERFICIAL GASTRITIS WITH BLEEDING (K29.31)	1
COGNITIVE COMMUNICATION DEFICIT (R41.841)	14
COGNITIVE COMMUNICATION DEFICIT (R41.841)	1
COGNITIVE DEFICITS FOLLOWING NONTRAUMATIC INTRACEREBRAL HEMORRHAGE (I69.11)	1
COLOSTOMY COMPLICATION, UNSPECIFIED (K94.00)	1
COMPLETE TRAUMATIC AMPUTATION AT LEVEL BETWEEN RIGHT HIP AND KNEE, SUBSEQUENT ENCOUNTER (S78.111D)	1
COMPLETE TRAUMATIC AMPUTATION OF RIGHT LOWER LEG, LEVEL UNSPECIFIED, INITIAL ENCOUNTER (S88.911A)	1
CONSTIPATION, UNSPECIFIED (K59.00)	23
CONSTIPATION, UNSPECIFIED (K59.00)	1
CONTRACTURE, LEFT HAND (M24.542)	3
CONTRACTURE, LEFT KNEE (M24.562)	1
CONTRACTURE, LEFT SHOULDER (M24.512)	1
CONTRACTURE, RIGHT KNEE (M24.561)	1
CONTRACTURE, UNSPECIFIED JOINT (M24.50)	1
CUSHING'S SYNDROME, UNSPECIFIED (E24.9)	1
DEFICIENCY OF OTHER SPECIFIED B GROUP VITAMINS (E53.8)	1
DELUSIONAL DISORDERS (F22)	1
DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE WITH BEHAVIORAL DISTURBANCE (F02.81)	1
DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE WITHOUT BEHAVIORAL DISTURBANCE (F02.80)	1
DEMENTIA WITH LEWY BODIES (G31.83)	2
DERMATITIS, UNSPECIFIED (L30.9)	1
DIABETES MELLITUS DUE TO UNDERLYING CONDITION WITH CIRCULATORY COMPLICATIONS (E08.5)	1
DIABETES MELLITUS DUE TO UNDERLYING CONDITION WITH DIABETIC NEUROPATHY, UNSPECIFIED (E08.40)	1
DIFFICULTY IN WALKING, NOT ELSEWHERE CLASSIFIED (R26.2)	7
DIFFICULTY IN WALKING, NOT ELSEWHERE CLASSIFIED (R26.2)	5
DISCITIS, UNSPECIFIED, THORACIC REGION (M46.44)	1
DISORDER OF BRAIN, UNSPECIFIED (G93.9)	1
DISORDER OF LIPOPROTEIN METABOLISM, UNSPECIFIED (E78.9)	1
DISORDERS OF GALLBLADDER, BILIARY TRACT AND PANCREAS IN DISEASES CLASSIFIED ELSEWHERE (K87)	1
DISORIENTATION, UNSPECIFIED (R41.0)	1
DISPLACED PILON FRACTURE OF LEFT TIBIA, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING (S82.872D)	1
DIVERTICULITIS OF INTESTINE, PART UNSPECIFIED, WITHOUT PERFORATION OR ABSCESS WITHOUT BLEEDING (K57.92)	1
DIVERTICULOSIS OF INTESTINE, PART UNSPECIFIED, WITHOUT PERFORATION OR ABSCESS WITHOUT BLEEDING (K57.90)	1
DIVERTICULOSIS OF SMALL INTESTINE WITHOUT PERFORATION OR ABSCESS WITHOUT BLEEDING (K57.10)	1
DIZZINESS AND GIDDINESS (R42)	1
DRY EYE SYNDROME OF BILATERAL LACRIMAL GLANDS (H04.123)	2
DRY EYE SYNDROME OF UNSPECIFIED LACRIMAL GLAND (H04.129)	7
DRY MOUTH, UNSPECIFIED (R68.2)	1
DYSARTHRIA AND ANARTHRIA (R47.1)	1
DYSARTHRIA AND ANARTHRIA (R47.1)	1
DYSARTHRIA FOLLOWING CEREBRAL INFARCTION (I69.322)	1
DYSARTHRIA FOLLOWING OTHER CEREBROVASCULAR DISEASE (I69.822)	1
DYSPHAGIA FOLLOWING UNSPECIFIED CEREBROVASCULAR DISEASE (I69.991)	1
DYSPHAGIA, ORAL PHASE (R13.11)	5
DYSPHAGIA, OROPHARYNGEAL PHASE (R13.12)	17
DYSPHAGIA, OROPHARYNGEAL PHASE (R13.12)	3
DYSPHAGIA, PHARYNGEAL PHASE (R13.13)	1
DYSPHAGIA, PHARYNGOESOPHAGEAL PHASE (R13.14)	1
DYSPHAGIA, UNSPECIFIED (R13.10)	2
DYSPHAGIA, UNSPECIFIED (R13.10)	2
EDEMA, UNSPECIFIED (R60.9)	3
EDEMA, UNSPECIFIED (R60.9)	3
ELEVATED BLOOD-PRESSURE READING, WITHOUT DIAGNOSIS OF HYPERTENSION (R03.0)	1

Brinton Woods Health Care Center, LLC
Diagnosis Report

Resident: All | **Physician: All** | **Status: Current** | **Unit: All** | **Floor: All**

Diagnosis	Number of Residents
ENCEPHALOPATHY, UNSPECIFIED (G93.40)	1
ENTEROCOLITIS DUE TO CLOSTRIDIUM DIFFICILE (A04.7)	3
ENTEROCOLITIS DUE TO CLOSTRIDIUM DIFFICILE (A04.7)	1
EPILEPSY, UNSPECIFIED, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUS (G40.909)	1
ESSENTIAL (PRIMARY) HYPERTENSION (I10)	31
ESSENTIAL (PRIMARY) HYPERTENSION (I10)	1
ESSENTIAL (PRIMARY) HYPERTENSION (I10)	10
FEEDING DIFFICULTIES (R63.3)	2
FLACCID HEMIPLEGIA AFFECTING RIGHT DOMINANT SIDE (G81.01)	1
FLUENCY DISORDER FOLLOWING NONTRAUMATIC SUBARACHNOID HEMORRHAGE (I69.023)	1
FRACTURE OF UNSPECIFIED PART OF NECK OF RIGHT FEMUR, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING (S72.001D)	1
FRACTURE OF UNSPECIFIED PART OF NECK OF UNSPECIFIED FEMUR, INITIAL ENCOUNTER FOR CLOSED FRACTURE (S72.009A)	1
FRACTURE OF UNSPECIFIED PART OF NECK OF UNSPECIFIED FEMUR, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING (S72.009D)	1
GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS (K21.9)	26
GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS (K21.9)	5
GASTROINTESTINAL HEMORRHAGE, UNSPECIFIED (K92.2)	2
GASTROSTOMY STATUS (Z93.1)	1
GENERALIZED ANXIETY DISORDER (F41.1)	3
GENERALIZED IDIOPATHIC EPILEPSY AND EPILEPTIC SYNDROMES, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUS (G40.309)	1
GENERALIZED PUSTULAR PSORIASIS (L40.1)	1
GLAUCOMA SECONDARY TO OTHER EYE DISORDERS, UNSPECIFIED EYE, STAGE UNSPECIFIED (H40.50X0)	1
GOUT, UNSPECIFIED (M10.9)	1
HALLUX VALGUS (ACQUIRED), LEFT FOOT (M20.12)	1
HEART FAILURE, UNSPECIFIED (I50.9)	2
HEART FAILURE, UNSPECIFIED (I50.9)	3
HEMATURIA, UNSPECIFIED (R31.9)	1
HEMIPLEGIA AND HEMIPARESIS FOLLOWING UNSPECIFIED CEREBROVASCULAR DISEASE AFFECTING LEFT NON-DOMINANT SIDE (I69.954)	1
HEMIPLEGIA AND HEMIPARESIS FOLLOWING UNSPECIFIED CEREBROVASCULAR DISEASE AFFECTING LEFT NON-DOMINANT SIDE (I69.954)	3
HEMIPLEGIA AND HEMIPARESIS FOLLOWING UNSPECIFIED CEREBROVASCULAR DISEASE AFFECTING RIGHT DOMINANT SIDE (I69.951)	2
HEMIPLEGIA AND HEMIPARESIS FOLLOWING UNSPECIFIED CEREBROVASCULAR DISEASE AFFECTING RIGHT NON-DOMINANT SIDE (I69.953)	1
HEMIPLEGIA AND HEMIPARESIS FOLLOWING UNSPECIFIED CEREBROVASCULAR DISEASE AFFECTING UNSPECIFIED SIDE (I69.959)	1
HEMIPLEGIA, UNSPECIFIED AFFECTING LEFT NONDOMINANT SIDE (G81.94)	1
HEMIPLEGIA, UNSPECIFIED AFFECTING UNSPECIFIED SIDE (G81.90)	1
HEMOTHORAX (J94.2)	1
HEREDITARY MOTOR AND SENSORY NEUROPATHY (G60.0)	1
HERPESVIRAL KERATITIS (B00.52)	1
HIRSUTISM (L68.0)	1
HISTORY OF FALLING (Z91.81)	1
HYPERKALEMIA (E87.5)	3
HYPERLIPIDEMIA, UNSPECIFIED (E78.5)	22
HYPERLIPIDEMIA, UNSPECIFIED (E78.5)	9
HYPEROSMOLALITY AND HYPERNATREMIA (E87.0)	1
HYPEROSMOLALITY AND HYPERNATREMIA (E87.0)	1
HYPERTROPHY OF BREAST (N62)	1
HYPO-OSMOLALITY AND HYPONATREMIA (E87.1)	1
HYPOCALCEMIA (E83.51)	1
HYPOKALEMIA (E87.6)	14
HYPOTENSION, UNSPECIFIED (I95.9)	2
HYPOTHYROIDISM, UNSPECIFIED (E03.9)	12
HYPOTHYROIDISM, UNSPECIFIED (E03.9)	2
HYPOXEMIA (R09.02)	1
IDIOPATHIC GOUT, RIGHT WRIST (M10.031)	1
IDIOPATHIC GOUT, UNSPECIFIED HAND (M10.049)	1
IDIOPATHIC GOUT, UNSPECIFIED SITE (M10.00)	2
INFLUENZA DUE TO IDENTIFIED NOVEL INFLUENZA A VIRUS WITH PNEUMONIA (J09.X1)	1
INFLUENZA DUE TO OTHER IDENTIFIED INFLUENZA VIRUS WITH OTHER RESPIRATORY MANIFESTATIONS (J10.1)	1
INFLUENZA DUE TO OTHER IDENTIFIED INFLUENZA VIRUS WITH OTHER RESPIRATORY MANIFESTATIONS (J10.1)	1
INSOMNIA, UNSPECIFIED (G47.00)	9

Brinton Woods Health Care Center, LLC
Diagnosis Report

Resident: All | **Physician: All** | **Status: Current** | **Unit: All** | **Floor: All**

Diagnosis	Number of Residents
IRON DEFICIENCY ANEMIA, UNSPECIFIED (D50.9)	1
IRRITABLE BOWEL SYNDROME WITHOUT DIARRHEA (K58.9)	1
LACERATION WITH FOREIGN BODY, UNSPECIFIED HIP, INITIAL ENCOUNTER (S71.029A)	1
LEFT VENTRICULAR FAILURE, UNSPECIFIED (I50.1)	1
LEGAL BLINDNESS, AS DEFINED IN USA (H54.8)	1
LOCALIZED EDEMA (R60.0)	14
LOW BACK PAIN (M54.5)	5
LOW BACK PAIN (M54.5)	2
MAJOR DEPRESSIVE DISORDER, RECURRENT, IN REMISSION, UNSPECIFIED (F33.40)	1
MAJOR DEPRESSIVE DISORDER, RECURRENT, MILD (F33.0)	1
MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED (F33.9)	32
MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED (F32.9)	4
MALIGNANT NEOPLASM OF LEFT KIDNEY, EXCEPT RENAL PELVIS (C64.2)	1
MALIGNANT NEOPLASM OF PROSTATE (C61)	1
MANIC EPISODE WITHOUT PSYCHOTIC SYMPTOMS, UNSPECIFIED (F30.10)	1
METABOLIC ENCEPHALOPATHY (G93.41)	1
METATARSALGIA, UNSPECIFIED FOOT (M77.40)	1
METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS INFECTION AS THE CAUSE OF DISEASES CLASSIFIED ELSEWHERE (B95.62)	1
METHICILLIN SUSCEPTIBLE STAPHYLOCOCCUS AUREUS INFECTION AS THE CAUSE OF DISEASES CLASSIFIED ELSEWHERE (B95.61)	1
MILD COGNITIVE IMPAIRMENT, SO STATED (G31.84)	5
MIXED HYPERLIPIDEMIA (E78.2)	1
MIXED INCONTINENCE (N39.46)	1
MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH DEPRESSIVE FEATURES (F06.31)	1
MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION, UNSPECIFIED (F06.30)	2
MORBID (SEVERE) OBESITY DUE TO EXCESS CALORIES (E66.01)	1
MULTIPLE FRACTURES OF RIBS, LEFT SIDE, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING (S22.42XD)	1
MULTIPLE SCLEROSIS (G35)	1
MUSCLE WEAKNESS (GENERALIZED) (M62.81)	43
MUSCLE WEAKNESS (GENERALIZED) (M62.81)	7
MYELOID LEUKEMIA, UNSPECIFIED IN REMISSION (C92.91)	1
NEUROMUSCULAR DYSFUNCTION OF BLADDER, UNSPECIFIED (N31.9)	4
NEUROMUSCULAR DYSFUNCTION OF BLADDER, UNSPECIFIED (N31.9)	2
NON-PRESSURE CHRONIC ULCER OF OTHER PART OF UNSPECIFIED LOWER LEG LIMITED TO BREAKDOWN OF SKIN (L97.801)	1
NON-PRESSURE CHRONIC ULCER OF UNSPECIFIED PART OF LEFT LOWER LEG LIMITED TO BREAKDOWN OF SKIN (L97.921)	1
NONDISPLACED AVULSION FRACTURE (CHIP FRACTURE) OF RIGHT TALUS, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING (S92.154D)	1
NONDISPLACED COMMINUTED FRACTURE OF SHAFT OF RIGHT FEMUR, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING (S72.354D)	1
NONDISPLACED INTERTROCHANTERIC FRACTURE OF LEFT FEMUR, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING (S72.145D)	1
NONDISPLACED INTERTROCHANTERIC FRACTURE OF RIGHT FEMUR, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING (S72.144D)	1
NONINFECTIVE GASTROENTERITIS AND COLITIS, UNSPECIFIED (K52.9)	1
NONRHEUMATIC MITRAL (VALVE) INSUFFICIENCY (I34.0)	1
NONTRAUMATIC ACUTE SUBDURAL HEMORRHAGE (I62.01)	1
NONTRAUMATIC INTRACEREBRAL HEMORRHAGE, UNSPECIFIED (I61.9)	1
NONTRAUMATIC INTRACEREBRAL HEMORRHAGE, UNSPECIFIED (I61.9)	1
NONTRAUMATIC SUBDURAL HEMORRHAGE, UNSPECIFIED (I62.00)	1
OBESITY, UNSPECIFIED (E66.9)	4
OBESITY, UNSPECIFIED (E66.9)	1
OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC) (G47.33)	4
OCCLUSION AND STENOSIS OF UNSPECIFIED CAROTID ARTERY (I65.29)	1
OSTEOARTHRITIS OF HIP, UNSPECIFIED (M16.9)	1
OTHER ABNORMALITIES OF GAIT AND MOBILITY (R26.89)	3
OTHER ABNORMALITIES OF GAIT AND MOBILITY (R26.89)	2
OTHER CEREBROVASCULAR DISEASE (I67.89)	1
OTHER CEREBROVASCULAR DISEASE (I67.89)	2
OTHER CHRONIC PAIN (G89.29)	5
OTHER CHRONIC PANCREATITIS (K86.1)	1
OTHER CHRONIC PANCREATITIS (K86.1)	1
OTHER CONSTIPATION (K59.09)	1
OTHER DISORDERS OF PERIPHERAL NERVOUS SYSTEM (G64)	1

Brinton Woods Health Care Center, LLC
Diagnosis Report

Resident: All | **Physician: All** | **Status: Current** | **Unit: All** | **Floor: All**

Diagnosis	Number of Residents
OTHER DYSPHAGIA (R13.19)	2
OTHER FRACTURE OF SHAFT OF RIGHT FEMUR, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING (S72.391D)	1
OTHER FRACTURE OF UNSPECIFIED LUMBAR VERTEBRA, SEQUELA (S32.008S)	1
OTHER FRACTURE OF UPPER AND LOWER END OF UNSPECIFIED FIBULA, INITIAL ENCOUNTER FOR CLOSED FRACTURE (S82.839A)	1
OTHER HAMMER TOE(S) (ACQUIRED), LEFT FOOT (M20.42)	1
OTHER IDIOPATHIC PERIPHERAL AUTONOMIC NEUROPATHY (G90.09)	1
OTHER LACK OF COORDINATION (R27.8)	8
OTHER MALAISE (R53.81)	1
OTHER NONSPECIFIC ABNORMAL FINDING OF LUNG FIELD (R91.8)	1
OTHER OSTEOPOROSIS WITHOUT CURRENT PATHOLOGICAL FRACTURE (M81.8)	1
OTHER RECURRENT DEPRESSIVE DISORDERS (F33.8)	2
OTHER RETENTION OF URINE (R33.8)	1
OTHER RETINAL DETACHMENTS (H33.8)	1
OTHER SEASONAL ALLERGIC RHINITIS (J30.2)	11
OTHER SEBORRHEIC KERATOSIS (L82.1)	1
OTHER SEQUELAE OF CEREBRAL INFARCTION (I69.398)	1
OTHER SPECIFIED ANXIETY DISORDERS (F41.8)	3
OTHER SPECIFIED CARDIAC ARRHYTHMIAS (I49.8)	1
OTHER SPECIFIED DISORDERS OF BONE DENSITY AND STRUCTURE (M85.8)	1
OTHER SPECIFIED DISORDERS OF BONE DENSITY AND STRUCTURE, MULTIPLE SITES (M85.89)	1
OTHER SPECIFIED DISORDERS OF BONE DENSITY AND STRUCTURE, RIGHT LOWER LEG (M85.861)	1
OTHER SPECIFIED DISORDERS OF BONE DENSITY AND STRUCTURE, UNSPECIFIED SITE (M85.80)	3
OTHER SPECIFIED FORMS OF TREMOR (G25.2)	2
OTHER SPECIFIED MENTAL DISORDERS DUE TO KNOWN PHYSIOLOGICAL CONDITION (F06.8)	1
OTHER SPECIFIED MENTAL DISORDERS DUE TO KNOWN PHYSIOLOGICAL CONDITION (F06.8)	3
OTHER SPECIFIED PERIPHERAL VASCULAR DISEASES (I73.89)	2
OTHER SYMBOLIC DYSFUNCTIONS (R48.8)	5
OTHER SYMBOLIC DYSFUNCTIONS (R48.8)	3
OTHER SYMPTOMS AND SIGNS INVOLVING COGNITIVE FUNCTIONS AND AWARENESS (R41.89)	1
OTHER SYMPTOMS AND SIGNS INVOLVING COGNITIVE FUNCTIONS FOLLOWING CEREBRAL INFARCTION (I69.318)	4
OVERACTIVE BLADDER (N32.81)	2
PAIN IN LEFT ARM (M79.602)	1
PAIN IN LEFT HAND (M79.642)	2
PAIN IN LEFT KNEE (M25.562)	1
PAIN IN LEFT SHOULDER (M25.512)	1
PAIN IN RIGHT HAND (M79.641)	1
PAIN IN UNSPECIFIED HIP (M25.559)	1
PAIN IN UNSPECIFIED JOINT (M25.50)	2
PARALYTIC GAIT (R26.1)	1
PARAPLEGIA, INCOMPLETE (G82.22)	1
PARAPLEGIA, UNSPECIFIED (G82.20)	1
PARKINSON'S DISEASE (G20)	4
PAROXYSMAL ATRIAL FIBRILLATION (I48.0)	2
PATHOLOGICAL FRACTURE, HIP, UNSPECIFIED, INITIAL ENCOUNTER FOR FRACTURE (M84.459A)	1
PERIPHERAL VASCULAR DISEASE, UNSPECIFIED (I73.9)	11
PERIPHERAL VASCULAR DISEASE, UNSPECIFIED (I73.9)	2
PERSONAL HISTORY OF MALIGNANT NEOPLASM OF BREAST (Z85.3)	1
PERSONAL HISTORY OF NICOTINE DEPENDENCE (Z87.891)	1
PERSONAL HISTORY OF OTHER MALIGNANT NEOPLASM OF BRONCHUS AND LUNG (Z85.118)	1
PERSONAL HISTORY OF PNEUMONIA (RECURRENT) (Z87.01)	1
PERSONAL HISTORY OF TRANSIENT ISCHEMIC ATTACK (TIA), AND CEREBRAL INFARCTION WITHOUT RESIDUAL DEFICITS (Z86.73)	1
PNEUMONIA, UNSPECIFIED ORGANISM (J18.9)	12
PNEUMONIA, UNSPECIFIED ORGANISM (J18.9)	2
PNEUMONITIS DUE TO INHALATION OF FOOD AND VOMIT (J69.0)	1
POLYNEUROPATHY, UNSPECIFIED (G62.9)	2
POLYOSTEOARTHRITIS, UNSPECIFIED (M15.9)	2
PRESENCE OF UNSPECIFIED ARTIFICIAL KNEE JOINT (Z96.659)	1
PRESENCE OF UNSPECIFIED ARTIFICIAL SHOULDER JOINT (Z96.619)	1
PRESSURE ULCER OF RIGHT HEEL, STAGE 1 (L89.611)	1
PRESSURE ULCER OF SACRAL REGION, STAGE 4 (L89.154)	1
PRIMARY GENERALIZED (OSTEO)ARTHRITIS (M15.0)	15
PRIMARY GENERALIZED (OSTEO)ARTHRITIS (M15.0)	1
PRIMARY OSTEOARTHRITIS OF OTHER JOINTS (M19.0)	1
PRIMARY OSTEOARTHRITIS, LEFT HAND (M19.042)	1

Resident: All | Physician: All | Status: Current | Unit: All | Floor: All

Diagnosis	Number of Residents
PSYCHOTIC DISORDER WITH DELUSIONS DUE TO KNOWN PHYSIOLOGICAL CONDITION (F06.2)	1
PULMONARY FIBROSIS, UNSPECIFIED (J84.10)	1
REPEATED FALLS (R29.6)	4
RESPIRATORY FAILURE, UNSPECIFIED, UNSPECIFIED WHETHER WITH HYPOXIA OR HYPERCAPNIA (J96.90)	1
RESTLESS LEGS SYNDROME (G25.81)	1
RESTLESS LEGS SYNDROME (G25.81)	2
RESTLESSNESS AND AGITATION (R45.1)	1
RETENTION OF URINE, UNSPECIFIED (R33.9)	8
RETENTION OF URINE, UNSPECIFIED (R33.9)	1
RHABDOMYOLYSIS (M62.82)	3
SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE (F25.0)	1
SCHIZOPHRENIA, UNSPECIFIED (F20.9)	1
SEBORRHEIC DERMATITIS, UNSPECIFIED (L21.9)	1
SECONDARY MALIGNANT NEOPLASM OF BONE (C79.51)	2
SECONDARY MULTIPLE ARTHRITIS (M15.3)	1
SENILE DEGENERATION OF BRAIN, NOT ELSEWHERE CLASSIFIED (G31.1)	1
SENILE ECTROPION OF LEFT LOWER EYELID (H02.135)	1
SENILE ECTROPION OF RIGHT LOWER EYELID (H02.132)	1
SEPSIS, UNSPECIFIED ORGANISM (A41.9)	1
SHORTNESS OF BREATH (R06.02)	1
SPINAL STENOSIS, CERVICAL REGION (M48.02)	1
SPINAL STENOSIS, LUMBAR REGION (M48.06)	2
SPINAL STENOSIS, LUMBAR REGION WITHOUT NEUROGENIC CLAUDICATION (M48.061)	1
SPONTANEOUS RUPTURE OF EXTENSOR TENDONS, UNSPECIFIED THIGH (M66.259)	1
STIFFNESS OF UNSPECIFIED JOINT, NOT ELSEWHERE CLASSIFIED (M25.60)	1
SYNCOPE AND COLLAPSE (R55)	3
SYNCOPE AND COLLAPSE (R55)	1
TACHYCARDIA, UNSPECIFIED (R00.0)	1
TINEA UNGUIUM (B35.1)	1
TRANSIENT CEREBRAL ISCHEMIC ATTACK, UNSPECIFIED (G45.9)	5
TRANSIENT CEREBRAL ISCHEMIC ATTACKS AND RELATED SYNDROMES (G45)	1
TREMOR, UNSPECIFIED (R25.1)	2
TYPE 2 DIABETES MELLITUS WITH DIABETIC NEUROPATHY, UNSPECIFIED (E11.40)	3
TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY (E11.42)	1
TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65)	1
TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9)	7
TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9)	2
ULCERATIVE (CHRONIC) PANCOLITIS WITH OTHER COMPLICATION (K51.018)	1
ULCERATIVE COLITIS, UNSPECIFIED, WITHOUT COMPLICATIONS (K51.90)	1
UMBILICAL HERNIA WITHOUT OBSTRUCTION OR GANGRENE (K42.9)	1
UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE (M17.12)	3
UNSPECIFIED ABNORMAL INVOLUNTARY MOVEMENTS (R25.9)	1
UNSPECIFIED ABNORMALITIES OF GAIT AND MOBILITY (R26.9)	1
UNSPECIFIED ABNORMALITIES OF GAIT AND MOBILITY (R26.9)	1
UNSPECIFIED ASTHMA, UNCOMPLICATED (J45.909)	1
UNSPECIFIED ATRIAL FIBRILLATION (I48.91)	8
UNSPECIFIED ATRIAL FIBRILLATION (I48.91)	4
UNSPECIFIED COMBINED SYSTOLIC (CONGESTIVE) AND DIASTOLIC (CONGESTIVE) HEART FAILURE (I50.40)	3
UNSPECIFIED CONVULSIONS (R56.9)	3
UNSPECIFIED DEMENTIA WITH BEHAVIORAL DISTURBANCE (F03.91)	8
UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE (F03.90)	12
UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE (F03.90)	3
UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE (F03.90)	1
UNSPECIFIED DIASTOLIC (CONGESTIVE) HEART FAILURE (I50.30)	1
UNSPECIFIED FRACTURE OF FIRST LUMBAR VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING (S32.019D)	1
UNSPECIFIED FRACTURE OF RIGHT LOWER LEG, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING (S82.91XD)	1
UNSPECIFIED FRACTURE OF SHAFT OF HUMERUS, LEFT ARM, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING (S42.302D)	1
UNSPECIFIED FRACTURE OF SHAFT OF LEFT TIBIA, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING (S82.202D)	1
UNSPECIFIED FRACTURE OF UNSPECIFIED FEMUR, INITIAL ENCOUNTER FOR CLOSED FRACTURE (S72.90XA)	1
UNSPECIFIED FRACTURE OF UNSPECIFIED FEMUR, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING (S72.90XD)	1
UNSPECIFIED GLAUCOMA (H40.9)	7
UNSPECIFIED GLAUCOMA (H40.9)	1

Brinton Woods Health Care Center, LLC
Diagnosis Report

Resident: All | Physician: All | **Status: Current** | **Unit: All** | **Floor: All**

Diagnosis	Number of Residents
UNSPECIFIED HEARING LOSS, UNSPECIFIED EAR (H91.90)	2
UNSPECIFIED HEMORRHOIDS (K64.9)	1
UNSPECIFIED LACK OF COORDINATION (R27.9)	3
UNSPECIFIED MACULAR DEGENERATION (H35.30)	2
UNSPECIFIED MASTOIDITIS, UNSPECIFIED EAR (H70.90)	1
UNSPECIFIED MENTAL DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION (F09)	1
UNSPECIFIED MOOD [AFFECTIVE] DISORDER (F39)	3
UNSPECIFIED OSTEOARTHRITIS, UNSPECIFIED SITE (M19.90)	6
UNSPECIFIED OSTEOARTHRITIS, UNSPECIFIED SITE (M19.90)	2
UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOLOGICAL CONDITION (F29)	4
UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOLOGICAL CONDITION (F29)	1
UNSPECIFIED PTOSIS OF RIGHT EYELID (H02.401)	1
UNSPECIFIED SEQUELAE OF UNSPECIFIED CEREBROVASCULAR DISEASE (I69.90)	1
UNSPECIFIED SYMBOLIC DYSFUNCTIONS (R48.9)	2
UNSPECIFIED SYMPTOMS AND SIGNS INVOLVING COGNITIVE FUNCTIONS FOLLOWING CEREBRAL INFARCTION (I69.319)	1
UNSTEADINESS ON FEET (R26.81)	20
URINARY TRACT INFECTION, SITE NOT SPECIFIED (N39.0)	19
URINARY TRACT INFECTION, SITE NOT SPECIFIED (N39.0)	4
VASCULAR DEMENTIA WITH BEHAVIORAL DISTURBANCE (F01.51)	1
VASCULAR DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE (F01.50)	1
VITAMIN B12 DEFICIENCY ANEMIA, UNSPECIFIED (D51.9)	1
VITAMIN D DEFICIENCY, UNSPECIFIED (E55.9)	35
VITAMIN D DEFICIENCY, UNSPECIFIED (E55.9)	2
WEDGE COMPRESSION FRACTURE OF SECOND THORACIC VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING (S22.020D)	1
ZOSTER WITHOUT COMPLICATIONS (B02.9)	1

EXHIBIT 7

KORTE
build smart.

AN INTRODUCTION TO SENIOR LIVING DESIGN AND CONSTRUCTION

SENIOR LIVING DESIGN AND CONSTRUCTION WITH A PURPOSE

A nursing home or senior living facility has a unique dual purpose: to deliver excellent care and to provide a high quality of life for senior citizens.

That's a major change from the past, when nursing homes followed the hospital model, and efficient care was the driving force behind design and construction. Dignity, privacy and lifestyle have become core values in senior care. And new, innovative materials and technologies have made it possible to cost-efficiently design and build better living environments that allow for improved quality of life.

As part of this trend in senior living and nursing home design, it's become increasingly important to build for the continuum of care. What we mean is that as seniors age and require different levels of care, senior living centers need facilities that can provide the right living environment and care. Smart architectural design and construction allow you to build the proper environments for seniors as they move from independent living to assisted living and into skilled care, or even specialty care. In this guide, we cover what these trends mean for your facility and your construction program.

SENIOR LIVING INTERIOR DESIGN

Every element of senior living interior design comes back to the dual purpose of quality care and quality of life. To better show you just what this means, we'll start by examining traditional nursing home design.

THE TRADITIONAL HOSPITAL MODEL OF NURSING HOME DESIGN

For years, nursing homes were synonymous with low-tech hospitals. Throughout the U.S., roughly 2 million beds have been built in skilled nursing centers, long-term care facilities and nursing homes. Nearly all of those facilities were designed with rooms branching off central, hospital-like corridors. Rooms were built to be semi-private, with two beds separated by a curtain, one by a window and another by a bathroom. In many ways, our seniors were seen purely as patients. Nearly all facilities incorporated group showers, a central dining facility for all residents and a kitchen that was off limits to residents. Maintenance functions weren't neatly separated from living areas. It was a one-size-fits-all model that provided sterile environments and lacked many amenities and individual spaces. Facilities were efficient, cost-effective and profitable, and residents could receive the care they needed. But nursing homes generally didn't make for a good home. They weren't a place to live and enjoy the golden years.

INTERIOR DESIGN THAT MEETS A SENIOR LIVING FACILITY'S DUAL PURPOSE

Today, as senior living moves toward the dual-purpose model of efficient care and quality lifestyle, good facilities incorporate the best design elements of hospitals, hotels and homes. And they're set up to be as friendly as possible to those who have disabilities.

INCORPORATING THE PRIVACY OF THE HOME INTO SENIOR LIVING INTERIOR DESIGN

To improve senior living facilities, interior designers can use elements of the traditional home, the biggest of which is privacy. As seniors progress from living on their own to receiving daily care in a nursing home, they still expect dignity and personal space. Today, facilities are increasingly providing private rooms to seniors, along with private bathrooms that feature individual showers or baths. It's become a priority to create living spaces that make it possible for seniors to invite their family members to visit. That includes individual spaces for games, entertainment and fun. To help create more privacy and personalization, some facilities go as far as providing house-like units with smaller numbers of residents and accessible patios, porches and sitting areas where people can enjoy the day together. These units sometimes include gas fireplaces, usable washing machines and dryers for visiting families.

Instead of a single, large dining area for all residents, facilities are transitioning to smaller, more private dining areas and open kitchens that are accessible to residents. The design of dining and kitchen areas has become increasingly important.

Interior designers are creating senior living facilities with comforting lighting, walls designed with inviting colors, themed and comfortable furniture and custom decorations. A true home.

INCORPORATING THE BEST OF HOTELS IN SENIOR LIVING DESIGN

Nursing home facilities that have long been associated with sterile environments are now being designed to create a first impression like a hotel. In many facilities, nursing stations have been transformed from a desk behind high walls to a concierge-like station. It's a place that encourages interaction between care providers and residents. Mini nursing stations with medical supplies are present at desks, shelves and wall cabinets throughout facilities to make it easier for staff to deliver more personal care and service. Maintenance and housekeeping duties are functionally designed to be separate from residents in order to create a more visually appealing home.

Senior living facilities now incorporate welcoming design into walls, flooring, furniture and outdoor areas in ways that had previously been unachievable. In the past, one of the limiting factors for design had been state regulations for cleanliness and infection control. After all, nursing homes are state-licensed facilities. But today, organizations like the Centers for Medicaid and Medicare Services have worked with regulators to create standards that incorporate personalization and call for a high quality of life. At the same time, new technologies and materials have allowed for a clean, healthy environment without limiting design capabilities. And many of these innovations have come directly from hotels.

One example of a new material is solution-dyed carpets with moisture backings. They're visually pleasing, meet regulations and can stand up to industrial–strength cleaners necessary for infection control. Other materials, such as new types of vinyl, painted gypsum boards and wall coverings, offer the same benefits. Furniture lines, created specially for those who need

assistance, come with removable elements, chair arms designed for lifting assistance and other features that make life easier for the elderly and caregivers. Part of senior living design is simply keeping seniors in mind in each detail.

But beyond the details of design, some the finest facilities offer amenities like hotel-style dining areas, pools, fitness centers, spas, libraries, computer centers, wellness facilities, business centers, art studios — even beauty salons and barbershops. Seniors are able to stay active and fit longer while enjoying a better daily experience.

INCORPORATING THE BEST OF HOSPITALS IN SENIOR LIVING DESIGN

In recent years, hospitals have seen many important developments and improvements in technology and interior design. Some of those positives translate directly to senior living.

New technology that's custom-made for care settings is improving staff communication and care throughout many facilities. Automated tracking and alerts can inform nurses and care providers when patients fall, require attendance or enter or exit certain areas. Nursing stations now come equipped with the latest computing technology, and facilities are set up to work with modern medical devices and IT infrastructures. In many new nursing homes, automated lifts come built into the facility and make it easier for care providers to move residents from room to room and up stairs.

Accommodations for medical care technology work in coordination with evidence-based design. Research study after research study has shown that environments with nurturing colors, green spaces and inviting decorations have a positive impact on patient outcomes and care. Using evidence-based design, your interior designer and nursing home architect can create an environment that tangibly improves the quality of life for your residents.

FUNCTIONAL ARCHITECTURE AND NURSING HOME DESIGN

Architecture has gotten smarter. Better modeling methods, computer-aided design technology and evidence-based design have changed the way we approach nursing home design. Architects can better structurally customize senior living facilities to suit the needs of senior residents. Your architect can create a facility that's primed to deliver quality care with a high quality of life. So what does that mean for your facility?

You'll want a modern architectural model that maximizes individual spaces while making every element of your building disability-friendly. It pervades all aspects of architectural design, from the organization of buildings on a senior living campus to the layout of rooms, closets and common spaces in a facility.

DISABILITY-FRIENDLY NURSING HOME DESIGN

Designing a senior living facility that's friendly to those with disabilities goes beyond complying with the standards set forth by the Americans with Disabilities Act (ADA). It takes into account the way that those with disabilities must navigate every element of their days. Why? Because delivering a high quality of life means enabling seniors to do as much as they can for themselves.

Making a facility disability-friendly means making halls and rooms big enough to accommodate wheelchairs and medical devices. It means creating ramps wherever possible instead of stairs. Closets in rooms should have the space to comfortably accommodate bulky

wheelchairs. Levers, closet rods, light switches and shelves shouldn't be high and out of reach. They should be low enough for seniors to conveniently access them. Individual rooms can come with medical closets that lock and open with a nurse's keys, so nurses aren't tied so tightly to the med cart and can be more accessible to seniors. Simply put, the design of personal rooms and common spaces should take into account the details of living with physical disabilities and make it possible for seniors to get around and perform tasks independently.

INNOVATIVE ARCHITECTURAL MODELS FOR NURSING HOME DESIGN

As senior living facilities have changed and adapted to deliver a high quality of life, new architectural building models have taken shape. One completely unconventional example is the Green House Project, where groups of 10 to 12 seniors live in houses that are custom designed to increase staff contact with seniors. These homes provide a foyer, a living room, an open kitchen, a family-style dining area, a sunroom den, an office, a beauty shop, a spa, a utility room and private bedrooms with full bathrooms and individual showers around the periphery. They truly have all the trappings of a home with the companionship of caring staff and other seniors.

Of course, on the surface it seems that delivering fully disability-friendly, custom group homes for seniors is tremendously expensive. And cost was one of the main reasons for the traditional model of nursing home design. Economies of scale made it possible for seniors to get affordable care and housing, while owners could operate nursing homes at a profit. But today, many new models blend the best of private and group homes with the cost efficiencies and scale of traditional care facilities.

Some senior living communities are broken into neighborhoods of house-like facilities that provide 8–10 bedrooms and many of the amenities of home. In total, there will still be hundreds of residents. They're organized with some functions performed in a central facility, while caregivers can efficiently move house to house to provide assistance. Meds for individual patients will be organized and locked in the house units. One senior living center in Wisconsin is actually arranged with houses in concentric circles. Even senior living centers made up of one large facility will come with patios and open, green spaces that provide views of nature, gardens and bodies of water. On the inside, modern facilities include natural lighting to brighten rooms, systems to raise indoor air quality, energy and water conservation and efficient lighting to deliver energy-efficiency savings.

Even in more traditionally styled facilities, private rooms are becoming the norm, and they come with many of the amenities of home, like microwaves, refrigerators and surfaces for dining. According to research from the Gerontological Society of America, published by the Oxford Journals, the cost of building private rooms is usually offset in less than two years time. Owners can cost-effectively renovate older facilities to make shared rooms more like private rooms, putting walls between beds or building a sliding door between them. One trend is to have senior couples in one room with a bed on one side and a living room on the other side.

SMART NURSING HOME CONSTRUCTION

Much like nursing home interior design and architectural design, in nursing home construction, it's important to remember the core purpose of a senior living center — to facilitate quality care and provide seniors a high quality of life. And in every construction project, you want to get the best possible value. We provide you some tips to do just that.

BUILDING TO ALL CODES FROM THE START

Every state and municipality has different accessibility codes. One key to rapid, cost-efficient construction is looping inspectors into the process early and often. That way, you can ensure that every element of your facility is to code and spec. Make sure your builder has a plan in place to meet all pertinent codes before construction begins.

BUILDING FOR THE CONTINUUM OF CARE

If you're having a construction team build or renovate your facility, you'll want a long-term plan in place from the start of design and construction. In many cases, that means building with future expansion in mind. You'll want special thought put into setting up the wiring, piping and utilities of your facility to extend beyond your initial building. If there's a plan in place to remove or extend certain walls when you expand, your builder should examine ways to use inexpensive materials on those walls, since you'll be removing them anyway. And structural loads should be set up to accommodate more weight as you expand.

In every project, you want to build for the life of your facility. A good builder will provide a complete Life Cycle Cost Analysis (LCCA) that shows the long-term tradeoffs of using different materials and construction solutions. Complete with your LCCA, you should also receive a Sustainability Return on Investment (SROI) report that shows the short-term costs and long-term savings of using different energy-efficient solutions. Your builder should make it easy for you to make informed construction decisions.

GETTING THE BEST VALUE FROM YOUR SENIOR LIVING CONSTRUCTION PROJECT

Taking into account the full lifecycle of your facility, the key to getting the best value is having the right team deliver it. Every job is different, and our belief has always been that the job is the boss. You'll want a partner who can assemble the right expertise and team for your job and find best-value solutions to help you nail your timeline and budget.

One of the most efficient ways to deliver a facility is through Design–Build, a single–source construction delivery method that aligns the design and construction elements under the same contract. When all the components of a project are facilitated through a single entity, it enables the Design–Builder to focus on the design and constructability of a facility, while delivering a project that reflects the vision of the owner. It also enables the Design–Builder to control costs and schedules, which translates to faster builds, better quality and less risk for the owner.

Savings are realized through early and continuous design reviews. Engineers, architects and contractors are integrated and work as a collaborative team with the owner, seeking best-value solutions throughout every phase of the project.

In short, giving customers more than they expect is a powerful tool in building long–term partnerships with our clients. For this reason and because of the many benefits Design-Build provides, we've adopted it, honed it and adapted our processes to it. At The Korte

Company, we're a fully integrated Design-Builder, using Design-Build in more than 90 percent of our projects.

STILLWATER SENIOR LIVING CASE STUDY

To give you an example of a senior living center that's enjoyed successful design and construction, we'll evaluate the building program of Stillwater Senior Living. Kathy Long, owner and founder of Genesis Development Group, planned the project after careful evaluation of the senior living market in Edwardsville, Illinois.

Her goal was to build a facility that met the dual mission of quality care and quality of life.

"It's all about person-centered care, "Kathy said. "The different individual needs and wants of an individual person. To achieve that goal, we need to design our buildings and equipment inside buildings to compliment owner and staff that will be facilitating that role."

Stillwater Senior Living is functionally designed to enable quality care. It's set up for people who have disabilities to navigate the facility and enjoy a comfortable residence. The building helps the care staff take advantage of the latest technology too. The Stillwater facility and staff are equipped with an innovative "Our Care System."

Kathy said:

"It's really important that you put the infrastructure in there. There's going to be a lot of improvement in different types of nurse call systems that need good WiFi in a building. This is kind of a new procedure. Residents have a device, and when they go into a room, they scan the device. It tells staff when residents have entered a room. We know when meds are administered, when people fall and when care providers get there to help. We know when people need a shower. Caregivers have a device with reminders — we can put notes in files that say whether residents weren't feeling good, or when it's someone's birthday. It helps us customize the care."

The design of the facility incorporates a beautiful interior that uses warm colors and wood finishes to create a home-like atmosphere. It's set up as a small, boutique hotel where seniors can enjoy their days. Perhaps one of the most unique features of the facility is the way it takes into account transgenerational design. In addition to featuring private rooms with space for personal visits, Stillwater incorporates a children's play area. Families can come and let kids run around while visiting their senior family members.

THE CONSTRUCTION PROGRAM OF STILLWATER SENIOR LIVING

As a new facility, Stillwater Senior Living did not opt to build their full vision all at once. Instead, they're expanding in phases, filling their initial facility with residents, then growing their building to serve seniors at different stages of their lives. Beginning with assisted living, Stillwater plans to add areas for independent living and memory care. As the builder for this facility, The Korte Company incorporated future expansion into building plans. We accommodated it by extending wiring, piping and utilities where the building expansion would

be located. And we used temporary, lower-cost materials for the parts of the facility that would be replaced. As part of the building program, we worked directly with the architect and expert subcontractors to reduce costs.

Wherever possible, we found cost-saving solutions, and we completed the project under budget, delivering $20,000 back to Stillwater. Despite a wet spring that threw many challenges at the project team, we got the job done in a tight, six-month timeline.

Kathy said, "It went really well. It was an open book. I knew what the cost was going to be as I made every decision. They had a time crunch and couldn't get started until March. But they had the project completed by the end of November, which is really very, very good. They did a tremendous job."

CONCLUSION

The right facility design and construction program will help you take advantage of the latest trends in senior living. So your facility can tangibly help caregivers provide excellent care and help seniors enjoy a high quality of life.

Information retrieved from https://www.korteco.com/sites/default/files/KOR-senior-living-v8.pdf on March 23rd, 2018

EXHIBIT 8

SKILLED NURSING news

Costly Design Features Can Pay Off for Skilled Nursing

By Alex Spanko | July 4, 2017

Last month, the Centers for Disease Control and Prevention issued a warning to skilled nursing operators and other health care providers about the dangers of Legionnaires' disease, an airborne illness that can claim lives — and costs operators hundreds of millions of dollars annually.

Advances in skilled nursing facility design have made disease prevention easier for providers to manage, but SNF operators work in the oldest physical plants in the long-term care space. Many of these facilities were built long before anyone knew about bacteria-fighting copper fixtures, negative airflow systems, or screens that subliminally signal staff to wash their hands. And upgrading an existing facility to mitigate shared disease risks could prove costly.

"Maybe it could cost as much as a new building," Perkins Eastman President and COO David Hoglund told Skilled Nursing News.

Like many architects and contractors asked to put a ballpark estimate on a project with so many variables, Hoglund — who helps lead the architecture firm's senior living practice — laughed while attempting to put a dollar figure on average SNF upgrades, citing the wide variety of differences and challenges that operators face from facility to facility.

"The variables are so big," he said. "Are you doing it empty or occupied? Are you redoing the mechanical systems — or are you just taking a person out of each room? That's why people kind of chuckle when you ask that."

But even in cases where it doesn't cost quite as much as a whole new building — for instance, if a contractor could take advantage of existing water, sewer, and gas infrastructure to save some cash — a complete SNF overhaul to meet newer standards of disease prevention and design could come in at 70% of the cost of a new building, Hoglund said.

Still, he and other architects agree that when it comes to weighing the costs and benefits, it's often wise to make these investments.

Single and Not Ready to Mingle

One of the most basic ways to prevent the spread of disease in SNFs, Hoglund noted, is the introduction of single-person rooms instead of the shared, hospital-style rooms that had prevailed in past years. It's also a pleasant side effect of a general trend toward single-person units amid growing demand for a less institutional, more residential feel.

"Almost everything we're doing in long-term care is private rooms" Hoglund said, "and we haven't designed a traditional side-by-side semi-private room in probably over 25 years."

Not only do private rooms minimize residents' exposure to others in large group settings, but they also allow for single-user bathrooms, greatly reducing the chances of bacteria spreading.

"There's no towel racks, grabbing the wrong counter. There's no touching the same handles that somebody else did. That's their room, and there isn't anybody touching it other than the staff," Hoglund said.

Making private rooms feel like home — and not a hospital suite — while still maintaining proper disease control protocols can be difficult. Melinda Avila-Torio, managing interior designer at THW Design, noted that instead of including medical-grade hand-washing sinks for staff to use in each room, a facility could employ corridor units to make the resident's quarters less like a clinical setting.

"We keep emphasizing the residential appeal," Avila-Torio said. "They don't want it to look like a hospital."

Subliminal Signals

That logic even extends to completely eliminating clinical reminders for staff members through a novel kind of subliminal messaging. Some facilities use screens near sinks that display different calming images — such as trees blowing in the breeze, or a view of a waterfront. Operators can then train their employees to wash their hands every time these images change, eliminating the need for hospital-style placards or verbal cues, said Carlos Moreno, a managing director at the senior housing- and health care-focused THW.

"You don't want to see a sign that says: 'Alright, 20 minutes ago, you washed hands, now it's time to wash hands again,'" Moreno said. "These are subliminal messages that indicate change, forcing you to think through your day, making you think: 'What did I just do, and what did I have to do next?'"

Of course, these fancy upgrades come with a price tag, but THW senior designer Alejandro Giraldo said that some operators phase in disease-fighting design elements gradually to save money and test new ideas.

"You can have three or four units that could have specific infection control components built in, and that's something you can manage in a project instead of the whole project," Giraldo said.

And Avila-Torio noted that some operators could look at it as an insurance policy against the costs associated with a serious disease outbreak.

"Every time you get hit with these costs of care, and remediate or eliminate an occurrence, it probably costs a lot," she said. "It would have cost less money if they had implemented that safeguard from the beginning."

Information obtained from https://skillednursingnews.com/2017/07/costly-design-features-can-pay-off-skilled-nursing/

EXHIBIT 9

Virtual Physician Coverage Provides On-Demand Consultations, Care Continuity

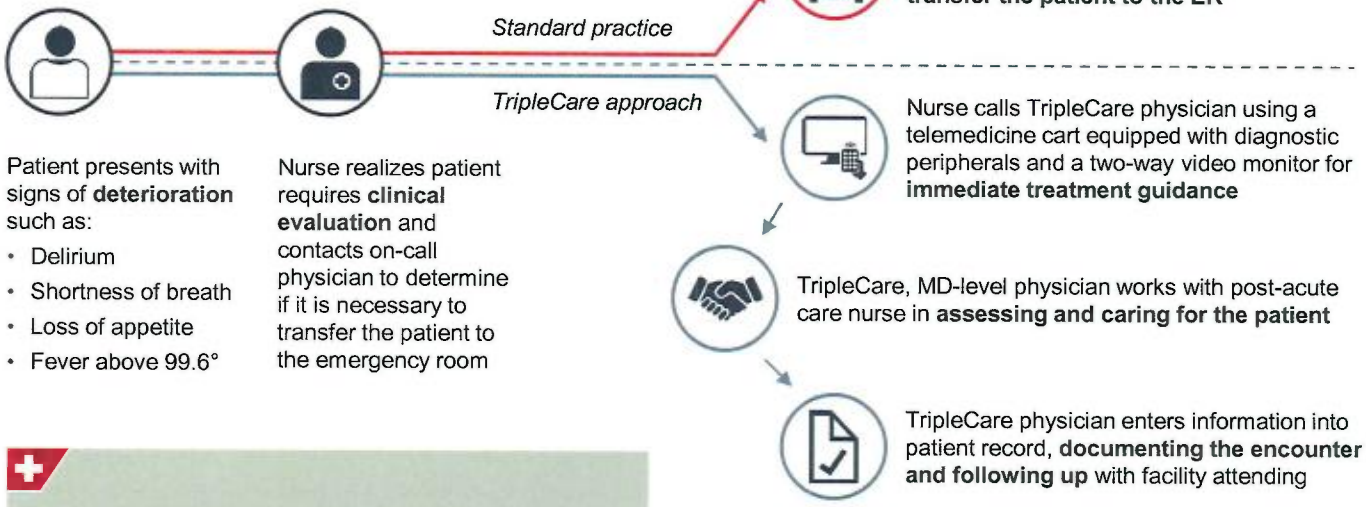
TripleCare, a telemedicine group serving over 60 skilled nursing facilities across eleven states, has developed a virtual consult model for remote physician coverage during evenings and weekends. TripleCare employs a group of 30 geriatricians, internists, and family medicine physicians to connect with and support post-acute staff when a patient's clinical status deteriorates.

On average, each facility interfaces with four or fewer TripleCare physicians over the course of their partnership, allowing for ongoing care continuity between post-acute staff and remote clinicians. TripleCare physicians also receive compensation on an hourly rather than fee-for-service basis, incentivizing care quality over panel size. In fact, TripleCare physicians typically spend between one to four hours with each patient.

TripleCare's service has been shown to improve clinical, operational, and financial performance for their partner sites, particularly through avoided hospital readmissions. In a single study, the platform accrued over $1.5 million in savings for total cost of care.

Post-Acute Staff Access Decision Support When Patient Condition Worsens

Collaborative Workflow Promotes Teamwork, Appropriate Care, and Seamless Transitions



Case in Brief: TripleCare

- Dedicated telemedicine group of 30 physicians headquartered in Long Island City, New York offering after-hours, weekends, and holiday remote consults to more than 60 skilled nursing facilities
- Telehealth platform involves bi-directional audiovisual conferencing unit, 18x zoom-capable camera, and an e-stethoscope on a mobile cart
- Physician-driven model largely involving geriatricians and internists available 113 hours/week to facilities

TripleCare Program Outcomes

83%	Treat-in-place resolution rate[1]
91	Avoided hospital readmissions[1]
>$1.5M	Savings in total cost of care[1]

1) All numbers represent the experience of a 364-bed, non-profit skilled nursing facility who used TripleCare 313 times across one year.

Sources: Service Line Strategy Advisor interviews, research, and analysis.

EXHIBIT 10

Blood Transfusion Service Agreement
Between
Chesapeake Vascular Access LLC (hereafter "CVA"), AND
Brinton Woods Health and Rehabilitation Center at Winfield (hereafter "Customer")
Effective Date:

Customer desires to provide on-site vascular access and blood transfusions to its patients, and CVA desires to provide the services to Customer's patients. In consideration of this desire, CVA and Customer (the "**Parties**") agree to the following terms and conditions:

1.0 RESPONSIBILITIES OF CVA

1.1 CVA will provide no-charge training to Customer's personnel, prior to initiation of the service, to qualify them for participation in the blood transfusion process defined in **Exhibit B**. CVA will maintain a record of qualified personnel at Customer's facility.

1.2 CVA will provide vascular access services and/or an initial transfusion consultation to Customer's patient(s) within 4 hours during normal business hours as defined in **Exhibit A.** CVA will transport blood samples to a qualified blood bank testing facility in a safe and expeditious manner.

1.3 CVA will pick up and deliver blood products, when made available by the blood bank, to Customer's facility location. CVA will provide qualified personnel, supplies and equipment (except as noted in Section 2.0) to conduct a safe and effective transfusion at the patient bedside.

1.4 Performance Indicators. CVA will provide Customer with regular reports demonstrating compliance with the below standards of performance:

- Order-to-transfusion time averaging less than 48 hours.
- Referral-to-transfusion ratio over 90%.
- Transfusion reaction rate of less than 5%.
- Vascular access response time less than 4 hours.
- Vascular access success rate 90% or greater.

2.0 RESPONSIBILITIES OF CUSTOMER

2.1 Customer will maintain a safe environment suitable to the provision of blood transfusions and/or vascular access procedures.

2.2 Customer will contact CVA via phone, fax or electronically to order a procedure.

2.3 The patient's medical records will be made available for review.

2.4 Customer will make available qualified personnel (as noted in section 1.1) to identify the patient along with CVA staff, as well as monitor the patient for delayed transfusion reaction

after the procedure.

2.5 Customer will provide necessary medications to manage a transfusion reaction should one occur, per **Exhibit C.**

2.6 Customer will provide a qualified and inspected infusion pump for the transfusion procedure.

2.7 Customer will promptly notify CVA if a transfusion reaction occurs, and cooperate with investigation of the reaction by CVA and/or blood bank.

3.0 REGULATIONS

3.1 The Parties will comply with applicable laws and industry standards, including without limitation, requirements, regulations, standards, recommendations, specifications, guidelines and directives of the Food and Drug Administration ("**FDA**") and current Standards for Blood Banks and Transfusing Services ("**AABB Standards**"). The responsibilities of the Parties specified in the AABB Standards are set forth in **Exhibit D**.

4.0 FEES AND PAYMENT

4.1 CVA will provide invoices for services; invoices are due within thirty (30) days. A late fee of 1% per month will be charged to past-due invoices. Invoices paid with credit card will incur a 3% processing fee.

4.2 Fees for services are listed in **Exhibit A.** CVA may update **Exhibit A,** on an annual basis, without terminating the remainder of the agreement with sixty (60) days prior written notice.

5.0 EXCLUSION OF LIABILITY

5.1 Customer acknowledges that testing, transportation and administration of blood products is not guaranteed. Errors in blood testing are possible. CVA is not responsible for losses suffered by a Customer's patients, staff or other third party, unless and to the extent attributable to the negligence of CVA or its employees.

5.2 Notwithstanding anything herein to the contrary, neither Party is liable to the other for any breach, loss or damage arising out of delay or failure to perform any obligation in this Agreement if such delay or failure occurs for reasons beyond that Party's control.

5.3 Indemnification. CVA and Customer shall each indemnify and hold harmless the other, their respective officers, directors, employees and agents from and against any and all actions, causes of actions, claims, damages, and demands of whatever type, costs, and expenses (including reasonable attorney's fees), resulting in whole or in part from the negligent acts or omissions of the indemnifying party, its officers, directors, employees and agents, or that which resulting from the fraudulent representation or illegal delivery of services hereunder, or for violation of any federal or state laws and local rules and regulations, governing the terms of this

Agreement and the services to be provided hereunder, or for breach of any of the representations and warranties hereinabove set forth. This indemnification provision shall survive the termination or cancellation of the Agreement.

6.0 TERM AND TERMINATION

6.1 This Agreement will begin on the Effective Date and expires twelve (12) months thereafter (the "**Term**") unless terminated as described herein. The Agreement will automatically renew for additional 12-month Terms unless the Parties terminate it as defined herein.

6.2 Customer may terminate this Agreement immediately upon written notice if CVA does not meet Performance Indicators listed in Section 1.4.

6.3 Either Party may terminate this Agreement by providing the other Party with at least thirty (30) days' prior written notice.

6.4 Unless otherwise provided in this Agreement, the following provisions will survive termination or expiration of this Agreement: Sections 2.7, 4.1, 5.1, 5.2 and 5.3.

7.0 GENERAL PROVISIONS

7.1 Confidentiality: Neither Party will disclose to any third party any provision in this Agreement unless: (a) required by law, in which case, the disclosing Party will provide prompt advance notice of disclosure so the other Party may seek a protective order or other remedy; (b) required by an accreditation or regulatory agency during an inspection, in which case, the disclosing Party will protect the disclosures through the use of a comprehensive nondisclosure agreement, or (c) such disclosure is to the disclosing Party's legal advisor(s), in which case, the disclosing Party will protect the disclosures through the use of a comprehensive nondisclosure agreement.

7.2 Laws of Agreement and Venue: This Agreement, the rights and obligations of the parties hereto and any claims or disputes relating thereto, shall be governed by and construed and enforced in accordance with the laws of the state or commonwealth where Customer is located.

7.3 Notices: The Parties will provide the notices required by this Agreement via a courier service that provides proof of delivery, to the names and addresses in the signature block. A Party may change its notice address by providing the other Party with prior written notice of the change of address.

7.4 Interpretation: If there is a conflict between this Agreement and any unreferenced order, request for proposal, proposal, invoice or verbal agreement, the terms of this Agreement govern. The descriptive headings contained in this Agreement are for convenience of reference only and do not affect the meaning or interpretation of this Agreement. This Agreement is the entire understanding of the Parties, and replaces all prior agreements and undertakings between the Parties for the provision of Blood Transfusions. No single remedy in this

Agreement is exclusive of any other remedy in the Agreement. The rights and remedies in this Agreement are not exclusive and are in addition to any other rights and remedies provided by the Regulations.

7.5 Modification and Assignment: No modifications to this Agreement will be effective unless made in writing and signed by duly authorized representatives of both parties.

This Agreement shall not be assigned in whole or in part by either party hereto without the express written consent of the other party which consent shall not be unreasonably withheld or delayed, except that either party may assign this Agreement to one of its affiliates or subsidiaries without the consent of the other. Any attempted assignment of this Agreement without consent is in violation of the provisions of this section and is void.

7.6 Waiver: No waiver of any default of, or failure to enforce, any provision in this Agreement will: (a) be deemed a waiver of any other default or right to enforce any other provision, or (b) affect the right of a Party to require prompt performance of the defaulted or unenforced provision at any future time, or (c) be deemed a waiver of the same provision on any other occasion.

7.7 Severability: If any provision in this Agreement is unenforceable and removed, the remaining provisions will remain in full force and effect. If applicable, the Parties will negotiate an enforceable provision that is similar to the removed provision.

7.8 Relationship of the Parties: Each of the Parties will participate in this Agreement as an independent contractor. This Agreement does not create any association, agency, partnership, employment relationship or joint venture between the Parties.

7.9 Disputes: The Parties will seek to remedy disputes via an agreed-upon mediator. If unsuccessful, the Parties will resolve the dispute, other than breaches of Section 7.1, by panel arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules through arbitration by a panel of three arbitrators. The place of arbitration is the State or commonwealth where Customer is located or other mutually agreeable location. The decision of the arbitrators will be final and binding and judgment upon the arbitrators' award may be entered by any court of competent jurisdiction.

7.10 Insurance: Each party agrees to carry, maintain and provide evidence of liability and other insurance in amounts to meet state and federal requirements.

Authorized representatives of the Parties have executed this Agreement as of the Effective Date.

	Customer		Chesapeake Vascular Access LLC
Signature:		Signature:	
Name, Title:	André Moshenberg, Administrator	Name, Title:	KRISTOFFER GUNDRUM, PARTNER
Address	1442 Buckhorn Road	Address	2400 Boston St. #102
City, State, ZIP	Sykesville, MD 21784	City, State, ZIP	Baltimore, MD. 21224
Date:	03/20/2017	Date:	3/21/17

END OF AGREEMENT, EXHIBITS TO FOLLOW

Chesapeake
Vascular Access

Exhibit A - Fee Schedule

VASCULAR ACCESS SERVICES:

Clinical support: declotting, dressing changes, indwelling line assessments, etc.	$160.00
Peripheral IV Insertion	$160.00
Midline Insertion or Exchange, all supplies and equipment provided	$350.00
PICC Insertion or Exchange, all supplies, ECG Tip Confirmation Included	$495.00
Acute CVC Placement, including all supplies and ECG tip confirmation	$565.00
Tunneled Catheter removal	$350.00
Response time greater than 4 hours – any case	($160.00)

TRANSFUSION SERVICES:

1 Unit Leuko-reduced RBC — $1,654.00

- Consultation
- Blood sampling, transportation and testing
- Transfusion procedure including monitoring
- All supplies ***reaction medications provided by customer***
- Documentation

Additional unit, same patient	$524.00
Additional Testing (as needed and approved by customer)	Market

EDUCATION:

1-Hour Course	$250.00
4-Hour Course, including Essentials of Vascular Access	$600.00
8-Hour Course	$1,000.00

2400 Boston St., Baltimore, MD. 21224 866-578-7802 tf/f
chesapeakevas.com info@chesapeakevas.com

Chesapeake
Vascular Access

Exhibit B

Transfusion Process

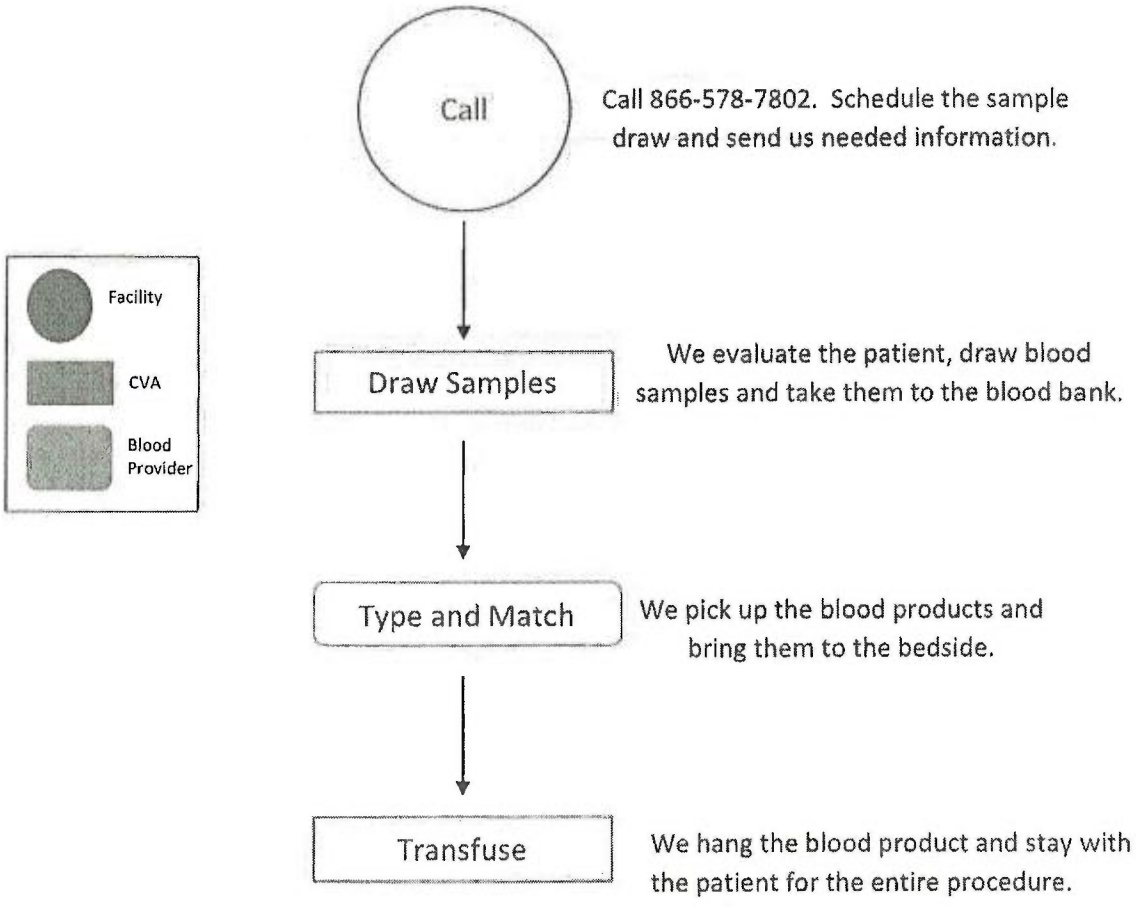


Exhibit C

Medications to be Made Available by Customer As Needed to Manage Transfusion Reactions

To Manage Mild Transfusion Reaction:

Diphenhydramine 25mg PO/GT x 1 - for fever

Acetaminophen 650mg PO/GT x 1 - for urticarial

Lasix 20mg IV x 1 – for fluid overload

Oxygen at 2L NC – for shortness of breath

To Manage Severe Transfusion Reaction:

Solumedrol 125mg IV x 1 – for severe allergic reaction

Diphenhydramine 50mg IV x1 – for severe allergic reaction

Acetaminophen 650 mg PO/GT x1 – for fever >103°F

Epinephrine 1:1000 (0.5mg / 0.5 mL) 0.5ml IM – for anaphylaxis

EXHIBIT D
DELEGATION OF RESPONSIBILITIES

In accordance with **30th** edition of the AABB Standards for Blood Banks and Transfusion Services, the following represents the delegation of responsibilities among the Blood Supplier, Chesapeake, and the host facility. **Bold headings indicate responsibility for all nested subheadings.**

AABB Standards	Responsibilities		
	Blood Supplier	**Chesapeake**	**Host Facility**
1. Organization	x	x	
2. Resources	x	x	
3. Equipment	x		
3.1 Selection of Equipment		x	x*
3.2 Qualification of Equipment			
3.3 Use of Equipment			
3.4 Unique Identification of Equipment			
3.5 Equipment Monitoring and Maintenance			
3.8 Warming Devices for Blood and Blood Components			
3.9 Information Systems			
4. Supplier and Customer Issues	x	x	
5. Process Control			
5.0 Process Control	x	x	
5.1 General Elements 5.1.1; 5.1.2; 5.1.3; 5.1.3.1; 5.1.4; 5.1.4.1; 5.1.5; 5.1.5.1;; 5.1.5.2; 5.1.5.2.1; 5.1.5.2.2; 5.1.5.35.1.6; 5.1.6.1; 5.1.6.2; 5.1.6.3; 5.1.6.3.1; 5.1.6.4; 5.1.6.5; 5.1.6.5.1; 5.1.6.5.2; 5.1.6.5.3; 5.1.7; 5.1.8; 5.1.8.1; 5.1.8.1.1; 5.1.8.1.2; 5.1.8.1.3; 5.1.8.1.3.1; 5.1.8.1.4; 5.1.8.2.1	x		
5.2 Information, Consents and Notifications 5.2.1; 5.2.2; 5.2.3; 5.2.4	x		
5.3 Care of Donors 5.3.1; 5.3.2; 5.3.2.1; 5.3.3; 5.3.3.1; 5.3.3.2; 5.3.4; 5.3.4.1	x		
5.4 Donor Qualification 5.4.1; 5.4.1.1; 5.4.1.2; 5.4.1.3; 5.4.1.3.1; 5.4.2; 5.4.2.1; 5.4.3; 5.4.3.1;			

AABB Standards	Responsibilities		
5.4.3.2; 5.4.4; 5.4.4.1; 5.4.4.2; 5.4.4.3; 5.4.4.5	x		
5.5 Additional Apheresis Donor Qualification Requirements 5.5.3.2; 5.5.3.3; 5.5.3.4; 5.5.3.4.1; 5.5.3.4.2; 5.5.3.4.3; 5.5.3.5; 5.5.3.5.1; 5.5.3.5.2; 5.5.4	N/A	N/A	
5.6 Blood Collection 5.6.1; 5.6.2; 5.6.2.1; 5.6.3; 5.6.3.1; 5.6.3.1.1; 5.6.3.2; 5.6.3.3; 5.6.4; 5.6.5; 5.6.5.1; 5.6.6; 5.6.6.1; 5.6.6.2; 5.6.6.2.1; 5.6.7; 5.6.7.1	x		
5.7 Preparation/Processing of Components 5.7.3.3; 5.7.4; 5.7.4.1; 5.7.4.1.1; 5.7.4.2; 5.7.4.2.1; 5.7.4.3; 5.7.4.4; 5.7.4.5; 5.7.4.6; 5.7.4.7; 5.7.4.8; 5.7.4.8.1; 5.7.4.9; 5.7.4.9.1; 5.7.4.10; 5.7.4.10.1;	x		
5.8 Testing of Donor Blood 5.8.1; 5.8.2; 5.8.3; 5.8.3.1; 5.8.3.2; 5.8.3.3; 5.8.4; 5.8.5; 5.8.5.1; 5.8.5.2; 5.8.6; 5.8.6.1; 5.8.7	x		
5.9 Final Labeling 5.9.1; 5.9.2; 5.9.3; 5.9.4; 5.9.5; 5.9.5.1; 5.9.5.2	x		
5.10 Final Inspection	x		
5.11 Samples and Requests 5.11.1; 5.11.1.1; 5.11.2; 5.11.2.1; 5.11.2.2		x	
5.11.2.3; 5.11.2.4 Specimen Acceptance	x		
5.11.3 Identifying Information	x		
5.11.4 Retention of Blood Samples	x		
5.12 Serologic Confirmation of Donor Blood ABO/Rh	x		
5.13 Serologic Confirmation of Donor Blood Red Cell Antigens Other Than ABO/Rh	x		
5.14 Pretransfusion Testing of Patient Blood 5.14.1; 5.14.2; 5.14.3; 5.14.3.1; 5.14.3.2; 5.14.3.3; 5.14.3.4; 5.14.4; 5.14.5	x		
5.15 Selection of Compatible Blood and Blood Components for			

AABB Standards	Responsibilities		
Transfusion 5.15.1; 5.15.2; 5.15.2.1; 5.15.3; 5.15.4; 5.15.5	x		
5.16 Crossmatch 5.16.1; 5.16.1.1; 5.16.2; 5.16.2.1; 5.16.2.2; 5.16.2.3; 5.16.2.4; 5.16.2.5	x		
5.17 Special Considerations for Neonates	N/A	N/A	
5.18 Special Considerations for Intrauterine Transfusion	N/A	N/A	
5.19 Selection of Compatible Blood and Components in Special Circumstances 5.19.1; 5.19.2; 5.19.3; 5.19.3.1; 5.19.3.1.1; 5.19.3.1.2; 5.19.3.1.3; 5.19.4; 5.19.5; 5.19.6; 5.19.7	x	x	
5.20 Preparation of Tissue	N/A	N/A	N/A
5.21 Preparation of Derivatives	N/A	N/A	N/A
5.22 Final Inspection Before Issue	x	x	
5.23 Issue of Blood and Blood Components	x	x	
5.24 Issue of Tissue and Derivatives	N/A	N/A	N/A
5.25 Discrepancy Resolution	x	x	
5.26 Reissue of Blood, Blood Components, Tissue, and Derivatives	N/A	N/A	N/A
5.27 Urgent Requirement for Blood and Blood Components 5.27.1; 5.27.2; 5.27.3; 5.27.4; 5.27.5; 5.27.5.1	N/A	N/A	N/A
5.28 Administration of Blood and Blood Components 5.28.1; 5.28.1.1; 5.28.2; 5.28.3; 5.28.4; 5.28.5; 5.28.6; 5.28.7; 5.28.8; 5.28.9; 5.28.10		x	
5.29 Medical Record Documentation 5.29.1; 5.29.2; 5.29.3		x	
5.30 Rh Immune Globulin			

AABB Standards	Responsibilities		
5.30.1; 5.30.2; 5.30.3; 5.30.4; 5.30.5	N/A	N/A	
6. Documents and Records	x	x	
7.0 Deviations, Nonconformances and Adverse Events	x	x	
7.1.3 Nonconformances	x	x	
7.1.4; 7.1.4.1 Released Nonconforming Blood, Blood Components, Tissue, or Derivatives	x	x	
7.2 Fatality Reporting	x	x	
7.5 Adverse Events Related to Transfusion	x	x	
7.5.1; 7.5.1.1; 7.5.1.2	x	x	
7.5.2 Laboratory Evaluation and Reporting of Immediate Transfusion Reactions	x	x	
7.5.2.1.5; 7.5.2.2; 7.5.2.3; 7.5.2.4	x	x	
7.5.4 Delayed Transfusion Reactions (Ag-Ab Rxns)	x	x	x*
7.5.4 Transmissible Diseases	x	x	
7.5.4.1; 7.5.4.1.1.; 7.5.4.1.27.5.5	x	x	
Look-Back	x	x	
7.5.5.2; 7.5.5.2.1; 7.5.5.2.2	x	x	
8. Assessments: Internal and External	x	x	
9. Process Improvement through Corrective and Preventive Action	x	x	
10. Facilities and Safety	x	x	x*

Section 3.1 - Customer will provide an infusion pump suitable for the infusion of blood products

Section 7.5.4 - Host Facility will report delayed transfusion reactions promptly to CVA.

Section 10 - Host Facility will maintain quarters and environment suitable to maintain safe operations.

ADDENDUM

Addendum to contract dated: October 28, 2009

This "ADDENDUM" is intended to be incorporated into and be a part of that specific agreement (the "Agreement") by and between Symphony Diagnostic Services No. 1, Inc. a California Corporation doing business as MobilexUSA and American Diagnostics Services, Inc, hereinafter referred to as "Provider" and Brinton Woods Nursing and Rehab., hereinafter referred to as "Facility".

Each of the parties hereto agree to the following terms and provisions:

For Ultrasound Services provided to residents of Facility, MobilexUSA or American Diagnostics Services, Inc will invoice Facility for services provided to residents designated as Medicare Part A or whose stay is covered by an "all-inclusive arrangement" between Facility and Medicare, private insurance carriers, or managed care organizations. Facility will pay MobilexUSA according to the current state specific Medicare fee schedule.

FACILITY

By: _____

Title: Administrator

SYMPHONY DIAGNOSTIC SERVICES NO. 1, INC. D/B/A MOBILEXUSA

By: _____

Title: RVP

NURSING FACILITY SERVICES AGREEMENT

THIS NURSING FACILITY SERVICES AGREEMENT ("Agreement") is effective on the 20th day of August, 2014 (the "Effective Date") by and between SEASONS HOSPICE & PALLIATIVE CARE OF Maryland, Inc. ("Hospice") and Brinton Woods Nursing & Rehabilitation Center at Winfield ("Facility") for patient Rebecca Chun only.

RECITALS

A. WHEREAS, Hospice operates a licensed hospice program.

B. WHEREAS, Facility is a duly licensed nursing facility that is certified to participate in the Medicare and/or Medicaid programs.

C. WHEREAS, the parties contemplate that from time to time individuals residing in Facility will need hospice care and individuals previously accepted into Hospice will need care in a nursing facility.

AGREEMENTS

In consideration of the Recitals and mutual agreements that follow, the parties agree to the following terms and conditions:

1. Definitions.

(a) "Facility Services" means those personal care and room and board services provided by Facility as specified in the Plan of Care for a Hospice Patient, including but not limited to: (i) providing food, including individualized requests and dietary supplements; (ii) assisting with activities of daily living such as mobility and ambulation, dressing, grooming, bathing, transferring, eating and toileting; (iii) arranging and assisting in socializing activities; (iv) assisting in the administration of medicine; (v) providing and maintaining the cleanliness of Hospice Patient's room; (vi) supervising and assisting in the use of any durable medical equipment and therapies included in the Plan of Care; (vii) providing laundry and personal care supplies; (viii) providing health monitoring of general conditions; (ix) contacting family/legal representative for purposes unrelated to the terminal condition; (x) arranging for the provision of medications not related to the management of the terminal illness; and (xi) providing the usual and customary room furnishings provided to Facility residents, including but not limited to, beds, linens, lamps and dressers. In the case of Medicaid Eligible Hospice Patients,

Facility Services shall include all services outlined in the Medicaid covered services rule, as may be amended from time to time.

(b) "Hospice Patient" means an individual who has elected, directly or through such individual's legal representative, to receive Hospice Services and is accepted by Hospice to receive Hospice Services.

(c) "Hospice Physician" means a duly licensed doctor of medicine or osteopathy employed or contracted by Hospice who, along with the Hospice Patient's attending physician (if any), is responsible for the palliation and management of a Hospice Patient's terminal illness and related conditions.

(d) "Hospice Services" means those services provided to a Hospice Patient that are reasonable and necessary for the palliation and management of such Hospice Patient's terminal illness and are specified in a Hospice Patient's Plan of Care. Hospice Services include: (i) nursing care and services by or under the supervision of a registered nurse; (ii) medical social services provided by a qualified social worker under the direction of a physician; (iii) physician services to the extent that these services are not provided by the attending physician; (iv) counseling services, including bereavement, dietary and spiritual counseling; (v) physical, respiratory, occupational and speech therapy services; (vi) home health aide/homemaker services; (vii) medical supplies; (viii) drugs and biologicals; (ix) use of medical appliances; and (x) medical direction and management of Hospice Patient.

(e) "Interdisciplinary Group" ("IDG") means a group of qualified individuals, including but not limited to: a doctor of medicine or osteopathy; a registered nurse; a social worker; and a pastoral or other counselor.

(f) "Medicaid Eligible Hospice Patient" means a Hospice Patient who either: is eligible for Medicaid benefits and who has elected to receive the Medicaid hospice benefit; or is eligible for both Medicaid and Medicare Part A benefits and who has elected the Medicare hospice benefit.

(g) "Medicare Eligible Hospice Patient" means a Hospice Patient who is eligible for Medicare Part A benefits, but who is not eligible for Medicaid benefits and who has elected to receive the Medicare Part A hospice benefit.

(h) "Other Facility Services" means all items and services provided by Facility which are not related to treatment of a Hospice Patient's terminal illness but specified in the Plan of Care.

(i) "Plan of Care" means a written care plan established, maintained, reviewed and modified, if necessary, at intervals identified by the IDG. The Plan of

Care must reflect Hospice Patient and family goals and interventions based on the problems identified in the Hospice Patient assessments. The Plan of Care will reflect the participation of the Hospice, Facility and the Hospice Patient and family to the extent possible. Specifically, the Plan of Care includes: (i) an identification of the Hospice Services, including interventions for pain management and symptom relief, needed to meet such Hospice Patient's needs and the related needs of Hospice Patient's family; (ii) a detailed statement of the scope and frequency of such Hospice Services; (iii) measurable outcomes anticipated from implementing and coordinating the Plan of Care; (iv) drugs and treatment necessary to meet the needs of the Hospice Patient; (v) medical supplies and appliances necessary to meet the needs of the Hospice Patient; and (vi) the IDG's documentation of the Hospice Patient's or representative's level of understanding, involvement and agreement with the Plan of Care. Hospice and Facility will jointly develop and agree upon a coordinated, interdisciplinary Plan of Care which is consistent with the hospice philosophy and is responsive to the unique needs of Hospice Patient and his or her expressed desire for hospice care. Hospice and Facility shall periodically conduct joint reviews of each Plan of Care as necessary to coordinate provision of Facility Services. The Plan of Care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care.

(j) "Private Pay Hospice Patient" means a Hospice Patient who is not eligible for the Medicare Part A hospice benefit, or the Medicaid hospice benefit, or if eligible, has revoked or elected not to receive the Medicare Part A hospice benefit and/or the Medicaid hospice benefit. This includes Hospice Patients with third party payors other than Medicare or Medicaid.

(k) "Purchased Hospice Services" means those Hospice Services specified in Exhibit A that are not core services under the Medicare Conditions of Participation for Hospice Care and that Hospice has elected to contract with Facility to provide.

(l) "Residential Hospice Care Day" means a day on which a Hospice Patient receives Facility Services, including the day of admission but excluding any days on which a Hospice Patient receives inpatient care and any other days on which Facility would not have received payment from Medicaid if the Hospice Patient had not been enrolled in hospice (*e.g.*, date of discharge, date of death).

(m) "Uncovered Items and Services" means those services provided by Facility which are not Hospice Services, Facility Services or Other Facility Services, including, but not limited to, telephone, guest trays and television hookup.

2. Responsibilities of Facility.

(a) Provision of Services.

(i) Facility Services. At the request of an authorized Hospice staff member, Facility shall admit Hospice Patients to Facility, subject to Facility's admission policies and procedures and the availability of beds. Facility shall immediately notify Hospice if Facility is unable to admit a Hospice Patient. Facility shall comply with Hospice Patient's Plan of Care and shall ensure Hospice Patients are kept comfortable, clean, well-groomed and protected from negligent and intentional harm including, but not limited to, accident, injury and infection. Facility's primary responsibility is to provide Facility Services based on each Hospice Patient's Plan of Care and ensure that the level of care provided is appropriately based on the individual Hospice Patient's needs. It is Facility's responsibility to provide Facility Services that meet the personal care and nursing needs that would have been provided by a Hospice Patient's primary caregiver at home in coordination with Hospice, and Facility shall perform Facility Services at the same level of care provided to each Hospice Patient before hospice care was elected. While Facility's nursing personnel may, as specified by Facility, assist in administering prescribed therapies to Hospice Patients under the Plan of Care, such assistance may only be provided to the extent the activity is permitted by law and only to the extent that Hospice would routinely utilize the services of a Hospice Patient's family in implementing the Plan of Care. Notwithstanding the foregoing, in times of Hospice Patient crisis Hospice may authorize and direct Facility staff to perform more sophisticated functions in order to ensure Hospice Patient comfort, and Hospice and Facility shall address potential crisis situations for individual Hospice Patients in the Plan of Care.

(ii) Availability. Facility shall be available to provide Facility Services 24 hours per day, 7 days per week and shall maintain sufficient personnel who have the requisite training, skills and experience to meet this obligation.

(iii) Purchased Hospice Services. At the request of an authorized Hospice staff member, Facility shall provide Hospice Patients with the Purchased Hospice Services identified in Exhibit A.

(iv) Notification of Services. Facility shall fully inform Hospice Patients of Facility Services, Other Facility Services and Uncovered Items and Services to be provided by Facility.

(b) Professional Standards and Credentials.

(i) Professional Standards. Facility shall ensure that all Facility Services are provided competently and efficiently. Facility Services shall meet or exceed

the standards of care for providers of such services and shall be in compliance with all applicable laws, rules, regulations, professional standards and licensure requirements.

(ii) Credentials.

[a] Licensure. Facility represents and warrants that it has and will maintain in good standing during the term of this Agreement all federal, state and local licenses and certificates required by law to provide Facility Services. Upon Hospice's request, Facility shall provide Hospice with evidence of such licenses and certifications.

[b] Qualifications of Personnel. Personnel who provide Facility Services shall be reasonably acceptable to Hospice. Facility represents and warrants that personnel providing Facility Services: [i] are duly licensed, credentialed, certified, and/or registered as required under applicable state laws; and [ii] possess the education, skills, training and other qualifications necessary to provide Facility Services. Based on criminal background checks conducted by Facility, Facility personnel who have direct contact with Hospice Patients or have access to Hospice Patient records have not been found to have engaged in improper or illegal conduct relating to the elderly, children or vulnerable individuals. Upon Hospice's request, Facility shall provide Hospice with proof of an individual's qualifications to provide Facility Services.

[c] Disciplinary Action. Facility represents and warrants that neither it nor any of its personnel is under suspension or subject to any disciplinary proceedings by any agency having jurisdiction over professional activities of Facility or its personnel and is not under any formal or informal investigation or preliminary inquiry by such department or agency for possible disciplinary action.

[d] Exclusion from Medicare or Medicaid. Facility represents and warrants that neither Facility nor its personnel has been, at any time, excluded from participation in any federally funded health care program including, without limitation, Medicare or Medicaid, nor has been convicted or found to have violated any federal or state fraud and abuse law or illegal remuneration law. Facility shall screen its personnel and contractors against the Office of Inspector General's List of Excluded Individuals and Entities ("LEIE") and the Government Services Administration's Excluded Parties List System upon hire or contracting, and on a monthly basis thereafter.

(c) Quality Assessment and Performance Improvement Activities. Facility shall cooperate with Hospice in its hospice-wide quality assessment and performance improvement activities. Components of the quality assessment and performance improvement program include (i) data collection; (ii) reporting adverse patient events, analyzing their causes, and implementing preventative actions and mechanisms; and (iii) taking actions to improve performance. Hospice shall provide

Facility with a description of its quality assessment and performance improvement program and information on performance improvement projects. Third party payors may also impose their own utilization management or quality assurance requirements which Facility must meet. Cooperating in such activities shall not constitute a waiver of any legal privileges or rights that may apply to the information that is shared. Hospice shall maintain the confidentiality of such information in whatever form it is provided.

(d) Coordination of Care.

(i) General. Facility shall participate in any meetings, when requested, for the coordination, supervision and evaluation by Hospice of the provision of Facility Services. Hospice and Facility shall communicate with one another regularly and as needed for each particular Hospice Patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day.

(ii) Design of Plan of Care. In accordance with applicable federal and state laws and regulations, Facility shall coordinate with Hospice in developing a Plan of Care for each Hospice Patient. Hospice retains primary responsibility for determining each Hospice Patient's appropriate Plan of Care. Facility shall ensure that each Hospice Patient's care plan includes both the most recent Hospice Plan of Care and a description of the Facility Services furnished by Facility to attain or maintain the Hospice Patient's highest practicable physical, mental and psychosocial well-being as required by federal regulations.

(iii) Modifications to Plan of Care. Facility will assist with periodic review and modification of the Plan of Care. Facility will not make any modifications to the Plan of Care without first consulting with Hospice. Hospice retains the sole authority for determining the appropriate course of hospice care provided to each Hospice Patient, including the determination to change the level of services provided.

(iv) Notification of Change in Condition. Facility shall immediately inform Hospice of any change in the condition of a Hospice Patient. This includes, without limitation, a significant change in a Hospice Patient's physical, mental, social or emotional status, clinical complications that suggest a need to alter the Plan of Care, a need to transfer the Hospice Patient to another facility, or the death of a Hospice Patient.

(v) Designated Facility Member. Facility shall designate a member of Facility's interdisciplinary team who is responsible for working with Hospice representatives to coordinate care to the Hospice Patient provided by Facility and Hospice. The designated interdisciplinary team member shall have a clinical background, function within their State scope of practice act, and have the ability to

assess the Hospice Patient or have access to someone that has the skills and capabilities to assess the Hospice Patient. The designated team member shall be responsible for:

[a] Collaboration with Hospice. Collaborating with Hospice representatives and coordinating Facility's participation in Hospice's care planning process for those Hospice Patients receiving Facility Services;

[b] Communication with Providers. Communicating with Hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the Hospice Patient and family;

[c] Communication with Hospice. Ensuring that Facility communicates with Hospice Physician, the Hospice Patient's attending physician (if any), and other practitioners participating in the provision of care to the Hospice Patient as needed to coordinate the hospice care with the medical care provided by other physicians;

[d] Orientation. Ensuring that Facility provides orientation in the policies and procedures of Facility, including patient rights, appropriate forms, and record keeping requirements, to Hospice personnel furnishing care to Hospice Patients at Facility; and

[e] Information from Hospice. Obtaining the following information from Hospice:

[i] Plan of Care, Medications and Orders. The most recent Hospice Plan of Care, medication information and physician orders specific to each Hospice Patient;

[ii] Election Form. Each Hospice Patient's Hospice election form;

[iii] Certifications. Physician certification and recertification of the terminal illness specific to each Hospice Patient;

[iv] Contact Information. Names and contact information for Hospice personnel involved in hospice care of each Hospice Patient; and

[v] On-Call System. Instructions on how to access Hospice's 24-hour on-call system.

(e) Policies and Procedures. In providing services to Hospice Patients, Facility shall abide by Hospice's policies and procedures, palliative care protocols and Plans of Care.

(f) Assist with Surveys and Complaints. Facility shall be available during federal, state, local and other surveys to assist Hospice in responding to surveyor questions and survey citations, attending exit conferences, drafting plans of correction for identified survey deficiencies and providing clinical expertise when necessary to appeal survey deficiencies. In the event of any complaint filed by or with respect to a Hospice Patient or any investigation initiated by any governmental agency or any litigation commenced against Hospice, Facility shall fully cooperate with Hospice in an effort to respond to and resolve the same in a timely and effective manner. Facility shall also cooperate fully with any insurance company providing protection to Hospice in connection with investigations. Facility shall notify Hospice promptly of any inquiries, claims, and investigations and cooperate fully with the directions of Hospice with respect thereto.

(g) Visiting and Access by Hospice.

(i) Visiting Privileges. Facility shall permit free access and unrestricted visiting privileges, including visits by children of any age, 24 hours per day, 7 days per week.

(ii) Visitor Accommodations. Facility shall provide adequate space, located conveniently to Hospice Patient, for private visiting among Hospice Patient, Hospice Patient's family members and any other visitors. Facility shall provide adequate accommodations for Hospice Patient's family members to remain with Hospice Patient up to 24 hours per day, and permit family members privacy following the death of a Hospice Patient.

(iii) Hospice Access to Facility. Facility shall permit employees, contractors, agents and volunteers of Hospice free and complete access to Facility 24 hours per day, as necessary, to permit Hospice to counsel, treat, attend and provide services to each Hospice Patient.

(iv) Hospice Physician. Facility shall grant full staff privileges to Hospice Physicians upon application and qualification for such privileges in accordance with Facility's requirements.

(h) Patient Transfer. Facility shall not transfer any Hospice Patient to another care setting without the prior approval of Hospice. If Facility fails to obtain the necessary prior approval, Hospice bears no financial responsibility for the costs of transfer or the costs of care provided in another setting.

(i) Physician Orders. If there are physician orders that are inconsistent with the Plan of Care or Hospice protocols, a registered nurse with Facility shall notify Hospice. An authorized representative of Hospice shall resolve differences directly with the physician and secure the necessary orders.

(j) Bereavement Services to Facility Staff. Facility shall be primarily responsible for providing any requested bereavement services to Facility staff after the death of a Hospice Patient who resided in Facility; provided, however, that Hospice may assist Facility in providing such bereavement services to grieving Facility staff members upon request from Facility.

3. Responsibilities of Hospice.

(a) Admission to and Discharge from Hospice Program.

(i) Assessment. If a resident of Facility requests the provision of Hospice Services, Hospice shall perform an assessment of such resident and shall notify Facility, either orally or in writing, whether such resident is authorized for admission as a Hospice Patient. Hospice shall maintain adequate records of all such authorizations of admission.

(ii) Assessing Continued Eligibility. Hospice shall have sole authority for assessing a Hospice Patient's continued eligibility for Hospice Services and for discharging a Hospice Patient from Hospice.

(b) Professional Management Responsibility.

(i) Compliance with Law. Hospice shall assume professional management responsibility for Hospice Services provided to Hospice Patients residing at Facility and their family units, pursuant to the Medicare Conditions of Participation for Hospice Care and state and local laws and regulations. This includes admission and/or discharge of patients, patient and family assessments, reassessments, establishment of the Plan of Care, authorization of all services and management of the care through IDG meetings. Hospice shall make arrangement for, and remain responsible for, any necessary continuous care or inpatient care related to a Hospice Patient's terminal illness and related conditions. Hospice acknowledges that it is responsible for providing Hospice Services to Hospice Patients residing at Facility at the same level and to the same extent as if Hospice Patients were receiving care in their own homes.

(ii) Management of Hospice Services. Hospice shall retain professional management responsibility to ensure that Hospice Services are furnished in a safe and effective manner by qualified personnel in accordance with Hospice Patient's

Plan of Care. Hospice Services shall be provided in a timely manner and shall meet the professional standards and principles that apply to individuals providing services in Facility.

(iii) Coordination and Evaluation. Hospice shall retain responsibility for coordinating, evaluating and administering the hospice program, as well as ensuring the continuity of care of Hospice Patients, which shall include coordination of Facility Services. Hospice's IDG shall communicate with Facility's medical director, Hospice Patient's attending physician and other physicians participating in the care of a Hospice Patient as needed to coordinate Hospice Services with the medical care provided by other physicians. Methods used to evaluate the care may include: [a] periodic supervisory visits; [b] review of the qualifications of personnel providing Facility Services; [c] review of documentation; [d] evaluation of the response of a Hospice Patient to the Plan of Care; [e] discussion with patient and patient's caregivers; [f] patient evaluation surveys; and [g] quality improvement data.

(iv) Assessment of Facility Services. Hospice shall develop, maintain and conduct an ongoing, comprehensive assessment of the quality and appropriateness of Facility and the provision of Facility Services. Such assessments shall be conducted at least annually.

(v) Evaluation. Hospice will review and/or revise all contracts annually and will evaluate the contracted care, treatment, and services to determine whether they are being provided according to the contract and the level of safety and quality as needed by the Hospice Patient and family.

(c) Hospice Care Training. Hospice shall provide orientation and ongoing hospice care training to Facility's personnel as necessary to facilitate the provision of safe and effective care to Hospice Patients. Such orientation must include Hospice policies and procedures regarding methods of comfort, pain control and symptom management as well as principles about death and dying, individual responses to death, patient rights, appropriate forms and recordkeeping requirements.

(d) Designation of Hospice Representative. For each Hospice Patient, Hospice shall designate a registered nurse who will be responsible for coordinating and supervising services provided to a Hospice Patient and be available 24 hours per day, 7 days per week for consultation with Facility concerning a Hospice Patient's Plan of Care. In addition, for each Hospice Patient residing at Facility, Hospice shall designate a member of the Hospice Patient's IDG to provide overall coordination of care for such Hospice Patient. Such hospice representative shall monitor Facility and be available to provide information to Facility regarding the provision of Facility Services and to coordinate the periodic evaluation of patient progress and outcomes of care upon request. Further, the hospice representative shall be responsible for communicating with Facility representatives and other health care providers who participate in the care of a Hospice

Patient's terminal illness and related conditions to ensure quality of care for Hospice Patients and their families.

(e) Provision of Information. Hospice shall promote open and frequent communication with Facility and shall provide Facility with sufficient information to ensure that the provision of Facility Services under this Agreement is in accordance with the Hospice Patient's Plan of Care, assessments, treatment planning and care coordination. At a minimum, Hospice shall provide the following information to Facility for each Hospice Patient residing at Facility:

(i) Plan of Care, Medications and Orders. The most recent Plan of Care, medication information and physician orders specific to each Hospice Patient residing at Facility;

(ii) Election Form. The hospice election form and any advanced directives;

(iii) Certifications. Physician certifications and recertifications of terminal illness;

(iv) Contact Information. Names and contact information for Hospice personnel involved in providing Hospice Services; and

(v) On-Call System. Instructions on how to access Hospice's 24-hour on-call system.

(f) Policies and Procedures. Hospice shall provide Facility with copies of Hospice's policies and procedures applicable to the provision of Facility Services and shall meet with Facility to review such policies and procedures, as necessary.

(g) Physician Orders. All physician orders communicated by Hospice under this Agreement shall be in writing and signed by the applicable attending physician or Hospice Physician; provided, however, that in the case of urgent or emergency circumstances, such orders may be communicated orally by any such persons. Hospice shall maintain adequate records of all physician orders communicated in connection with the Plan of Care.

(h) Purchased Hospice Services. Hospice may purchase from Facility Purchased Hospice Services. The terms of such sale are delineated in Exhibit A.

(i) Notification of Hospice Services. Hospice shall fully inform Hospice Patient of the Hospice Services to be provided by Hospice and Purchased Hospice Services, if any, to be provided by Facility.

(j) Assist with Surveys and Complaints. Hospice shall be available during federal, state, local and other surveys to assist Facility in responding to surveyor questions and survey citations, attending exit conferences, drafting plans of correction for identified survey deficiencies and providing medical expertise when necessary to appeal survey deficiencies. In the event of any complaint filed by or with respect to a Hospice Patient or any investigation initiated by any governmental agency or any litigation commenced against Facility, Hospice shall fully cooperate with Facility in an effort to respond to and resolve the same in a timely and effective manner. Hospice shall also cooperate fully with any insurance company providing protection to Facility in connection with investigations. Hospice shall notify Facility promptly of any inquiries, claims, and investigations and cooperate fully with the directions of Hospice with respect thereto.

(k) Summary of Hospice's Responsibilities. Exhibit B includes a chart that summarizes some of Hospice's major responsibilities to Hospice Patients under this Agreement. This chart is intended to provide examples of Hospice's responsibilities hereunder and is not exhaustive.

4. Billing and Payment.

(a) Billing and Payment for Facility Services Provided to Medicaid Eligible Hospice Patients.

(i) Rates. Hospice shall pay Facility a fixed payment rate for each Residential Hospice Care Day provided to a Medicaid Eligible Hospice Patient excluding any days on which a Hospice Patient receives inpatient care and any other days on which Facility would not have received payment from Medicaid if the Hospice Patient had not been enrolled in hospice (*e.g.*, date of discharge, date of death). The fixed payment rate shall be one hundred percent (100%) of Facility's applicable then current Medicaid per diem rate that would have been paid by the Medicaid program to Facility if the Medicaid Eligible Hospice Patient had not elected to receive hospice care, less the Medicaid Eligible Hospice Patient's required personal contribution amount, if any. Facility shall accept this rate as payment in full for Facility Services provided to such Medicaid Eligible Hospice Patient and shall not bill the Medicaid Eligible Hospice Patient or his/her family, representatives or any third party payor. Facility shall collect and retain the Medicaid Eligible Hospice Patient's required personal contribution amount, if any.

(ii) Billing and Payment. Within ten (10) calendar days of the end of the month and within at least 30 days of providing Facility Services, Facility shall submit to Hospice an accurate and complete statement of all Facility Services provided to Medicaid Eligible Hospice Patients. The statement shall be in a form acceptable to

Hospice and include information usually provided to third party payors to verify the services and charges reflected in the statement. Hospice shall pay Facility within 30 days after Hospice's receipt of payment from Medicaid for the applicable Residential Hospice Care Days identified on Facility's complete statement. Payment by Hospice in respect to such bills shall be considered final, unless adjustments are requested in writing by Facility within 30 days of receipt of payment. Hospice shall have no obligation to pay Facility for any service if Hospice does not receive a bill for such service within 60 days following the date on which the service was rendered.

(b) Billing and Payment for Facility Services Provided to Medicare Eligible Hospice Patients and Private Pay Hospice Patients. Facility shall bill each Medicare Eligible Hospice Patient and Private Pay Hospice Patient (or such patient's third party payor, if applicable) for Facility Services at a rate agreed upon by Facility and such patient or his or her third party payor. Facility shall accept such payment as payment in full for Facility Services. Hospice will not be responsible for reimbursing Facility for any portion of the cost of Facility Services provided to a Medicare Eligible Hospice Patient or Private Pay Hospice Patient. Facility shall not seek payment from Hospice in the event of default of financial obligations on the part of a Medicare Eligible Hospice Patient, Private Pay Hospice Patient or such patient's third party payors. Hospice will, to the extent permitted by law, provide Facility with any information it may reasonably require to obtain payment from any payor or other permissible payment source.

(i) MCO and other eligible 3rd party payors billing is determined by the contract/regulations for that MCO or 3rd party.

(c) Billing and Payment for Purchased Hospice Services Provided to All Hospice Patients. Facility shall bill Hospice for Purchased Hospice Services provided to Hospice Patients at the rates agreed to by Facility and Hospice in Exhibit A. Facility shall accept these rates as payment in full for Purchased Hospice Services provided to Hospice Patients and shall not bill such patients, their family, representatives or any third party payor. Facility represents and warrants that all Purchased Hospice Services for Medicaid Eligible Hospice Patients are not included in the applicable, then-current Medicaid per diem rate that Facility would have received if the Medicaid Eligible Hospice Patient had not elected to receive Hospice Services. The billing and payment procedures set forth in section 4(a)(ii) of this Agreement shall apply.

(d) Billing and Payment for Other Services. Facility shall bill Hospice Patients or the third party payor, if applicable, for (i) Other Facility Services; (ii) Uncovered Items and Services; and (iii) care provided by Facility upon the request of a Hospice Patient which is not reasonable or necessary for palliation or management of the terminal illness and not rendered in accordance with the applicable Plan of Care. Hospice shall bear no responsibility, obligation, or other liability to reimburse Facility for the cost of these services. Facility shall not bill Medicare or Medicaid for care or

services provided by Facility upon the request of a Hospice Patient which Hospice determines are related to the terminal illness or related conditions but not reasonable or medically necessary.

(e) Limitation on Hospice's Financial Responsibility. Except as specifically identified in this Agreement, Hospice shall bear no responsibility, obligation, or other liability to reimburse Facility for any charges, costs, expenses or other fees for services provided under this Agreement.

5. Insurance and Hold Harmless.

(a) Insurance. Each party shall obtain and maintain appropriate professional liability, commercial general liability, worker's compensation and employer's liability insurance coverage in accordance with the minimum amounts required from time to time by applicable federal and state laws and regulations, but at no time shall the terms or coverage amounts of Facility's professional liability insurance be less than $1 million per claim and $3 million in the aggregate. Either party may request evidence of insurance from the other party and such other party shall provide such evidence to the requesting party in a timely manner. Each party shall ensure that the other party receives at least 30 days' notice prior to the termination of any insurance policy required by this Agreement.

(b) Mutual Hold Harmless. Each party shall be responsible for the acts and omissions of itself and its employees and subcontractors and neither party agrees to indemnify any other party for any such act or omission, provided, however, that this Agreement shall not constitute a waiver by any party of any rights to indemnification, contribution or subrogation which such party may have by operation of law.

6. Records.

(a) Creation and Maintenance of Records. Each party shall prepare and maintain complete and detailed records concerning each Hospice Patient receiving Facility Services under this Agreement in accordance with prudent record-keeping procedures and as required by applicable federal and state laws and regulations and Medicare and Medicaid program guidelines. Each party shall retain such records for a minimum of six years from the date of discharge of each Hospice Patient or such other time period as required by applicable federal and state law. Each clinical record shall completely, promptly and accurately document all services provided to, and events concerning, each Hospice Patient, including evaluations, treatments, progress notes, authorizations to admission to Hospice and/or Facility, physician orders entered pursuant to this Agreement and discharge summaries. Each record shall document that the specified services are furnished in accordance with this Agreement and shall be readily accessible and systemically organized to facilitate retrieval by either party. Facility shall

cause each entry made for Facility Services provided to be signed and dated by the person providing Facility Services.

(b) Financial Recordkeeping. Facility shall keep accurate books of accounts and records covering all transactions relating to this Agreement (the "Financial Records") at its principal place of business. Hospice and its duly authorized

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cause each entry made for Facility Services provided to be signed and dated by the person providing Facility Services.

(b) Financial Recordkeeping. Facility shall keep accurate books of accounts and records covering all transactions relating to this Agreement (the "Financial Records") at its principal place of business. Hospice and its duly authorized representatives, including any such independent public accountant or other auditor, shall have the right during regular business hours and on reasonable written notice to Facility to examine Facility's Financial Records and to make copies thereof.

(c) Access by Hospice. Facility shall permit Hospice or its authorized representative, upon reasonable notice, to review and make photocopies of records maintained by Facility relating to the provision of Facility Services, including but not limited to, clinical records and billing and payment records. This section shall survive the termination of this Agreement.

(d) Inspection by Government. In accordance with 42 U.S.C. § 1395x(v)(1)(i) and 42 C.F.R. § 420.300, et seq., Facility shall make available, until the expiration of five years from the termination of this Agreement, upon written request, to the Secretary of Health and Human Services of the United States, and upon request, to the Comptroller General of the United States, or any of their duly authorized representatives, this Agreement and any of its books, documents and records that are necessary to certify the nature and costs of Medicare reimbursable services provided under this Agreement. If and to the extent Facility carries out any of its duties under this Agreement through a subcontract with a related organization having a value or cost of $10,000 or more over a 12-month period, then Facility shall ensure that the subcontract contains a clause comparable to the clause in the preceding sentence. Nothing contained in this section shall be construed as a waiver by either party of any legal rights of confidentiality with respect to patient records and proprietary information.

(e) Destruction of Records. Facility shall take reasonable precautions to safeguard records against loss, destruction and unauthorized disclosure.

7. Confidentiality. Each party acknowledges that as part of its performance under this Agreement, it may be required to disclose to the other party certain information pertaining to Hospice Patients (collectively, "Patient Information") and may be required to disclose certain business or financial information (collectively, with the Patient Information, the "Confidential Information"). Each party agrees that it shall treat Confidential Information with the same degree of care it affords its own similarly confidential information and shall not, except as specifically authorized in writing by the other party or as otherwise required by law, reproduce any Confidential Information or disclose or provide any Confidential Information to any person. A party that discloses Confidential Information shall be entitled to injunctive relief to prevent a breach or

threatened breach of this section, in addition to all other remedies that may be available. This section shall survive termination of this Agreement.

8. Term and Termination.

(a) Term. This Agreement shall have an initial term of one year beginning on the Effective Date ("Initial Term") and shall automatically renew for successive one-year terms, unless sooner terminated as provided below

(b) Termination.

(i) Without Cause. This Agreement may be terminated by either party for any reason after the Initial Term by providing at least 90 days' prior written notice to the other party.

(ii) Mutual Written Agreement. This Agreement may terminate at any time after the Initial Term upon written agreement of the parties.

(iii) For Cause. Either party may terminate this Agreement upon 30 days' prior written notice to the other party, if the other party breaches this Agreement and fails to cure such breach within such 30-day period.

(iv) Change in Law. In the event there are substantial changes or clarifications to any applicable laws, rules or regulations that materially affect, in the opinion of either party's legal counsel, any party's right to reimbursement from third party payors or any other legal right of any party to this Agreement, the affected party may, by written notice to the other party, propose such modifications to this Agreement as may be necessary to comply with such change or clarification. Upon receipt of such notice, the parties shall engage in good faith negotiations regarding any appropriate modifications to this Agreement. If such notice is given and the parties are unable within 60 days thereafter to agree to appropriate modifications to this Agreement, either party may terminate this Agreement by providing at least 30 days' notice to the other party.

(v) Immediate Termination. Notwithstanding the above, either party may immediately terminate this Agreement if:

[a] Failure to Have Qualifications. A party or its personnel are excluded from any federal health program or no longer have the necessary qualifications, certifications and/or licenses required by federal, state and/or local laws to provide Facility Services.

[b] Liquidation. A party commences or has commenced against it proceedings to liquidate, wind up, reorganize or seek protection, relief or a consolidation of its debts under any law relating to insolvency, reorganization or relief of debtors or seeking the appointment of a receiver or trustee.

[c] Failure to Have Insurance. A party ceases to have any of the insurance required under this Agreement.

[d] Threats to Health, Safety or Welfare. A party fails to perform its duties under this Agreement and the other party determines in its full discretion that such failure threatens the health, safety or welfare of any patient.

[e] Commission of Misconduct. A party commits an act of misconduct, fraud, dishonesty, misrepresentation or moral turpitude involving the other party or a mutual patient of the parties.

(c) Effect of Termination on Availability of Facility Services. In the event this Agreement is terminated, Facility shall work with Hospice in coordinating the continuation of Facility Services to existing Hospice Patients and shall continue to provide Facility Services to Hospice Patients after this Agreement is terminated, if Hospice determines that removing Facility Services would be detrimental to Hospice Patients. In such cases, Facility Services shall continue to be provided in accordance with the terms set forth in this Agreement. This section shall survive termination of this Agreement.

9. Notification of Material Events. Either party shall immediately notify the other party of:

(a) Incident Reporting. Any of the following alleged incidents involving a Hospice Patient residing at Facility. Each party's administrator should also be immediately notified of the following alleged incidents:

(i) mistreatment or neglect;
(ii) verbal, mental, sexual or physical abuse;
(iii) injuries of unknown source; or
(iv) misappropriation of patient property

(b) Licensure Actions. Any sanctions, intermediate or otherwise, administrative or judicial fines, penalties, or action by federal or state officials against the party or its personnel.

(c) Exclusion. Any threatened, proposed or actual exclusion of it or any of its subcontractors or personnel from any government program, including but not limited to, Medicare or Medicaid.

(d) Insurance. The cancellation or modification of any of the insurance coverage that the party is required to have under this Agreement.

(e) Liquidation. The commencement of any proceeding to liquidate, wind up, reorganize or seek protection, relief or a consolidation of Facility's or Hospice's

debts under any law relating to insolvency, reorganization or relief of debtors or seeking the appointment of a receiver or trustee.

(f) Business Address Change. Any change in business address.

10. Nondiscrimination. The parties agree that in the performance of this Agreement they will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, sex, age, religion, disability, national origin or any other protected class in any manner prohibited by federal or state laws.

11. Independent Contractor. In performance of the services discussed herein, Hospice and Facility shall each be, and at all times are, acting and performing as an independent contractor, and not as a partner, a co-venturer, an employee, an agent or a representative of the other. No employee or agent of one party to this Agreement shall be considered an employee or agent of the other party.

12. Use of Name or Marks. Neither Hospice nor Facility shall have the right to use the name, symbols, trademarks or service marks of the other party in advertising or promotional materials or otherwise without receiving the prior written approval of such other party; provided, however, that one party may use the name, symbols, or marks of the other party in written materials previously approved by the other party for the purpose of informing prospective Hospice Patients and attending physicians of the availability of the services described in this Agreement.

13. Miscellaneous Provisions.

(a) Amendment. No amendment, modification or discharge of this Agreement, and no waiver hereunder, shall be valid or binding unless set forth in writing and duly executed by the parties hereto.

(b) Severability. This Agreement is severable, and in the event that any one or more of the provisions hereof shall be deemed invalid, illegal or unenforceable in any respect, the validity, legality and enforceability of the remaining provisions contained herein shall not in any way be affected or impaired thereby.

(c) Headings. The descriptive headings in this Agreement are for convenience only and shall not affect the construction of this Agreement.

(d) Governing Law. This Agreement, the rights and obligations of the parties hereto, and any claims or disputes relating thereto, shall be governed by and construed in accordance with the laws of the State of Maryland. Any claims or disputes related to this Agreement shall be brought in Anne Arundel County.

(e) Waiver. The waiver by either party of a breach or violation of any provision in this Agreement shall not operate or be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any such provisions, rights or privileges hereunder.

(f) Binding Effect. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns. There are no third party beneficiaries of or to this Agreement.

(g) No Third Party Beneficiaries. Except as expressly provided elsewhere herein, nothing in this Agreement is intended to be construed or be deemed to create any rights or remedies in any third party.

(h) Force Majeure. In the event that either party's business or operations are substantially interrupted by acts of war, fire, labor strike, insurrection, riots, earthquakes or other acts of nature of any cause that is not the party's fault or is beyond that party's reasonable control, then that party shall be relieved of its obligations only as to those affected operations and only as to those affected portions of this Agreement for the duration of such interruption.

(i) No Requirement to Refer. This Agreement is not intended to influence the judgment of any physician or provider in choosing medical specialists or medical facilities appropriate for the proper care and treatment of residents. Neither Facility nor Hospice shall receive any compensation or remuneration for referrals.

(j) Nonexclusive Agreement. This Agreement is intended to be nonexclusive, and either party may use any provider for the same or similar services.

(k) Counterparts. This Agreement may be executed in any number of counterparts, all of which together shall constitute one and the same instrument.

(l) Notices. All notices or other communications which may be or are required to be given, served or sent by any party to the other party pursuant to this Agreement shall be in writing, addressed as set forth below, and shall be mailed by first-class, registered or certified mail, return receipt requested, postage prepaid, or transmitted by hand delivery or facsimile. Such notice or other communication shall be deemed sufficiently given or received for all purposes at such time as it is delivered to the addressee (with the return receipt, the delivery receipt, the affidavit or messenger or the answer back being deemed conclusive evidence of such delivery) or at such time as delivery is refused by the addressee upon presentation. Each party may designate by notice in writing a new address to which any notice or communication may thereafter be so given, served or sent.

TO: HOSPICE
Seasons Hospice & Palliative Care of Maryland, Inc.
6934 Aviation Boulevard, SuiteN
Glen Burnie, MD 21061
Attn: Executive Director

FOR BILLING, PLEASE ADDRESS INVOICES OR INQUIRIES TO:
Seasons Healthcare Management
6400 Shafer Court, Suite 700
Rosemont, IL 60018
(847) 692-1000
Attn: Nursing Home Invoices
Via Email: FinanceSeasonsNH_Connections@seasons.org
Via EFax: (847) 375-2770

TO: FACILITY
Brinton Woods Nursing & Rehabilitation Center at Winfield
1442 Buckhorn Road
Sykesville, MD 21784
Attn: Administrator

(n) Entire Agreement. This Agreement, including all of the exhibits and addenda attached hereto, contains the entire agreement of the parties hereto and supersedes all prior oral or written agreements or understandings between them with respect to the matters provided for herein. This Agreement may not be modified or amended except by mutual consent of the parties, and any such modification or amendment must be in writing duly executed by the parties hereto, and shall be attached to, and become a part of, this Agreement.

The parties have executed this Agreement as of the day, month and year first written above.

Agreed HOSPICE	Agreed FACILITY
By: Marshall Scott	By: Jaqueline Winfield Hardy
Name: Marshall Scott	Name: Jaqueline Winfield Hardy
Title: Director of Business Operations	Title: Administrator
Seasons Hospice & Palliative Care	

EXHIBIT A
PURCHASED HOSPICE SERVICES

1. Purchased Hospice Services. The following services and items will be purchased, as needed, by Hospice from Facility on the terms set forth in this Exhibit A and elsewhere in the Agreement. The rates identified reflect fair market value, without regard to the volume and value of referrals.

2. Authorized Personnel. The following hospice representatives are authorized to purchase or order items and services from Facility for Hospice Patients:

   - Hospice Director of Clinical Services;
   - Hospice Team Director; and
   - Hospice Executive Director

3. Billing and Payment. Billing and payment for Purchased Hospice Services shall be governed by this Agreement.

4. Professional Management Responsibility. Hospice retains administrative and financial management, and oversight of staff and services related to all Purchased Hospice Services to ensure the provision of quality care. All Purchased Hospice Services must be authorized by Hospice, furnished in a safe and effective manner by qualified personnel, and delivered in accordance with the Plan of Care.

EXHIBIT B
SUMMARY OF RESPONSIBILITIES

ROLE	HOSPICE	FACILITY	N/A
Admitting Hospice Patients, Beginning Services	X		
Assessing Hospice Patients, Including Who is Responsible for the Initial and Ongoing Assessment	X		
Identifying the Individual(s) Responsible for the Care Planning Process	X		
Coordinating, Supervising, and Evaluating the Care and Services Provided	X		
Scheduling Visits or Hours	X		
Discharge Planning from Hospice	X		

(b) Medicare or Medicaid Certification. Facility represents and warrants that it is currently, and will at all times during the term of this Addendum remain, certified to participate in the Medicare and/or Medicaid programs.

(c) Twenty-Four Hour Nursing Services. Facility shall provide 24-hour nursing services that meet the nursing needs of all Hospice Patients and are furnished in accordance with each patient's Plan of Care. Each Hospice Patient must receive all nursing services as prescribed. For each shift, Facility will identify to Hospice in advance a charge nurse or other member of Facility's nursing staff who will respond to Hospice's requests for information concerning Hospice Patients.

(d) Home-Like Atmosphere. Facility shall provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort and privacy of patients.

(e) Discharge Summary. Facility shall provide Hospice with a copy of the discharge summary at the time of discharge.

(f) Inpatient Clinical Record. Facility shall maintain an inpatient clinical record for each Hospice Patient that includes a record of all Respite Care furnished and events regarding care that occurred at Facility. A copy of the inpatient clinical record shall be available to Hospice at the time of discharge.

(g) Implementation of Agreement. Facility shall designate an individual within the facility who shall be responsible for the implementation of the provisions of this Addendum and the Agreement ("Responsible Facility Representative"). The current Responsible Facility Representative is identified at the end of this Addendum. Facility shall notify Hospice if a new individual is designated as the Responsible Facility Representative.

3. Hospice Responsibilities.

(a) Provision of Plan of Care to Facility. Upon a Hospice Patient's admission to Facility for Respite Care, Hospice shall furnish a copy of the current Plan Care. Hospice shall specify the Respite Care to be furnished by Facility to such Hospice Patient.

(b) Verification of Regulatory Requirements. Hospice shall verify compliance with the following requirements established by the Medicare Conditions of Participation for Hospice Care.

(i) Copy of Plan of Care. Hospice shall document in the patient's record that the Plan of Care has been provided to Facility and specify the Respite Care

that Facility will furnish. Hospice shall periodically review Hospice Patients' records to verify that these requirements are met.

(ii) Patient Care Policies. Hospice shall verify that Facility has established patient care policies that are consistent with Hospice's policies and agrees to abide by the palliative care protocols and Plans of Care established by Hospice for its patients. Hospice shall review Facility's policies to determine their consistency with Hospice policies.

(iii) Inpatient Clinical Records. Hospice shall periodically review Hospice Patients' inpatient clinical records to determine that they include a record of all Respite Care furnished and events regarding care that occurred at Facility. Facility shall make inpatient clinical records available to Hospice at the time of discharge.

(iv) Copy of Discharge Summary. Hospice shall document in the patient's record that Facility provided a copy of the discharge summary at the time of discharge. Hospice shall periodically review Hospice Patients' records to verify that this requirement is met.

(v) Responsible Facility Representative. The Responsible Facility Representative is identified at the end of this Addendum. Facility shall immediately notify Hospice if a new Responsible Facility Representative is appointed, and shall inform Hospice of the name and contact information of the new Responsible Facility Representative. Hospice shall maintain a record of Responsible Facility Representatives.

(vi) Hospice Training. Facility shall provide Hospice with a list of Facility personnel who will be providing Respite Care to Hospice Patients, indicating whether each person has already been provided with hospice training. For personnel who have already received training, Facility shall provide Hospice with the names of the individuals who gave the training and a description of the training. For personnel who have not received hospice training, Hospice shall provide training, and shall document the names of the individuals who gave the training and a description of the training. Upon hiring new personnel who will be providing care to Hospice Patients, Facility shall notify Hospice and indicate whether the personnel have received hospice training and, if so, the names of the individuals who gave the training and a description of the training.

(c) Professional Management Responsibility. Hospice retains administrative and financial management, and oversight of staff and services related to all Respite Care to ensure the provision of quality care. All Respite Care must be authorized by Hospice, furnished in a safe and effective manner by qualified personnel, and delivered in accordance with the Plan of Care. Facility is authorized to provide all Respite Care identified in the Plan of Care. Facility shall seek authorization from designated Hospice personnel prior to providing Respite Care not identified in the Plan of Care.

4. Billing and Payment.

(a) Medicaid Eligible Hospice Patients, Medicare Eligible Hospice Patients and Private Pay Hospice Patients. For each Respite Care Day provided to a Medicaid Eligible Hospice Patient or a Medicare Eligible Hospice Patient, Hospice shall pay Facility a fixed payment equal to 100% of the applicable then current rate Hospice receives from Medicare or Medicaid, except the day on which such patient is discharged from Facility, unless such patient dies while residing at Facility. Rates for reimbursement for Respite Care Days provided to Private Pay Hospice Patients, including those with third party payors other than Medicare or Medicaid, will be established in writing by Facility in advance for each such patient.

(b) Billing. The terms for billing for Respite Care shall be governed by the Agreement.

5. Responsible Facility Representative. Facility has identified the following individual as the Responsible Facility Representative: Sandi Singer Social Worker.

6. Conflicts. This Addendum shall be subject to the terms and conditions of the Agreement; provided that, in the event of a conflict between the terms and conditions of this Addendum and the terms and conditions of the Agreement, the terms and conditions of this Addendum shall control. Except as specifically amended herein, all other terms and conditions of the Agreement shall remain in full force and effect.

The parties have executed this Addendum as of the day, month and year first written above. August 21, 2014

Agreed HOSPICE	Agreed FACILITY
By: Marshall Scott	By: Jacqueline Wimberly-Hardy
Name: Marshall Scott	Name: Jacqueline Wimberly-Hardy
Title: Director of Business Operations	Title: Administrator
Seasons Hospice & Palliative Care	

Gilchrist
HOSPICE CARE
guiding the way.

November 28, 2011

Kristen M. MacDonald, MS, RD, NHA
Brinton Woods Health Care Center, LLC.
1442 Blackthorn Road
Sykesville, MD 21784

Dear Ms. MacDonald:

Enclosed please find your copy of the fully executed Nursing Facility Services Agreement between Gilchrist Hospice Care, Inc. and Brinton Woods Health Care Center, LLC., effective November 3, 2011.

We look forward to continuing to work with your facility and to providing hospice services to your residents.

If you have any questions, please do not hesitate to contact me at 443-849-8204 or Mr. Hal Friedman, Director of Development, at 443-849-8242.

Sincerely,

Catherine Y. Hamel
Executive Director

:lg

Enclosure

NURSING FACILITY SERVICES AGREEMENT

THIS NURSING FACILITY SERVICES AGREEMENT ("Agreement") is made and entered into this 3rd day of November, 2011 (the "Effective Date") by and between **GILCHRIST HOSPICE CARE, Inc.** ("Hospice") and **BRINTON WOODS HEALTH CARE CENTER, LLC**("Facility").

RECITALS

A. WHEREAS, Hospice operates a licensed hospice program.

B. WHEREAS, Facility is a duly licensed nursing facility that is certified to participate in the Medicare and/or Medicaid programs.

C. . WHEREAS, the parties contemplate that from time to time individuals residing in Facility will need hospice care and individuals previously accepted into Hospice will need care in a nursing facility.

AGREEMENTS

In consideration of the Recitals and mutual agreements that follow, the parties agree to the following terms and conditions:

1. Definitions.

(a) "Facility Services" means those personal care and room and board services provided by Facility as specified in the Plan of Care for a Hospice Patient including, but not limited to: (i) providing food, including individualized requests and dietary supplements; (ii) assisting with activities of daily living such as mobility and ambulation, dressing, grooming, bathing, transferring, eating and toileting; (iii) arranging and assisting in socializing activities; (iv) assisting in the administration of medicine; (v) providing and maintaining the cleanliness of Hospice Patient's room; (vi) supervising and assisting in the use of any durable medical equipment and therapies included in the Plan of Care; (vii) providing laundry and personal care supplies; (viii) providing health monitoring of general conditions; (ix) contacting family/legal representative for purposes unrelated to the terminal condition; (x) arranging for the provision of medications not related to the management of the terminal illness; and (xi) providing the usual and customary room furnishings provided to Facility residents including, but not limited to, beds, linens, lamps and dressers. In the case of Medicaid Eligible Hospice Patients, Facility Services shall include all services outlined in the Medicaid covered services rule, as may be amended from time to time.

(b) "Hospice Patient" means an individual who has elected, directly or through such individual's legal representative, to receive Hospice Services and is accepted by Hospice to receive Hospice Services.

(c) "Hospice Physician" means a duly licensed doctor of medicine or osteopathy employed or contracted by Hospice who, along with the Hospice Patient's attending physician (if any), is responsible for the palliation and management of a Hospice Patient's terminal illness and related conditions.

(d) "Hospice Services" means those services provided to a Hospice Patient that are reasonable and necessary for the palliation and management of such Hospice Patient's terminal illness and are specified in a Hospice Patient's Plan of Care. Hospice Services include: (i) nursing care and services by or under the supervision of a registered nurse; (ii) medical social services provided by a qualified social worker under the direction of a physician; (iii) physician services to the extent that these services are not provided by the attending physician; (iv) counseling services, including bereavement, dietary and spiritual counseling; (v) physical, respiratory, occupational and speech therapy services; (vi) home health aide/homemaker services; (vii) medical supplies; (viii) drugs and biologicals; (ix) use of medical appliances; and (x) medical direction and management of the Hospice Patient.

(e) "Interdisciplinary Group" ("IDG") means a group of qualified individuals including, but not limited to: a doctor of medicine or osteopathy; a registered nurse; a social worker; and a pastoral or other counselor.

(f) "Medicaid Eligible Hospice Patient" means a Hospice Patient who either: is eligible for Medicaid benefits and who has elected to receive the Medicaid hospice benefit; or is eligible for both Medicaid and Medicare Part A benefits and who has elected the Medicare hospice benefit.

(g) "Medicare Eligible Hospice Patient" means a Hospice Patient who is eligible for Medicare Part A benefits, but who is not eligible for Medicaid benefits and who has elected to receive the Medicare Part A hospice benefit.

(h) "Other Facility Services" means all items and services provided by Facility, which are not related to treatment of a Hospice Patient's terminal illness but specified in the Plan of Care.

(i) "Plan of Care" means a written care plan established, maintained, reviewed and modified, if necessary, at intervals identified by the IDG. The Plan of Care must reflect Hospice Patient and family goals and interventions based on the problems identified in the Hospice Patient assessments. The Plan of Care will reflect the participation of the Hospice, Facility and the Hospice Patient and family to the extent possible. Specifically, the Plan of Care includes: (i) an identification of the Hospice Services, including interventions for pain management and symptom relief, needed to meet such Hospice Patient's needs and the related needs of Hospice Patient's family; (ii) a

detailed statement of the scope and frequency of such Hospice Services; (iii) measurable outcomes anticipated from implementing and coordinating the Plan of Care; (iv) drugs and treatment necessary to meet the needs of the Hospice Patient; (v) medical supplies and appliances necessary to meet the needs of the Hospice Patient; and (vi) the IDG's documentation of the Hospice Patient's or representative's level of understanding, involvement and agreement with the Plan of Care. Hospice and Facility will jointly develop and agree upon a coordinated Plan of Care which is consistent with the hospice philosophy and is responsive to the unique needs of Hospice Patient and his or her expressed desire for hospice care. The Plan of Care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care.

(j) "Private Pay Hospice Patient" means a Hospice Patient who is not eligible for the Medicare Part A hospice benefit or the Medicaid hospice benefit, or if eligible, has revoked or elected not to receive the Medicare Part A hospice benefit and/or the Medicaid hospice benefit.

(k) "Residential Hospice Care Day" means a day on which a Hospice Patient receives Facility Services, including the day of admission but excluding the day of discharge and any days on which a Hospice Patient receives inpatient care.

(l) "Uncovered Items and Services" means those services provided by Facility that are not Hospice Services, Facility Services or Other Facility Services including, but not limited to, telephone, guest trays and television hookup.

2. Responsibilities of Facility.

(a) Provision of Services.

(i) Facility Services. At the request of an authorized Hospice staff member, Facility shall admit Hospice Patients to Facility, subject to Facility's admission policies and procedures and the availability of beds. Facility shall immediately notify Hospice if Facility is unable to admit a Hospice Patient. Facility shall comply with Hospice Patient's Plan of Care and shall ensure Hospice Patients are kept comfortable, clean, well-groomed and protected from negligent and intentional harm including, but not limited to, accident, injury and infection. Facility's primary responsibility is to provide Facility Services. It is Facility's responsibility to provide Facility Services that meet the personal care and nursing needs that would have been provided by a Hospice Patient's primary caregiver at home, and Facility shall perform Facility Services at the same level of care provided to each Hospice Patient before hospice care was elected. While Facility's nursing personnel may, as specified by Facility, assist in administering prescribed therapies to Hospice Patients under the Plan of Care, such assistance may only be provided to the extent the activity is permitted by law and only to the extent that Hospice would routinely utilize the services of a Hospice Patient's family in implementing the Plan of Care. Notwithstanding the foregoing, in times of Hospice Patient crisis Hospice may authorize and direct Facility staff to perform

more sophisticated functions in order to ensure Hospice Patient comfort, and Hospice and Facility shall address potential crisis situations for individual Hospice Patients in the Plan of Care.

(ii) Availability. Facility shall be available to provide Facility Services 24 hours per day, 7 days per week and shall maintain sufficient personnel who have the requisite training, skills and experience to meet this obligation.

(iii) Notification of Services. Facility shall fully inform Hospice Patients of Facility Services, Other Facility Services and Uncovered Items and Services to be provided by Facility.

(b) Professional Standards and Credentials.

(i) Professional Standards. Facility shall ensure that all Facility Services are provided competently and efficiently. Facility Services shall meet or exceed the standards of care for providers of such services and shall be in compliance with all applicable laws, rules, regulations, professional standards and licensure requirements.

(ii) Credentials.

[a] Licensure. Facility represents and warrants that it has and will maintain in good standing during the term of this Agreement all federal, state and local licenses and certificates required by law to provide Facility Services. Upon Hospice's request, Facility shall provide Hospice with evidence of such licenses and certifications.

[b] Qualifications of Personnel. Personnel who provide Facility Services shall be reasonably acceptable to Hospice. Facility represents and warrants that personnel providing Facility Services: [i] are duly licensed, credentialed, certified, and/or registered as required under applicable state laws; and [ii] possess the education, skills, training and other qualifications necessary to provide Facility Services. Based on criminal background checks conducted by Facility, Facility personnel who have direct contact with Hospice Patients or have access to Hospice Patient records have not been found to have engaged in improper or illegal conduct relating to the elderly, children or vulnerable individuals. Upon Hospice's request, Facility shall provide Hospice with proof of an individual's qualifications to provide Facility Services.

[c] Disciplinary Action. Facility represents and warrants that neither it nor any of its personnel is under suspension or subject to any disciplinary proceedings by any agency having jurisdiction over professional activities of Facility or its personnel and is not under any formal or informal investigation or preliminary inquiry by such department or agency for possible disciplinary action.

[d] Exclusion from Medicare or Medicaid. Facility represents and warrants that neither Facility nor its personnel has been, at any time,

excluded from participation in any federally funded health care program including, without limitation, Medicare or Medicaid, nor has been convicted or found to have violated any federal or state fraud and abuse law or illegal remuneration law.

(c) Quality Assessment and Performance Improvement Activities. Facility shall cooperate with Hospice in its hospice-wide quality assessment and performance improvement activities. Components of the quality assessment and performance improvement program include (i) data collection; (ii) reporting adverse patient events, analyzing their causes, and implementing preventive actions and mechanisms; and (iii) taking actions to improve performance. Hospice shall provide Facility with a description of its quality assessment and performance improvement program and information on performance improvement projects. Third party payors may also impose their own utilization management or quality assurance requirements, which Facility must meet. Cooperating in such activities shall not constitute a waiver of any legal privileges or rights that may apply to the information that is shared. Hospice shall maintain the confidentiality of such information in whatever form it is provided.

(d) Coordination of Care.

(i) General. Facility shall participate in any meetings, when requested, for the coordination, supervision and evaluation by Hospice of the provision of Facility Services. Hospice and Facility shall communicate with one another regularly and as needed for each particular Hospice Patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day.

(ii) Design of Plan of Care. In accordance with applicable federal and state laws and regulations, Facility shall coordinate with Hospice in developing a Plan of Care for each Hospice Patient. Hospice retains primary responsibility for development of the Plan of Care.

(iii) Modifications to Plan of Care. Facility will assist with periodic review and modification of the Plan of Care. Facility will not make any modifications to the Plan of Care without first consulting with Hospice. Hospice retains the sole authority for determining the appropriate level of hospice care provided to each Hospice Patient.

(iv) Notification of Change in Condition. Facility shall immediately inform Hospice of any change in the condition of a Hospice Patient. This includes, without limitation, a significant change in a Hospice Patient's physical, mental, social or emotional status, clinical complications that suggest a need to alter the Plan of Care, a need to transfer the Hospice Patient to another facility, or the death of a Hospice Patient.

(e) Policies and Procedures. In providing services to Hospice Patients, Facility shall abide by Hospice's policies and procedures, palliative care protocols and Plans of Care.

(f) Assist with Surveys and Complaints. Facility shall be available during federal, state, local and other surveys to assist Hospice in responding to surveyor questions and survey citations, attending exit conferences, drafting plans of correction for identified survey deficiencies and providing clinical expertise when necessary to appeal survey deficiencies. In the event of any complaint filed by or with respect to a Hospice Patient or any investigation initiated by any governmental agency or any litigation commenced against Hospice, Facility shall fully cooperate with Hospice in an effort to respond to and resolve the same in a timely and effective manner. Facility shall also cooperate fully with any insurance company providing protection to Hospice in connection with investigations. Facility shall notify Hospice promptly of any inquiries, claims, and investigations and cooperate fully with the directions of Hospice with respect thereto

(g) Visiting and Access by Hospice.

(i) Visiting Privileges. Facility shall permit free access and unrestricted visiting privileges, including visits by children of any age, 24 hours per day, 7 days per week.

(ii) Visitor Accommodations. Facility shall provide adequate space, located conveniently to Hospice Patient, for private visiting among Hospice Patient, Hospice Patient's family members and any other visitors. Facility shall provide adequate accommodations for Hospice Patient's family members to remain with Hospice Patient up to 24 hours per day, and permit family members privacy following the death of a Hospice Patient.

(iii) Hospice Access to Facility. Facility shall permit employees, contractors, agents and volunteers of Hospice free and complete access to Facility 24 hours per day, as necessary, to permit Hospice to counsel, treat, attend and provide services to each Hospice Patient.

(iv) Hospice Physician. Facility shall grant full staff privileges to Hospice Physicians upon application and qualification for such privileges in accordance with Facility's requirements.

(h) Patient Transfer. Facility shall not transfer any Hospice Patient to another care setting without the prior approval of Hospice. If Facility fails to obtain the necessary prior approval, Hospice bears no financial responsibility for the costs of transfer or the costs of care provided in another setting.

(i) Physician Orders. If there are physician orders that are inconsistent with the Plan of Care or Hospice protocols, a registered nurse with Facility shall notify Hospice. An authorized representative of Hospice shall resolve differences directly with the physician and secure the necessary orders.

(j) Bereavement Services to Facility Staff. Facility shall be primarily responsible for providing any requested bereavement services to Facility staff after the

death of a Hospice Patient who resided in Facility; provided, however, that Hospice may assist Facility in providing such bereavement services to grieving Facility staff members upon request from Facility.

3. Responsibilities of Hospice.

(a) Admission to and Discharge from Hospice Program.

(i) Assessment. If a resident of Facility requests the provision of Hospice Services, Hospice shall perform an assessment of such resident and shall notify Facility, either orally or in writing, whether such resident is authorized for admission as a Hospice Patient. Hospice shall maintain adequate records of all such authorizations of admission.

(ii) Assessing Continued Eligibility. Hospice shall have sole authority for assessing a Hospice Patient's continued eligibility for Hospice Services and for discharging a Hospice Patient from Hospice.

(b) Professional Management Responsibility.

(i) Compliance with Law. Hospice shall assume professional management responsibility for Hospice Services provided to Hospice Patients residing at Facility and their family units, pursuant to the Medicare Conditions of Participation for Hospice Care and state and local laws and regulations. This includes admission and/or discharge of patients, patient and family assessments, reassessments, establishment of the Plan of Care, authorization of all services and management of the care through IDG meetings. Hospice shall make arrangements for, and remain responsible for; any necessary continuous care or inpatient care related to a Hospice Patient's terminal illness and related conditions. Hospice acknowledges that it is responsible for providing Hospice Services to Hospice Patients residing at Facility at the same level and to the same extent as if Hospice Patients were receiving care in their own homes.

(ii) Management of Hospice Services. Hospice shall retain professional management responsibility to ensure that Hospice Services are furnished in a safe and effective manner by qualified personnel in accordance with Hospice Patient's Plan of Care

(iii) Coordination and Evaluation. Hospice shall retain responsibility for coordinating, evaluating and administering the hospice program, as well as ensuring the continuity of care of Hospice Patients, which shall include coordination of Facility Services. Hospice's IDG shall communicate with Facility's medical director, Hospice Patient's attending physician and other physicians participating in the care of a Hospice Patient as needed to coordinate Hospice Services with the medical care provided by other physicians. Methods used to evaluate the care may include: [a] periodic supervisory visits; [b] review of the qualifications of personnel providing Facility Services; [c] review of documentation; [d] evaluation of the response of a Hospice

Patient to the Plan of Care; [e] discussion with patient and patient's caregivers; [f] patient evaluation surveys; and [g] quality improvement data.

(iv) Assessment of Facility Services. Hospice shall develop, maintain and conduct an ongoing, comprehensive assessment of the quality and appropriateness of Facility and the provision of Facility Services. Such assessments shall be conducted at least annually.

(c) Hospice Care Training. Hospice shall provide orientation and ongoing hospice care training to Facility's personnel as necessary to facilitate the provision of safe and effective care to Hospice Patients. Such orientation must include Hospice policies and procedures regarding methods of comfort, pain control and symptom management as well as principles about death and dying, individual responses to death, patient rights, appropriate forms and recordkeeping requirements.

(d) Designation of Hospice Representative. For each Hospice Patient, Hospice shall designate a registered nurse who will be responsible for coordinating and supervising services provided to a Hospice Patient and be available 24 hours per day, 7 days per week for consultation with Facility concerning a Hospice Patient's Plan of Care. In addition, for each Hospice Patient residing at Facility, Hospice shall designate a member of the Hospice Patient's IDG to provide overall coordination of care for such Hospice Patient. Such hospice representative shall monitor Facility and be available to provide information to Facility regarding the provision of Facility Services and to coordinate the periodic evaluation of patient progress and outcomes of care upon request. Further, the hospice representative shall be responsible for communicating with Facility representatives and other health care providers who participate in the care of a Hospice Patient's terminal illness and related conditions to ensure quality of care for Hospice Patients and their families.

(e) Provision of Information. Hospice shall promote open and frequent communication with Facility and shall provide Facility with sufficient information to ensure that the provision of Facility Services under this Agreement is in accordance with the Hospice Patient's Plan of Care, assessments, and treatment planning and care coordination. At a minimum, Hospice shall provide the following information to Facility for each Hospice Patient residing at Facility:

(i) Plan of Care, Medications and Orders. The most recent Plan of Care, medication information and physician orders specific to each Hospice Patient residing at Facility;

(ii) Election Form. The hospice election form and any advanced directives;

(iii) Certifications. Physician certifications and recertifications of terminal illness;

(iv) Contact Information. Names and contact information for Hospice personnel involved in providing Hospice Services; and

(v) On-Call System. Instructions on how to access Hospice's 24-hour on-call system.

(f) Policies and Procedures. Hospice shall provide Facility with copies of applicable Hospice policies and procedures and shall meet with Facility to review such policies and procedures, as necessary.

(g) Physician Orders. All physician orders communicated by Hospice under this Agreement shall be in writing and signed by the applicable attending physician or Hospice Physician; provided, however, that in the case of urgent or emergency circumstances, such orders may be communicated orally by any such persons. Hospice shall maintain records of all physician orders communicated in connection with the Plan of Care.

(h) Notification of Hospice Services. Hospice shall fully inform Hospice Patient of the Hospice Services to be provided by Hospice and Purchased Hospice Services, if any, to be provided by Facility.

(i) Assist with Surveys and Complaints. Hospice shall be available during federal, state, local and other surveys to assist Facility in responding to surveyor questions and survey citations, attending exit conferences, drafting plans of correction for identified survey deficiencies and providing medical expertise when necessary to appeal survey deficiencies. In the event of any complaint filed by or with respect to a Hospice Patient or any investigation initiated by any governmental agency or any litigation commenced against Facility, Hospice shall fully cooperate with Facility in an effort to respond to and resolve the same in a timely and effective manner. Hospice shall also cooperate fully with any insurance company providing protection to Facility in connection with investigations. Hospice shall notify Facility promptly of any inquiries, claims, and investigations and cooperate fully with the directions of Hospice with respect thereto.

4. Billing and Payment.

(a) Billing and Payment for Facility Services Provided to Medicaid Eligible Hospice Patients.

(i) Rates. Hospice shall pay Facility a fixed payment rate for each Residential Hospice Care Day provided to a Medicaid Eligible Hospice Patient, except the day on which such patient is discharged from Facility, unless such patient dies while residing at Facility. The fixed payment rate shall be 100 percent (100%) of Facility's then current Medicaid per diem rate that would have been paid by the Medicaid program to Facility if the Medicaid Eligible Hospice Patient had not elected to receive hospice care, less the Medicaid Eligible Hospice Patient's required personal contribution amount, if any. Facility shall accept this rate as payment in full for Facility Services

provided to such Medicaid Eligible Hospice Patient and shall not bill the Medicaid Eligible Hospice Patient or his/her family, representatives or any third party payor. Facility shall collect and retain the Medicaid Eligible Hospice Patient's required personal contribution amount, if any.

(ii) Billing and Payment. Within ten (10) calendar days of the end of the month and within at least 30 days of providing Facility Services, Facility shall submit to Hospice an accurate and complete statement of all Facility Services provided to Medicaid Eligible Hospice Patients. The statement shall be in a form acceptable to Hospice and include information usually provided to third party payors to verify the services and charges reflected in the statement. Hospice shall pay Facility within 30 days after receipt of a complete statement. Payment by Hospice in respect to such bills shall be considered final, unless adjustments are requested in writing by Facility within 30 days of receipt of payment. Hospice shall have no obligation to pay Facility for any service if Hospice does not receive a bill for such service within 120 days following the date on which the service was rendered.

(b) Billing and Payment for Facility Services Provided to Medicare Eligible Hospice Patients and Private Pay Hospice Patients. Facility shall bill each Medicare Eligible Hospice Patient and Private Pay Hospice Patient (or such patient's third party payor, if applicable) for Facility Services at a rate agreed upon by Facility and such patient or his or her third party payor. Facility shall accept such payment as payment in full for Facility Services. Hospice will not be responsible for reimbursing Facility for any portion of the cost of Facility Services provided to a Medicare Eligible Hospice Patient or Private Pay Hospice Patient. Facility shall not seek payment from Hospice in the event of default of financial obligations on the part of a Medicare Eligible Hospice Patient, Private Pay Hospice Patient or such patient's third party payors. Hospice will, to the extent permitted by law, provide Facility with any information it may reasonably require to obtain payment from any payor or other permissible payment source.

(c) Billing and Payment for Purchased Hospice Services Provided to All Hospice Patients. Facility shall bill Hospice for Purchased Hospice Services provided to Hospice Patients at the rates agreed to by Facility and Hospice. Facility represents and warrants that all Purchased Hospice Services for Medicaid Eligible Hospice Patients are not included in the applicable, then current Medicaid per diem rate that Facility would have received if the Medicaid Eligible Hospice Patient had not elected to receive Hospice Services. The billing and payment procedures set forth in section 4(a)(ii) of this Agreement shall apply.

(d) Billing and Payment for Other Services. Facility shall bill Hospice Patients or the third party payor, if applicable, for (i) Other Facility Services; (ii) Uncovered Items and Services; and (iii) care provided by Facility upon the request of a Hospice Patient which is not reasonable or necessary for palliation or management of the terminal illness and not rendered in accordance with the applicable Plan of Care.

Records") at its principal place of business. Hospice and its duly authorized representatives, including any independent public accountant or other auditor, shall have the right during regular business hours and on reasonable written notice to Facility to examine Facility's Financial Records and to make copies thereof.

(c) Access by Hospice. Facility shall permit Hospice or its authorized representative, upon reasonable notice, to review and make photocopies of records maintained by Facility relating to the provision of Facility Services including, but not limited to, clinical records and billing and payment records. This section shall survive the termination of this Agreement.

(d) Inspection by Government. In accordance with 42 U.S.C. § 1395x(v)(1)(i) and 42 C.F.R. § 420.300, et seq., Facility shall make available, until the expiration of five years from the termination of this Agreement, upon written request, to the Secretary of Health and Human Services of the United States, and upon request, to the Comptroller General of the United States, or any of their duly authorized representatives, this Agreement and any of its books, documents and records that are necessary to certify the nature and costs of Medicare reimbursable services provided under this Agreement. If and to the extent Facility carries out any of its duties under this Agreement through a subcontract with a related organization having a value or cost of $10,000 or more over a 12-month period, then Facility shall ensure that the subcontract contains a clause comparable to the clause in the preceding sentence. Nothing contained in this section shall be construed as a waiver by either party of any legal rights of confidentiality with respect to patient records and proprietary information.

(e) Destruction of Records. Facility shall take reasonable precautions to safeguard records against loss, destruction and unauthorized disclosure.

7. Confidentiality. Each party acknowledges that as part of its performance under this Agreement, it may be required to disclose to the other party certain information pertaining to Hospice Patients (collectively, "Patient Information") and may be required to disclose certain business or financial information (collectively, with the Patient Information, the "Confidential Information"). Each party agrees that it shall treat Confidential Information with the same degree of care it affords its own similarly confidential information and shall not, except as specifically authorized in writing by the other party or as otherwise required by law, reproduce any Confidential Information or disclose or provide any Confidential Information to any person. A party that discloses Confidential Information shall be entitled to injunctive relief to prevent a breach or threatened breach of this section, in addition to all other remedies that may be available. This section shall survive termination of this Agreement.

8. Term and Termination.

(a) Term. This Agreement shall have an initial term of one year beginning on the Effective Date ("Initial Term") and shall automatically renew for successive one-year terms, unless sooner terminated as provided below.

(b) Termination.

(i) Without Cause. This Agreement may be terminated by either party for any reason after the Initial Term by providing at least 90 days' prior written notice to the other party.

(ii) Mutual Written Agreement. This Agreement may terminate at any time after the Initial Term upon written agreement of the parties.

(iii) For Cause. Either party may terminate this Agreement upon 30 days' prior written notice to the other party, if the other party breaches this Agreement and fails to cure such breach within such 30-day period. (iv)

Change in Law. In the event there are substantial changes or clarifications to any applicable laws, rules or regulations that materially affect, in the opinion of either party's legal counsel, any party's right to reimbursement from third party payors or any other legal right of any party to this Agreement, the affected party may, by written notice to the other party, propose such modifications to this Agreement as may be necessary to comply with such change or clarification. Upon receipt of such notice, the parties shall engage in good faith negotiations regarding any appropriate modifications to this Agreement. If such notice is given and the parties are unable within 60 days thereafter to agree to appropriate modifications to this Agreement, either party may terminate this Agreement by providing at least 30 days' notice to the other party.

(v) Immediate Termination. Notwithstanding the above, either party may immediately terminate this Agreement if:

[a] Failure to Have Qualifications. A party or its personnel are excluded from any federal health program or no longer have the necessary qualifications, certifications and/or licenses required by federal, state and/or local laws to provide Facility Services.

[b] Liquidation. A party commences or has commenced against it proceedings to liquidate, wind up, reorganize or seek protection, relief or a consolidation of its debts under any law relating to insolvency, reorganization or relief of debtors or seeking the appointment of a receiver or trustee.

[c] Failure to Have Insurance. A party ceases to have any of the insurance required under this Agreement.

[d] Threats to Health, Safety or Welfare. A party fails to perform its duties under this Agreement and the other party determines in its full discretion that such failure threatens the health, safety or welfare of any patient.

[e] Commission of Misconduct. A party commits an act of misconduct, fraud, dishonesty, misrepresentation or moral turpitude involving the other party or a mutual patient of the parties.

(c) Effect of Termination on Availability of Facility Services. In the event this Agreement is terminated, Facility shall work with Hospice in coordinating the continuation of Facility Services to existing Hospice Patients and shall continue to provide Facility Services to Hospice Patients after this Agreement is terminated, if Hospice determines that removing Facility Services would be detrimental to Hospice Patients. In such cases, Facility Services shall continue to be provided in accordance with the terms set forth in this Agreement. This section shall survive termination of this Agreement.

9. Notification of Material Events. Either party shall immediately notify the other party of:

(a) Ownership Change. Any change in 10% or more of its ownership.

(b) Business Address Change. Any change in business address.

(c) Licensure Actions. Any sanctions, intermediate or otherwise, administrative or judicial fines, penalties, or action by federal or state officials against the party or its personnel.

(d) Exclusion. Any threatened, proposed or actual exclusion of it or any of its subcontractors or personnel from any government program including, but not limited to, Medicare or Medicaid.

(e) Insurance. The cancellation or modification of any of the insurance coverage that the party is required to have under this Agreement.

(f) Liquidation. The commencement of any proceeding to liquidate, wind up, reorganize or seek protection, relief or a consolidation of Facility's or Hospice's debts under any law relating to insolvency, reorganization or relief of debtors or seeking the appointment of a receiver or trustee.

(g) Incident Reporting. Any of the following alleged incidents involving a Hospice Patient residing at Facility:

(i) Mistreatment or neglect;

(ii) Verbal, mental, sexual or physical abuse;

(iii) Injuries of an unknown source; or

(iv) Misappropriation of patient property.

10. Nondiscrimination. The parties agree that in the performance of this Agreement they will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, sex, age, religion, national origin, or any other protected class in any manner prohibited by federal or state laws.

11. Independent Contractor. In performance of the services discussed herein, Hospice and Facility shall each be, and at all times are, acting and performing as an independent contractor, and not as a partner, a co-venturer, an employee, an agent or a representative of the other. No employee or agent of one party to this Agreement shall be considered an employee or agent of the other party.

12. Use of Name or Marks. Neither Hospice nor Facility shall have the right to use the name, symbols, trademarks or service marks of the other party in advertising or promotional materials or otherwise without receiving the prior written approval of such other party; provided, however, that one party may use the name, symbols, or marks of the other party in written materials previously approved by the other party for the purpose of informing prospective Hospice Patients and attending physicians of the availability of the services described in this Agreement.

13. Miscellaneous Provisions

(a) Amendment. No amendment, modification or discharge of this Agreement, and no waiver hereunder, shall be valid or binding unless set forth in writing and duly executed by the parties hereto.

(b) Severability. This Agreement is severable, and in the event that any one or more of the provisions hereof shall be deemed invalid, illegal or unenforceable in any respect, the validity, legality and enforceability of the remaining provisions contained herein shall not in any way be affected or impaired thereby.

(c) Headings. The descriptive headings in this Agreement are for convenience only and shall not affect the construction of this Agreement.

(d) Governing Law. This Agreement, the rights and obligations of the parties hereto, and any claims or disputes relating thereto, shall be governed by and construed in accordance with the laws of the State of Maryland. Any claims or disputes related to this Agreement shall be brought in Baltimore County Circuit Court, Baltimore County, Maryland.

(e) Nonassignability. Neither party shall assign or transfer, in whole or in part, this Agreement or any of its rights, duties or obligations under this Agreement without the prior written consent of the other party, and any assignment or transfer without such consent shall be null and void.

(f) Waiver. The waiver by either party of a breach or violation of any provision in this Agreement shall not operate or be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any such provisions, rights or privileges hereunder.

(g) Binding Effect. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns. There are no third party beneficiaries of or to this Agreement.

TO: FACILITY
Brinton Woods Health Care Center, LLC.
1442 Buckhorn Road
Sykesville, MD 21784
Attn: Kristin M. MacDonald, MS, RD, NHA
FAX No.: 410 - 795 - 5501
Medicare Provider No.: 21547

(n) Entire Agreement. This instrument contains the entire agreement of the parties hereto and supersedes all prior oral or written agreements or understandings between them with respect to the matters provided for herein. This Agreement may not be modified or amended except by mutual consent of the parties, and any such modification or amendment must be in writing duly executed by the parties hereto, and shall be attached to, and become a part of, this Agreement.

The parties have executed this Agreement as of the day, month and year first written above.

HOSPICE:
GILCHRIST HOSPICE CARE

By: _____
Name: Catherine Y. Hamel
Title: Executive Director

FACILITY:
BRINTON WOODS HEALTH CARE
CENTER, LLC.

By: _____
Name: Kristin M. MacDonald
Title: Administrator

ADDENDUM B
GENERAL INPATIENT SERVICES

THIS INPATIENT CARE ADDENDUM is effective on the 20th day of August, 2014 (the "Effective Date") and amends and is made part of the NURSING FACILITY SERVICES AGREEMENT ("Agreement") by and between SEASONS HOSPICE & PALLIATIVE CARE OF Maryland, Inc. ("Hospice") and Brinton Woods Nursing & Rehabilitation Center at Winfield ("Facility") dated August 20, 2014 (the "Agreement") for patient Rebecca Chun only.

RECITAL

Hospice and Facility desire to modify the Agreement to address the provision of Inpatient Services to Hospice Patients.

AGREEMENTS

1. Definitions. Capitalized terms not otherwise defined in this Addendum shall have the meanings given to them in the Agreement.

(a) "General Inpatient Care Day" means a day on which a Hospice Patient receives Inpatient Services for pain control or symptom management which cannot be managed in other settings. Any portion of a 24 hour period, if less than 24 hours, shall constitute a General Inpatient Care Day and shall be compensated pursuant to this Agreement, except the day on which the Hospice Patient is discharged unless such patient dies as an inpatient.

(b) "Inpatient Services" means inpatient beds and related services that are available at, and provided by, Facility pursuant to its customary policies, including services necessary for pain control, or for symptom management. Such services include, without limitation, nursing, dietary, housekeeping, therapies, emergency, laboratory, radiology, respiratory, pharmacy, oxygen services and related ancillary services.

2. Responsibilities of Facility.

(a) Provision of Inpatient Services. At the request of an authorized Hospice staff member, Facility shall provide Inpatient Services to Hospice Patients in accordance with Facility's obligations to provide Facility Services to Hospice Patients under the Agreement, except as such obligations are superseded by this Addendum. Facility shall provide Hospice Patients with beds in Facility. While Facility does not

guarantee the availability of any specific number of beds, it will make beds available to Hospice Patients on the same priority basis as its other patients.

(b) Medicare Certification. Facility represents and warrants that it is currently, and will at all times during the term of this Addendum remain, certified to participate in the Medicare program.

(c) Twenty-Four Hour Nursing Services. Facility shall provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's Plan of Care, and each shift shall include a registered nurse who provides direct patient care. Each Hospice Patient must receive all nursing services as prescribed. For each shift, Facility will identify to Hospice in advance a charge nurse or other member of Facility's nursing staff who will respond to Hospice's requests for information concerning Hospice Patients.

(d) Home-Like Atmosphere. Facility shall provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort and privacy of patients.

(e) Discharge Summary. Facility shall provide Hospice with a copy of the discharge summary at the time of discharge.

(f) Inpatient Clinical Record. Facility shall maintain an inpatient clinical record for each Hospice Patient that includes a record of all Inpatient Services furnished and events regarding care that occurred at Facility. A copy of the inpatient clinical record shall be available to Hospice at the time of discharge.

(g) Implementation of Agreement. Facility shall designate an individual within the facility who shall be responsible for the implementation of the provisions of this Addendum and the Agreement ("Responsible Facility Representative"). The current Responsible Facility Representative is identified at the end of this Addendum. Facility shall notify Hospice if a new individual is designated as the Responsible Facility Representative.

3. Hospice Responsibilities.

(a) Provision of Plan of Care to Facility. Upon a Hospice Patient's admission to Facility for Inpatient Services, Hospice shall furnish a copy of the current Plan Care. Hospice shall specify the Inpatient Services to be furnished by Facility to such Hospice Patient.

(b) Verification of Regulatory Requirements. Hospice shall verify compliance the following requirements established by the Medicare Conditions of Participation for Hospice Care.

(i) Copy of Plan of Care. Hospice shall document in the patient's record that the Plan of Care has been provided to Facility and specify the Inpatient Services that Facility will furnish. Hospice shall periodically review Hospice Patients' records to verify that these requirements are met.

(ii) Patient Care Policies. Hospice shall verify that Facility has established patient care policies that are consistent with Hospice's policies and agrees to abide by the palliative care protocols and Plans of Care established by Hospice for its patients. Hospice shall review Facility's policies to determine their consistency with Hospice policies.

(iii) Inpatient Clinical Records. Hospice shall periodically review Hospice Patients' inpatient clinical records to determine that they include a record of all Inpatient Services furnished and events regarding care that occurred at Facility. Facility shall make inpatient clinical records available to Hospice at the time of discharge.

(iv) Copy of Discharge Summary. Hospice shall document in the patient's record that Facility provided a copy of the discharge summary at the time of discharge. Hospice shall periodically review Hospice Patients' records to verify that this requirement is met.

(v) Responsible Facility Representative. The Responsible Facility Representative is identified at the end of this Addendum. Facility shall immediately notify Hospice if a new Responsible Facility Representative is appointed, and shall inform Hospice of the name and contact information of the new Responsible Facility Representative. Hospice shall maintain a record of Responsible Facility Representatives.

(vi) Hospice Training. Facility shall provide Hospice with a list of Facility personnel who will be providing Inpatient Services to Hospice Patients, indicating whether each person has already been provided with hospice training. For personnel who have already received training, Facility shall provide Hospice with the names of the individuals who gave the training and a description of the training. For personnel who have not received hospice training, Hospice shall provide training, and shall document the names of the individuals who gave the training and a description of the training. Upon hiring new personnel who will be providing care to Hospice Patients, Facility shall notify Hospice and indicate whether the personnel have received hospice training and, if so, the names of the individuals who gave the training and a description of the training.

(c) Professional Management Responsibility. Hospice retains administrative and financial management, and oversight of staff and services related to all Inpatient Services to ensure the provision of quality care. All Inpatient Services must be authorized by Hospice, furnished in a safe and effective manner by qualified personnel, and delivered in accordance with the Plan of Care. Facility is authorized to provide all

Inpatient Services identified in the Plan of Care. Facility shall seek authorization from designated Hospice personnel prior to providing Inpatient Services not identified in the Plan of Care.

4. Billing and Payment.

(a) Medicaid Eligible Hospice Patients, Medicare Eligible Hospice Patients and Private Pay Hospice Patients. Hospice shall pay Facility a fixed rate for each General Inpatient Care Day provided to a Medicaid Eligible Hospice Patient or a Medicare Eligible Hospice Patient, except the day on which such patient is discharged from Facility, unless such patient dies while residing at Facility, unless Medicaid does not reimburse for the day of death. The fixed payment rate shall be $325 for each General Inpatient Care Day provided to such Medicare Eligible Hospice Patients and Medicaid Eligible Hospice Patients. Facility shall accept this rate as payment in full for each General Inpatient Care Day provided to Medicaid Eligible Hospice Patients and Medicare Eligible Hospice Patients and shall not bill such patients, their family, representatives or any third party payor. The rate represents fair market value and does not take into account the volume or value of referrals. Rates for reimbursement for General Inpatient Care Days provided to Private Pay Hospice Patients, including those with third party payors other than Medicare or Medicaid will be established in writing by Facility in advance for each such patient.

(b) Billing. The terms for billing for General Inpatient Care shall be governed by the Agreement.

5. Responsible Facility Representative. Facility has identified the following individual as the Responsible Facility Representative Sandi Singer.

6. Conflicts. This Addendum shall be subject to the terms and conditions of the Agreement; provided that, in the event of a conflict between the terms and conditions of this Addendum and the terms and conditions of the Agreement, the terms and conditions of this Addendum shall control. Except as specifically amended herein, all other terms and conditions of the Agreement shall remain in full force and effect.

The parties have executed this Addendum as of the day, month and year first written above.

Agreed HOSPICE	Agreed FACILITY
By: Marshall Scott	By: Jacqueline Wembely-Hardy
Name: Marshall Scott	Name: Jacqueline Wembely-Hardy
Title: Director of Business Operations	Title: Administrator
Seasons Hospice & Palliative Care	

MOBILE X-RAY AND EKG SERVICES AGREEMENT

THIS MOBILE X-RAY AND EKG SERVICES AGREEMENT (the "Agreement") is made and entered into as of this 24 day of Feb., 2005 ("Commencement Date"), by and between **GOLDEN AGE GUEST HOME** ("Facility"), and **SYMPHONY DIAGNOSTIC SERVICES No.1, INC.**, a California corporation **d/b/a MOBILEX USA.**

NOW THEREFORE, in consideration of the mutual covenants, premises and agreements herein contained, and other good and valuable consideration, receipt of which is hereby acknowledged, the parties hereto agree as follows:

1. Services. MobilexUSA shall provide portable x-ray and EKG services to residents or patients of the Facility, only on the order of a duly licensed and authorized physician. All x-rays will be interpreted by a duly licensed and qualified Radiologist (the "Radiologist"). The Radiologist will dictate a report for each examination. MobilexUSA will promptly fax an abbreviated verbal report to the Facility. For all STAT and positive exams, MobilexUSA will place a call as well as faxed verbal report to the Facility. A transcribed full written report will follow. MobilexUSA will perform EKGs and upon request have an interpretive written report issued.

2. Payment. MobilexUSA will invoice Facility for services provided to all patients designated as Medicare Part A or patients whose stay is covered by an "all inclusive arrangement" between Facility and Medicare, private insurance carriers, or managed care organizations. MobilexUSA will invoice Facility monthly according to the current Medicare fee schedule less a 5% discount, plus an additional 5% if payment is made within agreed upon payment terms. Facility is eligible for 10% total discount based on these terms.

MobilexUSA will invoice Medicare, Medicaid or appropriate third party insurance for services provided to those residents or patients not covered by Medicare Part A or an "all inclusive arrangement" between Facility and Medicare, private insurance carrier or managed care organization.

The Facility will provide MobilexUSA with a listing of all Medicare Part A patients or patients whose care is under an "all inclusive charge" arrangement by the fifth (5^{th}) working day of each new month for patients serviced in the previous month. Facility agrees to fax this listing to MobilexUSA at the MobilexUSA Billing Center number 800-288-1059. Facility agrees to use its best efforts to provide MobilexUSA with accurate and timely billing and patient information so that MobilexUSA can process patient charges to either the facility or appropriate insurance carrier.

MobilexUSA will provide the Facility by the tenth (10^{th}) working day of each month an invoice containing all Medicare Part A and other patients for whom the Facility is responsible for portable x-ray and related services.

Facility agrees to pay each MobilexUSA invoice in full within 45 days of the invoice date. Facility agrees that Facility requested changes to any invoice (i.e. changes in patient insurance status) must be submitted to MobilexUSA within 60 days from the date of service.

Facility and MobilexUSA shall comply with all applicable laws (including, without limitation, all Medicare and Medicaid statutes, regulations, and manuals), and with all applicable agreements with and policies of other third party payers, in connection with Facility's billing for services provided by MobilexUSA pursuant to this Agreement. The facility will notify MobilexUSA if there is a change to their Medicare certification status so that the proper procedures may be implemented.

3. **Term.** The term of this Agreement shall be for a period of one (1) year beginning on the Commencement Date ("Initial Term") and shall be automatically renewed for successive one (1) year terms ("Renewal Term") unless written notice of termination is provided to the other party hereto at least 60 days in advance. Either party may terminate this Agreement with or without cause by giving the other party not less than 30 (30) days' prior written notice.

4. **Compliance with Laws.** MobilexUSA shall insure that all services required of MobilexUSA hereunder are provided by qualified and appropriately licensed and/or certified personnel and in accordance with all applicable laws. MobilexUSA shall comply fully with Title VII of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; and the Age Discrimination Act of 1975; and shall render services to Facility's patients without discrimination due to gender, race, religion, color, national origin, handicapping condition, or age.

5. **Inspection of Books and Records.** As an independent contractor, MobilexUSA shall, in accordance with 42 U.S.C. §1395x(v)(1)(I) (Social Security Act §1861(v)(1)(I) and 42 C.F.R. Part 420, Subpart D §420.300 et seq., until the expiration of four (4) year after the furnishing of Medicare reimbursable services pursuant to this Agreement, upon proper written request, allow the Comptroller General of the United States, the Department of Health and Human services, and their duly authorized representatives access to this Agreement and to MobilexUSA's books, documents and records (as such terms are defined in 42 C.F.R. § 420.301) necessary to verify the nature and extent of costs of Medicare reimbursable services provided under this Agreement. In accordance with such laws and regulations, if Medicare or Medicaid reimbursable services provided by MobilexUSA under this Agreement are carried out by means of a subcontract with an organization related to MobilexUSA, and such related organization provides the services at a value or cost of $10,000 or more over a twelve-month period, then the subcontract between MobilexUSA and the related organization shall contain a clause comparable to the clause specified in the preceding sentence. No attorney-client, accountant-client or other legal privilege will be deemed to have been waived by any party hereto by virtue of this Agreement.

6. **Insurance.** MobilexUSA shall secure and maintain at all times during the term of this Agreement and any renewals or extensions hereof, professional and general liability insurance with a company with an A.M. best rating of not less than A-VI, with such coverages and in such amounts as are customarily carried by similar providers in the state where services

are provided, provided that such coverage shall be in a minimum amount of at least $1,000,000 per claim or occurrence and $3,000,000 in the aggregate, insuring MobilexUSA, its employees and agents for the services delivered by them hereunder. Upon request, a copy of a certificate of insurance shall be provided evidencing such coverage.

Facility shall secure and maintain at all times during the term of this Agreement, at Facility's sole expense, professional and general liability insurance with a company with an A.M. best rating of not less than A-VI covering Facility, with such coverages and in such amounts as are customarily carried by similar providers in the state where services are provided, provided that such coverage shall be in a minimum amount of at least $1,000,000 per claim or occurrence and $3,000,000 in the aggregate, insuring Facility, its employees and agents for the services delivered by them hereunder. Upon request, a copy of a certificate of insurance shall be provided evidencing such coverage.

7. **Independent Contractor.** MobilexUSA shall not be considered an employee or agent of Facility for any purpose and no partnership, joint venture or co-venture shall be created by virtue of this Agreement or the performance by MobilexUSA hereunder. The parties hereto are independent contractors, contracting with one another solely for the purposes set out herein. MobilexUSA acknowledges that as an independent contractor, neither MobilexUSA nor its employees or agents are covered under Facility's workers' compensation insurance and are not entitled to any fringe benefits afforded to employees of Facility.

8. **Health Information Portability and Accountability Act.** MobilexUSA and the facility are covered entities (as defined in the 1996 Health Information Portability and Accountability Act ("HIPAA") and the regulation promulgated there under) and therefore must be in compliance with all applicable aspects of HIPAA and will treat all protected health information in accordance with the provisions of HIPAA.

9. **Standards of Conduct.** By signing this Agreement, the facility hereby acknowledges and understands that MobilexUSA has implemented a compliance program governing the conduct of all MobilexUSA employees. The facility further acknowledges that it has received a copy of the MobilexUSA Standards of Conduct (a copy of which is attached and referred to as ("Standards") and will ensure that each of its employees who have any interactions with MobilexUSA receives a copy of the Standards for reference.

10. **Exclusions from State and Federal Healthcare Programs.** The facility represents and warrants it has not been excluded from any federal healthcare program, that no basis for such exclusion exists, and that it has not been subject to any final adverse action as defined under the Health Care Fraud and Abuse Data Collection Program. The facility agrees to notify MobilexUSA immediately if it is subject to an inquiry, investigation, or final adverse action by a governmental agency, third-party payer, or intermediary as to the provision of services under this Agreement. MobilexUSA, at its sole discretion, shall have the right to terminate this Agreement immediately upon notice, by the facility or otherwise, of such an event.

11. Notices. All notices provided for or contemplated by this Agreement shall be in writing and shall be deemed given when deposited in the U.S. Mail, postage prepaid, certified mail, return receipt requested, addressed as follows:

If to Facility:
Golden Age Guest Home
1442 Buckhorn Road
Sykesville, MD 21784
Attn: Administrator

If to Mobilex:
Symphony Diagnostic Services No. 1, Inc.,
d/b/a MobilexUSA
185 Witmer Road
Horsham, PA 19044
Attn: Maryland Regional Manager

Copy to:
MobilexUSA
2622 Lord Baltimore Drive
Suite H
Baltimore, MD 21244
Attn: Regional Manager

12. General Terms and Conditions. All of the provisions of the General Terms and Conditions addendum, attached to this Agreement, are hereby incorporated by reference herein.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first written above.

FACILITY

By: JAMES C. TALBOTT, PRES.
Print Name Title

Authorized Signature:

James C Talbott 02-24-05
Name Date

SYMPHONY DIAGNOSTIC SERVICES NO. 1, INC. D/B/A MOBILEXUSA

By: _____
Robbin Reichert Date

Title: Director of Sales _____
Date

GENERAL TERMS AND CONDITIONS
(Addendum to Mobile X-Ray and EKG Services Agreement)

A. Confidentiality. Neither MobilexUSA or any of its staff shall disclose to any third party, except where permitted or required by law or where such disclosure is expressly approved by Facility in writing, any patient or medical record information regarding Facility's patients, and MobilexUSA and all MobilexUSA staff shall comply with all federal and state laws and regulations, and all rules, regulations, and policies of Facility regarding the confidentiality of such information. Facility shall provide MobilexUSA copies of all such rules, regulations, and policies.

All documentation and records relating to Facility's patients shall be and remain the sole property of Facility, subject to the patient's rights in such records. Facility further covenants and warrants that it and its employees and agents shall at all times during the term of this Agreement and after expiration or termination of this Agreement, maintain the confidentiality of MobilexUSA's operations, prices, rates, clients and patients, methods and any other information relative to MobilexUSA. Further, Facility shall not use such confidential information in any manner adverse to MobilexUSA's or its patients' interests.

B. Miscellaneous.

(1) This Agreement shall be governed by and construed in accordance with the laws of the state in which services are to be performed. This agreement shall be interpreted in accordance with its plain meaning and not for or against any party hereto. All captions herein are for organizational purposes only and not intended to limit the meaning of anything herein or to have an independent legal meaning.

(2) Notwithstanding any other provision of this Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payer, or any other federal, state or local government or agency passes, issues or promulgates any law, rules, regulation, standard or interpretation, or any court of competent jurisdiction renders any decision or issues any order, at any time while this Agreement is in effect, which prohibits, restricts, limits or in any way substantially changes the method or amount of reimbursement or payment for services rendered under this Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend this Agreement to the satisfaction of both parties, to compensate for such prohibition, restriction, limitation or change. If this Agreement is not so amended in writing within ten (10) days after said notice was given, this Agreement shall terminate as of midnight on the tenth (10) day after said notice was given.

(3) Nothing herein shall require Facility to designate any minimum number of residents or patients for whom MobilexUSA shall provide services.

(4) This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement. Signed facsimile copies of this Agreement shall be legal, valid and binding upon the parties hereto.

(5) In the event any provision of this Agreement is held to be invalid, illegal, or unenforceable for any reason and in any respect, if the extent of such invalidity, illegality or unenforceability does not destroy the basis of the bargain herein such invalidity, illegality, or unenforceability shall in no event affect, prejudice, or disturb the validity of the remainder of this Agreement, which shall be in full force and effect, enforceable in accordance with its terms as if such provisions had not been included, or had been modified as provided below, as the case may be. To carry out the intent of the parties hereto as fully as possible, the invalid, illegal or unenforceable provision(s), if possible, shall be deemed modified to the extent necessary and possible to render such provision(s) valid and enforceable. The parties hereto shall negotiate in good faith to modify this Agreement so as to effect the original intent of the parties as closely as possible.

(6) Neither party shall be liable or deemed to be in default for any delay or failure in performance under this Agreement or other interruption of service deemed to result, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquakes, floods, failure of transportation, strikes or other work interruptions by either party's employees, or any other similar cause beyond the reasonable control of either party.

(7) **Assignment.** Neither party may assign or transfer, in whole or in part, this Agreement or any of its rights duties or obligations under this Agreement and MobilexUSA shall not subcontract any of its services hereunder without the prior written consent of the other party. Any such purported assignment or transfer of this Agreement, in whole or in part, without the other party's consent shall be null and void. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

(8) **Counterparts.** This Agreement may be executed in any number of counterparts, each of which shall be deemed an original.

(9) **Attorneys' Fees.** In the event of any litigation or arbitration proceeding between the parties concerning the subject matter of this Agreement, the prevailing party shall be entitled to a judgment against the other for an amount equal to reasonable attorneys' fees and expenses and court and other costs incurred.

RADIOLOGY-ULTRASOUND CONTRACT PRICING ADDENDUM

Addendum to contract entered into March 1, 2005 between **MobilexUSA** and **Brinton Woods Nursing and Rehabilitation Center.**

MobilexUSA will invoice Facility for x-ray services provided to all patients designated as Medicare Part A and whose stay is covered by an "all inclusive arrangement" between Facility and Medicare. MobilexUSA will invoice Facility monthly according to the prevailing state specific Medicare fee schedule applicable to the locality of the Facility less a twenty percent (20%) discount. An additional 10% prompt pay discount will be applied if payment is made within net 30 days.

MobilexUSA will invoice Facility for x-ray services provided to all patients designated as Managed Care, VA or private insurance carriers and are covered by an "all inclusive arrangement." Facility will pay MobilexUSA at the global rate (GB) according to the prevailing Medicare fee schedule applicable to the locality of the Facility less a twenty percent (20%) discount. An additional 10% prompt pay discount applies if payment is made within net 30 days.

MobilexUSA will invoice Facility for EKG, and/or holter monitoring services provided to all patients designated as Medicare Part A or patients whose stay is covered by an "all inclusive arrangement" between Facility and Medicare, private insurance carriers, or managed care organizations. Facility will pay MobilexUSA according to the prevailing state specific Medicare fee schedule applicable to the locality of the Facility less a twenty percent (20%) discount. The 10% prompt pay discount applies if payment made within net 30 days.

For Ultrasound Services provided to residents of Facility, MobilexUSA will invoice Facility for services provided to residents designated as Medicare Part A or whose stay is covered by an "all-inclusive arrangement" between Facility and Medicare, private insurance carriers, or managed care organizations. Facility will pay MobilexUSA according to the prevailing state specific Medicare fee schedule. The 10% prompt pay discount has been approved by the President of the Ultrasound Division to be applied for Brinton Woods. The facilities will need to manually calculate this reduction, as Mobilex nationally does not extend this discount, so it is not a programmed feature for billing.

This agreement supersedes all existing radiology pricing agreements and is effective March 1, 2011.

BRINTON WOODS Health Care Center, LLC

Signature Daren Cortese 3/21/11

Daren Cortese — Date

Title: Owner

MOBILEXUSA:

Signature _____ 3-22-11

Date

Title: Dave Williams — RGM-MA Region

Name (Please Print) — Title

HOSPICE SERVICE AGREEMENT

THIS HOSPICE SERVICE AGREEMENT (the "Agreement") is made and entered into this ~~5th~~ day of ~~June~~ December, 1997, by and between Carroll Hospice, Inc. ("Hospice") a Maryland corporation, and Golden Age Guest Home ("Nursing Facility"), a Maryland corporation.

RECITALS

A. Hospice is a patient- and family-centered program, certified and licensed to provide comprehensive interdisciplinary services for the palliation and management of terminal illness. Hospice desires to provide such services to residents of Nursing Facility in cooperation with the management and staff of Nursing Facility.

B. Nursing Facility is skilled and experienced in the operation of a nursing facility and in the provision of long-term care services to its residents, including the provision of assistance with activities of daily living. Nursing Facility is certified to participate in the Medicare and Medicaid programs, and has established policies and protocols for the care of terminally ill patients consistent with those of Hospice.

C. Nursing Facility, a long-term care facility, occasionally has among its residents individuals who are terminally ill with a medical prognosis of six months or less. The parties contemplate that, from time to time, individuals residing in Nursing Facility will need Hospice Services as defined in Section 1.10, and individuals previously accepted into Hospice will need care in Nursing Facility. Hospice and Nursing Facility desire by entering into this Agreement to make it possible for individuals with terminal illness to receive needed Hospice Services in conjunction with Nursing Facility Services as defined in section 1.14.

NOW, THEREFORE, in consideration of the foregoing and the mutual covenants and agreements herein contained, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto, intending to be legally bound, hereby agree as follows:

1. DEFINITIONS

As used herein, the following terms shall have the meanings set forth below:

1.1 "Attending Physician" means a duly licensed doctor of medicine or osteopathy who, upon the election of Hospice Services, is identified by a Hospice Patient (or such patient's legal representative) as having the most significant role in the determination and delivery of such Hospice Patient's medical care.

1.2 "Cost Distribution Chart" means the Statement of Financial Responsibility for Charges, a form of which is attached hereto as Exhibit A, which indicates the party responsible for payment of each element of the Residential Hospice Patient's care.

1.3 "Effective Date" means the date of execution of this Agreement.

1.4 "Eligible Resident" means a resident of the Nursing Facility and who meets all the following criteria:

(a) the resident's attending physician has certified in writing that the person is terminally ill, with a medical prognosis of six months or less if the illness runs its normal course;

(b) the resident's attending physician has provided a written order for hospice care in the such resident's chart;

(c) the resident is appropriate for hospice care, in accordance with criteria established by Hospice; and

(d) if the resident is eligible for Medicare or Medical Hospice Benefit coverage and reimbursement for hospice home care services, the resident has made a Medicare or Medicaid Hospice Benefit Election with the result that Hospice can be reimbursed for Hospice Services provided to the resident.

1.5 "Hospice Care Coordinator" means a registered nurse employed by Hospice to direct the Interdisciplinary Group; to develop and interpret the Hospice Plan of Care with each Hospice Patient, his/her family, and Nursing Facility staff; and to act as the Hospice representative to Nursing Facility with respect to specific care decisions.

1.6 "Hospice Designated Representative" means one or more Hospice employees identified in writing by Hospice to Nursing Facility who can pre-authorize charges for services or supplies not described in the Hospice Plan of Care.

1.7 "Hospice Patient" means an individual who elects, directly or through such individual's legal representative, to receive Hospice Services and is accepted by Hospice to receive Hospice Services.

1.8 "Hospice Physician" means a duly licensed doctor of medicine of osteopathy employed by Hospice to render physician services to each Hospice Patient, as necessary, in accordance with the applicable Hospice Plan of Care.

1.9 "Hospice Plan of Care" means a written, interdisciplinary plan of care established and maintained for each Hospice Patient which contains an assessment of the Hospice Patient's needs, identifies the services to be provided, and describes in detail the scope and frequency of

Hospice Services and supplies to palliate and manage the Hospice Patient's terminal illness. The Hospice Plan of Care shall be established by the Attending Physician, the Medical Director, the Interdisciplinary Group, the Hospice Patient, and his/her family, where appropriate, prior to the provision of Hospice Services. The Hospice Plan of Care shall specify which services and supplies are related to Hospice Patient's terminal illness and, therefore, shall be furnished or paid for by Hospice.

1.10 "Hospice Services" means those services provided to Hospice Patient for the palliation and management of such Hospice Patient's terminal illness, either directly or under arrangement by Hospice, as specified in the Hospice Plan of Care. Hospice Services include nursing care and services by or under the supervision of a registered nurse; medical social services provided by a qualified social worker under the direction of a physician; physician services to the extent that these services are not provided by the Attending Physician; counseling services, including bereavement, dietary and spiritual counseling; physical therapy, occupational therapy, and speech-language pathology services; home health aid/homemaker services; medical supplies; drugs and biologicals; instruction in the use of medical appliances; and inpatient care when needed for pain control, symptom management, and respite purposes.

1.11 "Interdisciplinary Group" means the group which shall implement, supervise, and/or collaborate regarding the provision of Hospice Services at Nursing Facility, consisting of, without limitation, the following Hospice employees:

(a) a doctor of medicine or osteopathy;

(b) a registered nurse;

(c) a social worker; and

(d) a pastoral or other counselor.

Nursing Facility may appoint one or more of its staff members to the Interdisciplinary Group. The Interdisciplinary Group is responsible for the establishment, periodic review, and updating of the Hospice Plan of Care for each Hospice Patient; the provision and supervision of the Hospice Services; and the establishment of policies governing the day to day provision of Hospice Services.

1.12 "Medical Director" means a doctor of medicine or osteopathy, duly licensed in the State of Maryland, who is retained by Hospice to provide physician services to Hospice Patients as needed and in accordance with each Hospice Patient's Plan of Care, and to assume overall responsibility for the medical component of the Hospice Services.

1.13 "Nursing Facility Plan of Care" means a written care plan established, maintained, reviewed and modified, if necessary, by a Nursing Facility interdisciplinary team which includes

the Attending Physician, a registered professional nurse with responsibility for the Residential Hospice Patient, and other appropriate staff, and with the participation of the Residential Hospice Patient, and his/her family to the extent practicable, and subject to the approval of Hospice.

1.14 "Nursing Facility Services" means, collectively, Nursing Facility Room and Board Services and Other Nursing Facility Services.

1.15 "Nursing Facility Room and Board Services" means those personal care services provided by Nursing Facility as specified in the Hospice Plan of Care or the Nursing Facility Plan of Care for a Residential Hospice Patient, including, but not limited to: providing food (and accommodating individualized requests); assisting in activities of daily living, socializing activities, the administration of medicine; maintaining the cleanliness of the Residential Hospice Patient's room; supervising and assisting in the use of any durable medical equipment and therapies included in the Hospice Plan of Care; providing laundry and personal care supplies; and providing the usual and customary room furnishings provided to Nursing Facility Residents, including, but not limited to, beds, linens, lamps and dressers.

1.16 "Other Nursing Facility Services" means all items and services provided by Nursing Facility which are not related to treatment of the Residential Hospice Patient's terminal illness but are specified in the Nursing Facility Plan of Care.

1.17 "Purchased Hospice Services" means those Hospice Services specified in Exhibit B that Hospice has contracted with Nursing Facility to provide.

1.18 "Residential Hospice Patient" means a Hospice Patient who resides in Nursing Facility.

1.19 "Uncovered Items and Services" means those services provided by Nursing Facility which are not Hospice Services, Nursing Facility Room and Board Services, or Other Nursing Facility Services, including, but not limited to, telephone service, guest trays, and television hookups.

2. SERVICES TO BE PROVIDED BY HOSPICE

2.1 Admission to Hospice Program.

(a) If an Eligible Resident requests the provision of Hospice Services, Hospice shall perform an assessment of such Eligible Resident and shall notify the Nursing Facility, either orally or in writing, whether such Eligible Resident is authorized for admission as a Residential Hospice Patient. Hospice shall maintain adequate records of each authorization of Hospice admission.

(b) On or prior to the execution of this Agreement, Hospice shall provide Nursing Facility with its current criteria for admission. Hospice will promptly provide Nursing Facility with any modification to these criteria.

2.2 Design and Maintenance of Hospice Plan of Care.

(a) Nursing Facility Residents. In accordance with federal and state law, Hospice shall develop a Hospice Plan of Care for each new Residential Hospice Patient. Promptly upon consent of the Residential Hospice Patient (or his/her legal representative), Hospice shall furnish Nursing Facility with a copy of the Hospice Plan of Care.

(b) Non-residential Hospice Patients. Promptly upon the admission of a Hospice Patient who has not been residing in a nursing home to the Nursing Facility, and upon consent of the Hospice Patient (or his/her legal representative), Hospice shall furnish Nursing Facility with a copy of the then-current Hospice Plan of Care.

(c) Modification. At intervals established by the Interdisciplinary Group, the Interdisciplinary Group will review and modify, if necessary, the Hospice Plan of Care. The Interdisciplinary Group will consult with Nursing Facility, as reasonably necessary, with respect to the modification of a Hospice Plan of Care, and will provide Nursing Facility with any modifications thereto.

(d) Monitoring. Hospice will promptly inform Nursing Facility of any identified change in the condition of a Residential Hospice Patient which requires supplementation, modification or alteration of the Nursing Facility Plan of Care.

(e) Physician Orders. All physician orders communicated to Nursing Facility on behalf of Hospice in connection with the Hospice Plan of Care shall be in writing and signed by the applicable Attending Physician or Hospice Physician; *provided, however* that in the case of urgent or emergency circumstances, such orders may be communicated by the physician orally and confirmed in writing thereafter. Hospice shall maintain adequate records of all physician orders communicated in connection with the Hospice Plan of Care.

2.3 Notification of Hospice Services. Hospice shall fully inform Residential Hospice Patients of the Hospice Services to be provided by the Hospice and the Nursing Facility Services, and Purchased Hospice Services, if any, to be provided by the Nursing Facility.

2.4 Provision of Hospice Services. Hospice shall provide Hospice Services, as required by federal and state law, 24 hours a day, seven days a week. Hospice will provide Hospice Services to each Residential Hospice Patient in accordance with the Hospice Plan of Care for that patient.

2.5 Supervision of Hospice Plan of Care. Hospice shall be responsible for the professional management of the Hospice Plan of Care, including any Purchased Hospice Services.

2.6 Cost Distribution Chart. Hospice shall be responsible for the preparation of the Cost Distribution Chart, and shall produce a final version thereof with the consultation of Nursing Facility.

2.7 Training. Hospice shall provide in-service training with respect to the care of Hospice Patients to Nursing Facility staff at least twice per year, in accordance with the National Hospice Standards of Care and federal and state regulations.

3. SERVICES TO BE PROVIDED BY NURSING FACILITY

3.1 Admission to Nursing Facility.

(a) Request for Admission. In the event that a non-residential Hospice Patient requests admission to the Nursing Facility, Nursing Facility shall admit such Hospice Patient, subject to Nursing Facility's admission policies and procedures and to the availability of beds. Nursing Facility shall notify Hospice in writing as to whether such Hospice patient is authorized for admission as a Residential Hospice Patient. Nursing Facility shall maintain adequate records of all such authorizations of admission.

(b) Admission Policies. On or prior to the execution of this Agreement, Nursing Facility shall provide Hospice with its current admission policies and procedures. Nursing Facility will promptly provide Hospice with any modification to such policies and procedures.

3.2 Notification of Nursing Facility Residents. Nursing Facility shall inform each terminally ill resident of the Nursing Facility of that resident's option to elect to receive Hospice Services, subject to such resident's meeting the Hospice's criteria for admission.

3.3 Notification of Services. Nursing Facility shall fully inform Residential Hospice Patients of the Other Nursing Facility Services and Uncovered Items and Services to be provided by Nursing Facility.

3.4 Design and Maintenance of Nursing Facility Plan of Care.

(a) Design of Plan. In accordance with federal and state law, Nursing Facility shall develop a Nursing Facility Plan of Care for each new Residential Hospice Patient. Promptly upon consent of the new Residential Hospice Patient (or his/her legal representative), Nursing Facility shall provide a copy of the Nursing Facility Plan of Care to Hospice for review. The Nursing Facility Plan of Care shall be subject to the approval of Hospice.

(b) Modification. The Nursing Facility will periodically review and modify the Nursing Facility Plan of Care, subject to the approval of Hospice.

(c) Monitoring of Residential Hospice Patient. Nursing Facility shall immediately inform Hospice of any change in the condition of a Residential Hospice Patient and any change in the level of care that may require a change in the Hospice Plan of Care.

3.5 Provision of Nursing Facility Services. Nursing Facility shall provide Nursing Facility Services, as necessary and appropriate, 24 hours a day, seven days a week. Nursing Facility will provide Nursing Facility Services and Purchased Hospice Services, if any, to each Residential Hospice Patient in accordance with the Hospice Plan of Care and the Nursing Facility Plan of Care for that Residential Hospice Patient. Such Nursing Facility Services shall include all personal services that the Nursing Facility provides to its non-Hospice patients, and shall make available to each Residential Hospice Patient the program of therapies and activities that is made available to other residents of the Nursing Facility.

3.6 Patient Care. In providing the Nursing Facility Services and Purchased Hospice Services, Nursing Facility shall provide care to each Residential Hospice Patient to keep him/her comfortable, clean, well-groomed, and protected from accident, injury and infection.

3.7 Facility Requirements.

(a) Patient Room. Nursing Facility shall provide each Residential Hospice Patient with a clean, home-like room, designed and equipped for the comfort, privacy and safety of the Residential Hospice Patient and his/her personal belongings, which will accommodate visitors as contemplated by Section 3.7(c) hereof.

(b) Visiting Privileges. Nursing Facility shall permit free access and unrestricted visiting privileges (including, but not limited to, visits by children of any age) 24 hours a day, seven days a week.

(c) Visitor Accommodations. Nursing Facility shall provide adequate space, located as conveniently as possible to the Residential Hospice Patient, for private visiting among the Residential Hospice Patient, the Residential Hospice Patient's family members, and any other visitors. Nursing Facility shall provide adequate accommodations for the Residential Hospice Patient's family members and any other visitors. Nursing Facility shall provide adequate accommodations for the Residential Hospice Patient's family members to remain with the Residential Hospice Patient at all times, and to permit family members privacy following the death of the Residential Hospice Patient.

(d) Hospice Access to Facility. Nursing Facility shall permit employees, contractors, agents and volunteers affiliated with the Hospice free, complete access to the

Nursing Facility at all times to permit Hospice to counsel, treat, attend and provide services to each Residential Hospice Patient.

(e) Personnel and Training. Upon Hospice's request, Nursing Facility shall cause Nursing Facility personnel who provide Nursing Facility Services to Residential Hospice Patients under this Agreement (i) to attend, at reasonable times and locations, training provided by Hospice in the care of Hospice Patients, and (ii) to attend meetings and conferences of the Interdisciplinary Group. Nursing Facility personnel who provide Nursing Facility Services to Hospice Patient shall be reasonably acceptable to Hospice.

3.8 Facility Protocols. Nursing Facility shall institute, maintain and conduct administrative procedures and patient care protocols which are: (i) consistent with the procedures and protocols of Hospice, including but not limited to resuscitation, nutrition and hydration; (ii) in accordance with recognized professional standards of care for terminally ill patients; and (iii) reasonably necessary to implement the provisions of this Agreement. Upon the execution of this Agreement, Nursing Facility shall provide Hospice with copies of any written administrative procedures and patient care protocols, and shall provide Hospice with any future amendments or modifications thereto prior to the implementation of such amendments or modifications.

3.9 Patient Transfer. Except as dictated by emergency medical conditions, Nursing Facility agrees not to transfer any Residential Hospice patient to another care setting without the prior written approval of Hospice. If Nursing Facility fails to obtain such approval, it shall bear the financial responsibility for the costs of transfer and the additional costs of care provided in the new setting.

4. REPRESENTATIONS, WARRANTIES AND COVENANTS OF HOSPICE

Hospice hereby represents, warrants and covenants to Nursing Facility as follows:

4.1 Organization. Hospice is a corporation duly organized, validly existing, and in good standing, and has all requisite corporate power to conduct its business as presently conducted.

4.2 Authorization of this Agreement. The execution, delivery and performance of this Agreement has been duly authorized by all requisite corporate action on the part of Hospice. This Agreement has been duly executed and delivered by Hospice and constitutes a valid and binding obligation of Hospice.

4.3 Compliance. Hospice has complied, and in performing this Agreement shall comply, in all material respects with all applicable law with respect to health and safety and the provision of hospice care.

4.4 Licensure. Hospice is duly certified as a Medicare provider under Title XVIII of the Social Security Act and as a Medicaid provider under Title XIX of the Social Security Act. Hospice possesses all federal, state and local licenses and permits required for the conduct of its business as presently conducted. Such licenses and permits are in full force and effect, no violations are or have been recorded in respect to any such licenses or permits, and no proceeding is pending or, to the knowledge of Hospice, threatened that threatens to revoke or limit any thereof. Upon request of Nursing Facility, Hospice shall furnish true and complete copies of any of the licenses or permits.

4.5 No Litigation. There is no action, suit, investigation or proceeding pending, or to the knowledge of Hospice, threatened against Hospice. Hospice shall promptly notify Nursing Facility of the commencement of any action or proceeding against Hospice with respect to any of its licenses, permits, or other legal authorizations, including, but not limited to any sanctions, intermediate or otherwise, administrative or judicial fines, penalties, investigations or reports of action by federal or state officials.

4.6 Insolvency. Hospice shall inform Nursing Facility in the event that any proceeding shall be instituted by or against Hospice in bankruptcy, or seeking liquidation, winding up, reorganization, protection, relief of composition of its debts under any law related to bankruptcy, insolvency, reorganization or relief of debtors, or seeking the appointment of a receiver or trustee.

4.7 Adequate Staffing and Facilities. As of the date hereof, Hospice has, and will maintain throughout the term of this Agreement, a sufficient number of medical, nursing and other staff to permit Hospice to perform its obligations hereunder. Such staff will be duly licensed, certified or registered in accordance with federal and state law.

5. REPRESENTATIONS, WARRANTIES AND COVENANTS OF NURSING FACILITY

Nursing Facility hereby represents, warrants and covenants to Hospice as follows:

5.1 Organization. Nursing Facility is a corporation duly organized, validly existing, and in good standing, and has all requisite corporate power to conduct its business as presently conducted.

5.2 Authorization of this Agreement. The execution, delivery and performance of this Agreement has been duly authorized by all requisite corporate action on the part of Nursing Facility.

5.3 Compliance. Nursing Facility has complied, and in performing this Agreement shall comply, in all material respects with all applicable law with respect to health and safety and the provision of nursing home care, including the Patient Self-Determination Act.

5.4 Licensure. Nursing Facility is duly certified as a Medicare provider under Title XVIII of the Social Security Act and as a Medicaid provider under Title XIX of the Social Security Act. Nursing Facility possesses all federal, state and local licenses and permits required for the conduct of its business as presently concluded. Such licenses and permits are in full force and effect, no violations are or have been recorded in respect of any such licenses or permits, and no proceedings are pending or, to the knowledge of Nursing Facility, threatened to revoke or limit any thereof. Upon request of Hospice, Nursing Facility shall furnish true and complete copies of any of the licenses or permits.

5.5 No Litigation. There is no action, suit, investigation or proceeding pending or, to the knowledge of Nursing Facility, threatened against the Nursing Facility. Nursing Facility shall promptly notify Hospice of the commencement of any action or proceeding against Nursing Facility with respect to any of its licenses, permits or other legal authorizations, including, but not limited to any sanctions, intermediate or otherwise, administrative or judicial fines, penalties, investigations or reports of action by federal or state officials.

5.6 Insolvency. Nursing Facility shall inform Hospice in the event that any proceedings shall be instituted by or against Nursing Facility in bankruptcy, or seeking liquidation, winding up, reorganization, protection, relief of composition of its debts under any law relating to bankruptcy, insolvency, reorganization or relief of debtors or seeking the appointment of a receiver or trustee.

5.7 Adequate Staffing and Facilities. Nursing Facility has, and will, remain throughout the term of this Agreement, a sufficient number of nursing and other staff who have the requisite training, skills and experience to permit Nursing Facility to perform its obligations hereunder. Such staff will be duly licensed, certified or registered in accordance with federal and state law. Nursing Facility has, and will maintain, adequate facilities and equipment throughout the term of this Agreement to perform its obligations hereunder.

5.8 Cost Distribution Charts. Nursing Facility shall maintain a copy of the Cost Distribution Chart for each Residential Hospice Patient in such patient's "chart," and shall instruct the Nursing Facility staff and Attending Physician to consult the Cost Distribution Chart when ordering treatment.

5.9 Control of Expenditures. In the event that any of the services or supplies required by the Nursing Facility Services or Purchased Hospice Services are available from a vendor outside the Nursing Facility, Hospice shall have the right either to obtain the relevant services or supplies from such vendor or to pay Nursing Facility the reasonable and customary rates for such services or supplies. Except when dictated by emergency medical conditions, Nursing Facility shall obtain the prior approval of a Hospice Designated Representative before purchasing services or supplies not described in the Hospice Plan of Care or the Nursing Facility Plan of Care.

6. REIMBURSEMENT

6.1 Reimbursement of Nursing Facility. Nursing Facility shall bill Hospice for all Nursing Facility Services, Purchased Hospice Services, and all other services provided to each Residential Hospice Patient. With respect to those services and supplies subject to reimbursement from Medicare or Medicaid, Nursing Facility hereby agrees to accept the Medicare or Medicaid reimbursement as full and fair payment therefor. With respect to all other services and supplies, Hospice shall reimburse Nursing Facility at the reasonable and customary rates set forth on Exhibit C hereto, and Nursing Home agrees to accept such payment as payment in full. Under no circumstances shall Nursing Facility bill or collect money from a Residential Hospice Patient or his/her family in connection with the provision of Nursing Facility Services or Purchased Hospice Services.

6.2 Reimbursement of Hospice. Nursing Facility agrees to provide appropriate assistance to Hospice in the preparation of all forms required by Medicare, Medicaid, and any third party payors.

6.3 Billing. Within 60 days after the provision of Nursing Facility Services and Purchased Hospice Services, Nursing Facility shall submit to Hospice all bills issued pursuant to Section 6.1 on forms acceptable to Hospice that include information usually provided to third party payors to verify the services and charges reflected in such billings. Nursing Facility shall issue a separate bill for each patient. Hospice shall pay Nursing Facility either (a) within 60 days after receipt of each Nursing Facility bill or (b) if applicable, upon payment by Medicare or Medicaid to Hospice, whichever is later. Payment by Hospice in respect to such bills shall be considered final, unless adjustments are requested in writing by Nursing Facility within 30 days of receipt of payment.

6.4 Financial Record Keeping. Nursing Facility will keep accurate books of account and records (the "Financial Records") at its principal place of business covering all transactions relating to this Agreement. Hospice may, at its expense, retain an independent public accountant or other auditor to review the Financial Records and prepare a detailed statement showing the charges made to Hospice by Nursing Facility. Hospice and its duly authorized representatives, including any such independent public accountant or other auditor shall have the right, upon reasonable written notice to Nursing Facility and during regular business hours, to examine Nursing Facility's Financial Records and to make copies thereof.

7. RECORDS

7.1 Compilation of Records.

(a) Preparation. Nursing Facility and Hospice shall each prepare and maintain complete and detailed clinical records concerning each Residential Hospice Patient, in accordance with prudent record-keeping procedures and as required by federal and state law,

including Medicare and Medicaid program guidelines. Each clinical record shall completely, promptly and accurately document all services provided to, and events concerning, each Residential Hospice Patient (including evaluations, treatments, progress notes, authorizations to admission to Hospice and/or Nursing Facility and physician orders entered pursuant to this Agreement). Nursing Facility and Hospice shall cause each entry made for services provided hereunder to be signed by the person providing the services.

(b) Storage. Nursing Facility and Hospice shall each retain such records for seven years from the date of discharge of each Residential Hospice Patient, or such longer time period as may be required by law. Each such record shall document the services furnished in accordance with this Agreement and shall be readily accessible and systematically organized to facilitate retrieval by either party.

7.2 Access. Subject to any required authorization by the subject Residential Hospice Patient (or his/her legal representative), Nursing Facility and Hospice shall each permit the other party access to all records relating to the provision of services under this Agreement, including the Hospice Plan of Care, the Nursing Home Plan of Care, all medical records and all records relating to billing and payment. Each party shall have the right, upon reasonable written notice and during regular business hours, to examine the records maintained by the other party and to make copies thereof.

7.3 Inspection. To the extent required by federal or state law, Nursing Facility and Hospice shall make available, upon written request of an authorized federal or state official, their respective books, documents, and records necessary to verify the nature and extent of costs of Nursing Facility Services or Hospice Services.

7.4 Destruction of Records. Nursing Facility and Hospice shall take reasonable precautions to safeguard records against loss, destruction, and unauthorized disclosure.

8. DESIGNATION OF LIAISON; DISPUTE RESOLUTION

8.1 Liaison. On or prior to the execution of this Agreement, Hospice and Nursing Facility may each designate a number of representatives, in addition to the Hospice Care Coordinator, to serve as liaison between them and to facilitate cooperative efforts in the performance of their respective obligations under this Agreement. Thereafter, each of Hospice and Nursing Facility will promptly notify the other party of any change in its representatives.

8.2 Dispute Resolution. Within 60 days of execution of this Agreement, Hospice and Nursing Facility shall develop, maintain, and conduct, as necessary, clearly articulated dispute resolution procedures and shall act promptly to mediate any disputes concerning the provision of care to Residential Hospice Patients.

9. QUALITY ASSURANCE

9.1 Hospice shall develop, maintain, and conduct an ongoing, comprehensive assessment to evaluate the quality and appropriateness of Hospice Services and Nursing Facility Services, as set forth and described in "The Carroll Hospice Standards of Care", attached hereto as Exhibit D (the "Quality Assurance Program"). Nursing Facility shall cooperate with Hospice in the conduct of the Quality Assurance Program and facilitate the administration of such program in relation to Nursing Facility Services. Hospice shall cooperate with Nursing Facility in the conduct of Nursing Facility's quality assessment and assurance committee as it relates to Residential Hospice Patients.

10. CONFIDENTIALITY

10.1 Confidentiality of Hospice Information. In the performance of its obligations under this Agreement, Hospice shall be required to disclose to Nursing Facility certain information pertaining to Hospice Patients including, but not limited to, assessments, medical records, patient and family histories and the Hospice Plan of Care (collectively, "Patient Information") and may be required to disclose certain business or financial information of the Hospice (collectively, with the Patient Information, the "Hospice Confidential Information"). Nursing Facility agrees that it shall not, except as specifically authorized in writing by Hospice or as otherwise required by law, reproduce, disclose, or provide any Hospice Confidential Information to any person.

10.2 Confidentiality of Nursing Facility Information. In the performance of its obligations under this Agreement, Nursing Facility shall be required to disclose to Hospice certain Patient Information pertaining to Nursing Facility residents, including the Nursing Facility Plan of Care, and may be required to disclose to Hospice certain business or financial information of the Nursing Facility (collectively, with the Patient Information, the "Nursing Facility Confidential Information"). Hospice agrees that it shall not, except as specifically authorized in writing by Nursing Facility or as otherwise required by law, reproduce, disclose, or provide any Nursing Facility Confidential Information to any person.

11. USE OF NAME OR MARKS

11.1 Neither Nursing Facility or Hospice shall have the right to use the name, symbols, trademarks or service marks of the other party in advertising, promotional materials, or otherwise without receiving the prior written approval of such party; *provided, however,* that one party may use the name, symbols, or marks of the other party for the purpose of information.

12. INSURANCE AND INDEMNIFICATION

12.1 Nursing Facility Insurance. Nursing Facility shall obtain and maintain, at its sole cost and expense, professional liability insurance, including coverage for any acts of professional

malpractice, covering Nursing Facility, its directors, officers, employees, and agents in an amount not less than $1,000,000 per claim and $3,000,000 in the aggregate, and general liability insurance in an amount not less than $1,000,000, naming Hospice as an additional insured party. At the request of Hospice, Nursing Facility shall furnish to Hospice satisfactory evidence of its liability insurance and shall notify Hospice 30 day prior to any material change in or termination of insurance coverage.

12.2 Hospice Insurance. Hospice shall obtain and maintain, at its sole cost and expense, professional liability insurance, including coverage of any acts of professional malpractice, covering Hospice, its directors, officers, employees, volunteers, and agents in an amount not less than $1,000,000 per claim and $3,000,000 in the aggregate, and comprehensive general liability insurance naming Nursing Facility as an additional insured party. At the request of Nursing Facility, Hospice shall furnish to Nursing Facility satisfactory evidence of its liability insurance coverage and shall notify Nursing Facility thirty 30 days prior to any material change in or termination of insurance coverage.

12.3 Indemnification.

(a) Nursing Facility agrees to indemnify and hold harmless and defend Hospice, its directors, officers, employees, volunteers, and agents from and against any and all claims, suits, damages, fines, penalties, liabilities and expenses (including reasonable attorney's fees and court costs) resulting from or arising out of, any claimed willful or negligent act or omission by Nursing Facility or any of its directors, officers, employees, agents or volunteers pertaining to the services hereunder.

(b) Hospice agrees to indemnify and hold harmless and defend Nursing Facility, its directors, officers, employees, volunteers, and agents from and against any and all claims, suits, damages, fines, penalties, liabilities and expenses (including reasonable attorney's fees and court costs) resulting from or arising out of, any claimed willful or negligent act or omission by Hospice or any of its directors, officers, employees, agents or volunteers pertaining to the services hereunder.

(c) For purposes of such indemnification, the following provisions shall apply. A person or entity entitled to be indemnified under paragraph (a) or (b) above (an "Indemnified Person") shall promptly notify the party having the obligation under this Agreement to indemnify the Indemnified Person ("Indemnifier") with respect to any notice of a claim, threat to institute a proceeding, or commencement of an action. The Indemnifier will, if requested by the Indemnified Person, assume the defense of any litigation or proceeding for which indemnity hereunder is available, including the retention of counsel and payment of reasonable fees of such counsel, in which event, except as provided below, the Indemnifier will not be responsible for any other fees or expenses of any other counsel retained for the Indemnified Person. However, if the Indemnified Person and Indemnifier reasonably conclude that the representation of both parties by the same counsel may involve a conflict due to actual or potential differing interests

between them, the Indemnifier shall pay the reasonable fees of counsel for the Indemnified Person. The Indemnifier shall not be liable for any settlement of any litigation or proceeding effected without its written consent, which consent shall not be unreasonably withheld.

13. TERMS AND TERMINATION

13.1 Term of Agreement. The initial term of this Agreement shall be one year beginning with the Effective Date, with automatic one year renewals, unless sooner terminated as provided below.

13.2 Termination Without Cause. Either party may terminate this Agreement for any reason or no reason prior to the expiration of its term by providing at least 90 days written notice of termination to the other party prior to the date of such termination. Such termination shall be effective without prior notice or consent of any Residential Hospice Patient, Attending Physician, or other third party.

13.3 Termination for Cause.

Either party shall have the right to terminate this Agreement for the following reasons:

(a) In the event that Nursing Facility does not provide a material portion of the Nursing Facility Room and Board Services or Purchased Hospice Services, if any, to be provided under this Agreement for a period of 30 consecutive days, upon ten days written notice given prior to the effective date of such termination;

(b) In the event that Hospice does not provide a material portion of the Hospice Services to be provided under this Agreement for a period of 30 consecutive days, upon ten days written notice given prior to the effective date of such termination;

(c) If any license, certification or accreditation of a party which is material to the performance of this Agreement is suspended or revoked;

(d) If any administrative or judicial fines, penalties or sanctions in excess of $10,000 are imposed upon one of the parties;

(e) If one of the parties commences or has commenced against it proceedings to liquidate, wind-up, reorganize or seek protection, relief or a composition of its debts under any law relating to insolvency, reorganization or relief of debtors or seeking the appointment of a receiver or trustee;

(f) If Hospice fails to develop and maintain a Hospice Plan of Care pursuant to federal and state law and in accordance with this Agreement;

(g) If Nursing Facility fails to develop and maintain a Nursing Facility Plan of Care pursuant to federal and state law and in accordance with this Agreement; or

(h) If an action is prosecuted to final judgment against a party for violation of federal or state law.

13.4 Effect of Termination on Availability of Services. In the event that this Agreement is terminated pursuant to section 13.2 or 13.3, each of Nursing Facility and Hospice may negotiate separately with a former Residential Hospice Patient (or such patient's legal representative) to contract for the continuation of care. Nursing Facility agrees not to discharge any former Residential Hospice Patient until an alternative placement is found that is mutually agreeable to Nursing Facility, Hospice and the former Residential Hospice Patient.

13.5 Termination of Hospice Services by Residential Hospice Patient.

(a) A Residential Hospice Patient may terminate receipt of Hospice Services and/or any Nursing Facility Services provided pursuant to this Agreement by written notice, including, but not limited to, use of Hospice's revocation form, given by the Residential Hospice Patient (or his/her legal representative) to Hospice and Nursing Facility. Such termination shall be effective upon delivery of such notice to both Nursing Facility and Hospice, or upon such time as specified in the written notice.

(b) Termination of receipt of Hospice Services and/or Nursing Facility Services by an individual Residential Hospice Patient shall not constitute termination of this Agreement as a whole.

(c) In the event that a Residential Hospice Patient terminates receipt of Hospice Services and Nursing Facility Services, each of Hospice and Nursing Facility may negotiate separately with the former Residential Hospice Patient (or such patient's legal representative) to contract for the continuation of care.

14. GENERAL PROVISIONS

14.1 Notices. Except as otherwise specified herein, all notices, demands, requests, or other communications which may be or are required to be given, served, or sent by any party to any other party pursuant to this Agreement shall be in writing and shall be delivered by hand; mailed by first-class, registered or certified mail, return receipt requested, postage prepaid; or transmitted by facsimile transmission addressed as follows:

(i) If to Hospice:

Carroll Hospice
95 Carroll Street
Westminster, MD 21157
Attention: Marie Bossie
Fax No: (410) 871-7216

with a copy (which shall not constitute notice) to:

Board of Trustees of Carroll Hospice
95 Carroll Street
Westminster, MD 21157

(ii) If to Nursing Facility

Golden Age Guest Home
1442 Buckhorn Road
Sykesville, MD 21784
Attention: Mr. James Talbott
Phone No: 410-795-2737
Fax No: 410-795-5501

Each party may designate by notice in writing a new address to which any notice, demand, request or communication may thereafter be given, served or sent. Each notice, demand, request or communication which shall be mailed, delivered or transmitted in the manner described above shall be deemed sufficiently given, served, sent and received for all purposes at such time as it is (a) delivered personally to the addressee; (b) received in the mail by the addressee (with the return receipt, the deliver receipt, or the affidavit of messenger being conclusive evidence of its receipt); (c) with respect to a facsimile transmission, the machine confirmation being deemed conclusive evidence of such delivery; or (d) at such time as delivery is refused by the addressee upon presentation.

14.2 Severability. If any part of any provision of this Agreement or any other Agreement, document or writing given pursuant to or in connection with this Agreement shall be invalid or unenforceable under applicable law, that part shall be ineffective to the extent of such invalidity or unenforceability only, without in any way affecting the remaining parts and provisions of this Agreement.

14.3 Survival. It is the express intention and agreement of the parties hereto that the provisions of this Agreement concerning Reimbursement, Records, Confidentiality, Use of Name or Marks, Insurance and Indemnification, and Term and Termination, and the shall survive the

termination of this Agreement for any reason, and that the covenants made herein shall survive the execution and termination of this Agreement until they are no longer effective by their terms.

14.4 Waiver. Neither the waiver by either of the parties hereto of a breach of or a default under any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasions, to enforce any of the provisions of this Agreement or to exercise any right or privilege thereunder shall thereafter be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any such provisions, rights or privileges hereunder.

14.5 Binding Effect. Subject to provisions hereof restricting assignment, this Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective successors and permitted assigns.

14.6 Non-assignability. This Agreement shall not be assignable, in whole or in part, by either party without the prior written consent of the other party hereto.

14.7 Limitation on Benefits of this Agreement. It is the explicit intention of the parties hereto that no person or entity other than the parties hereto is or shall be entitled to bring any action to enforce any provision of this Agreement against either of the parties hereto, and that the covenants, undertakings, and agreement set forth in this agreement shall be solely for the benefit of, and shall be enforceable only by, the parties hereto or their respective successors and assigns as permitted hereunder.

14.8 Amendment. This Agreement shall not be amended, altered or modified, except by an instrument in writing duly executed by the parties hereto.

14.9 Entire Agreement. This Agreement, including Exhibits A through D, constitutes the entire agreement between the parties hereto with respect to the subject matter hereof, and it supersedes all prior oral or written agreements, commitments or understandings with respect to the matters provided for herein.

14.10 Headings. Headings contained in this Agreement are inserted for convenience of reference only, shall not be deemed to be part of this Agreement for any purpose, and shall not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

14.11 References. Except as otherwise specified, references to sections contained in this Agreement shall be to the correspondingly numbered sections as set forth in this Agreement.

14.12 Governing Law. This Agreement, the rights and obligations of the parties hereto, and any claims or disputes relating thereto, shall be governed by and construed in accordance with the laws of the State of Maryland.

Patient Name: _____

Exhibit A
Statement of Financial Responsibility for Charges

Carroll Hospice and Nursing Facility Agree that financial responsibility for services provided by Nursing Facility shall be as follows (to be indicated by an "x" in the appropriate column):

Medical Service	Hospice	Nursing Facility	Patient
X-ray and lab fees			
Medical supplies			
Oxygen and supplies			
PT OT ST			
Special duty nurses			
Consultant physician's fees			
Personal physician's fees			
Carroll Hospice's physician fees			
Ambulance			
Acute hospital admissions			
Gerichair, walker, wheel chair			
Turning fees			
Incontinent Care			
Hand feeding			
Suction			
Tube feeding			
Room and Board			
Telephone			
Prescription drugs related to terminal illness			
Prescription drugs not related to terminal illness			
Non-prescription drugs related to terminal illness			
Personal care supplies			
Special mattress			
Special foods as a result of special diet			
Guest trays			
Television hookup			
Personal laundry			
Clothing			
Miscellaneous			

Exhibit B

Carroll Hospice
Purchased Hospice Services

	Monthly Rental Fees	Purchase Fees
Portable Liquid Oxygen System	$36.00	
Stationary Liquid Oxygen Tank	$69.00	
Liquid Oxygen Per Pound Purchase		$.90
Oxygen Concentrator with Back-up and Monthly Follow-up	$155.00	
H Cylinder (Reg) Flow Meter	$40.00	
Cylinder Refills H Purchase		$20.00
E Cylinder (Reg) Flow Meter	$20.00	
Cylinder Refills E Purchase		$10.00
Aerosol Therapy	$35.00	
Air Compressor	$40.00	
Suction Machine	$40.00	
Wheelchair, Removable Arms and Elevated Footrests	$42.00	
Geri-chair	$40.00	
Seat Lift Chair	$111.00	
Full Electric Hospital Bed with Mattress, Rails, and Overbed Table	$98.00	
Humidifier	$25.50	
Infusion Pump	$60.00	

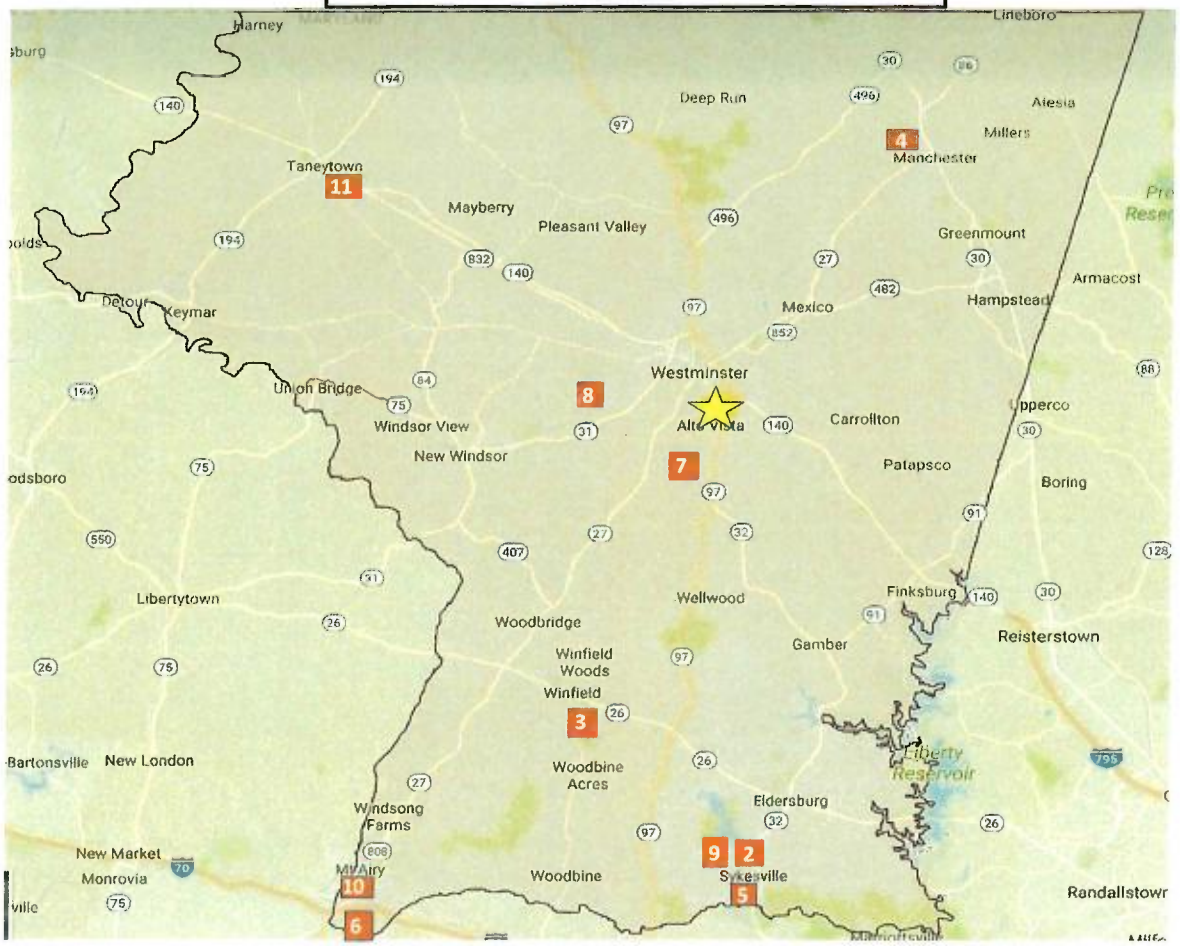
	Monthly Rental Fees	Purchase Fees
Mattress Cover - Purchase		$8.00
Alternating Pressure Pad and Pump	$36.00	
Egg Crate Pad (Wheelchair) Egg Crate Pad (Bed)		$10.00 $14.00
Trapeze Bar	$20.00	
Patient Lift	$50.00	
IV Pole	$15.00	
Commode	$20.00	
Commode Bucket - Purchase		$5.00
Folding Walker	$15.00	
Depends, Sm Adult Bx/60		$58.00
Attends, Sm Adult Bx/96		$71.00
Therapy: Physical Occupational Speech	$50.00/visit	

- *Additional items not listed will be negotiated on an individual basis and added to this fee schedule. If Golden Age Guest Home provides the equipment at the above rates. The rental fee for less than 30 days in a month will be reimbursed at a prorated daily rate, utilizing the monthly rental fee.*

EXHIBIT 11

Comprehensive Care Facilities in Carroll County

CY 2015



Legend	
☆	Carroll Hospital Center
2	Integrace Fairhaven, Inc.
3	Brinton Woods Nursing and Rehabilitation Center
4	Long View Healthcare Center, LLC
5	Transitions Healthcare at Sykesville
6	Pleasant View Nursing Home of Mt. Airy
7	Westminster Healthcare Center (Golden Living Center)
8	Carroll Lutheran Village Healthcare Center
9	Integrace Copper Ridge Nursing Home
10	Lorien Mt. Airy
11	Lorien - Taneytown

EXHIBIT 12

BRG
Berkeley Research Group

Examination of ER visits and readmissions to Carroll from Brinton Woods
Medicare FFS patient, only
CY2015

(October 2017)

Purpose: Document Medicare readmissions and ER visits from Brinton Woods to Carroll Hospital
Patient population: Medicare FFS, only
(regardless of patient origin/patient residence)
Time period: CY2015
Utilization documented below:

- ER visits, Medicare FFS: Any ER visit to Carroll between day of admission to Brinton Woods and day of discharge from Brinton Woods
- Readmissions, Medicare FFS: Any Medicare FFS patient at Brinton Woods who was admitted to Carroll equal to or one day after a day at Brinton Woods

Findings

Brinton Woods
(ID: 215247)

# of SNF claims	264
# of unique patients	209

Utilization at Carroll Hospital Center, only

	# Unique Pats	*# Visits*	*Total Payments**	*Days*
Emergency Room Visits	15	17	$5,626	
Inpatient Stays	26	37	$602,740	231

* Total Payments exclude the SNF payments

Data source:
Medicare Standard Claims File, CY2015

EXHIBIT 13

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Financial Statements and
Supplementary Financial Information

June 30, 2016 and 2015

(With Independent Auditors' Report Thereon)

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Table of Contents

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

Independent Auditors' Report

The Board of Directors
LifeBridge Health, Inc. and Subsidiaries:

We have audited the accompanying consolidated financial statements of LifeBridge Health, Inc. and Subsidiaries (the Corporation), which comprise the consolidated balance sheets as of June 30, 2016 and 2015, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly in all material respects, the financial position of LifeBridge Health, Inc. and Subsidiaries as of June 30, 2016 and 2015, and the results of their operations, changes in their net assets and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Emphasis of Matter

As discussed in note 3 to the consolidated financial statements, the Corporation acquired Carroll County Health Services Corporation. Our opinion is not modified with respect to this matter.

Supplemental Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Schedules 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

October 12, 2016

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2016 and 2015

(Dollars in thousands)

Assets		2016	2015
Current assets:			
Cash and cash equivalents	$	322,937	356,973
Investments		23,352	23,761
Assets limited as to use, current portion		67,660	30,565
Patient service receivables, net of allowance for doubtful accounts of $62,213 in 2016 and $58,346 in 2015		141,651	142,212
Other receivables		11,508	10,164
Inventory		31,514	29,482
Prepaid expenses		18,761	19,079
Pledges receivable, current portion		3,296	6,693
Total current assets		620,679	618,929
Board-designated investments		243,289	250,000
Long-term investments		253,757	258,685
Donor-restricted investments		20,541	21,644
Reinsurance recovery receivable		15,694	15,935
Assets limited as to use, net of current portion		43,601	33,187
Pledges receivable, net of current portion		3,405	5,477
Property and equipment, net		629,477	595,143
Deferred financing costs, net of accumulated amortization of $1,077 in 2016 and $767 in 2015		4,137	4,073
Beneficial interest in split interest agreement		4,477	4,628
Investment in unconsolidated affiliates		44,040	33,865
Other assets, net		48,142	43,082
Total assets	$	1,931,239	1,884,648

(Continued)

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2016 and 2015

(Dollars in thousands)

Liabilities and Net Assets		2016	2015
Current liabilities:			
Accounts payable and accrued liabilities	$	119,225	117,874
Accrued salaries, wages and benefits		80,361	80,534
Advances from third-party payors		46,246	41,780
Current portion of long-term debt and capital lease obligations		12,921	14,711
Other current liabilities		16,871	14,418
Total current liabilities		275,624	269,317
Other long-term liabilities		167,009	130,856
Long-term debt and capital lease obligations, net of current portion		564,559	558,170
Total liabilities		1,007,192	958,343
Net assets:			
Unrestricted		849,676	844,907
Noncontrolling interest in consolidated subsidiaries		5,099	3,922
Total unrestricted net assets		854,775	848,829
Temporarily restricted		53,385	61,660
Permanently restricted		15,887	15,816
		924,047	926,305
Total liabilities and net assets	$	1,931,239	1,884,648

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended June 30, 2016 and 2015

(Dollars in thousands)

	2016	2015
Unrestricted revenues, gains and other support:		
Patient service revenue (net of contractual allowances and discounts)	$ 1,435,810	1,201,545
Provision for bad debts	56,982	54,845
Net patient service revenue	1,378,828	1,146,700
Net assets released from restrictions used for operations	3,537	3,665
Other operating revenue	95,060	62,764
Total operating revenues	1,477,425	1,213,129
Expenses:		
Salaries and employee benefits	795,094	662,338
Supplies	253,599	195,387
Purchased services	254,211	201,240
Depreciation, amortization and gain/loss on sale of assets	75,699	62,957
Repairs and maintenance	20,538	19,774
Interest	28,574	20,687
Total expenses	1,427,715	1,162,383
Operating income	49,710	50,746
Other income, net:		
Investment income	16,028	21,161
Unrealized losses on trading investments	(22,110)	(10,978)
Other	779	4,563
Total other (expense) income, net	(5,303)	14,746
Excess of revenues over expenses before loss on refinancing of debt and inherent contribution	44,407	65,492
Loss on refinancing of debt	(3,720)	—
Excess of revenues over expenses before inherent contribution	40,687	65,492
Inherent contribution – CCHS	—	134,032
Excess of revenues over expenses	$ 40,687	199,524

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2016 and 2015

(Dollars in thousands)

	Unrestricted	Temporarily restricted	Permanently restricted	Total net assets
Net assets at June 30, 2014	$ 660,778	49,703	14,647	725,128
Excess of revenues over expenses	199,524	—	—	199,524
Inherent contribution – CCHS	—	10,733	1,173	11,906
Unrealized loss on investments	—	(370)	(3)	(373)
Net assets released from restrictions used for the purchase of property and equipment	5,347	(5,347)	—	—
Restricted gifts and bequests	—	10,789	3	10,792
Net assets released from restrictions used for operations	—	(3,661)	(4)	(3,665)
Net change in value of beneficial interest in split interest agreement	—	5	—	5
Adjustment to pension liability	(16,548)	—	—	(16,548)
Other	(272)	(192)	—	(464)
Change in net assets	188,051	11,957	1,169	201,177
Net assets at June 30, 2015	848,829	61,660	15,816	926,305
Excess of revenues over expenses	40,687	—	—	40,687
Unrealized loss on investments	—	(1,842)	(5)	(1,847)
Net assets released from restrictions used for the purchase of property and equipment	7,613	(7,613)	—	—
Restricted gifts and bequests	—	4,908	76	4,984
Net assets released from restrictions used for operations	—	(3,537)	—	(3,537)
Net change in value of beneficial interest in split interest agreement	—	(151)	—	(151)
Adjustment to pension liability	(41,513)	—	—	(41,513)
Other	(841)	(40)	—	(881)
Change in net assets	5,946	(8,275)	71	(2,258)
Net assets at June 30, 2016	$ 854,775	53,385	15,887	924,047

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended June 30, 2016 and 2015

(Dollars in thousands)

	2016	2015
Cash flows from operating activities:		
Change in net assets	$ (2,258)	201,177
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	76,059	62,697
Loss (gain) on disposal of equipment	(360)	260
Gain on sale of Courtland Gardens	—	(3,409)
Change in pension liability	41,513	16,548
Provision for bad debts	56,982	54,845
Realized and unrealized gains on investments, net	17,593	(2,412)
Inherent contribution – CCHS	—	(145,938)
Restricted gifts and bequests	(4,984)	(10,789)
Change in beneficial interest of split interest agreement	151	5
Earnings on investments in unconsolidated affiliates	(3,277)	(5,342)
Loss on refinancing of debt	3,720	—
Change in operating assets and liabilities:		
Increase in patient service receivables, net	(56,421)	(41,962)
Increase in other receivables	(1,344)	(1,021)
Decrease (increase) in pledges receivable	5,469	(4,438)
Increase in inventory	(2,032)	(2,136)
Decrease in prepaid expenses	318	115
Decrease (increase) in reinsurance recovery receivable	241	(2,570)
(Increase) decrease in other assets	(5,637)	5,877
Decrease in accounts payable and accrued liabilities, and accrued salaries, wages, and benefits	(7,481)	(10,462)
Increase (decrease) in advances from third-party payors	4,466	(944)
(Decrease) increase in other current and long-term liabilities	(2,907)	1,121
Net cash provided by operating activities	119,811	111,222
Cash flows from investing activities:		
Change in donor-restricted investments	1,103	(8,968)
Addition of cash from CCHS acquisition	—	15,719
Change in current and long-term investments	(3,698)	(49,422)
Change in assets limited as to use	(49,356)	28,098
Investment in/distributions from unconsolidated affiliates, net	(6,898)	(6,543)
Additions to operating property	(101,221)	(44,462)
Proceeds from the sale of property	360	31
Settlement of swap	—	(13,998)
Acquisition of physician practices	—	(1,404)
Net cash used in investing activities	(159,710)	(80,949)
Cash flows from financing activities:		
Payment on debt and capital lease obligations	(182,127)	(53,800)
Proceeds from issuance of debt	183,006	150,000
Restricted gifts and bequests	4,984	10,789
Net cash provided by financing activities	5,863	106,989
Net (decrease) increase in cash and cash equivalents	(34,036)	137,262
Cash and cash equivalents:		
Beginning of year	356,973	219,711
End of year	$ 322,937	356,973
Supplemental cash flow disclosures:		
Cash paid during the year for interest	$ 24,444	19,412
Cash paid during the year for income taxes	52	44
Accounts payable related to purchase of operating property	8,659	11,210

See accompanying notes to consolidated financial statements.

(1) Organization

On October 1, 1998, Sinai Health System, Inc. merged with Northwest Health System, Inc. to form LifeBridge Health, Inc. (LifeBridge). LifeBridge is a not-for-profit, nonstock Maryland corporation.

LifeBridge's subsidiaries include Sinai Hospital of Baltimore, Inc. (Sinai); Northwest Hospital Center, Inc. (Northwest); Levindale Hebrew Geriatric Center and Hospital, Inc. (Levindale); Children's Hospital of Baltimore City, Inc.; The Baltimore Jewish Health Foundation, Inc. (BJHF); The Baltimore Jewish Eldercare Foundation, Inc. (BJEF); Children's Hospital at Sinai Foundation, Inc. (CHSF); LifeBridge Anesthesia Associates, LLC (LAA); LifeBridge Insurance Company, Ltd. (LifeBridge Insurance); LifeBridge Investments, Inc. (Investments); LifeBridge Health ACO, LLC; LifeBridge Physician Network, LLC; 8600 Liberty Road, LLC; and LifeBridge 23 Crossroads Drive Medical Office Building, LLC. This group will be referred to as Legacy LifeBridge. Except for LifeBridge Insurance and Investments, all of the entities named above are not-for-profit and tax-exempt. Sinai and Levindale are constituent agencies of THE ASSOCIATED: Jewish Community Federation of Baltimore, Inc. (AJCF), a charitable corporation.

Effective April 1, 2015, Carroll County Health Services Corporation (CCHS), the parent of Carroll Hospital Center, Inc. (Carroll) and other related entities, became a subsidiary of LifeBridge. CCHS is further discussed below and the acquisition of CCHS by LifeBridge is further discussed in note 3.

Investments is a for-profit corporation that holds, directly and indirectly, interests in a variety of for-profit businesses. Investments' wholly owned subsidiaries include:

- *Practice Dynamics, Inc.*
- *LifeBridge Health and Fitness, LLC*
- *Sinai Eldersburg Real Estate, LLC*
- *General Surgery Specialists, LLC*
- *BW Primary Care, LLC*
- *LifeBridge Community Practices, LLC*
- *The Center for Urologic Specialties, LLC*
- *LifeBridge Community Physicians, LLC (Community Physicians)*

Investments also holds interests in numerous other health-related businesses.

Community Physicians is a for-profit corporation that provides physician and related services through numerous subsidiaries.

Courtland Gardens Nursing and Rehabilitation Center, Inc. is a wholly owned subsidiary of Levindale. On September 1, 2014, Levindale sold substantially all of the assets of Courtland, except for cash and accounts receivable, for $8,215.

CCHS is a not-for-profit, nonstock Maryland Corporation. The accompanying consolidated financial statements include the accounts of CCHS and it's wholly or partially owned subsidiaries.

Wholly owned direct and indirect subsidiaries of CCHS include:

Carroll Hospital Center, Inc (Carroll); Carroll Hospital Center Foundation, Inc. (Carroll Foundation); Carroll Hospice, Inc. (CH); Carroll Regional Cancer Center Physicians, LLC (CRCCP); and Carroll Hospital Center MOB Investment, LLC. Carroll also holds interests in various health-related companies.

Prior to June 30, 2016, Carroll owned Cen-Mar Assurance Company (Cen-Mar). Cen-Mar was merged into LifeBridge Insuracne on June 30, 2016.

Carroll County Med-Services, Inc. (CCMS) is a wholly owned, for-profit subsidiary of CCHS that is involved in real estate holdings, physician services, and other activities, and also maintains ownership interests in various joint ventures. Wholly owned direct and indirect subsidiaries of CCMS include: Carroll Health Group, LLC; Carroll County CMO, LLC; Carroll PHO, LLC; and Carroll ACO, LLC.

(2) Significant Accounting Policies

(a) Basis of Presentation

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. All controlled and direct member entities are consolidated. The accompanying consolidated financial statements include the accounts of LifeBridge Health, Inc. and Subsidiaries (the Corporation). All entities where the Corporation exercises significant influence, but does not have control, are accounted for under the equity method. All other unconsolidated entities are accounted for under the cost method. All significant intercompany accounts and transactions have been eliminated.

(b) Cash and Cash Equivalents

Cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less at the date of purchase.

(c) Assets Limited as to Use

Assets limited as to use primarily consists of assets held by trustees under bond indenture agreements, a self-insured workers' compensation reserve fund, and designated assets set aside by the Board of Directors for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes. A portion of the designated assets set aside by the Board of Directors are contractually designated.

(d) Inventory

Inventories, which consist primarily of medical supplies and pharmaceuticals, are stated at the lower of cost (using the moving average cost method of valuation) or market.

(Continued)

(e) Investments, Long-Term Investments and Donor-Restricted Investments

The Corporation's investment portfolio is considered a trading portfolio and is classified as current or noncurrent assets based on management's intention as to use. All debt and equity securities are reported in the consolidated balance sheets at fair value, principally based on quoted market prices.

The Corporation has investments in alternative investments, primarily funds of hedge funds, totaling $138,838 and $146,923 at June 30, 2016 and 2015, respectively. These funds utilize various types of debt and equity securities and derivative instruments in their investment strategies. Also included in alternative investments are BJEF's and BJHF's funds that are invested on their behalf by the Associated Jewish Charities (AJC), an affiliate of AJCF. The underlying investments for these funds include cash of $241, equities of $23,368, private equity of $2,987, fixed income of $4,013, inflation hedging funds of $2,460, and alternative investments of $15,606. Alternative investments are recorded based on the Net Asset Value (NAV) of the shares in each investment company or partnership.

Investments in unconsolidated affiliates are accounted for under the cost or equity method of accounting as appropriate and are included in other assets and investment in unconsolidated affiliates, respectively, in the consolidated balance sheets. The Corporation's equity income or loss is recognized in other operating revenue within the excess of revenue over expenses in the accompanying consolidated statements of operations.

Investments also include assets restricted by donor, and assets designated by the Board of Directors for future capital improvements and other purposes over which it retains control and may, at its discretion, use for other purposes. Purchases and sales of securities are recorded on a trade-date basis.

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

Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures*, establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 Inputs – Unadjusted quoted prices in active markets for identical assets or liabilities accessible to the reporting entity at the measurement date.

(Continued)

- Level 2 Inputs – Other than quoted prices included in Level 1 inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the asset or liability.
- Level 3 Inputs – Unobservable inputs for the asset or liability used to measure fair value to the extent that observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity for the asset or liability at measurement date.

The hierarchy requires the use of observable market data when available. Assets and liabilities are classified in their entirety based on the lowest level input that is significant to the fair value measurements.

(f) Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter of the period of the lease term or the estimated useful life of the equipment. Maintenance and repair costs are expensed as incurred. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

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

(g) Deferred Financing Costs and Other Assets

Deferred financing costs and other assets consist primarily of deferred financing costs, intangibles related to practice acquisitions, notes receivable, and the cash surrender value of split dollar life insurance. The deferred financing costs are amortized using the effective-interest method over the term of the related debt. Amortization expense was $513 and $2,430 for the years ended June 30, 2016 and 2015, respectively. Such amortization is included in depreciation and amortization in the consolidated financial statements.

(h) Beneficial Interest in Split Interest Agreement

CHSF holds a 25% interest in a trust, of which management has estimated the present value of the future income stream. CHSF will receive 25% of the net annual income until 2024, when at the end the trust will terminate, and 25% of the principal will be distributed to CHSF. Management has reported the beneficial interest at fair value based on the fair value of the underlying trust investments.

(Continued)

(i) Advances from Third-Party Payors

Advances from third-party payors are comprised of advance funding from CareFirst BlueCross BlueShield, Medicaid, Aetna, United/MAMSI, and other insurance providers.

(j) Self-Insurance Programs

The Corporation maintains self-insurance programs for professional and general liability, workers' compensation, and employee health benefits. The provision for estimated self-insurance program claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. The estimates are based on historical trends, claims asserted, and reported incidents.

(k) Other Long-Term Liabilities

Other long-term liabilities consist of self-insurance liabilities, pension plan liabilities, asset retirement obligations, and deferred compensation plan liabilities.

(l) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Corporation are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date those promises become unconditional. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions.

(m) Net Assets

Net assets and revenues, expenses, gains and losses are classified based on the existence or absence of externally imposed stipulations. Accordingly, net assets of the Corporation and changes therein are classified and reported as follows:

Unrestricted net assets – Net assets that are not subject to externally imposed stipulations.

Temporarily restricted net assets – Net assets subject to externally imposed stipulations that may or will be met either by actions of the Corporation and/or the passage of time.

Permanently restricted net assets – Net assets subject to externally imposed stipulations that they be maintained by the Corporation in perpetuity.

Revenues are reported as increases in unrestricted net assets unless use of the related asset is limited by externally imposed restrictions. Expenses are reported as decreases in unrestricted net assets. Gains and losses are reported as increases or decreases in unrestricted net assets unless use of the related asset is limited by externally imposed restrictions or law. Expirations of temporary restrictions of net assets (i.e., the externally stipulated purpose has been fulfilled and/or the stipulated time period has

elapsed) are reported as reclassifications between the applicable classes of net assets if used to acquire capital assets; otherwise, they are recorded as unrestricted operating revenue.

(n) Net Patient Service Revenue

Net patient service revenue for Sinai, Northwest, Carroll and the chronic hospital component of Levindale is recorded at rates established by the State of Maryland Health Services Cost Review Commission (HSCRC) and, accordingly, reflects actual charges to patients based on rates in effect during the period in which the services are rendered. On January 29, 2014, the Corporation and the Health Services Cost Review Commission (HSCRC) agreed to implement the Global Budget Revenue (GBR) methodology, effective July 1, 2013, for Sinai, Northwest and Levindale. The term of the Agreement will continue through June 30, 2016 and will renew for a one-year period unless it is canceled by the HSCRC or by the applicable Hospital. The GBR model is a revenue constraint and quality improvement system, designed by the HSCRC to provide hospitals with strong financial incentives to manage their resources efficiently and effectively in order to slow the rate of increase in healthcare costs and improve healthcare delivery processes and outcomes. The GBR model is consistent with the Hospitals' mission to provide the highest value of care possible to their patients and the communities they serve.

The GBR agreement establishes a prospective, fixed revenue base (the GBR cap) for each fiscal year. This includes both inpatient and outpatient regulated services. Under GBR, the Corporation's revenue for all HSCRC-regulated services is predetermined for the upcoming year, regardless of changes in volume, service mix intensity, or mix of inpatient or outpatient services that occur during the year. The GBR agreement allows the Corporation to adjust unit rates, within certain limits, to achieve the overall revenue base for the Corporation at year-end. Any overcharge or undercharge versus the GBR cap is prospectively added to the subsequent year's GBR cap. Beginning in fiscal year 2016, the GBR is adjusted for changes in market share. Effective with fiscal year 2017, market-shift adjustments will be made semi-annually, on January and July 1. The GBR cap is adjusted annually for inflation, and for changes in payor mix and uncompensated care, and changes in population within the Corporation's service area. A hospital's GBR cap may also be adjusted based on the hospital's performance on various quality and utilization metrics established from time to time by the HSCRC.

Prior to implementation of the GBR methodology, Carroll and the HSCRC agreed to a three year contract for Carroll to implement the Total Patient Revenue (TPR) methodology effective July 1, 2010, which was renewed for an additional three year period effective July 1, 2013. Similar to the GBR, the TPR agreement establishes a prospective, fixed revenue base, the "TPR cap," for the upcoming year. Effective with fiscal year 2017, all TPR agreements have been terminated and reinstituted as GBR agreements using the same parameters described above.

Contractual adjustments, which represent the difference between amounts billed as patient service revenue and amounts paid by third-party payors, are accrued in the period in which the related services are rendered. Because the Corporation does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue.

Medicare reimburses Northwest and Levindale for skilled nursing services under the Medicare skilled nursing Prospective Payment System (PPS). Under PPS, the payment rate is based on patient resource utilization as calculated by a patient classification system known as Resource Utilization Groups.

Medicaid reimburses Levindale for long-term care services facilities based on Levindale's actual costs. However, beginning in January 2015, the cost data from the 2012 cost reports was used to set Resource Utilization Group (similar to Medicare) rates which are adjusted for changes in case mix. The case mix from two quarters prior is used to adjust the rates on a quarterly basis.

All other patient service revenue is recorded at the estimated net realizable amounts from patients, third-party payors, and others for services rendered.

(o) Other Operating Revenue

Other operating revenue includes income of LifeBridge Health and Fitness LLC, revenue from retail pharmacy and other support services, and revenue generated from investments in joint ventures that offer health care services or services that support or complement the delivery of care.

(p) Grants

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

(q) Meaningful Use Incentives

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

The Corporation recognizes EHR incentives when the payment is received. During the years ended June 30, 2016 and 2015, certain hospitals and physicians satisfied the meaningful use criteria. As a result, the Corporation recognized $3,349 and $3,728 of EHR incentives during fiscal years 2016 and 2015, respectively, in other operating revenue.

(Dollars in thousands)

(r) Charity Care and Bad Debt

Sinai, Northwest, Carroll, Levindale and Courtland provide care to patients who meet certain criteria under their charity care policies without charge or at amounts less than their established rates. Because the facilities do not pursue the collection of amounts determined to qualify as charity care, those amounts are not reported as revenue. The amount of charity care provided during the years ended June 30, 2016 and 2015, based on patient charges forgone, was $11,720 and $9,179, respectively. The total direct and indirect costs to provide the care amounted to approximately $10,044 and $7,548 for the years ended June 30, 2016 and 2015, respectively.

All patient accounts are handled consistently and appropriately to maximize cash flow and to identify bad debt accounts timely. Active accounts are considered bad debt accounts when they meet specific collection activity guidelines and/or are reviewed by the appropriate management and deemed to be uncollectible. Every effort is made to identify and pursue all account balance liquidation options, including but not limited to third party payor reimbursement, patient payment arrangements, Medicaid eligibility and financial assistance. Third party receivable management agencies provide extended business office services and insurance outsource services to ensure maximum effort is taken to recover insurance and self-pay dollars before transfer to bad debt. Contractual arrangements with third party collection agencies are used to assist in the recovery of bad debt after all internal collection efforts have been exhausted. In so doing, the collection agencies must operate consistently with the goal of maximum bad debt recovery and strict adherence with Fair Debt Collections Practices Act (FDCPA) rules and regulations, while maintaining positive patient relations.

		2016	2015
Beginning allowance	$	58,346	35,085
Plus provision for bad debt		56,982	54,845
Less bad debt write-offs, net of recoveries		(53,115)	(31,584)
Ending allowance	$	62,213	58,346

(s) Income Taxes

LifeBridge and its not-for-profit subsidiaries have been recognized by the Internal Revenue Service as tax-exempt pursuant to Section 501(c)(3) of the Internal Revenue Code.

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

(Continued)

asset are reflected in the year of the change. The Corporation accounts for uncertain tax positions in accordance with ASC Topic 740.

(t) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(u) Excess of Revenues over Expenses

The accompanying consolidated statements of operations include excess of revenue over expenses. Changes in unrestricted net assets that are excluded from excess of revenues over expenses, consistent with industry practice, include changes in the funded status of defined-benefit pension plans, permanent transfers of assets to and from affiliates for other than goods and services, the cumulative effect of a change in accounting principles, and contributions received for additions of long-lived assets.

(v) Employee Pension Plan

Pension benefits are administered by the Corporation. The Corporation accounts for its defined-benefit pension plans within the framework of ASC Topic 958, *Not-for-Profit Entities, Section 715, Compensation-Retirement Benefits* (Topic 958, Section 715), which requires the recognition of the overfunded or underfunded status of a defined-benefit pension plan as an asset or liability. The plans are subject to annual actuarial evaluations, which involve various assumptions creating changes in elements of expense and liability measurement. Key assumptions include the discount rate, the expected rate of return on plan assets, retirement, mortality, and turnover. The Corporation evaluates these assumptions annually and modifies them as appropriate.

Additionally, Topic 958, Section 715 requires the measurement date for plan assets and liabilities to coincide with the employer's year-end and requires the disclosure in the notes to the consolidated financial statements of additional information about certain effects on net periodic benefit cost for the next fiscal year that arise from delayed recognition of the gains or losses, prior service costs or credits, and transition asset or obligation. During fiscal year 2016, LifeBridge adopted the RP-2014 Mortality Table with generational improvements. See footnote 11 for further discussion.

(3) Carroll County Health Services Corporation

The Corporation became the sole corporate member of CCHS and all of its subsidiaries on April 1, 2015. Beginning on that date the financial position and results of operations of CCHS were consolidated. As part of the transaction, LifeBridge contributed $50,000 to Carroll Foundation to be used solely in furtherance of the Foundation's charitable purposes of supporting the missions of CCHS and LifeBridge committed to provide $250,000 to meet the strategic needs of CCHS and its affiliates. LifeBridge established a $250,000 board-designated fund containing the funds required to meet the commitment. The affiliation was accounted

(Continued)

(Dollars in thousands)

for under the purchase accounting method for business combinations. As a result, the Corporation recorded an inherent contribution related to the transaction of $145,938 in fiscal year 2015.

The following table summarizes the estimated fair value of assets acquired and liabilities assumed at April 1, 2015 (the acquisition date prior to the Foundation Contribution):

Assets:		
Current assets	$	91,236
Property and equipment		144,403
Other long-term assets		144,079
Total assets	$	379,718
Liabilities:		
Current liabilities	$	58,769
Long-term liabilities		175,011
Total liabilities		233,780
Net assets:		
Unrestricted		134,032
Temporarily restricted		10,733
Permanently restricted		1,173
Total net assets		145,938
Total liabilities and net assets	$	379,718

The following table summarizes the Corporation's pro forma consolidated results as though the acquisition occurred at July 1, 2014:

		2015
Total operating revenues	$	1,435,203
Operating income		51,757
Other income, net		144,690
Changes in net assets:		
Unrestricted	$	184,931
Temporarily restricted		12,488
Permanently restricted		1,169
Total changes in net assets	$	198,588

(Continued)

(Dollars in thousands)

(4) Investments

Investments, which consist of assets limited as to use, board-designated investments, donor-restricted investments, and long-term investments in the accompanying consolidated balance sheets, are stated at fair value or under the equity method, as appropriate, as of June 30, 2016 and 2015, and consist of the following:

	2016	2015
Assets limited as to use:		
Self-insurance fund:		
Cash and cash equivalents	$ —	3,128
Mutual funds	22,060	2,197
Equity securities	9,210	7,106
U.S. Treasury	944	11,389
Government securities	—	1,705
Fixed income	8,789	11,350
Alternative investments	2,598	4,364
Self-insurance fund	43,601	41,239
Debt service fund:		
Cash and cash equivalents	20,598	11,501
Government securities	47,062	7,328
Debt Service Fund	67,660	18,829
Collateral held for lines of credit and other:		
Cash and cash equivalents	—	89
Mutual funds	—	1,230
Equity securities	—	2,297
Fixed income	—	68
Collateral held for lines of credit	—	3,684
Less current portion	(67,660)	(30,565)
Assets limited as to use, net of current portion	$ 43,601	33,187
Donor-restricted investments:		
Cash and cash equivalents	$ 4,825	5,418
Mutual funds	5,649	6,082
Equity securities	2,585	2,091
U.S. Treasury	3,557	3,238
Government securities	3,016	3,324
Fixed income	566	1,205
Alternative investments	343	286
Donor-restricted investments	$ 20,541	21,644
Beneficial interest in split interest agreement	$ 4,477	4,628

(Continued)

(Dollars in thousands)

There are other investments restricted by donors other than pledges receivable, donor-restricted investments, and beneficial interest that are included in long-term investments as of June 30, 2016 and 2015. As of June 30, 2016 and 2015 current, long-term, and board-designated investments are as follows:

	2016	2015
Current, long-term, and board-designated investments:		
Cash and cash equivalents	$ 8,747	56,619
Mutual funds	177,303	165,392
Equity securities	159,173	132,483
Government securities	10,111	8,849
Fixed income	29,167	26,830
Alternative investments	135,897	142,273
Current, long-term and board-designated investments	520,398	532,446
Less current portion	(23,352)	(23,761)
Long-term and board-designated investments	$ 497,046	508,685

Investment income and gains and losses on long-term investments, board-designated investments, donor-restricted investments, and assets limited as to use are comprised of the following for the years ended June 30, 2016 and 2015:

	2016	2015
Investment income:		
Interest income and dividends	$ 9,516	7,398
Realized gains on sale of securities	6,512	13,763
Investment income	16,028	21,161
Unrealized (losses) gains on trading securities	(22,110)	(10,978)
Other changes in net assets:		
Changes in unrealized gains on temporarily and permanently restricted net assets	(1,847)	(373)
Total investment return	$ (7,929)	9,810

(5) Pledges Receivable

Contributions and pledges to raise funds are recorded as temporarily restricted net assets until the donor-intended purpose is met and the cash is collected. Future pledges are discounted at the treasury bill rate to reflect the time value of money, and an allowance for potentially uncollectible pledges has been established.

(Continued)

(Dollars in thousands)

Sinai, Northwest, Carroll, and Levindale have recorded total pledges as of June 30, 2016 and 2015 as follows:

	2016	2015
Gross pledges receivable	$ 9,051	15,878
Less:		
Discount for time value of money	(782)	(1,232)
Allowance for uncollectible accounts	(1,568)	(2,476)
	$ 6,701	12,170

Total anticipated future payments are as follows:

Less than one year	$ 3,550
One to five years	5,288
Five years and thereafter	213
	$ 9,051

(6) Property and Equipment

As described in note 13, Sinai and Levindale leases from an affiliate of AJCF lease all land, land improvements, buildings, and fixed equipment located at those entities' primary locations; LifeBridge entities own the movable equipment. Property and equipment are classified as follows at June 30:

	Estimated useful life	2016	2015
Land		$ 11,657	7,302
Land improvements	8 to 20 years	35,931	35,913
Building and improvements	10 to 40 years	863,963	829,588
Fixed equipment	8 to 20 years	101,411	88,710
Movable equipment	3 to 15 years	479,705	453,896
		1,492,667	1,415,409
Less accumulated depreciation		(926,430)	(867,451)
		566,237	547,958
Construction in progress		63,240	47,185
Property and equipment, net		$ 629,477	595,143

Depreciation, amortization, and gain/loss on sale of assets were $75,699 and $62,957 for the years ended June 30, 2016 and 2015, respectively. Of this, depreciation expense was $75,546 and $60,267 for the years ended June 30, 2016 and 2015, respectively.

(Continued)

(Dollars in thousands)

Included in property and equipment is building and equipment, net of accumulated amortization, of $18,774 and $9,258 for the years ended June 30, 2016 and 2015, respectively, financed with capital lease obligations. Accumulated amortization related to the building and equipment under capital leases was $11,806 and $21,222 at June 30, 2016 and 2015, respectively.

(7) Investments in Joint Ventures

Investments in joint ventures and partnerships, accounted for under the equity method, consist of the following at June 30, 2016 and 2015:

Joint Venture	Business purpose	2016 Percentage ownership	2016 Balance	2015 Percentage ownership	2015 Balance
MNR Industries, LLC	Urgent Care Centers	40%	$ 23,291	40%	$ 23,123
Baltimore County Radiology, LLC	Outpatient Radiology	25	5,724	—	—
Riverside Health of Maryland, Inc.	Medicaid Managed Care Plan	—	—	20	2,736
Mt. Airy Med-Services, LLC	Real Estate	50	4,952	50	375
Lochearn Nursing Home, LLC	Nursing Home	10	1,997	—	—
Mt. Airy Plaza, LLC	Real Estate	50	1,628	50	1,649
LifeBridge Sports Medicine & Rehabilitation, LLC	Physical Therapy	50	1,303	50	1,165
Carroll Care Pharmacies, LLC	Pharmacies	49	1,037	49	1,018
Other Joint Ventures	Miscellaneous	5–50	4,108	5–50	3,799
	Total		$ 44,040		$ 33,865

For those joint ventures and partnerships accounted for using the equity method, LifeBridge recorded equity in earnings of joint ventures and partnerships. For those joint ventures and partnerships accounted for using the cost method, LifeBridge recorded dividend income. Such amounts are included in other operating revenue in the consolidated statements of operations.

(Continued)

(Dollars in thousands)

(8) Long-Term Debt and Capital Lease Obligations

As of June 30, long-term debt and capital lease obligations consist of the following:

	2016	2015
Maryland Health and Higher Educational Facilities Authority (MHHEFA):		
Revenue Bonds Series 2006	$ —	35,000
Revenue Bonds Series 2008	237,590	266,285
Revenue Bonds Series 2011	47,465	48,315
Revenue Bonds Series 2012A	55,152	56,620
Revenue Bonds Series 2015	159,685	—
Other debt:		
Bank of America line of credit	—	100,000
M&T Bank taxable loan	45,905	50,000
BB&T line of credit	—	2,351
Capital leases	18,501	7,206
Other	539	343
	564,837	566,120
Less current portion	(12,921)	(14,711)
Unamortized premium	12,685	6,805
Unamortized discount	(42)	(44)
Long-term debt, net	$ 564,559	558,170

In November 2006, the Maryland Health and Higher Educational Facilities Authority (MHHEFA or the Authority) loaned $35,000 from the proceeds of bonds (Series 2006 Bonds) to CCHS and certain of its subsidiaries, resulting in proceeds of $35,000. The Series 2006 Bonds were repaid as part of the Series 2015 Bond offering, further discussed below.

In January 2008, MHHEFA loaned $285,815 from the proceeds of bonds (Series 2008 Bonds) to LifeBridge and certain of its subsidiaries. Portions of the Series 2008 Bonds are payable on July 1 of each year through 2047. The Series 2008 Bonds bear interest at a weighted fixed rate of 5.35%. Approximately, $27,640 of the Series 2008 Bonds were repaid as part of the Series 2015 Bond offering, further discussed below.

In March 2011, the Authority loaned $50,695 from the proceeds of bonds (Series 2011 Bonds) to LifeBridge and certain of its subsidiaries. Portions of the Series 2011 Bonds are payable on July 1 of each year through 2041. The Series 2011 Bonds bear interest at a weighted fixed rate of 5.99%.

In May 2012, MHHEFA loaned $89,790 from the proceeds of bonds (Series 2012A Bonds) to CCHS and certain of its subsidiaries (the Series 2012 Bonds). The Series 2012 Bonds were issued in three series: $26,995 of serial bonds maturing in 2013 through 2027, $7,505 of term bonds maturing in 2030, and $25,280 of term bonds maturing in 2037 (Series 2012A Bonds); $15,010 of term bonds maturing in 2037 (Series 2012B Bonds); and $15,000 of term bonds maturing in 2042 (Series 2012C Bonds).

(Continued)

On April 1, 2015, LifeBridge established a two-year loan facility with Bank of America in the amount of $250,000 (2015 Line of Credit) that matures on March 31, 2017, with a variable rate of interest on amounts drawn of 30-day LIBOR plus 88 basis points. The 2015 Line of Credit is secured on parity with the Series 2008 and 2011 Bonds. On April 1, 2015, LifeBridge drew $100,000 on the 2015 Line of Credit, of which $50,000 was transferred to Carroll Foundation for the Foundation Contribution and $39,800 was used to pay off the Series 2012B and 2012C Bonds Bank. The Line of Credit was repaid during the year ended June 30, 2016. The outstanding obligation was $0 and $100,000 for the years ended June 30, 2016 and 2015, respectively.

On May 1, 2015, a single obligated group (the Obligated Group) was formed, consisting of LifeBridge, Sinai, Northwest, Levindale, BJHF, CHSF, CCHS, Carroll, CCMS, CHG, CH, and CRCCP. Members of the Obligated Group are jointly and severally liable for all of the outstanding bonds issued by the Authority on behalf of LifeBridge and CCHS and their respective affiliates, together with the other obligations on parity with such bonds.

On June 26, 2015, LifeBridge entered into a $50,000 direct bank placement with M&T Bank (2015 M&T Loan). The interest rates range from 1.57% to 3.28%, with maturity dates ranging from July 1, 2016 to July 1, 2025. The 2015 M&T Loan is secured on parity with the bonds.

On July 30, 2015, the Authority issued $159,685 in bonds (Series 2015 Bonds) on behalf of LifeBridge Health. The proceeds of the Series 2015 Bonds have been and will be used to finance and refinance the cost of construction, renovation, and equipping of certain additional facilities for the Obligated Group, to refund a portion of the Series 2008 Bonds and the Authority's Carroll Issue, Series 2006 bonds, and refinance the portion of the Bank of America Line of Credit that had been used to repay Carroll's loan from BB&T Bank. The remaining Bank of America line of credit was repaid by the Corporation in July.

The Series 2008, 2011, 2012A, and 2015 Bonds are governed by a Master Loan Agreement. Under the Master Loan Agreement, the Authority maintains a security interest in the revenue of the obligors. In addition, the Master Loan Agreement requires Obligated Group members to adhere to limitations on mergers, disposition of assets, and additional indebtedness and certain financial covenants. The financial covenants include a rate covenant, which requires the Obligated Group to achieve a debt service coverage ratio of 1.10; a liquidity covenant, which requires the Obligated Group to maintain 65 days cash on hand; and a debt-to-capitalization covenant, which requires the Obligated Group to maintain a debt-to-capitalization ratio of not more than 65%, all measured as of June 30 in each fiscal year. In the fiscal year ended June 30, 2016, the Obligated Group met all of its covenants.

On April 28, 2015, Carroll entered into a termination agreement related to its floating-to-fixed interest rate swap agreement with Bank of America. Carroll paid Bank of America $13,998 to terminate the swap agreement. The Corporation recognized a realized gain on settlement of approximately $600. This amount was recognized within other income, net within the consolidated statements of operations.

The Corporation is obligated under several noncancelable capital leases for hospital equipment and office building space.

(Continued)

(Dollars in thousands)

The total future principal payments on long-term debt and capital lease payments are as follows:

	MHHEFA and other debt	Capital lease obligations
Years ending June 30:		
2017	$ 11,329	2,517
2018	10,750	2,196
2019	11,270	2,231
2020	11,795	2,269
2021	12,345	2,304
Thereafter	488,847	10,324
	$ 546,336	21,841
Less interest portion		(3,340)
		$ 18,501

(9) M&T Bank Line of Credit

Sinai maintains a $5,000 line of credit with M&T Bank. As of June 30, 2016 and 2015, there were no balances outstanding on this line of credit.

(10) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at June 30:

	2016	2015
Healthcare services:		
Capital equipment/construction	$ 23,160	24,824
Other healthcare services:		
Service grants	496	215
Donor-specified healthcare services	14,452	20,491
Enrichment and research	15,277	16,130
	$ 53,385	61,660

Permanently restricted net assets of $15,887 and $15,816 at June 30, 2016 and 2015, respectively, are to investments to be held in perpetuity, the income from which is expendable to support healthcare services.

(Continued)

(Dollars in thousands)

(11) Employee Benefit Plans

(a) LifeBridge Health Pension Plans (Sinai and Levindale)

The Corporation sponsors noncontributory defined-benefit pension plans (the Sinai/Levindale Plans) covering full-time, nonunion and union employees of Sinai and Levindale. Annual contributions to the Sinai/Levindale Plans are made at a level equal to or greater than the funding requirement as determined by the Sinai/Levindale Plans' consulting actuary. Contributions are intended to provide not only for benefits attributed to service to date, but also for those expected to be earned in the future.

The following tables set forth the Sinai/Levindale Plans' funded status and amounts recognized in the accompanying consolidated financial statements as of June 30, 2016 and 2015:

	2016	2015
Measurement date	June 30, 2016	June 30, 2015
Change in projected benefit obligation:		
Benefit obligation at beginning of year	$ 185,808	174,787
Service cost	7,729	7,490
Interest cost	8,085	7,369
Actuarial loss	19,264	6,933
Benefits paid	(5,815)	(10,321)
Expenses paid from assets	(346)	(450)
Benefit obligation at end of year	214,725	185,808
Change in plan assets:		
Fair value of plan assets at beginning of year	158,657	157,068
Actual return on plan assets	(5,461)	3,666
Company contributions	10,542	8,694
Benefits paid	(5,815)	(10,321)
Expenses paid from assets	(346)	(450)
Fair value of plan assets at end of year	157,577	158,657
Funded status	$ (57,148)	(27,151)

(Continued)

(Dollars in thousands)

Amounts recognized in the consolidated financial statements consist of the following at June 30:

		2016	2015
Amounts recognized in the consolidated balance sheets:			
Other long-term liabilities	$	57,148	27,151
Amounts recognized in unrestricted net assets:			
Net actuarial loss	$	74,421	41,086
Prior service cost		—	43
	$	74,421	41,129

The Corporation has estimated $16,721 for its defined-benefit contributions to the Sinai/Levindale Plans for the fiscal year ending June 30, 2017. The accumulated benefit obligation is $196,562 and $169,323 at June 30, 2016 and 2015, respectively.

Net periodic pension expense for the years ended June 30, 2016 and 2015 was as follows:

		2016	2015
Service cost	$	7,730	7,490
Interest cost		8,085	7,369
Expected return on plan assets		(10,963)	(10,982)
Amortization of net loss		2,353	1,149
Amortization of prior service cost		43	89
Net periodic benefit cost	$	7,248	5,115

The estimated net actuarial loss and prior service cost to be amortized from unrestricted net assets into net periodic pension benefit cost over the next fiscal year are $5,555 and $0, respectively.

(Continued)

(Dollars in thousands)

Actuarial assumptions used were as follows:

	2016	2015
Assumptions used to determine annual pension expense:		
Discount rate	4.47%	4.40%
Expected return on plan assets	7.00	7.25
Rate of compensation increase	2.50	2.50
Assumptions used to determine end-of-year liabilities:		
Discount rate	3.68%	4.47%
Expected return on plan assets	7.00	7.00
Rate of compensation increase	2.50	2.50
Plan asset allocation:		
Asset category:		
Cash and cash equivalents	2.00%	2.00%
Fixed income/debt securities	26.00	25.00
Equity securities	47.00	48.00
Alternative investments	25.00	25.00
Total	100.00%	100.00%

In selecting the expected long-term rate on asset, Sinai and Levindale considered the average rate of earnings on the funds invested or to be invested to provide for the benefits of these plans. This included considering the Sinai/Levindale Plans' asset allocation and the expected returns likely to be earned over the life of the plans. Target asset allocation is as follows:

	Target
Target allocation on assets:	
Equity securities	45%
Alternative investments	30
Fixed income/debt securities	25

Following are the benefit payments expected to be disbursed from plan assets:

Years ending June 30:		
2017	$	11,125
2018		11,204
2019		11,363
2020		12,068
2021		11,839
Thereafter		65,242

(Continued)

(Dollars in thousands)

The fair values of assets of the Sinai/Levindale Plans held by PNC Institutional Investments by level at June 30, 2016 were as follows:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 4,860	—	—	4,860
Mutual funds	54,886	—	—	54,886
Fixed income	—	5,635	—	5,635
Equity securities	56,382	—	—	56,382
Alternative investments	—	—	35,814	35,814
Total assets	$ 116,128	5,635	35,814	157,577

The fair values of assets of the Sinai/Levindale Plans held by PNC Institutional Investments by level at June 30, 2015 were as follows:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 5,411	—	—	5,411
Mutual funds	53,314	—	—	53,314
Fixed income	—	6,140	—	6,140
Equity securities	57,330	—	—	57,330
Alternative investments	—	—	36,462	36,462
Total assets	$ 116,055	6,140	36,462	158,657

For the years ended June 30, 2016 and 2015, there were no significant transfers into or out of Levels 1, 2, or 3.

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

	Total
Balance as of June 30, 2015	$ 36,462
Additions:	
Contributions/purchases	36,392
Disbursements:	
Withdrawals/sales	(35,744)
Net change in value	(1,296)
Balance as of June 30, 2016	$ 35,814

(Continued)

(Dollars in thousands)

The following table summarizes redemption terms for the hedge fund-of-funds vehicles held as of June 30, 2016:

	Fund 1	Fund 2	Fund 3	Fund 4	Fund 5	Fund 6
Redemption timing:						
Redemption frequency	Quarterly	Quarterly	Quarterly	Annually	Monthly	Annually
Required notice	33 days	65 days	65 days	45 days	30 days	90 days
Audit reserve:						
Percentage held back for audit reserve	10%	5%	10%	—%	—%	5%

(b) Carroll Plan

CCHS sponsors a Defined Benefit Cash Balance Plan (the Carroll Plan) covering employees of Carroll, CCMS, and Carroll Foundation. CCHS's funding policy is to make contributions to the Carroll Plan based on actuarially determined amounts necessary to provide assets sufficient to meet benefits to be paid to plan participants and to meet the minimum funding requirements of the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code, plus such amounts as CCHS may determine to be appropriate from time to time. Under the cash balance plan structure, the benefits under the Carroll Plan are determined based on employee tenure rather than age. CCHS elected to freeze benefit accruals and participation in the Carroll Plan on December 31, 2006.

The information below describes certain actions of CCHS for the years ended June 30, 2016 and 2015. As discussed in footnote 3, the fiscal year 2015 statements of operations of the Corporations includes CCHS activity for the period April 1, 2015 through June 30, 2015.

(Continued)

(Dollars in thousands)

The following tables set forth the changes in the projected benefit obligation, the changes in the Carroll Plan's assets, the Carroll Plan's funded status, the amounts recognized in the consolidated financial statements, and the Carroll Plan's net periodic pension cost as of June 30, 2016 and 2015:

		2016	2015
Measurement date		June 30, 2016	June 30, 2015
Change in projected benefit obligation:			
Projected benefit obligation at beginning of year	$	68,498	66,031
Interest cost		3,004	2,755
Actuarial loss		7,514	1,919
Benefits paid		(2,397)	(2,207)
Benefit obligation at end of year		76,619	68,498
Change in plan assets:			
Fair value of plan assets at beginning of year		61,131	58,548
Actual return on plan assets		1,739	1,190
Employer contribution		3,600	3,600
Benefits paid		(2,397)	(2,207)
Fair value of plan assets at end of year		64,073	61,131
Funded status	$	(12,546)	(7,367)

The accumulated benefit obligation for the Plan was $76,619 and $68,498 at June 30, 2016 and 2015, respectively.

Net periodic pension expense for the year ended June 30, 2016 was as follows:

		2016	2015
Components of net periodic pension expense:			
Interest cost	$	3,004	2,755
Expected return on plan assets		(4,315)	(4,140)
Amortization of actuarial loss		1,870	1,484
Net periodic pension expense	$	559	99

The estimated net actuarial loss and prior service cost to be amortized from unrestricted net assets into net periodic pension benefit cost over the next fiscal year is $2,499 and $0, respectively.

(Continued)

(Dollars in thousands)

Assumptions to determine the benefit obligation as of June 30, 2016 and 2015 were as follows:

	2016	2015
Discount rate	3.72%	4.47%

Assumptions used in the determination of net periodic pension expense for the year ended June 30, 2016 and 2015 were as follows:

	2016	2015
Discount rate	4.47%	4.25%
Expected long-term rate of return on plan assets	7.00	7.00

Deferred pension costs, which have not yet been recognized in periodic pension expense but are accrued in unrestricted net assets, are $32,962 and $24,742 at June 30, 2016 and 2015, respectively. Deferred pension costs represent unrecognized actuarial losses or unexpected changes in the projected benefit obligation and plan assets over time primarily due to changes in assumed discount rates and investment experience. The amount of deferred pension costs expected to be recognized as a component of net periodic pension costs during the year ended June 30, 2017 is $380.

CCHS's weighted average asset allocations for the plan assets as of June 30, 2016 and 2015 were as follows:

	2016	2015
Cash and cash equivalents	8.0%	7.0%
Fixed income/debt securities	22.0	19.0
Mutual funds and equity securities	53.0	56.0
Alternative investments	17.0	18.0
	100.0%	100.0%

Pension plan assets are invested in accordance with the CCHS's investment policy in an attempt to maximize return with reasonable and prudent levels of risk. This structure includes various assets classes, investment management styles, asset allocation, and acceptable ranges that, in total, are expected to produce a sufficient level of overall diversification and total investment return over the long term. CCHS periodically reviews performance to test progress toward attainment of longer term targets, to compare results with appropriate indices and peer groups, and to assess overall investment risk levels.

(Continued)

(Dollars in thousands)

The following table presents the Plan's assets measured at fair value at June 30, 2016:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 5,366	—	—	5,366
Mutual funds	34,179	—	—	34,179
Fixed income	—	13,716	—	13,716
Alternative investments	—	—	10,812	10,812
Total assets	$ 39,545	13,716	10,812	64,073

The following table presents the Plan's assets measured at fair value at June 30, 2015:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 4,205	—	—	4,205
Mutual funds	34,102	—	—	34,102
Fixed income	—	12,199	—	12,199
Alternative investments	—	—	10,625	10,625
Total assets	$ 38,307	12,199	10,625	61,131

During fiscal year 2016, Level 3 investments within the pension plan assets increased by $7. This increase was the result of purchases of $3,391, redemptions of $2,828 and losses in investments of $556. During fiscal year 2015, Level 3 investments within the pension plan assets decreased by $78. This decrease was the result of purchases of $0, redemptions of $447 and gain on earnings in investments of $369. There were no significant transfers between Levels 1, 2 and 3 during the years ended June 30, 2016 and 2015.

CCHS follows ASU No. 2009-12, and applied its provisions to its pension plan asset portfolio. The guidance amends ASC Topic 820 and permits, as a practical expedient, fair value of investments within its scope to be estimated using net asset value (NAV) or its equivalent. The alternative investments classified within Level 3 of the fair value hierarchy have been recorded using NAV.

The Carroll Plan invests in alternative investments which are primarily hedge fund of funds and real estate funds.

For the alternative investments, redemption requests can be made either quarterly or annually. The notice required in order to make a redemption is within a range of 65 to 100 days. The audit reserve requirements are 10% for each fund. There are generally no gate provisions with the exception of one fund which has a gate of 25% of net asset value (NAV).

(Continued)

(Dollars in thousands)

CCHS expects to contribute $2,070 to the Carroll Plan during the year-ending June 30, 2017.

The following benefit payments, which reflect future services, as appropriate, are expected to be paid from the Plan's assets during the years ending June 30 of the indicated year:

2017	$ 2,677
2018	2,802
2019	2,920
2020	3,123
2021	3,337
2022–2026	19,075
	$ 33,934

CCHS expensed total employer contributions of $1,291 and $290 for the year ended June 30, 2016 and 2015, respectively.

(c) Contributory Plans

Northwest has a qualified noncontributory defined-contribution pension plan (the NW Plan) covering substantially all employees who work at least 1,000 hours per year, who have completed two years of continuous service as of the beginning of the plan year, and who have attained the age of 21 as of the beginning of the plan year. Participants in the NW Plan are 100% vested. Northwest makes annual contributions to the NW Plan equivalent to 1.5% of the participants' salaries for employees who have been in the NW Plan from one to five years, 4.0% for those in the plan from six to 19 years, and 6.5% thereafter. It is Northwest's policy to fund plan costs as they accrue. Plan expense was approximately $2,849 and $2,794 for the years ended June 30, 2016 and 2015, respectively, and is included in salaries and employee benefits in the accompanying consolidated statements of operations.

Certain LifeBridge entities have supplemental 403(b) retirement plans for eligible employees. The entities may elect to match varying percentages of an employee's contribution up to a certain percentage of the employee's annual salary. The associated expense was approximately $4,710 and $4,774 for the years ended June 30, 2016 and 2015, respectively, and is included in salaries and employee benefits in the accompanying consolidated statements of operations.

Certain companies under Community Physicians and Investments maintain a defined-contribution plan for employees meeting certain eligibility requirements. Eligible employees can also make contributions. Under the plan, the employer may elect to match a percentage of eligible employees' contributions each year. The related expense was approximately $1,627 and $1,668 for the years ended June 30, 2016 and 2015, respectively, and is included in salaries and employee benefits in the accompanying consolidated statements of operations.

Certain LifeBridge entities maintain a nonqualified deferred compensation plan for key employees and physicians. The Corporation establishes a separate deferral account on its books for each participant for each plan year. In general, participants are entitled to receive the deferred funds upon their death, attainment of the specified vesting date, or involuntary termination of their employment without cause,

whichever occurs first. The related expense was approximately $4,823 and $3,469 for the years ended June 30, 2016 and 2015, respectively, and is included in salaries and employee benefits in the accompanying consolidated statements of operations.

(d) Postretirement Plan Other than Pension

Carroll sponsors a postretirement plan other than pension for employees. Carroll employees retired from active employment at 65 years of age or older or at 55 years of age after earning at least 10 years of vesting service are eligible for health and prescription drug benefits under Carroll's self-insured health plan. Effective January 1, 2009, individuals are no longer permitted to participate in this Plan once they are Medicare eligible. Plan participants contribute premiums to the Plan in amounts determined by Carroll for Pre-Medicare and post-Medicare age retirees. At June 30, 2016 and 2015, Carroll has accrued a liability of $425 and $376, respectively, related to this Plan.

(12) Regulation and Reimbursement

The Corporation and other healthcare providers in Maryland are subject to certain inherent risks, including the following:

- Dependence on revenues derived from reimbursement by the Federal Medicare and State Medicaid programs;
- Regulation of hospital rates by the State of Maryland Health Services Cost Review Commission (HSCRC);
- Government regulation, government budgetary constraints, and proposed legislative and regulatory changes; and
- Lawsuits alleging malpractice and related claims.

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

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

The current rate of reimbursement for hospital services to patients under the Medicare and Medicaid programs is based on an agreement between the Center for Medicaid and Medicare Services (CMS) and the State of Maryland. This agreement is based upon a waiver from Medicare prospective payment system reimbursement principles granted to the State of Maryland by CMS.

In January 2014, CMS approved Maryland's new waiver for a five-year period beginning January 1, 2014 for inpatient and outpatient hospital services. The new waiver requires Maryland to adopt a payment structure

that incentivizes efficient utilization of hospital resources, limits hospital per capita growth in all-payer and Medicare spending, generate Medicare savings of $330 million over five years, limit growth in total cost of care per Medicare beneficiary, reduce hospital readmissions, and reduce certain hospital-acquired conditions.

(13) Related-Party Transactions

Land Leases

Sinai and Levindale are constituent agencies of AJCF, a charitable corporation.

The legal title to substantially all land, land improvements, buildings, and fixed equipment included in Sinai's and Levindale's operating property is held by an affiliate of AJCF. Sinai and Levindale have entered into leases with the AJCF affiliate with respect to these assets. The leases allow Sinai and Levindale to conduct their business on the property as currently conducted. Rent under each lease is $1.00 per year. The leases may not be terminated before December 31, 2050.

Other

In addition to its arrangement with AJCF, Sinai receives services from certain other constituent agencies of AJCF.

(14) Income Taxes

At June 30, 2016, Investments has approximately $62,019 in net operating loss carryforwards for income tax purposes. The net operating loss carryforwards for tax purposes are available to reduce future taxable income and expire in varying periods through 2036.

The net operating loss carryforwards created a federal net deferred tax asset of approximately $21,087 and $18,670 as of June 30, 2016 and 2015, respectively, and a state deferred tax asset of approximately $3,358 and $2,996 as of June 30, 2016 and 2015, respectively. Management has determined that it is more likely than not that Investments will not be able to utilize the deferred tax assets; therefore, a full valuation allowance was recorded against the net deferred assets as of June 30, 2016 and 2015.

At June 30, 2016, CCHS has approximately $65,243 of net operating loss carryforwards, primarily at CCMS, that will expire through 2033. The net operating loss carryforwards created a net deferred tax asset of approximately $28,928 and $24,801 as of June 30, 2016 and 2015, respectively. Management has determined that it is more likely than not that CCHS will not be able to utilize the deferred tax assets; therefore, a full valuation allowance has been recorded against the deferred tax asset as of June 30, 2016 and 2015.

(Continued)

(Dollars in thousands)

(15) Other Long-Term Liabilities

Other long-term liabilities at June 30, 2016 and 2015 are as follows:

	2016	2015
Professional/general liability (note 16(a))	$ 52,174	51,924
Pension liability	70,119	34,894
Medical office building	33,128	34,256
Asset retirement obligation	3,260	3,260
Deferred compensation	6,967	4,864
Other	1,361	1,658
	$ 167,009	130,856

At June 30, 2016 and 2015, there was $13,023 and $12,121 included in other current liabilities related to professional liabilities, respectively.

(16) Self-Insurance Programs

(a) Professional/General Liability

The Corporation is self-insured, through LifeBridge Insurance (and Cen-Mar prior to June 30, 2016), for most medical malpractice and general liability claims arising out of the operations of LifeBridge and its subsidiaries. Estimated liabilities have been recorded for both reported and incurred but not reported claims.

LifeBridge Insurance and Cen-Mar purchase reinsurance coverage from other carriers to cover their liabilities in excess of various retentions. The amounts that LifeBridge subsidiaries must transfer to LifeBridge Insurance and Cen-Mar to fund medical malpractice and general liability claims are actuarially determined and are sufficient to cover expected liabilities. Management's estimate of the liability for medical malpractice and general liability claims, including incurred but not reported claims, is principally based on actuarial estimates performed by an independent third-party actuary. Professional liability coverage for certain employed physicians is provided by commercial insurance carriers.

(b) Workers' Compensation

Sinai, Northwest, Levindale, LAA, and CCMS and its subsidiaries are insured for workers' compensation liability through a combination of self-insurance and excess insurance. Losses for asserted and unasserted claims are accrued based on estimates derived from past experiences, as well as other considerations including the nature of each claim or incident, relevant trend factors, and estimates of incurred but not reported amounts.

LifeBridge has accrued a liability for known and incurred but not reported claims of $7,005 and $6,899 at June 30, 2016 and 2015, respectively. These amounts are included in accounts payable and accrued liabilities in the accompanying consolidated balance sheets. Management believes these accruals are

(Continued)

(Dollars in thousands)

is adequate to provide for all workers' compensation claims that have been incurred through June 30, 2016.

All other entities have occurrence-based commercial insurance coverage. There are no material insurance recoveries related to workers' compensation as of June 30, 2016.

LifeBridge maintains stop-loss policies on workers' compensation claims. Legacy LifeBridge is insured for individual claims exceeding $450. CCHS is insured for individual claims exceeding $500.

(c) Health Insurance

LifeBridge is self-insured for employee health claims. LifeBridge has accrued a liability of $3,655 and $3,517 at June 30, 2016 and 2015, respectively, for known claims and incurred but not reported claims. These amounts are included in accounts payable and accrued liabilities in the accompanying consolidated balance sheets.

(17) Concentration of Credit Risk

The Corporation grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2016 and 2015 is as follows:

	2016	2015
Medicare	30%	27%
Medicaid	9	10
BlueCross	12	13
Commercial and other	40	40
Self-pay	9	10
	100%	100%

The mix of net patient service revenue for the Corporation for the years ended June 30, 2016 and 2015 is as follows:

	2016	2015
Medicare	42%	41%
Medicaid	7	5
BlueCross	14	14
Commercial and other	33	36
Self-pay	4	4
	100%	100%

(Continued)

(Dollars in thousands)

(18) Commitments and Contingencies

(a) Litigation

The Corporation is subject to numerous laws and regulations of federal, state, and local governments. The Corporation's compliance with these laws and regulations can be subject to periodic governmental review and interpretation, which can result in regulatory action unknown or unasserted at this time. Management is aware of certain asserted and unasserted legal claims and regulatory matters arising in the ordinary course of business. After consultation with legal counsel, it is management's opinion that the ultimate resolution of these claims will not have a material adverse effect on the Corporation's financial position.

(b) Letters of Credit

M&T Bank has established an open letter of credit for Sinai of $211 (which has not been drawn upon) to guarantee Sinai's obligation for liabilities assumed as a member of a risk retention group during the period 1988 to 1994. Additionally, M&T Bank has established a standby letter of credit of $2,407 to serve as collateral as required by the Maryland Office of Unemployment Insurance. M&T Bank has established a standby letter of credit for Levindale of $411 as required by the State of Maryland Department of Labor, Licensing, and Regulation. M&T Bank has established a standby letter of credit for LifeBridge Health & Fitness of $200 as required by the State of Maryland Office of the Attorney General. M&T Bank has established a standby letters of credit of $52 and of $84 to serve as collateral as required by the City of Baltimore for the completion of certain construction work at Sinai.

(c) Operating Leases

The Corporation has entered into operating lease agreements for hospital equipment and office space, which expire on various dates through year 2026. Total rental expense for the years ended June 30, 2016 and 2015 for all operating leases was approximately $24,135 and $21,540, respectively. Future minimum lease payments under all noncancelable operating leases are as follows:

ears ending June 30:	
2017	$ 18,079
2018	15,757
2019	14,957
2020	14,090
2021	12,915
Thereafter	17,894
	$ 93,692

(Continued)

(Dollars in thousands)

(19) Noncontrolling Interest

The reconciliation of a noncontrolling interest reported in unrestricted net assets is as follows:

	LifeBridge Health, Inc.	Noncontrolling interest	Unrestricted net assets
Balance at June 30, 2014	$ 660,970	(192)	660,778
Operating income	50,276	470	50,746
Nonoperating income	14,746	—	14,746
Excess of revenues over expenses	65,022	470	65,492
CCHS acquisition	130,388	3,644	134,032
Change in funded status of pension plan	(16,548)	—	(16,548)
Net assets released for purchase of property and equipment	5,347	—	5,347
Other	(272)	—	(272)
Change in net assets	183,937	4,114	188,051
Balance at June 30, 2015	844,907	3,922	848,829
Operating income	48,533	1,177	49,710
Nonoperating income	(5,303)	—	(5,303)
Loss on refinancing of debt	(3,720)	—	(3,720)
Excess of revenues over expenses	39,510	1,177	40,687
Change in funded status of pension plan	(41,513)	—	(41,513)
Net assets released for purchase of property and equipment	7,613	—	7,613
Other	(841)	—	(841)
Change in net assets	4,769	1,177	5,946
Balance at June 30, 2016	$ 849,676	5,099	854,775

(20) Functional Expenses

The Corporation provides general healthcare services to patients. Expenses for the years ended June 30, 2016 and 2015 related to providing these services are as follows:

	2016	2015
Healthcare services	$ 1,069,047	875,650
General and administrative	358,668	286,733
	$ 1,427,715	1,162,383

(Continued)

(21) Fair Value of Financial Instruments

The following methods and assumptions were used by the Corporation in estimating the fair value of its financial instruments:

(a) Assets and Liabilities

Cash and cash equivalents, patient service receivables, other receivables, inventory, prepaid expenses, pledges receivable, accounts payable and accrued liabilities, advances to third-party payors, and other current liabilities – The carrying amounts reported in the consolidated balance sheet approximate the related fair values.

Investments (donor-restricted, assets limited as to use, and long-term), and beneficial interest in split interest agreements – Fair values are based on quoted market prices of individual securities or investments if available, or are estimated using quoted market prices for similar securities or investment managers' best estimate of underlying fair value.

Investment in unconsolidated affiliates – Investments in unconsolidated affiliates are not readily marketable. Therefore, it is not practicable to estimate their fair value and such investments are recorded in accordance with the equity method or at cost.

(b) Long-Term Debt

The Series 2008 MHHEFA Bonds bear interest at fixed rates and had a fair value of $244,684 and $273,529 at June 30, 2016 and 2015, respectively. The fair market value of the fixed rate Series 2011 MHHEFA Bonds was $56,556 and $55,110 as of June 30, 2016 and 2015, respectively. The fair market value of the variable rate Series 2006 MHHEFA Bonds was $0 and $35,582 as of June 30, 2016 and 2015, respectively. The fair market value of the fixed rate Series 2012A MHHEFA Bonds was $62,742 and $60,244 as of June 30, 2016 and 2015, respectively. The fair market value of the variable rate Series 2015 MHHEFA Bonds was $185,798 as of June 30, 2016.

The fair value of other long-term debt, and bank loans payable approximates its carrying value.

The fair value of the Corporation's long-term MHHEFA debt is measured using quoted offered-side prices when quoted market prices are available. If quoted market prices are not available, the fair value is determined by discounting the future cash flows of each instrument at rates that reflect, among other things, market interest rates and the Corporation's credit standing. In determining an appropriate spread to reflect its credit standing, the Corporation considers credit default swap spreads, bond yields of other long-term debt, and interest rates currently offered for similar debt instruments of comparable maturities by the Corporation's bankers as well as other banks that regularly compete to provide financing to the Corporation.

(Continued)

(Dollars in thousands)

(c) Fair Value Hierarchy

The following table presents assets that are measured at fair value on a recurring basis as of June 30, 2016:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 34,170	—	—	34,170
Equity securities and mutual funds	375,980	—	—	375,980
Treasury securities	4,501	—	—	4,501
Government securities	—	60,189	—	60,189
Fixed income	—	38,522	—	38,522
Beneficial interest in split-interest agreement	—	4,477	—	4,477
Total assets	$ 414,651	103,188	—	517,839

The following table presents assets that are measured at fair value on a recurring basis as of June 30, 2015:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 76,755	—	—	76,755
Equity securities and mutual funds	318,878	—	—	318,878
Treasury securities	14,627	—	—	14,627
Government securities	—	21,206	—	21,206
Fixed income	—	39,453	—	39,453
Beneficial interest in split-interest agreement	—	4,628	—	4,628
Total assets	$ 410,260	65,287	—	475,547

See note 2(e) for information on investments of the Corporation that are treated under the equity method and are not reported above.

For the years ended June 30, 2016 and 2015, there were no significant transfers into or out of Levels 1, 2, or 3.

(22) Subsequent Events

Management evaluated all events and transactions that occurred after June 30, 2016 and through October 12, 2016. The Corporation did not have any subsequent events during this period that were required to be recognized or disclosed.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidating Balance Sheet Information

June 30, 2016

(Dollars in thousands)

Assets	Sinai Hospital Consolidated	Northwest Hospital	Carroll Hospital	Levindale Hebrew Geriatric Ctr & Hospital	Other LifeBridge Entities	Eliminations	LifeBridge Health Consolidated
Current assets:							
Cash and cash equivalents	$ 121,957	104,929	23,238	20,248	52,565	—	322,937
Investments	12,695	3,395	6,987	276	(1)	—	23,352
Assets limited as to use, current portion	46,082	13,262	4,260	418	3,638	—	67,660
Patient service receivables, net of allowance for doubtful accounts	74,694	22,527	20,646	7,944	15,840	—	141,651
Other receivables	61,719	4,191	4,455	536	25,984	(85,377)	11,508
Inventory	22,572	5,081	3,600	183	78	—	31,514
Prepaid expenses	5,165	1,003	5,327	350	6,916	—	18,761
Pledges receivable, current portion	1,602	216	1,365	113	—	—	3,296
Total current assets	346,486	154,604	69,878	30,068	105,020	(85,377)	620,679
Board-designated investments	92,770	55,966	—	17,046	77,507	—	243,289
Long-term investments	43,563	26,280	132,460	8,005	43,449	—	253,757
Donor-restricted investments	12,695	3,395	4,175	276	—	—	20,541
Reinsurance recovery receivable	—	—	—	—	15,694	—	15,694
Assets limited as to use, net of current portion	—	—	—	—	43,601	—	43,601
Pledges receivable, net of current portion	1,747	295	1,100	263	—	—	3,405
Property and equipment, net	238,342	112,208	120,471	40,491	117,965	—	629,477
Deferred financing costs, net of accumulated amortization	2,004	647	1,365	121	—	—	4,137
Beneficial interest in split interest agreement	4,477	—	—	—	—	—	4,477
Investment in unconsolidated affiliates	—	—	3,000	—	158,076	(117,036)	44,040
Other assets, net of accumulated amortization	13,070	2,277	14,939	65	17,791	—	48,142
Total assets	$ 755,154	355,672	347,388	96,335	579,103	(202,413)	1,931,239

(Continued)

Schedule 1

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidating Balance Sheet Information

June 30, 2016

(Dollars in thousands)

Liabilities and Net Assets	Sinai Hospital Consolidated	Northwest Hospital	Carroll Hospital	Levindale Hebrew Geriatric Ctr & Hospital	Other LifeBridge Entities	Eliminations	LifeBridge Health Consolidated
Current liabilities:							
Accounts payable and accrued liabilities	$ 66,718	18,759	19,029	4,571	95,525	(85,377)	119,225
Accrued salaries, wages, and benefits	35,094	9,479	9,470	3,091	23,227	—	80,361
Advances from third-party payors	28,077	7,773	6,962	3,434	—	—	46,246
Current portion of long-term debt and capital lease obligations	3,128	1,039	1,850	163	6,741	—	12,921
Other current liabilities	1,373	320	532	13	14,633	—	16,871
Total current liabilities	134,390	37,370	37,843	11,272	140,126	(85,377)	275,624
Other long-term liabilities	72,758	10,756	28,014	5,747	49,734	—	167,009
Long-term debt and capital lease obligations, net of current portion	272,976	89,913	134,497	9,305	57,868	—	564,559
Total liabilities	480,124	138,039	200,354	26,324	247,728	(85,377)	1,007,192
Net assets:							
Unrestricted net assets	227,852	209,936	85,847	68,852	324,225	(67,036)	849,676
Noncontrolling interest in consolidated subsidiaries	—	—	4,793	—	306	—	5,099
Total unrestricted net assets	227,852	209,936	90,640	68,852	324,531	(67,036)	854,775
Temporarily restricted	36,687	7,697	55,221	1,159	2,621	(50,000)	53,385
Permanently restricted	10,491	—	1,173	—	4,223	—	15,887
	275,030	217,633	147,034	70,011	331,375	(117,036)	924,047
Total liabilities and net assets	$ 755,154	355,672	347,388	96,335	579,103	(202,413)	1,931,239

See accompanying independent auditors' report.

Schedule 2

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidating Statement of Operations Information

Year ended June 30, 2016

(Dollars in thousands)

	Sinai Hospital Consolidated	Northwest Hospital	Carroll Hospital	Levindale Hebrew Geriatric Ctr & Hospital	Other LifeBridge Entities	Eliminations	LifeBridge Health Consolidated
Unrestricted revenues, gains, and other support:							
Patient service revenue (net of contractual allowances and discounts)	$ 717,728	243,716	257,505	77,946	138,915	—	1,435,810
Provision for bad debts	28,141	13,365	7,411	3,297	4,768	—	56,982
Net patient service revenue	689,587	230,351	250,094	74,649	134,147	—	1,378,828
Net assets released from restrictions used for operations	3,191	—	—	111	235	—	3,537
Other operating revenue	53,043	16,847	5,359	2,036	60,506	(42,731)	95,060
Total operating revenues	745,821	247,198	255,453	76,796	194,888	(42,731)	1,477,425
Expenses:							
Salaries and employee benefits	375,433	127,658	118,540	46,803	126,199	461	795,094
Supplies	143,312	44,306	43,124	6,296	16,561	—	253,599
Purchased services	138,430	40,956	54,755	14,869	48,393	(43,192)	254,211
Depreciation, amortization, and gain/loss on sale of assets	33,370	11,725	15,904	3,056	11,644	—	75,699
Repairs and maintenance	13,249	4,537	1,273	880	599	—	20,538
Interest	11,132	4,104	5,525	509	7,304	—	28,574
Total expenses	714,926	233,286	239,121	72,413	210,700	(42,731)	1,427,715
Operating income (loss)	30,895	13,912	16,332	4,383	(15,812)	—	49,710
Other income (loss), net:							
Investment income	6,383	561	7,779	(221)	1,526	—	16,028
Unrealized gains on trading investments	(9,063)	(4,796)	(6,130)	(217)	(1,904)	—	(22,110)
Other	—	—	252	—	527	—	779
Total other income (loss), net	(2,680)	(4,235)	1,901	(438)	149	—	(5,303)
Excess (deficiency) of revenues over expenses before inherent contributions	28,215	9,677	18,233	3,945	(15,663)	—	44,407
Loss on refinancing of debt	(1,568)	(541)	(1,592)	(19)	—	—	(3,720)
Excess of revenues over expenses	$ 26,647	9,136	16,641	3,926	(15,663)	—	40,687

See accompanying independent auditors' report.

KPMG

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Financial Statements and
Supplementary Financial Information

June 30, 2017 and 2016

(With Independent Auditors' Report Thereon)

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Table of Contents

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

Independent Auditors' Report

The Board of Directors
LifeBridge Health, Inc. and Subsidiaries:

We have audited the accompanying consolidated financial statements of LifeBridge Health, Inc. and Subsidiaries (the Corporation), which comprise the consolidated balance sheets as of June 30, 2017 and 2016, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly in all material respects, the financial position of LifeBridge Health, Inc. and Subsidiaries as of June 30, 2017 and 2016, and the results of their operations, changes in their net assets and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG

Supplemental Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Schedules 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

October 18, 2017

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2017 and 2016

(Dollars in thousands)

Assets		2017	2016
Current assets:			
Cash and cash equivalents	$	356,365	322,937
Investments		24,583	23,352
Assets limited as to use, current portion		68,496	67,660
Patient service receivables, net of allowance for doubtful accounts of $67,941 in 2017 and $62,213 in 2016		145,639	141,651
Other receivables		17,011	11,508
Inventory		30,515	31,514
Prepaid expenses		15,185	18,761
Pledges receivable, current portion		2,671	3,296
Total current assets		660,465	620,679
Board-designated investments		238,677	243,289
Long-term investments		315,320	253,757
Donor-restricted investments		21,389	20,541
Reinsurance recovery receivable		15,548	15,694
Assets limited as to use, net of current portion		33,039	43,601
Pledges receivable, net of current portion		5,122	3,405
Property and equipment, net		651,173	629,477
Beneficial interest in split interest agreement		4,757	4,477
Investment in unconsolidated affiliates		50,882	44,040
Other assets, net		63,941	48,142
Total assets	$	2,060,313	1,927,102

(Continued)

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2017 and 2016

(Dollars in thousands)

Liabilities and Net Assets		2017	2016
Current liabilities:			
Accounts payable and accrued liabilities	$	128,730	119,225
Accrued salaries, wages and benefits		79,444	80,361
Advances from third-party payors		41,935	46,246
Current portion of long-term debt and capital lease obligations, net		13,928	12,921
Other current liabilities		20,135	16,871
Total current liabilities		284,172	275,624
Other long-term liabilities		135,704	167,009
Long-term debt and capital lease obligations, net		571,178	560,422
Total liabilities		991,054	1,003,055
Net assets:			
Unrestricted		983,910	849,676
Noncontrolling interest in consolidated subsidiaries		14,626	5,099
Total unrestricted net assets		998,536	854,775
Temporarily restricted		54,532	53,385
Permanently restricted		16,191	15,887
		1,069,259	924,047
Total liabilities and net assets	$	2,060,313	1,927,102

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended June 30, 2017 and 2016

(Dollars in thousands)

	2017	2016
Unrestricted revenues, gains and other support:		
Patient service revenue (net of contractual allowances and discounts)	$ 1,508,948	1,473,620
Provision for bad debts	(47,341)	(56,982)
Net patient service revenue	1,461,607	1,416,638
Net assets released from restrictions used for operations	3,879	3,537
Other operating revenue	61,568	57,250
Total operating revenues	1,527,054	1,477,425
Expenses:		
Salaries and employee benefits	809,022	795,094
Supplies	258,614	253,599
Purchased services	278,077	254,211
Depreciation, amortization and gain/loss on sale of assets	77,214	75,699
Repairs and maintenance	21,306	20,538
Interest	28,567	28,574
Total expenses	1,472,800	1,427,715
Operating income	54,254	49,710
Other income (loss), net:		
Investment income	30,908	16,028
Unrealized gain (loss) on trading investments	36,654	(22,110)
Other	(10)	779
Loss on refinancing of debt	(10,802)	(3,720)
Total other income (expense), net	56,750	(9,023)
Excess of revenues over expenses	$ 111,004	40,687

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2017 and 2016

(Dollars in thousands)

	Unrestricted	Temporarily restricted	Permanently restricted	Total net assets
Net assets at June 30, 2015	$ 848,829	61,660	15,816	926,305
Excess of revenues over expenses	40,687	—	—	40,687
Unrealized loss on investments	—	(1,842)	(5)	(1,847)
Net assets released from restrictions used for the purchase of property and equipment	7,613	(7,613)	—	—
Restricted gifts and bequests	—	4,908	76	4,984
Net assets released from restrictions used for operations	—	(3,537)	—	(3,537)
Net change in value of beneficial interest in split interest agreement	—	(151)	—	(151)
Adjustment to pension liability	(41,513)	—	—	(41,513)
Other	(841)	(40)	—	(881)
Change in net assets	5,946	(8,275)	71	(2,258)
Net assets at June 30, 2016	854,775	53,385	15,887	924,047
Excess of revenues over expenses	111,004	—	—	111,004
Unrealized gain on investments	—	3,305	—	3,305
Net assets released from restrictions used for the purchase of property and equipment	4,147	(4,147)	—	—
Restricted gifts and bequests	—	5,640	304	5,944
Net assets released from restrictions used for operations	—	(3,879)	—	(3,879)
Net change in value of beneficial interest in split interest agreement	—	280	—	280
Adjustment to pension liability	20,341	—	—	20,341
Fair value of noncontrolling interests in acquisitions	9,754	—	—	9,754
Other	(1,485)	(52)	—	(1,537)
Change in net assets	143,761	1,147	304	145,212
Net assets at June 30, 2017	$ 998,536	54,532	16,191	1,069,259

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended June 30, 2017 and 2016

(Dollars in thousands)

	2017	2016
Cash flows from operating activities:		
Change in net assets	$ 145,212	(2,258)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	77,193	76,059
Loss (gain) on disposal of equipment	21	(360)
Change in pension liability	(20,341)	41,513
Provision for bad debts	47,341	56,982
Realized and unrealized gains (loss) on investments, net	(63,501)	17,593
Restricted gifts and bequests	(5,944)	(4,984)
Change in beneficial interest of split interest agreement	(280)	151
Earnings on investments in unconsolidated affiliates	(3,527)	(3,277)
Distributions to noncontrolling interest owners	2,400	—
Fair value of noncontrolling interests in acquisitions	(9,754)	—
Amortization of deferred financing costs and discounts	894	—
Loss on refinancing of debt	10,802	3,720
Change in operating assets and liabilities:		
Increase in patient service receivables, net	(51,329)	(56,421)
Increase in other receivables	(5,503)	(1,344)
Decrease (increase) in pledges receivable	(1,092)	5,469
Decrease (increase) in inventory	999	(2,032)
Decrease in prepaid expenses	3,576	318
Decrease in reinsurance recovery receivable	146	241
Increase in other assets	(5,155)	(5,637)
(Increase) decrease in accounts payable and accrued liabilities, and accrued salaries, wages, and benefits	9,457	(7,481)
(Decrease) increase in advances from third-party payors	(4,311)	4,466
Decrease in other current and long-term liabilities	(8,195)	(2,907)
Net cash provided by operating activities	119,109	119,811
Cash flows from investing activities:		
Change in donor-restricted investments	3,764	1,103
Change in current and long-term investments	707	(3,698)
Change in assets limited as to use	(38,021)	(49,356)
Investment in/distributions from unconsolidated affiliates, net	(3,315)	(6,898)
Additions to operating property	(75,064)	(101,221)
Purchases of alternative investments	(3,939)	—
Proceeds from sales of alternative investments	51,686	—
Proceeds from the sale of property	—	360
Cash paid for acquisitions	(11,047)	—
Net cash used in investing activities	(75,229)	(159,710)
Cash flows from financing activities:		
Payment on debt and capital lease obligations	(144,708)	(182,127)
Payment of deferred financing costs	(1,176)	—
Proceeds from issuance of debt	131,888	183,006
Distributions to noncontrolling interest owners	(2,400)	—
Restricted gifts and bequests	5,944	4,984
Net cash (used in) provided by financing activities	(10,452)	5,863
Net increase (decrease) in cash and cash equivalents	33,428	(34,036)
Cash and cash equivalents:		
Beginning of year	322,937	356,973
End of year	$ 356,365	322,937
Supplemental cash flow disclosures:		
Cash paid during the year for interest	$ 20,569	24,444
Cash paid during the year for income taxes	72	52
Accounts payable related to purchase of operating property	7,791	8,659

See accompanying notes to consolidated financial statements.

(1) Organization

On October 1, 1998, Sinai Health System, Inc. merged with Northwest Health System, Inc. to form LifeBridge Health, Inc. (LifeBridge). LifeBridge is a not-for-profit, nonstock Maryland corporation.

LifeBridge's subsidiaries include Sinai Hospital of Baltimore, Inc. (Sinai); Northwest Hospital Center, Inc. (Northwest); Levindale Hebrew Geriatric Center and Hospital, Inc. (Levindale); Children's Hospital of Baltimore City, Inc.; The Baltimore Jewish Health Foundation, Inc. (BJHF); The Baltimore Jewish Eldercare Foundation, Inc. (BJEF); Children's Hospital at Sinai Foundation, Inc. (CHSF); LifeBridge Anesthesia Associates, LLC (LAA); LifeBridge Insurance Company, Ltd. (LifeBridge Insurance); Courtland Gardens Nursing and Rehabilitation Center, Inc. (Courtland); LifeBridge Investments, Inc. (Investments); LifeBridge Health ACO, LLC; LifeBridge Physician Network, LLC; 8600 Liberty Road, LLC; and LifeBridge 23 Crossroads Drive Medical Office Building, LLC. Except for LifeBridge Insurance and Investments, all of the entities named above are not-for-profit and tax-exempt. Sinai and Levindale are constituent agencies of THE ASSOCIATED: Jewish Community Federation of Baltimore, Inc. (AJCF), a charitable corporation.

Effective April 1, 2015, Carroll County Health Services Corporation (CCHS), the parent of Carroll Hospital Center, Inc. (Carroll) and other related entities, became a subsidiary of LifeBridge. CCHS is further discussed below.

Investments is a for-profit corporation that holds, directly and indirectly, interests in a variety of for-profit businesses. Investments' wholly owned subsidiaries include:

- *Practice Dynamics, Inc.*
- *LifeBridge Health and Fitness, LLC*
- *Sinai Eldersburg Real Estate, LLC*
- *General Surgery Specialists, LLC*
- *BW Primary Care, LLC*
- *LifeBridge Community Practices, LLC*
- *The Center for Urologic Specialties, LLC*
- *LifeBridge Community Physicians, Inc. (Community Physicians)*

Investments also holds interests in numerous other health-related businesses.

Community Physicians is a for-profit corporation that provides physician and related services through numerous subsidiaries.

CCHS is a not-for-profit, nonstock Maryland corporation. The accompanying consolidated financial statements include the accounts of CCHS and its wholly or partially owned subsidiaries.

Wholly owned subsidiaries of Carroll include Carroll Hospital Center Foundation, Inc. (Carroll Foundation); Carroll Hospice, Inc. (CH); Carroll Regional Cancer Center Physicians, LLC (CRCCP); and Carroll Hospital Center MOB Investment, LLC. Carroll also holds interests in various health-related companies.

(Continued)

Prior to June 30, 2016, Carroll owned Cen-Mar Assurance Company (Cen-Mar). Cen-Mar was merged into LifeBridge Insurance on June 30, 2016.

Carroll County Med-Services, Inc. (CCMS) is a wholly owned, for-profit subsidiary of CCHS that is involved in real estate holdings, physician services, and other activities, and also maintains ownership interests in various joint ventures. Wholly owned subsidiaries of CCMS include: Carroll Health Group, LLC; Carroll PHO, LLC; and Carroll ACO, LLC. CCMS also holds interests in various health-related companies.

(2) Significant Accounting Policies

(a) Basis of Presentation

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. All controlled and direct member entities are consolidated. The accompanying consolidated financial statements include the accounts of LifeBridge Health, Inc. and Subsidiaries (the Corporation). All entities where the Corporation exercises significant influence, but does not have control, are accounted for under the equity method. All other unconsolidated entities are accounted for under the cost method. All significant intercompany accounts and transactions have been eliminated.

(b) Cash and Cash Equivalents

Cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less at the date of purchase.

(c) Assets Limited as to Use

Assets limited as to use primarily consists of assets held by trustees under bond indenture agreements, a self-insured workers' compensation reserve fund, and designated assets set aside by the Board of Directors for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes. A portion of the designated assets set aside by the Board of Directors is contractually designated.

(d) Inventory

Inventories, which consist primarily of medical supplies and pharmaceuticals, are stated at the lower of cost (using the moving average cost method of valuation) or market.

(e) Investments, Long-Term Investments and Donor-Restricted Investments

The Corporation's investment portfolio is considered a trading portfolio and is classified as current or noncurrent assets based on management's intention as to use. All debt and equity securities are reported in the consolidated balance sheets at fair value, principally based on quoted market prices.

(Continued)

The Corporation has investments in alternative investments, primarily funds of hedge funds, totaling $99,451 and $138,838 at June 30, 2017 and 2016, respectively. These funds utilize various types of debt and equity securities and derivative instruments in their investment strategies. Also included in alternative investments are BJEF's and BJHF's funds that are invested on their behalf by the Associated Jewish Charities (AJC), an affiliate of AJCF. Alternative investments are recorded under the equity method which is based on the Net Asset Value (NAV) of the shares in each Investment Company or partnership.

Investments in unconsolidated affiliates are accounted for under the cost or equity method of accounting as appropriate and are included in other assets and investment in unconsolidated affiliates, respectively, in the consolidated balance sheets. The Corporation's equity income or loss is recognized in other operating revenue within the excess of revenue over expenses in the accompanying consolidated statements of operations.

Investments also include assets restricted by donor, and assets designated by the Board of Directors for future capital improvements and other purposes over which it retains control and may, at its discretion, use for other purposes. Purchases and sales of securities are recorded on a trade-date basis.

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

Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures*, establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 Inputs – Unadjusted quoted prices in active markets for identical assets or liabilities accessible to the reporting entity at the measurement date.
- Level 2 Inputs – Other than quoted prices included in Level 1 inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the asset or liability.
- Level 3 Inputs – Unobservable inputs for the asset or liability used to measure fair value to the extent that observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity for the asset or liability at measurement date.

(Continued)

The hierarchy requires the use of observable market data when available. Assets and liabilities are classified in their entirety based on the lowest level input that is significant to the fair value measurements.

(f) Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter of the period of the lease term or the estimated useful life of the equipment. Maintenance and repair costs are expensed as incurred. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

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

(g) Impairment of Long-Lived Assets

Management regularly evaluates whether events or changes in circumstances have occurred that could indicate impairment in the value of long-lived assets. In accordance with the provisions of ASC 360, if there is an indication that the carrying value of an asset is not recoverable, the Corporation estimates the projected undiscounted cash flows, excluding interest and taxes, of the related individual entities to determine if an impairment loss should be recognized. The amount of impairment loss is determined by comparing the historical carrying value of the asset to its estimated fair value. Estimated fair value is determined through an evaluation of recent and projected financial performance of facilities using standard industry valuation techniques.

In addition to consideration of impairment upon the events or changes in circumstances described above, management regularly evaluates the remaining lives of its long-lived assets. If estimates are changed, the carrying value of affected assets is allocated over the remaining lives. In estimating the future cash flows for determining whether an asset is impaired and if expected future cash flows used in measuring assets are impaired, the Corporation groups its assets at the lowest level for which there are identifiable cash flows independent of other groups of assets. The Corporation did not record a loss on impairment during the years ended June 30, 2017 and 2016.

(h) Goodwill and Other Assets, Net

Other assets consist primarily of goodwill and other intangibles related to practice acquisitions, notes receivable, and the cash surrender value of split dollar life insurance.

(Continued)

Goodwill represents the excess of the aggregate purchase price over the fair value of the net assets acquired in a business combination. ASC Topic 350, *Intangibles – Goodwill and Other*, requires that tangible and indefinite-lived assets, as well as goodwill must be analyzed in order to determine whether their value has been impaired.

Goodwill is assessed annually for impairment at the reporting unit. As of June 30, 2017 and 2016, the Corporation had one reporting unit, which included all subsidiaries. The Corporation first assesses qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount as a basis for determining whether it is necessary to perform the two-step goodwill impairment tests as described in Topic 350. The more-likely than-not threshold is defined as having a likelihood of more than 50%. The Corporation determined that it was not more likely than not that the fair value of its reporting unit was less than its carrying amount. Accordingly, the Corporation concluded that goodwill was not impaired as of June 30, 2017 and 2016 without having to perform the two-step impairment test.

(i) Beneficial Interest in Split Interest Agreement

CHSF holds a 25% interest in a trust, of which management has estimated the present value of the future income stream. CHSF will receive 25% of the net annual income until 2024, when the trust will terminate, and 25% of the principal will be distributed to CHSF. Management has reported the beneficial interest at fair value based on the fair value of the underlying trust investments.

(j) Advances from Third-Party Payors

Advances from third-party payors are comprised of advance funding from CareFirst BlueCross BlueShield, Medicaid, Aetna, United/MAMSI, and other insurance providers.

(k) Self-Insurance Programs

The Corporation maintains self-insurance programs for professional and general liability, workers' compensation, and employee health benefits. The provision for estimated self-insurance program claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. The estimates are based on historical trends, claims asserted, and reported incidents.

(l) Other Long-Term Liabilities

Other long-term liabilities consist of self-insurance liabilities, pension plan liabilities, asset retirement obligations, and deferred compensation plan liabilities.

(m) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Corporation are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date those promises become unconditional. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net assets

(Continued)

released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions.

(n) Net Assets

Net assets and revenues, expenses, gains and losses are classified based on the existence or absence of externally imposed stipulations. Accordingly, net assets of the Corporation and changes therein are classified and reported as follows:

Unrestricted net assets – Net assets that are not subject to externally imposed stipulations.

Temporarily restricted net assets – Net assets subject to externally imposed stipulations that may or will be met either by actions of the Corporation and/or the passage of time.

Permanently restricted net assets – Net assets subject to externally imposed stipulations that they be maintained by the Corporation in perpetuity.

Revenues are reported as increases in unrestricted net assets unless use of the related asset is limited by externally imposed restrictions. Expenses are reported as decreases in unrestricted net assets. Gains and losses are reported as increases or decreases in unrestricted net assets unless use of the related asset is limited by externally imposed restrictions or law. Expirations of temporary restrictions of net assets (i.e., the externally stipulated purpose has been fulfilled and/or the stipulated time period has elapsed) are reported as reclassifications between the applicable classes of net assets if used to acquire capital assets; otherwise, they are recorded as unrestricted operating revenue.

(o) Net Patient Service Revenue

Net patient service revenue for Sinai, Northwest, Carroll and the chronic hospital component of Levindale is recorded at rates established by the State of Maryland Health Services Cost Review Commission (HSCRC) and, accordingly, reflects actual charges to patients based on rates in effect during the period in which the services are rendered. On January 29, 2014, the Corporation and the Health Services Cost Review Commission (HSCRC) agreed to implement the Global Budget Revenue (GBR) methodology, effective July 1, 2013, for Sinai, Northwest and Levindale. The term of the Agreement continued through June 30, 2017 and will renew for a one-year period unless it is canceled by the HSCRC or by the applicable Hospital. The GBR model is a revenue constraint and quality improvement system, designed by the HSCRC to provide hospitals with strong financial incentives to manage their resources efficiently and effectively in order to slow the rate of increase in healthcare costs and improve healthcare delivery processes and outcomes. The GBR model is consistent with the Hospitals' mission to provide the highest value of care possible to their patients and the communities they serve.

The GBR agreement establishes a prospective, fixed revenue base (the GBR cap) for each fiscal year. This includes both inpatient and outpatient regulated services. Under GBR, the Corporation's revenue for all HSCRC-regulated services is predetermined for the upcoming year, regardless of changes in volume (subject to certain limits), service mix intensity, or mix of inpatient or outpatient services that occur during the year. The GBR agreement allows the Corporation to adjust unit rates, within certain limits, to achieve the overall revenue base for the Corporation at year-end. Any overcharge or

(Continued)

undercharge versus the GBR cap is prospectively added to the subsequent year's GBR cap. Beginning in fiscal year 2017, the GBR is adjusted for changes in market share. Effective with fiscal year 2017, market-shift adjustments will be made semi-annually, on January and July 1. The GBR cap is adjusted annually for inflation, changes in payor mix and uncompensated care, and changes in population within the Corporation's service area. A hospital's GBR cap may also be adjusted based on the hospital's performance on various quality and utilization metrics established from time to time by the HSCRC.

Prior to implementation of the GBR methodology, Carroll and the HSCRC agreed to a three year contract for Carroll to implement the Total Patient Revenue (TPR) methodology effective July 1, 2010, which was renewed for an additional three year period effective July 1, 2013. Similar to the GBR, the TPR agreement establishes a prospective, fixed revenue base, the "TPR cap," for the upcoming year. Effective in fiscal year 2017, all TPR agreements have been terminated and reinstituted as GBR agreements using the same parameters described above.

Contractual adjustments, which represent the difference between amounts billed as patient service revenue and amounts paid by third-party payors, are accrued in the period in which the related services are rendered. Because the Corporation does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue.

Medicare reimburses Northwest and Levindale for skilled nursing services under the Medicare skilled nursing Prospective Payment System (PPS). Under PPS, the payment rate is based on patient resource utilization as calculated by a patient classification system known as Resource Utilization Groups.

Medicaid reimburses Levindale for long-term care services based on Levindale's actual costs. However, beginning in January 2015, the cost data from the 2012 cost reports was used to set Resource Utilization Group (similar to Medicare) rates which are adjusted for changes in case mix. The case mix from two quarters prior is used to adjust the rates on a quarterly basis.

All other patient service revenue is recorded at the estimated net realizable amounts from patients, third-party payors, and others for services rendered.

During 2017, the Corporation changed its policy for recording pharmacy revenues to record them in net patient service revenues from other operating revenues. The Corporation determined that this change is appropriate as the majority of pharmacy revenues are derived from the Corporation's patients. Accordingly, the Corporation reclassified approximately $37,810 from other operating revenues to net patient service revenues during the year ended June 30, 2016. The change did not impact total operating revenues, operating income or the excess of revenues over expenses.

(p) Other Operating Revenue

Other operating revenue includes income of LifeBridge Health and Fitness LLC, revenue from other support services, and revenue generated from investments in joint ventures that offer health care services or services that support or complement the delivery of care.

(Continued)

(Dollars in thousands)

(q) Grants

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

(r) Charity Care and Bad Debt

Sinai, Northwest, Carroll, and Levindale provide care to patients who meet certain criteria under their charity care policies without charge or at amounts less than their established rates. Because the facilities do not pursue the collection of amounts determined to qualify as charity care, those amounts are not reported as revenue. The amount of charity care provided during the years ended June 30, 2017 and 2016, based on patient charges forgone, was $11,394 and $11,720, respectively. The total direct and indirect costs to provide the care amounted to approximately $9,274 and $10,044 for the years ended June 30, 2017 and 2016, respectively.

All patient accounts are handled consistently and appropriately to maximize cash flow and to identify bad debt accounts timely. Active accounts are considered bad debt accounts when they meet specific collection activity guidelines and/or are reviewed by the appropriate management and deemed to be uncollectible. Every effort is made to identify and pursue all account balance liquidation options, including but not limited to third party payor reimbursement, patient payment arrangements, Medicaid eligibility and financial assistance. Third party receivable management agencies provide extended business office services and insurance outsource services to ensure maximum effort is taken to recover insurance and self-pay dollars before transfer to bad debt. Contractual arrangements with third party collection agencies are used to assist in the recovery of bad debt after all internal collection efforts have been exhausted. In so doing, the collection agencies must operate consistently with the goal of maximum bad debt recovery and strict adherence with Fair Debt Collections Practices Act (FDCPA) rules and regulations, while maintaining positive patient relations.

		2017	2016
Beginning allowance	$	62,213	58,346
Plus provision for bad debt		47,341	56,982
Less bad debt write-offs, net of recoveries		(41,613)	(53,115)
Ending allowance	$	67,941	62,213

(s) Income Taxes

LifeBridge and its not-for-profit subsidiaries have been recognized by the Internal Revenue Service as tax-exempt pursuant to Section 501(c)(3) of the Internal Revenue Code.

(Continued)

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

(t) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(u) Excess of Revenues over Expenses

The accompanying consolidated statements of operations include excess of revenue over expenses. Changes in unrestricted net assets that are excluded from excess of revenues over expenses, consistent with industry practice, include changes in the funded status of defined-benefit pension plans, permanent transfers of assets to and from affiliates for other than goods and services, and contributions received for additions of long-lived assets.

(v) Employee Pension Plan

Pension benefits are administered by the Corporation. The Corporation accounts for its defined-benefit pension plans within the framework of ASC Topic 958, *Not-for-Profit Entities, Section 715, Compensation-Retirement Benefits* (Topic 958, Section 715), which requires the recognition of the overfunded or underfunded status of a defined-benefit pension plan as an asset or liability. The plans are subject to annual actuarial evaluations, which involve various assumptions creating changes in elements of expense and liability measurement. Key assumptions include the discount rate, the expected rate of return on plan assets, retirement, mortality, and turnover. The Corporation evaluates these assumptions annually and modifies them as appropriate.

Additionally, Topic 958, Section 715 requires the measurement date for plan assets and liabilities to coincide with the employer's year-end and requires the disclosure in the notes to the consolidated financial statements of additional information about certain effects on net periodic benefit cost for the next fiscal year that arise from delayed recognition of the gains or losses, prior service costs or credits, and transition asset or obligation. During fiscal year 2017, LifeBridge adopted the RP-2014 Mortality Table with generational improvements. See note 11 for further discussion.

(Continued)

(w) Management's Assessment and Plans

The Corporation adopted Accounting Standards Update (ASU) 2014-15, *Disclosure of Uncertainties about an Entity's Ability to Continue as a Going Concern*, (ASU 2014-15) during 2017. ASU 2014-15 requires management to evaluate an entity's ability to continue as a going concern within one year after the date that the financial statements are issued (or available to be issued, when applicable). Management determined that there were no conditions or events that raise substantial doubt about the Corporation's ability to continue as a going concern and the Corporation will continue to meet its obligations through October 18, 2018.

(x) New Accounting Pronouncements

In 2017, the Corporation adopted Accounting Standards Update (ASU) 2015-03, *Simplifying the Presentation of Debt Issuance Costs*. The presentation of debt issuance costs on the balance sheet has been changed from an asset to a direct reduction of debt, similar to the presentation of debt discounts. As a result of this change, $4,060 and $4,137 of deferred financing costs were classified as a direct reduction of debt at June 30, 2017 and 2016. The related consolidated statements of operations and changes in net assets for the periods were not affected by the adoption of ASU 2015-03.

In 2017, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2017-07, *Compensation – Retirement Benefits (Topic 715)*. The ASU attempts to improve the presentation of net periodic pension and postretirement benefit costs. The ASU does not prescribe where the amount of net benefit cost should be presented in an employer's statement of operations, but it does require that the service cost component be presented in the same line item as other employee compensation costs and that the remaining components be presented separately from those line items and outside of operations. It also stipulates that only the service cost component is eligible for capitalization in assets, as applicable. The new standard is effective for fiscal years beginning after December 15, 2018. Early adoption is permitted. In fiscal 2017, the Corporation retrospectively adopted the standard, which resulted in no reclassification of net periodic benefit cost from salaries and employee benefits to pension costs other than service costs within other income (loss) for the years ended June 30, 2017 and 2016.

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

The FASB issued ASU No. 2016-02, *Leases* (ASU 2016-02), which will require lessees to recognize most leases on-balance sheet, increasing their reported assets and liabilities – sometimes very significantly. This update was developed to provide financial statement users with more information

(Continued)

(Dollars in thousands)

about an entity's leasing activities, and will require changes in processes and internal controls. The adoption of ASU 2016-02 is effective fiscal year 2020, and will require application of the new guidance at the beginning of the earliest comparable period presented. Early adoption is permitted. The Corporation is currently assessing the impact of the adoption of ASU No. 2016-02 which is expected to have a material impact on its financial position.

The FASB issued ASU No. 2016-14, *Not-for-Profit Entities* (ASU 2016-14), which amends the requirements for financial statements and notes in Topic 958, Not-for-Profit Entities (NFP), require a NFP to the following:

- Reduces the number of net asset classes presented from three to two: with donor restrictions and without donor restrictions;
- Requires all NFPs to present expenses by their functional and their natural classifications in one location in the financial statements;
- Requires NFPs to provide quantitative and qualitative information about management of liquid resources and availability of financial assets to meet cash needs within one year of the balance sheet date; and
- Retains the option to present operating cash flows in the statement of cash flows using either the direct or indirect method.

The adoption of ASU 2016-14 is effective in fiscal year 2019, and is applied retrospectively in the year of adoption. The Corporation does not anticipate that the adoption of this ASU will have a material impact on its financial position and results of operations.

(3) Investments

Investments, which consist of assets limited as to use, board-designated investments, donor-restricted investments, and long-term investments in the accompanying consolidated balance sheets, are stated at fair value or under the equity method, as appropriate, as of June 30, 2017 and 2016, and consist of the following:

	2017	2016
Assets limited as to use:		
Self-insurance fund:		
Mutual funds	$ 19,163	22,060
Equity securities	9,411	9,210
U.S. Treasury	—	944
Fixed income	1,859	8,789
Alternative investments	2,606	2,598
Self-insurance fund	33,039	43,601

(Continued)

(Dollars in thousands)

	2017	2016
Debt service fund:		
Cash and cash equivalents	$ 7,374	12,376
Government securities	7,479	1,888
Debt service fund	14,853	14,264
Construction funds:		
Cash and cash equivalents	24,395	8,222
Government securities	29,248	45,174
	53,643	53,396
Total assets limited as to use	101,535	111,261
Less current portion	(68,496)	(67,660)
Assets limited as to use, net of current portion	$ 33,039	43,601
Donor-restricted investments:		
Cash and cash equivalents	$ 4,703	4,825
Mutual funds	5,963	5,649
Equity securities	2,464	2,585
U.S. Treasury	4,333	3,557
Government securities	2,533	3,016
Fixed income	984	566
Alternative investments	409	343
Donor-restricted investments	$ 21,389	20,541
Beneficial interest in split interest agreement	$ 4,757	4,477

(Continued)

(Dollars in thousands)

There are other investments restricted by donors other than pledges receivable, donor-restricted investments, and beneficial interest that are included in long-term investments as of June 30, 2017 and 2016. As of June 30, 2017 and 2016 current, long-term, and board-designated investments are as follows:

		2017	2016
Current, long-term, and board-designated investments:			
Cash and cash equivalents	$	37,331	8,747
Mutual funds		162,576	177,303
Equity securities		186,741	159,173
Government securities		6,780	10,111
Fixed income		88,307	29,167
Alternative investments		96,845	135,897
Current, long-term and board-designated investments		578,580	520,398
Less current portion		(24,583)	(23,352)
Long-term and board-designated investments	$	553,997	497,046

Investment income and gains and losses on long-term investments, board-designated investments, donor-restricted investments, and assets limited as to use are comprised of the following for the years ended June 30, 2017 and 2016:

		2017	2016
Investment income:			
Interest income and dividends	$	7,366	9,516
Realized gains on sale of securities		23,542	6,512
Investment income		30,908	16,028
Unrealized gains (losses) on trading securities		36,654	(22,110)
Other changes in net assets:			
Changes in unrealized gains (losses) on temporarily and permanently restricted net assets		3,305	(1,847)
Total investment return	$	70,867	(7,929)

(4) Pledges Receivable

Contributions and pledges to raise funds are recorded as temporarily restricted net assets until the donor-intended purpose is met and the cash is collected. Future pledges are discounted at the Treasury bill rate to reflect the time value of money, and an allowance for potentially uncollectible pledges has been established.

(Continued)

(Dollars in thousands)

Sinai, Northwest, Carroll, and Levindale have recorded total pledges as of June 30, 2017 and 2016 as follows:

	2017	2016
Gross pledges receivable	$ 9,259	9,051
Less:		
Discount for time value of money	(517)	(782)
Allowance for uncollectible accounts	(949)	(1,568)
	$ 7,793	6,701

Total anticipated future payments are as follows:

Less than one year	$ 3,341
One to five years	5,915
Five years and thereafter	3
	$ 9,259

(5) Property and Equipment

As described in note 13, Sinai and Levindale leases from an affiliate of AJCF all land, land improvements, buildings, and fixed equipment located at those entities' primary locations; LifeBridge entities own the movable equipment. Property and equipment are classified as follows at June 30:

	Estimated useful life	2017	2016
Land		$ 24,175	11,657
Land improvements	8 to 20 years	36,322	35,931
Building and improvements	10 to 40 years	927,766	863,963
Fixed equipment	8 to 20 years	107,785	101,411
Movable equipment	3 to 15 years	499,839	479,705
		1,595,887	1,492,667
Less accumulated depreciation		(995,195)	(926,430)
		600,692	566,237
Construction in progress		50,481	63,240
Property and equipment, net		$ 651,173	629,477

(Continued)

(Dollars in thousands)

Depreciation, amortization, and gain/loss on sale of assets were $77,214 and $75,699 for the years ended June 30, 2017 and 2016, respectively. Of this, depreciation expense was $76,815 and $75,546 for the years ended June 30, 2017 and 2016, respectively.

Included in property and equipment is building and equipment, net of accumulated amortization, of $16,452 and $18,774 for the years ended June 30, 2017 and 2016, respectively, financed with capital lease obligations. Accumulated amortization related to the building and equipment under capital leases was $14,128 and $11,806 at June 30, 2017 and 2016, respectively.

During 2017, the Corporation acquired a skilled nursing facility and two surgical centers for approximately $11,000. These acquisitions did not significantly impact the Corporation's total assets, liabilities, net assets, total operating revenues, operating income or the excess of revenues over expenses.

(6) Investments in Joint Ventures

Investments in joint ventures and partnerships, accounted for under the equity method, consist of the following at June 30, 2017 and 2016:

Joint Venture	Business purpose	2017 Percentage ownership	2017 Balance	2016 Percentage ownership	2016 Balance
MNR Industries, LLC	Urgent Care Centers	40 %	$ 24,587	40 %	$ 23,291
Baltimore County Radiology, LLC	Outpatient Radiology	25	7,148	25	5,724
Mt. Airy Med-Services, LLC	Real Estate	50	4,419	50	4,952
Future Care Old Court, LLC	Nursing Home	40	2,965	—	—
Lochearn Nursing Home, LLC	Nursing Home	10	2,000	10	1,997
Mt. Airy Plaza, LLC	Real Estate	50	1,594	50	1,628
LifeBridge Sports Medicine & Rehabilitation, LLC	Physical Therapy	50	1,173	50	1,303
Advanced Health Collaborative, LLC	Medicare Advantage Plan	25	1,266	—	—
Carroll Care Pharmacies, LLC	Pharmacies	49	944	49	1,037
Other Joint Ventures	Miscellaneous	5–50	4,786	5–50	4,108
Total			$ 50,882		$ 44,040

For those joint ventures and partnerships accounted for using the equity method, the Corporation recorded equity in earnings of joint ventures and partnerships. For those joint ventures and partnerships accounted for using the cost method, the Corporation recorded dividend income. Such amounts are included in other operating revenue in the consolidated statements of operations.

(Continued)

(Dollars in thousands)

(7) Other Assets

As of June 30, other assets are comprised of the following balances:

		2017	2016
Goodwill	$	16,902	2,108
Investment in Premier		12,496	10,264
Notes Receivable		11,442	12,249
Other Intangible Assets		11,510	12,150
Deferred compensation assets		9,181	8,896
Other		2,410	2,475
Other assets	$	63,941	48,142

(8) Long-Term Debt and Capital Lease Obligations

As of June 30, long-term debt and capital lease obligations consist of the following:

		2017	2016
Maryland Health and Higher Educational Facilities Authority (MHHEFA):			
Revenue Bonds Series 2008	$	155,380	237,590
Revenue Bonds Series 2011		5,015	47,465
Revenue Bonds Series 2012A		53,670	55,152
Revenue Bonds Series 2015		159,685	159,685
Revenue Bonds Series 2016		120,695	—
Other debt:			
M&T Bank taxable loan		41,345	45,905
Capital leases		16,545	18,501
Other		14,454	539
		566,789	564,837
Less current portion		(13,928)	(12,921)
Plus unamortized premium		22,380	12,685
Less deferred Financing Costs		(4,060)	(4,137)
Less unamortized discount		(3)	(42)
Long-term debt, net	$	571,178	560,422

(Continued)

A single obligated group (the Obligated Group), consisting of LifeBridge, Sinai, Northwest, Levindale, BJHF, CHSF, CCHS, Carroll, CCMS, CHG, CH, and CRCCP, has been formed with respect to certain bonds issued by the Maryland Health and Higher Educational Facilities Authority (MHHEFA) and certain other obligations. Members of the Obligated Group are jointly and severally liable for all of the outstanding bonds issued by MHHEFA on behalf of LifeBridge and CCHS and their respective affiliates, together with other obligations issued on parity with such bonds.

In January 2008, MHHEFA loaned $285,815 from the proceeds of bonds (Series 2008 Bonds) to LifeBridge and certain of its subsidiaries. Portions of the Series 2008 Bonds are payable on July 1 of each year through 2047. The Series 2008 Bonds bear interest at a weighted fixed rate of 5.35%. Approximately, $27,640 of the Series 2008 Bonds were repaid as part of the Series 2015 Bond offering, further discussed below. Approximately $74,655 of the Series 2008 Bonds were repaid as part of the Series 2016 Bond offering, further discussed below.

In March 2011, MHHEFA loaned $50,695 from the proceeds of bonds (Series 2011 Bonds) to LifeBridge and certain of its subsidiaries. Portions of the Series 2011 Bonds are payable on July 1 of each year through 2041. The Series 2011 Bonds bear interest at a weighted fixed rate of 5.99%. Approximately $46,040 of the Series 2011 Bonds were repaid as part of the Series 2016 Bond offering, further discussed below.

In May 2012, MHHEFA loaned $59,780 from the proceeds of bonds (Series 2012A Bonds) to CCHS and certain of its subsidiaries (the Series 2012 Bonds). The Series 2012 Bonds were issued in three series: $26,995 of serial bonds maturing in 2013 through 2027 with interest rates ranging from 2% to 5%, $7,505 of term bonds maturing in 2030 with an interest rate of 4%, and $25,280 of term bonds maturing in 2037 (Series 2012A Bonds) with an interest rate of 5%.

On June 26, 2015, LifeBridge entered into a $50,000 direct bank placement with M&T Bank (2015 M&T Bank Taxable Loan). The interest rates range from 1.57% to 3.28%, with maturity dates ranging from July 1, 2016 to July 1, 2025. The 2015 M&T Loan is secured on parity with the bonds.

On July 30, 2015, MHHEFA issued $159,685 in bonds (Series 2015 Bonds) on behalf of LifeBridge. The proceeds of the Series 2015 Bonds have been and will be used to finance and refinance the cost of construction, renovation, and equipping of certain additional facilities for the Obligated Group, to refund a portion of the Series 2008 Bonds and the Authority's Carroll Issue, Series 2006 bonds, and refinance the portion of a line of credit from Bank of America that had been used to repay Carroll's loan from BB&T Bank. The remaining Bank of America line of credit was repaid by the Corporation. $33,130 of the bonds are serial bonds with maturity dates ranging from 2018 through 2030 and interest rates ranging from 2% to 5%. $14,260, $26,325, $35,970, and $50,000 of the bonds are term bonds that are due in 2035, 2040, 2047 and 2047, respectively, with interest rates of 4%, 5%, 4.1%, and 5%, respectively.

On October 25, 2016, MHHEFA issued $120,695 in bonds (Series 2016 Bonds) on behalf of LifeBridge Health. The proceeds of the Series 2016 Bonds were used to refinance the Series 2008 Bonds. $40,465 of the bonds are serial bonds with maturity dates ranging from 2017 through 2036 and interest rates ranging from 2% to 5%. $40,640 of the bonds are term bonds that are due in 2041 with an interest rate of 4%. The remaining $39,590 of the bonds are term bonds that are due in 2047 with an interest rate of 5%.

(Continued)

(Dollars in thousands)

The Series 2008, 2011, 2012A, 2015, and 2016 Bonds are governed by a Master Loan Agreement. Under the Master Loan Agreement, MHHEFA maintains a security interest in the revenue of the obligors. In addition, the Master Loan Agreement requires Obligated Group members to adhere to limitations on mergers, disposition of assets, and additional indebtedness and certain financial covenants. The financial covenants include a rate covenant, which requires the Obligated Group to achieve a debt service coverage ratio of 1.10; a liquidity covenant, which requires the Obligated Group to maintain 65 days cash on hand; and a debt-to-capitalization covenant, which requires the Obligated Group to maintain a debt-to-capitalization ratio of not more than 65%, all measured as of June 30 in each fiscal year.

In 2017, the Corporation acquired Springwell Partners, LLC (Springwell). Upon acquisition, the Corporation assumed the debt of Springwell. The debt consists of two term notes that were amended in February 2017. The first term note of $8,453 bears monthly interest of one month LIBOR plus 1.6% which approximates 2.7% as of June 30, 2017. The second term note of $5,614 bears monthly interest of 4.75%. Both term notes mature February 5, 2022 and one secured by certain property and equipment. The outstanding principal of the two notes as of June 30, 2017 was $13,978.

Deferred financing costs are amortized using the effective-interest method over the term of the related debt. Amortization expense was $1,168 and $513 for the years ended June 30, 2017 and 2016, respectively. Such amortization is included in interest expense in the consolidated financial statements.

The Corporation is obligated under several noncancelable capital leases for hospital equipment and office building space.

The total future principal payments on long-term debt and capital lease payments are as follows:

	MHHEFA and other debt	Capital lease obligations
Years ending June 30:		
2018	$ 12,689	2,240
2019	11,924	2,214
2020	12,455	2,258
2021	13,031	2,304
2022	25,507	2,351
Thereafter	474,638	7,973
	$ 550,244	19,340
Less interest portion		(2,795)
		$ 16,545

(9) M&T Bank Line of Credit

Sinai maintains a $5,000 line of credit with M&T Bank. As of June 30, 2017 and 2016, there were no balances outstanding on this line of credit.

(Continued)

(Dollars in thousands)

(10) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at June 30:

	2017	2016
Healthcare services:		
Capital equipment/construction	$ 24,358	23,160
Other healthcare services:		
Service grants	415	496
Donor-specified healthcare services	14,216	14,452
Enrichment and research	15,543	15,277
	$ 54,532	53,385

Permanently restricted net assets of $16,191 and $15,887 at June 30, 2017 and 2016, respectively, are to investments to be held in perpetuity, the income from which is expendable to support healthcare services.

(11) Employee Benefit Plans

(a) LifeBridge Health Pension Plans (Sinai and Levindale)

The Corporation sponsors two noncontributory defined-benefit pension plans (the Sinai/Levindale Plans) covering full-time, nonunion and union employees of Sinai and Levindale. Annual contributions to the Sinai/Levindale Plans are made at a level equal to or greater than the funding requirement as determined by the Sinai/Levindale Plans' consulting actuary. Contributions are intended to provide not only for benefits attributed to service to date, but also for those expected to be earned in the future.

The following tables set forth the Sinai/Levindale Plans' funded status and amounts recognized in the accompanying consolidated financial statements as of June 30, 2017 and 2016:

	2017	2016
Measurement date	June 30, 2017	June 30, 2016
Change in projected benefit obligation:		
Benefit obligation at beginning of year	$ 214,725	185,808
Service cost	8,263	7,729
Interest cost	5,972	8,085
Actuarial loss	1,582	19,264
Benefits paid	(10,006)	(5,815)
Expenses paid from assets	(204)	(346)
Benefit obligation at end of year	220,332	214,725

(Continued)

(Dollars in thousands)

		2017	2016
Change in plan assets:			
Fair value of plan assets at beginning of year	$	157,577	158,657
Actual return on plan assets		22,425	(5,461)
Company contributions		16,721	10,542
Benefits paid		(10,006)	(5,815)
Expenses paid from assets		(204)	(346)
Fair value of plan assets at end of year		186,513	157,577
Funded status	$	(33,819)	(57,148)

Amounts recognized in the consolidated financial statements consist of the following at June 30:

		2017	2016
Amounts recognized in the consolidated balance sheets:			
Other long-term liabilities	$	33,819	57,148
Amounts recognized in unrestricted net assets:			
Net actuarial loss	$	58,991	74,421
Prior service cost		—	—
	$	58,991	74,421

The Corporation has estimated $11,423 for its defined-benefit contributions to the Sinai/Levindale Plans for the fiscal year ending June 30, 2018. The accumulated benefit obligation for the Sinai/Levindale Plans is $201,702 and $196,562 at June 30, 2017 and 2016, respectively.

Net periodic pension expense for the years ended June 30, 2017 and 2016 was as follows:

		2017	2016
Pension costs:			
Service cost	$	8,263	7,729
Interest cost		5,972	8,085
Expected return on plan assets		(10,969)	(10,963)
Amortization of net loss		5,555	2,353
Amortization of prior service cost		—	44
Net periodic benefit cost	$	8,821	7,248

The estimated net actuarial loss and prior service cost to be amortized from unrestricted net assets into net periodic pension benefit cost over the next fiscal year are $3,928 and $0, respectively.

(Continued)

(Dollars in thousands)

Actuarial assumptions used were as follows:

	2017	2016
Assumptions used to determine annual pension expense:		
Discount rate	3.68 %	4.47 %
Expected return on plan assets	7.00	7.00
Rate of compensation increase	2.50	2.50
Assumptions used to determine end-of-year liabilities:		
Discount rate	3.85 %	3.68 %
Expected return on plan assets	7.00	7.00
Rate of compensation increase	2.50	2.50
Plan asset allocation:		
Asset category:		
Cash and cash equivalents	— %	2.00 %
Fixed income/debt securities	26.00	26.00
Equity securities/mutual funds	56.00	47.00
Alternative investments	18.00	25.00
Total	100.00 %	100.00 %

In selecting the expected long-term rate of return on plan assets, Sinai and Levindale considered the average rate of earnings on the funds invested or to be invested to provide for the benefits of these plans. This included considering the Sinai/Levindale Plans' asset allocation and the expected returns likely to be earned over the life of the plans. Target asset allocation is as follows:

	Target
Target allocation on assets:	
Equity securities	52 %
Alternative investments	23
Fixed income/debt securities	25

(Continued)

(Dollars in thousands)

Following are the benefit payments expected to be disbursed from plan assets:

Years ending June 30:		
2018	$	11,668
2019		11,689
2020		12,215
2021		12,084
2022		12,346
Thereafter		68,857

The fair values of assets of the Sinai/Levindale Plans held by PNC Institutional Investments by level at June 30, 2017 were as follows:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 8,901	—	—	8,901
Mutual funds	73,860	—	—	73,860
Fixed income securities	—	7,017	—	7,017
Equity securities	79,158	—	—	79,158
Alternative investments	—	—	17,577	17,577
Total assets	$ 161,919	7,017	17,577	186,513

The fair values of assets of the Sinai/Levindale Plans held by PNC Institutional Investments by level at June 30, 2016 were as follows:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 4,860	—	—	4,860
Mutual funds	54,886	—	—	54,886
Fixed income securities	—	5,635	—	5,635
Equity securities	56,382	—	—	56,382
Alternative investments	—	—	35,814	35,814
Total assets	$ 116,128	5,635	35,814	157,577

(Continued)

(Dollars in thousands)

For the years ended June 30, 2017 and 2016, there were no significant transfers into or out of Levels 1, 2, or 3. Changes to the fair values based on the Level 3 inputs are summarized as follows:

	Total
Balance as of June 30, 2016	$ 35,814
Additions:	
Contributions/purchases	8,119
Disbursements:	
Withdrawals/sales	(19,730)
Net change in value	(6,626)
Balance as of June 30, 2017	$ 17,577

The following table summarizes redemption terms for the hedge fund-of-funds vehicles held as of June 30, 2017:

	Fund 1	Fund 2	Fund 3
Redemption timing:			
Redemption frequency	Quarterly	Monthly	Annually
Required notice	65 days	30 days	90 days
Audit reserve:			
Percentage held back for audit reserve	10 %	— %	5 %

(b) Carroll Plan

CCHS sponsors a Defined Benefit Cash Balance Plan (the Carroll Plan) covering employees of Carroll, CCMS, and Carroll Foundation. CCHS's funding policy is to make contributions to the Carroll Plan based on actuarially determined amounts necessary to provide assets sufficient to meet benefits to be paid to plan participants and to meet the minimum funding requirements of the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code, plus such amounts as CCHS may determine to be appropriate from time to time. Under the cash balance plan structure, the benefits under the Carroll Plan are determined based on employee tenure rather than age. CCHS elected to freeze benefit accruals and participation in the Carroll Plan on December 31, 2006.

The information below describes certain actions of CCHS for the years ended June 30, 2017 and 2016.

(Continued)

(Dollars in thousands)

The following tables set forth the changes in the projected benefit obligation, the changes in the Carroll Plan's assets, the Carroll Plan's funded status, the amounts recognized in the consolidated financial statements, and the Carroll Plan's net periodic pension cost as of June 30, 2017 and 2016:

		2017	2016
Measurement date		June 30, 2017	June 30, 2016
Change in projected benefit obligation:			
Projected benefit obligation at beginning of year	$	76,619	68,498
Interest cost		2,345	3,004
Actuarial loss		(3,032)	7,514
Benefits paid		(2,301)	(2,397)
Benefit obligation at end of year		73,631	76,619
Change in plan assets:			
Fair value of plan assets at beginning of year		64,073	61,131
Actual return on plan assets		3,876	1,739
Employer contribution		2,070	3,600
Benefits paid		(2,301)	(2,397)
Fair value of plan assets at end of year		67,718	64,073
Funded status	$	(5,913)	(12,546)

The accumulated benefit obligation for the Carroll Plan was $73,631 and $76,619 at June 30, 2017 and 2016, respectively. The pension obligations of $5,913 and $12,546 as of June 30, 2017 and 2016, respectively, are included in other long-term liabilities in the consolidated balance sheets.

Net periodic pension expense for the years ended June 30, 2017 and 2016 was as follows:

		2017	2016
Pension expense:			
Components of net periodic pension expense:			
Interest cost	$	2,345	3,004
Expected return on plan assets		(4,464)	(4,315)
Amortization of actuarial loss		2,499	1,870
Net periodic pension expense	$	380	559

The estimated net actuarial loss and prior service cost to be amortized from unrestricted net assets into net periodic pension benefit cost over the next fiscal year is $2,111 and $0, respectively.

(Continued)

(Dollars in thousands)

Assumptions to determine the benefit obligation as of June 30, 2017 and 2016 were as follows:

	2017	2016
Discount rate	3.87 %	3.72 %

Assumptions used in the determination of net periodic pension expense for the year ended June 30, 2017 and 2016 were as follows:

	2017	2016
Discount rate	3.72 %	4.47 %
Expected long-term rate of return on plan assets	7.00	7.00

Deferred pension costs, which have not yet been recognized in periodic pension expense but are accrued in unrestricted net assets, are $28,019 and $32,962 at June 30, 2017 and 2016, respectively. Deferred pension costs represent unrecognized actuarial losses or unexpected changes in the projected benefit obligation and plan assets over time primarily due to changes in assumed discount rates and investment experience.

CCHS's weighted average asset allocations for the plan assets for the years ended June 30, 2017 and 2016 were as follows:

	2017	2016
Cash and cash equivalents	6.0 %	8.0 %
Fixed income/debt securities	18.0	22.0
Mutual funds and equity securities	49.0	53.0
Alternative investments	27.0	17.0
	100.0 %	100.0 %

Pension plan assets are invested in accordance with the CCHS's investment policy in an attempt to maximize return with reasonable and prudent levels of risk. This structure includes various assets classes, investment management styles, asset allocation, and acceptable ranges that, in total, are expected to produce a sufficient level of overall diversification and total investment return over the long term. CCHS periodically reviews performance to test progress toward attainment of longer term targets, to compare results with appropriate indices and peer groups, and to assess overall investment risk levels.

(Continued)

(Dollars in thousands)

The following table presents the Plan's assets measured at fair value at June 30, 2017:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 3,995	—	—	3,995
Mutual funds	32,988	—	—	32,988
Fixed income	—	12,437	—	12,437
Alternative investments	—	—	18,298	18,298
Total assets	$ 36,983	12,437	18,298	67,718

The following table presents the Plan's assets measured at fair value at June 30, 2016:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 5,366	—	—	5,366
Mutual funds	34,179	—	—	34,179
Fixed income	—	13,716	—	13,716
Alternative investments	—	—	10,812	10,812
Total assets	$ 39,545	13,716	10,812	64,073

During fiscal year 2017, Level 3 investments within the pension plan assets increased by $7,486. This increase was the result of purchases of $14,772, redemptions of $3,391 and losses in investments of $3,895. During fiscal year 2016, Level 3 investments within the pension plan assets increased by $7. This increase was the result of purchases of $3,391, redemptions of $2,828 and losses in investments of $556. There were no significant transfers between Levels 1, 2 and 3 during the years ended June 30, 2017 and 2016.

CCHS follows ASU No. 2009-12, and applied its provisions to its pension plan asset portfolio. The guidance amends ASC Topic 820 and permits, as a practical expedient, fair value of investments within its scope to be estimated using net asset value (NAV) or its equivalent. The alternative investments classified within Level 3 of the fair value hierarchy have been recorded using NAV.

The Carroll Plan invests in alternative investments which are primarily hedge fund of funds and real estate funds.

For the alternative investments, redemption requests can be made either quarterly or annually. The notice required in order to make a redemption is within a range of 65 to 100 days. The audit reserve requirements are 10% for each fund. There are generally no gate provisions with the exception of one fund which has a gate of 25% of net asset value (NAV).

(Continued)

(Dollars in thousands)

CCHS expects to contribute $3,580 to the Carroll Plan during the year-ending June 30, 2018.

The following benefit payments, which reflect future services, as appropriate, are expected to be paid from the Carroll Plan's assets during the years ending June 30 of the indicated year:

2018	$	2,905
2019		3,047
2020		3,243
2021		3,426
2022		3,589
2023–2027		20,087
	$	36,297

CCHS expensed total employer contributions of $1,280 and $1,291 for the years ended June 30, 2017 and 2016, respectively.

(c) Contributory Plans

Northwest has a qualified noncontributory defined-contribution pension plan (the NW Plan) covering substantially all employees who work at least 1,000 hours per year, who have completed two years of continuous service as of the beginning of the plan year, and who have attained the age of 21 as of the beginning of the plan year. Participants in the NW Plan are 100% vested. Northwest makes annual contributions to the NW Plan equivalent to 1.5% of the participants' salaries for employees who have been in the NW Plan from one to five years, 4.0% for those in the plan from six to 19 years, and 6.5% thereafter. It is Northwest's policy to fund plan costs as they accrue. Plan expense was approximately $2,181 and $2,849 for the years ended June 30, 2017 and 2016, respectively, and is included in salaries and employee benefits in the accompanying consolidated statements of operations.

Certain LifeBridge entities have supplemental 403(b) retirement plans for eligible employees. The entities may elect to match varying percentages of an employee's contribution up to a certain percentage of the employee's annual salary. The associated expense was approximately $4,810 and $4,710 for the years ended June 30, 2017 and 2016, respectively, and is included in salaries and employee benefits in the accompanying consolidated statements of operations.

Certain companies under Community Physicians and Investments maintain a defined-contribution plan for employees meeting certain eligibility requirements. Eligible employees can also make contributions. Under the plan, the employer may elect to match a percentage of eligible employees' contributions each year. The related expense was approximately $850 and $1,630 for the years ended June 30, 2017 and 2016, respectively, and is included in salaries and employee benefits in the accompanying consolidated statements of operations.

(Continued)

Certain LifeBridge entities maintain a nonqualified deferred compensation plan for key employees and physicians. The Corporation establishes a separate deferral account on its books for each participant for each plan year. In general, participants are entitled to receive the deferred funds upon their death, attainment of the specified vesting date, or involuntary termination of their employment without cause, whichever occurs first. The related expense was approximately $4,189 and $4,823 for the years ended June 30, 2017 and 2016, respectively, and is included in salaries and employee benefits in the accompanying consolidated statements of operations.

(d) Postretirement Plan Other than Pension

Carroll sponsors a postretirement plan other than pension for employees. Carroll employees retired from active employment at 65 years of age or older or at 55 years of age after earning at least 10 years of vesting service are eligible for health and prescription drug benefits under Carroll's self-insured health plan. Effective January 1, 2009, individuals are no longer permitted to participate in this Plan once they are Medicare eligible. Plan participants contribute premiums to the Plan in amounts determined by Carroll for pre-Medicare and post-Medicare age retirees. At June 30, 2017 and 2016, Carroll has accrued a liability of $425 related to this plan.

(12) Regulation and Reimbursement

The Corporation and other healthcare providers in Maryland are subject to certain inherent risks, including the following:

- Dependence on revenues derived from reimbursement by the Federal Medicare and State Medicaid programs;
- Regulation of hospital rates by the State of Maryland Health Services Cost Review Commission (HSCRC);
- Government regulation, government budgetary constraints, and proposed legislative and regulatory changes; and
- Lawsuits alleging malpractice and related claims.

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

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

(Continued)

The current rate of reimbursement for hospital services to patients under the Medicare and Medicaid programs is based on an agreement between the Centers for Medicaid and Medicare Services (CMS) and the State of Maryland. This agreement is based upon a waiver from Medicare prospective payment system reimbursement principles granted to the State of Maryland by CMS.

In January 2014, CMS approved Maryland's new waiver for a five-year period beginning January 1, 2014 for inpatient and outpatient hospital services. The new waiver required Maryland to adopt a payment structure that incentivizes efficient utilization of hospital resources, limits hospital per capita growth in all-payer and Medicare spending, generate Medicare savings of $330 million over five years, limit growth in total cost of care per Medicare beneficiary, reduce hospital readmissions, and reduce certain hospital-acquired conditions.

(13) Related-Party Transactions

Land Leases

Sinai and Levindale are constituent agencies of AJCF, a charitable corporation.

The legal title to substantially all land, land improvements, buildings, and fixed equipment included in Sinai's and Levindale's operating property is held by an affiliate of AJCF. Sinai and Levindale have entered into leases with the AJCF affiliate with respect to these assets. The leases allow Sinai and Levindale to conduct their business on the property as currently conducted. Rent under each lease is $1.00 per year. The leases may not be terminated before December 31, 2050.

Other

In addition to its arrangement with AJCF, Sinai receives services from certain other constituent agencies of AJCF.

(14) Income Taxes

At June 30, 2017, Investments has approximately $60,226 in net operating loss carryforwards for income tax purposes. The net operating loss carryforwards for tax purposes are available to reduce future taxable income and expire in varying periods through 2037.

The net operating loss carryforwards created a federal net deferred tax asset of approximately $20,477 and $21,087 as of June 30, 2017 and 2016, respectively, and a state deferred tax asset of approximately $3,340 and $3,358 as of June 30, 2017 and 2016, respectively. Management has determined that it is more likely than not that Investments will not be able to utilize the deferred tax assets; therefore, a full valuation allowance was recorded against the net deferred assets as of June 30, 2017 and 2016.

At June 30, 2017, Carroll has approximately $75,656 in net operating loss carryforwards for income tax purposes. The net operating loss carryforwards for tax purposes are available to reduce future taxable income and expire in varying periods through 2037.

(Continued)

(Dollars in thousands)

The net operating loss carryforwards created a federal net deferred tax asset of approximately $25,723 and $21,621 as of June 30, 2017 and 2016, respectively, and a state deferred tax asset of approximately $4,120 and $3,463 as of June 30, 2017 and 2016, respectively. Management has determined that it is more likely than not that Carroll will not be able to utilize the deferred tax assets; therefore, a full valuation allowance was recorded against the net deferred assets as of June 30, 2017 and 2016.

(15) Other Long-Term Liabilities

Other long-term liabilities at June 30, 2017 and 2016 are as follows:

	2017	2016
Professional/general liability (note 16(a))	$ 46,598	52,174
Pension liability	40,157	70,119
Medical office building	31,924	33,128
Asset retirement obligation	3,260	3,260
Deferred compensation	8,208	6,967
Other	5,557	1,361
	$ 135,704	167,009

At June 30, 2017 and 2016, there was $16,303 and $13,023 included in other current liabilities related to professional liabilities, respectively.

(16) Self-Insurance Programs

(a) Professional/General Liability

The Corporation is self-insured, through LifeBridge Insurance (and Cen-Mar prior to June 30, 2016), for most medical malpractice and general liability claims arising out of the operations of LifeBridge and its subsidiaries. Estimated liabilities have been recorded for both reported and incurred but not reported claims.

LifeBridge Insurance and Cen-Mar purchase reinsurance coverage from other highly rated insurance carriers to cover their liabilities in excess of various retentions. The amounts that LifeBridge subsidiaries must transfer to LifeBridge Insurance and Cen-Mar to fund medical malpractice and general liability claims are actuarially determined and are sufficient to cover expected liabilities. Management's estimate of the liability for medical malpractice and general liability claims, including incurred but not reported claims, is principally based on actuarial estimates performed by an independent third-party actuary. Professional liability coverage for certain employed physicians is provided by commercial insurance carriers. The receivable for the expected reinsurance receivable is recorded within other assets on the consolidated balance sheets. Amounts in excess of the self-insured limits are insured by highly rated commercial insurance companies.

(Continued)

(Dollars in thousands)

(b) Workers' Compensation

Sinai, Northwest, Levindale, LAA, and CCMS and its subsidiaries are insured for workers' compensation liability through a combination of self-insurance and excess insurance. Losses for asserted and unasserted claims are accrued based on estimates derived from past experiences, as well as other considerations including the nature of each claim or incident, relevant trend factors, and estimates of incurred but not reported amounts.

LifeBridge has accrued a liability for known and incurred but not reported claims of $8,032 and $7,005 at June 30, 2017 and 2016, respectively. These amounts are included in accounts payable and accrued liabilities in the accompanying consolidated balance sheets. Management believes these accruals are adequate to provide for all workers' compensation claims that have been incurred through June 30, 2017.

All other entities have occurrence-based commercial insurance coverage. There are no material insurance recoveries related to workers' compensation as of June 30, 2017.

LifeBridge maintains stop-loss policies on workers' compensation claims. The Corporation is insured for individual claims exceeding $450.

(c) Health Insurance

LifeBridge is self-insured for employee health claims. LifeBridge has accrued a liability of $3,721 and $3,655 at June 30, 2017 and 2016, respectively, for known claims and incurred but not reported claims. These amounts are included in accounts payable and accrued liabilities in the accompanying consolidated balance sheets.

(17) Concentration of Credit Risk

The Corporation grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2017 and 2016 is as follows:

	2017	2016
Medicare	31 %	30 %
Medicaid	8	9
BlueCross	10	12
Commercial and other	41	40
Self-pay	10	9
	100 %	100 %

(Continued)

(Dollars in thousands)

The mix of net patient service revenue for the Corporation for the years ended June 30, 2017 and 2016 is as follows:

	2017	2016
Medicare	42 %	42 %
Medicaid	6	7
BlueCross	12	14
Commercial and other	37	33
Self-pay	3	4
	100 %	100 %

(18) Commitments and Contingencies

(a) Litigation

The Corporation is subject to numerous laws and regulations of federal, state, and local governments. The Corporation's compliance with these laws and regulations can be subject to periodic governmental review and interpretation, which can result in regulatory action unknown or unasserted at this time. Management is aware of certain asserted and unasserted legal claims and regulatory matters arising in the ordinary course of business. After consultation with legal counsel, it is management's opinion that the ultimate resolution of these claims will not have a material adverse effect on the Corporation's financial position.

(b) Letters of Credit

M&T Bank has established an open letter of credit for Sinai of $211 (which has not been drawn upon) to guarantee Sinai's obligation for liabilities assumed as a member of a risk retention group during the period 1988 to 1994. Additionally, M&T Bank has established a standby letter of credit of $2,399 to serve as collateral as required by the Maryland Office of Unemployment Insurance. M&T Bank has established a standby letter of credit for Levindale of $421 as required by the State of Maryland Department of Labor, Licensing, and Regulation. M&T Bank has established a standby letter of credit for LifeBridge Health & Fitness of $200 as required by the State of Maryland Office of the Attorney General. M&T Bank has established standby letters of credit of $52 and of $84 to serve as collateral as required by the City of Baltimore for the completion of certain construction work at Sinai. M&T has established standby letters of credit of $94, $76, $42 and $4 to serve as collateral as required by Baltimore County for the completion of certain construction work at Northwest.

(Continued)

(Dollars in thousands)

(c) Operating Leases

The Corporation has entered into operating lease agreements for hospital equipment and office space, which expire on various dates through year 2026. Total rental expense for the years ended June 30, 2017 and 2016 for all operating leases was approximately $27,342 and $24,135, respectively. Future minimum lease payments under all noncancelable operating leases are as follows:

Years ending June 30:	
2018	$ 17,663
2019	17,307
2020	16,052
2021	14,545
2022	13,198
Thereafter	17,657
	$ 96,422

(19) Noncontrolling Interest

The reconciliation of a noncontrolling interest reported in unrestricted net assets is as follows:

	LifeBridge Health, Inc.	Noncontrolling interest	Unrestricted net assets
Balance at June 30, 2015	$ 844,907	3,922	848,829
Operating income	48,533	1,177	49,710
Nonoperating loss	(9,023)	—	(9,023)
Excess of revenues over expenses	39,510	1,177	40,687
Change in funded status of pension plan	(41,513)	—	(41,513)
Net assets released for purchase of property and equipment	7,613	—	7,613
Other	(841)	—	(841)
Change in net assets	4,769	1,177	5,946
Balance at June 30, 2016	849,676	5,099	854,775

(Continued)

(Dollars in thousands)

	LifeBridge Health, Inc.	Noncontrolling interest	Unrestricted net assets
Operating income	$ 52,081	2,173	54,254
Nonoperating income	56,750	—	56,750
Excess of revenues over expenses	108,831	2,173	111,004
Change in funded status of pension plan	20,341	—	20,341
Net assets released for purchase of property and equipment	4,147	—	4,147
Fair value of noncontrolling interests of acquisitions	—	9,754	9,754
Other	915	(2,400)	(1,485)
Change in net assets	134,234	9,527	143,761
Balance at June 30, 2017	$ 983,910	14,626	998,536

(20) Functional Expenses

The Corporation provides general healthcare services to patients. Expenses for the years ended June 30, 2017 and 2016 related to providing these services are as follows:

	2017	2016
Healthcare services	$ 1,098,642	1,069,047
General and administrative	374,158	358,668
	$ 1,472,800	1,427,715

(21) Fair Value of Financial Instruments

The following methods and assumptions were used by the Corporation in estimating the fair value of its financial instruments:

(a) Assets and Liabilities

Cash and cash equivalents, patient service receivables, other receivables, inventory, prepaid expenses, pledges receivable, accounts payable and accrued liabilities, advances to third-party payors, and other current liabilities – The carrying amounts reported in the consolidated balance sheet approximate the related fair values.

Investments (donor-restricted, assets limited as to use, and long-term), and beneficial interest in split interest agreements – Fair values are based on quoted market prices of individual securities or investments if available, or are estimated using quoted market prices for similar securities or investment managers' best estimate of underlying fair value.

(Continued)

(Dollars in thousands)

Investment in unconsolidated affiliates – Investments in unconsolidated affiliates are not readily marketable. Therefore, it is not practicable to estimate their fair value and such investments are recorded in accordance with the equity method or at cost.

(b) Long-Term Debt

The Series 2008 MHHEFA Bonds bear interest at fixed rates and had a fair value of $155,736 and $244,684 at June 30, 2017 and 2016, respectively. The fair market value of the fixed rate Series 2011 MHHEFA Bonds was $5,358 and $56,556 as of June 30, 2017 and 2016, respectively. The fair market value of the fixed rate Series 2012A MHHEFA Bonds was $58,933 and $62,742 as of June 30, 2017 and 2016, respectively. The fair market value of the variable rate Series 2015 MHHEFA Bonds was $175,838 and $185,798 as of June 30, 2017 and 2016, respectively. The fair market value of the variable rate Series 2016 MHHEFA Bonds was $131,581 as of June 30, 2017.

The fair value of other long-term debt, and bank loans payable approximates its carrying value.

The fair value of the Corporation's long-term MHHEFA debt is measured using quoted offered-side prices when quoted market prices are available. If quoted market prices are not available, the fair value is determined by discounting the future cash flows of each instrument at rates that reflect, among other things, market interest rates and the Corporation's credit standing. In determining an appropriate spread to reflect its credit standing, the Corporation considers credit default swap spreads, bond yields of other long-term debt, and interest rates currently offered for similar debt instruments of comparable maturities by the Corporation's bankers as well as other banks that regularly compete to provide financing to the Corporation.

(c) Fair Value Hierarchy

The following table presents assets that are measured at fair value on a recurring basis as of June 30, 2017:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 73,803	—	—	73,803
Equity securities and mutual funds	386,318	—	—	386,318
Treasury securities	4,333	—	—	4,333
Government securities	—	46,040	—	46,040
Fixed income	—	91,150	—	91,150
Beneficial interest in split-interest agreement	—	4,757	—	4,757
Total assets	$ 464,454	141,947	—	606,401

(Continued)

(Dollars in thousands)

The following table presents assets that are measured at fair value on a recurring basis as of June 30, 2016:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 34,170	—	—	34,170
Equity securities and mutual funds	375,980	—	—	375,980
Treasury securities	4,501	—	—	4,501
Government securities	—	60,189	—	60,189
Fixed income	—	38,522	—	38,522
Beneficial interest in split-interest agreement	—	4,477	—	4,477
Total assets	$ 414,651	103,188	—	517,839

See note 2(e) for information on investments of the Corporation that are treated under the equity method and are not reported above.

For the years ended June 30, 2017 and 2016, there were no significant transfers into or out of Levels 1, 2, or 3.

During the year ended June 30 2017, in connection with business combinations during the year the Corporation recorded the fair value of equipment of $24,715, debt of $14,961 and noncontrolling interests of $9,754. The Corporation determined that the fair values were based on Level 3 inputs. The Corporation used a market multiple analysis approach, a widely accepted valuation technique, to develop the fair values.

(22) Subsequent Events

Management evaluated all events and transactions that occurred after June 30, 2017 and through October 18, 2017. The Corporation did not have any subsequent events during this period that were required to be recognized or disclosed.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidating Balance Sheet Information

June 30, 2017

(Dollars in thousands)

Assets	Sinai Hospital Consolidated	Northwest Hospital	Carroll Hospital	Levindale Hebrew Geriatric Ctr & Hospital	Other LifeBridge Entities	Eliminations	LifeBridge Health Consolidated
Current assets:							
Cash and cash equivalents	$ 66,953	55,684	38,630	20,087	175,011	—	356,365
Investments	13,265	3,407	7,043	276	592	—	24,583
Assets limited as to use, current portion	44,802	12,830	5,137	283	5,444	—	68,496
Patient service receivables, net of allowance for doubtful accounts	73,885	23,434	20,741	8,300	19,279	—	145,639
Other receivables	75,552	5,321	12,363	674	33,779	(110,678)	17,011
Inventory	22,308	5,088	2,728	211	180	—	30,515
Prepaid expenses	2,536	782	3,585	133	8,149	—	15,185
Pledges receivable, current portion	859	180	1,525	107	—	—	2,671
Total current assets	300,160	106,726	91,752	30,071	242,434	(110,678)	660,465
Board-designated investments	92,852	57,180	—	17,683	70,962	—	238,677
Long-term investments	59,517	36,653	145,005	11,334	62,811	—	315,320
Donor-restricted investments	13,265	3,407	4,952	276	(511)	—	21,389
Reinsurance recovery receivable	—	—	—	—	15,548	—	15,548
Assets limited as to use, net of current portion	—	—	—	—	33,039	—	33,039
Pledges receivable, net of current portion	1,372	148	1,270	173	2,159	—	5,122
Property and equipment, net	230,406	106,812	118,089	40,461	155,405	—	651,173
Beneficial interest in split interest agreement	4,757	—	—	—	—	—	4,757
Investment in unconsolidated affiliates	—	—	1,230	—	195,537	(145,885)	50,882
Other assets, net of accumulated amortization	13,853	2,709	18,559	60	28,760	—	63,941
Total assets	$ 716,182	313,635	380,857	100,058	806,144	(256,563)	2,060,313

(Continued)

Schedule 1

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidating Balance Sheet Information

June 30, 2017

(Dollars in thousands)

Liabilities and Net Assets	Sinai Hospital Consolidated	Northwest Hospital	Carroll Hospital	Levindale Hebrew Geriatric Ctr & Hospital	Other LifeBridge Entities	Eliminations	LifeBridge Health Consolidated
Current liabilities:							
Accounts payable and accrued liabilities	$ 64,065	23,432	30,942	8,640	112,329	(110,678)	128,730
Accrued salaries, wages, and benefits	34,846	9,785	10,124	3,302	21,387	—	79,444
Advances from third-party payors	26,493	6,742	5,340	3,360	—	—	41,935
Current portion of long-term debt and capital lease, net obligations	3,848	1,271	1,625	221	6,963	—	13,928
Other current liabilities	1,645	327	157	—	18,006	—	20,135
Total current liabilities	130,897	41,557	48,188	15,523	158,685	(110,678)	284,172
Other long-term liabilities	51,212	10,587	20,811	5,043	48,051	—	135,704
Long-term debt and capital lease obligations, net	274,111	89,999	131,494	10,364	65,210	—	571,178
Total liabilities	456,220	142,143	200,493	30,930	271,946	(110,678)	991,054
Net assets:							
Unrestricted net assets	212,435	163,631	118,887	68,317	520,962	(100,322)	983,910
Noncontrolling interest in consolidated subsidiaries	—	—	4,134	—	6,055	4,437	14,626
Total unrestricted net assets	212,435	163,631	123,021	68,317	527,017	(95,885)	998,536
Temporarily restricted	36,732	7,861	56,170	811	2,958	(50,000)	54,532
Permanently restricted	10,795	—	1,173	—	4,223	—	16,191
	259,962	171,492	180,364	69,128	534,198	(145,885)	1,069,259
Total liabilities and net assets	$ 716,182	313,635	380,857	100,058	806,144	(256,563)	2,060,313

See accompanying independent auditors' report.

Schedule 2

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidating Statement of Operations Information

Year ended June 30, 2017

(Dollars in thousands)

	Sinai Hospital Consolidated	Northwest Hospital	Carroll Hospital	Levindale Hebrew Geriatric Ctr & Hospital	Other LifeBridge Entities	Eliminations	LifeBridge Health Consolidated
Unrestricted revenues, gains, and other support:							
Patient service revenue (net of contractual allowances and discounts)	$ 763,077	266,417	241,640	78,701	159,113	—	1,508,948
Provision for bad debts	(22,204)	(12,962)	(4,237)	(2,588)	(5,350)	—	(47,341)
Net patient service revenue	740,873	253,455	237,403	76,113	153,763	—	1,461,607
Net assets released from restrictions used for operations	3,473	—	40	108	258	—	3,879
Other operating revenue	24,810	2,990	12,030	2,209	43,888	(24,359)	61,568
Total operating revenues	769,156	256,445	249,473	78,430	197,909	(24,359)	1,527,054
Expenses:							
Salaries and employee benefits	375,539	132,274	120,665	48,172	131,841	531	809,022
Supplies	161,411	49,687	26,051	6,111	18,674	(3,320)	258,614
Purchased services	136,459	39,543	54,623	15,441	53,581	(21,570)	278,077
Depreciation, amortization, and gain/loss on sale of assets	32,580	11,337	14,908	2,790	15,599	—	77,214
Repairs and maintenance	13,429	4,446	1,445	977	1,009	—	21,306
Interest	8,450	3,261	5,492	269	11,095	—	28,567
Total expenses	727,868	240,548	223,184	73,760	231,799	(24,359)	1,472,800
Operating income (loss)	41,288	15,897	26,289	4,670	(33,890)	—	54,254
Other income (loss), net:							
Investment income	14,912	7,984	2,220	855	4,937	—	30,908
Unrealized gains on trading investments	13,761	7,226	12,493	2,968	206	—	36,654
Other	419	—	11	—	(440)	—	(10)
Loss on refinancing of debt	(7,302)	(2,091)	—	(1,409)	—	—	(10,802)
Total other income, net	21,790	13,119	14,724	2,414	4,703	—	56,750
Excess (deficit) of revenues over expenses	$ 63,078	29,016	41,013	7,084	(29,187)	—	111,004

See accompanying independent auditors' report.

EXHIBIT 14

BRINTON WOODS
HEALTH CARE CENTER, LLC

FINANCIAL STATEMENTS

Year Ended December 31, 2016

BRINTON WOODS HEALTH CARE CENTER, LLC

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McGibney & Associates, LLC

To the Board of Directors
Brinton Woods Health Care Center, LLC
Sykesville, Maryland

INDEPENDENT ACCOUNTANT'S REVIEW REPORT

We have reviewed the accompanying financial statements of Brinton Woods Health Care Center, LLC (the "Company"), which comprise the balance sheet as of December 31, 2016, and the related statement of income, members' equity, and cash flow for the year then ended, and the related notes to the financial statement. 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 these 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 the financial statements that are free from material misstatement 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 review, 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.

McGibney and Associates, LLC
February 23, 2017

BRINTON WOODS HEALTH CARE CENTER, LLC

Balance Sheet
December 31, 2016

ASSETS

Current Assets	
Cash	$ 284,814
Accounts receivable, net of allowance for doubtful accounts of $50,000	822,228
Prepaid expenses	46,316
Due from Medicaid/Medicare	45,589
Total Current Assets	1,198,947
Property and Equipment	
Leasehold improvements	28,537
Furniture, fixtures, and equipment	368,882
	397,419
Less Accumulated Depreciation and Amortization	315,689
Net Property and Equipment	81,730
Total Assets	$ 1,280,677

LIABILITIES AND MEMBERS' EQUITY

Current Liabilities	
Accounts payable	$ 192,345
Accrued liabilities	94,892
Accrued payroll	140,129
Accrued payroll taxes	12,742
Accrued vacation	75,061
Working Capital Loan - DHMH	31,388
Due to Brinton Woods Management Company, LLC	36,931
Total Current Liabilities	583,488
Members' Equity	
Members' contributions	100,000
Cumulative earnings	597,189
Distributions	-
Total Members' Equity	697,189
Total Liabilities and Members' Equity	$ 1,280,677

See accompanying notes and independent accountant's review report.

BRINTON WOODS HEALTH CARE CENTER, LLC

Statement of Income and Members' Equity
Year Ended December 31, 2016

Revenue	
Private	$ 659,988
Managed Care	123,492
Medicaid	2,814,205
Medicare	2,689,476
Non-operating revenue	5,241
Total Revenue	6,292,402
Expenses	
Nursing care services	2,283,110
Other patient care services	1,213,703
Routine services	832,847
Administrative services	842,049
Capital/property services	367,294
Capital value rental	484,888
Other services	93,286
Total Expenses	6,117,177
Net Income	175,225
Members' Equity - December 31, 2015	521,964
Distributions	-
Members' Equity - December 31, 2016	$ 697,189

See accompanying notes and independent accountant's review report.

BRINTON WOODS HEALTH CARE CENTER, LLC

Statement of Members' Equity
Year Ended December 31, 2016

	Members' Contributions	Cumulative Earnings	Total
Balance - Beginning of Year	$ 100,000	$ 421,964	$ 521,964
Net income	-	175,225	175,225
Distributions	-	-	-
Balance - End of Year	$ 100,000	$ 597,189	$ 697,189

See accompanying notes and independent accountant's review report.

BRINTON WOODS HEALTH CARE CENTER, LLC

Statement of Cash Flows
Year Ended December 31, 2016

Cash Flows From Operating Activities	
Net income	$ 175,225
Adjustments to reconcile net income to net cash provided by operating activities	
Amortization/depreciation	38,570
Changes in assets and liabilities	
Increase in receivables	(59,002)
Decrease in prepaid expenses	10,804
Decrease in Due from Medicare and Medicaid	34,084
Increase in accounts payable	10,500
Decrease in other current liabilities	(85,662)
Net Cash Flows Provided by Operating Activities	124,519
Cash Flows from Investing Activities	
Capital expenditures	(19,354)
Net Cash Flows Used in Investing Activities	(19,354)
Cash Flows from Financing Activities	
Distributions	-
Net Cash Flows Used in Financing Activities	-
Net Increase (Decrease) in Cash and Cash Equivalents	105,165
Cash and Cash Equivalents - Beginning of Year	179,649
Cash and Cash Equivalents - End of Year	$ 284,814
Supplementary Cash Flow Information	
Cash paid for interest	$ -

See accompanying notes and independent accountant's review report.

NOTE A - THE COMPANY AND ITS SIGNIFICANT ACCOUNTING POLICIES

Nature of Business

Brinton Woods Health Care Center, LLC (the "Company") was organized in Maryland in 2005 and began operations on May 1, 2005, primarily to provide skilled nursing for seniors on an inpatient basis.

Basis of Accounting

The financial statements have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. Under this method of accounting, revenue is recognized when amounts are earned and when the amount and timing of the revenue can be reasonably estimated. Expenses are recognized when they occur.

Cash and Cash Equivalents

For the purposes of the Statement of Cash Flows, the Company considers all highly liquid debt instruments purchased with a maturity of three months or less to be cash equivalents.

Credit Risk

The Company maintains its cash balances at a financial institution. Accounts are insured by the Federal Deposit Insurance Corporation ("FDIC") up to $250,000. At various times, the Company maintained deposits in excess of FDIC limitations. The Company believes it is not exposed to any significant credit risk on its cash balances.

Accounts Receivables - Allowance for Doubtful Accounts

The Organization provides for estimated losses on accounts receivable based on prior bad debt experience and a review of existing receivables. Based on these factors, management determined the allowance for doubtful accounts at the year ended December 31, 2016 was $50,000.

Property and Equipment

Property and equipment are carried at cost. Depreciation is computed using the straight-line method over the estimated useful lives of the assets ranging from five to fifteen years.

Income Taxes

The Company is organized as a limited liability company. As such, the Company pays no income taxes direct. The applicable income (loss) is allocated to the members and reported on their tax returns.

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 revenues and expenses during the reporting period. Actual results could differ from those estimates.

NOTE B - ACCOUNTS RECEIVABLES

Accounts receivables consist of the following at December 31, 2016:

Accounts Receivables	
Private/insurance	$ 212,035
Medicaid	363,434
Medicare	296,759
Total Accounts Receivables	872,228
Less allowance for doubtful accounts	50,000
Net Accounts Receivables	$ 822,228

NOTE C - PROPERTY AND EQUIPMENT

Property and equipment consists of the following at December 31, 2016:

Assets	
Building improvements	$ 28,537
Furniture and equipment	368,882
Total Assets	397,419
Less Accumulated Depreciation and Amortization	315,689
Net Property and Equipment	$ 81,730

Depreciation expense was $38,570 for the year ended December 31, 2016.

NOTE D - LINE-OF-CREDIT

The Company has a $300,000 revolving line-of-credit from BB&T Bank that is limited to an amount not to exceed eighty percent of eligible account receivable. The revolving line-of-credit is secured by all the assets of the by all the assets of the Company, Haven Nursing Home, Inc., Brinton Woods Senior Living III, LLC, Brinton Woods Senior Living, LLC, and Brinton Woods Management Company, LLC, and is also personally guaranteed by Daren Cortese, Marvin Rabovsky, and Gary Yankanich. The term of the revolving line-of-credit shall end on the earlier of the date on which the Bank makes demand for the payment of the revolving credit or May 1, 2026. Advances under the revolving credit shall bear the interest at the greater of a floating rate which shall be equal at all times to the Wall Street Journal Prime Rate plus one percent annum or three and twenty-five one hundredths (3.25%) per annum. The borrower has specific covenants relating to any outstanding revolving line of credit: to maintain a debt service coverage ratio of not less than 1.25 to 1, occupancy equal to eighty-five percent (85%), and the borrower shall at all times maintain a combined net worth of at least $500,000. There is no outstanding balance at December 31, 2016.

Interest expense was $0 for the year ended December 31, 2016.

NOTE E - RELATED PARTY TRANSACTIONS

Operating Lease

The Company leases the long-term care center from Brinton Woods Senior Living, LLC, a related company. The lease is for twenty years and expires April 30, 2026. Total rent expense was $420,000 for the year ended December 31, 2016. The base rent is $35,000 per month. Future minimum lease rentals are as follows:

2017	$ 420,000
2018	420,000
2019	420,000
2020	420,000
2021	420,000
Thereafter	1,820,000
Total	$ 3,920,000

Due from Brinton Woods Senior Living, LLC	$ -

There is $0 due from Brinton Woods Senior Living, LLC, a related company as of December 31, 2016.

Management Services

The Company has an agreement with Brinton Woods Management Company, LLC, an entity related to the partners to provide management services. The management agreement is for 3 years and expires on April 30, 2018. The term of this agreement shall thereafter continue for successive three year periods unless terminated upon the expiration of the initial term or any successive term by either party, with or without cause, upon not fewer than ninety days prior written notice to the other party. The management fee is equal to five percent of the gross revenue.

Management fee expense was $309,487 for the year ended December 31, 2016.
Due to Brinton Woods Management Company, LLC at year ended December 31, 2016 was $36,931.

Other

A member of the Company receives commissions for services rendered as an insurance broker. The Company purchased insurance using this service from this related party.

NOTE F – RETIREMENT PLAN

The Company adopted a 401(K) qualified deferred compensation plan in 2012. Per the plan, an employee can elect to make tax deferred contributions to the plan. The Company has no obligation to make contributions to the plan, but can make contributions at the discretion of the Company, determined on an annual basis. For the year ended December 31, 2016, the company matched contributions based on 25% of the employee deferrals, up to 3% of compensation. The Company matching contributions was $7,579.

NOTE G - MAJOR CUSTOMER

During the year ended December 31, 2016, sales to the Maryland Medicaid Program represented 45% of total sales. At December 31, 2016, accounts receivables from this customer represented 42% of total accounts receivables.

During the year ended December 31, 2016, sales to the Medicare Program represented 43% of total sales. At December 31, 2016, accounts receivables from this customer represented 34% of total accounts receivables.

Both of these programs rely on government financing (Federal and/or state), which future funding could be subject to budgetary controls.

Both programs are subject to a final settlement based on cost reports prepared after the year end that reflects their applicable rules and regulations. Interim calculations for these final settlements have been made and amounts due to/from the programs have been considered and reflected in the financial statements.

NOTE H - COMMITMENT AND CONTINGENCIES

Brinton Woods Senior Living, LLC (the "Borrower") has obtained a promissory note from BB&T Bank. The Note Payable to BB&T was amended, commencing as of October 1, 2015. The principle was increased by $600,000, to the sum of $2,025,000. Additionally, the interest rate changed from 5.75% to 4.50%, monthly principal payments increased from $7,500 to $10,657.89. These principal payments continue through May 18, 2021, at which time the interest rate shall convert to either a new fixed rate, which shall be in effect for five years or a floating rate at the option of the borrower. The note is collateralized by all the assets of the Company, Haven Nursing Home, Inc., Brinton Woods Senior Living III, LLC, Brinton Woods Health Care Center, LLC, and Brinton Woods Management Company, LLC, and is also personally guaranteed by the Daren Cortese, Marvin Rabovsky, and Gary Yankanich. The borrower has specific covenants relating to any outstanding revolving line of credit: to maintain a debt service coverage ratio of not less than 1.25 to 1, occupancy equal to eighty-five percent (85%), and the borrower shall at all time maintain a combined net worth of at least $500,000.

In addition, the assets of Brinton Woods Health Care, LLC are pledged as collateral for the outstanding balances of loans / line of credit made by BB&T Bank to the following related companies:

	Balance	Purpose
Brinton Woods Senior Living, LLC	1,857,631	Asset Purchase
Brinton Woods Senior Living III, LLC	5,380,271	Asset Purchase
Brinton Woods of Rock Creek, LLC	-	$2,000,000 Maximum Line of Credit
Brinton Woods of Frankford, LLC	400,000	$2,500,000 Maximum Line of Credit
Haven Nursing Home, Inc.	-	$ 400,000 Maximum Line of Credit

NOTE I – SUBSEQUENT EVENTS

The company has evaluated subsequent events through February 23, 2017, the date which the financial statements were available to be issued. No significant subsequent events have been identified that would require adjustment of the accompanying financial statements.

BRINTON WOODS
HEALTH CARE CENTER, LLC

SUPPLEMENTARY INFORMATION

Year Ended December 31, 2016

BRINTON WOODS HEALTH CARE CENTER, LLC

Schedule of Expenses
Year Ended December 31, 2016

Nursing Care Services	
Salaries/wages - DON	$ 77,832
Salaries/wages - administrative	201,412
Salaries/wages - RN	271,892
Salaries/wages - LPN	328,928
Salaries/wages - CMA	100,857
Salaries/wages - aides	754,601
Salaries/wages - orientation	480
Nursing Supplies	64,424
Oxygen supplies	9,732
Tubefeeding Nutrition	2,450
Contract nursing services	24,188
Employee benefits	320,258
Salaries/wages - PTO	126,056
Total Nursing Care Services	2,283,110
Other Patient Care Services	
Pharmacy	
Contract service - pharmacy	4,950
OTC drugs	28,483
Prescription drugs	194,725
Total Pharmacy	228,158
Recreational Activities	
Salaries/wages - activities	60,279
Activities supplies	5,665
Cable TV	7,926
Contract service - activities	3,021
Total Recreational Activities	76,891
Other Services	
Salaries/wages - social service	51,404
Contract service - social service	2,760
Contract service - medical director	21,000
Contract service - medical other	3,394
Contract service - swallowing tests	395
Physical therapy	228,139
Occupational therapy	208,636
Speech therapy	85,675
Contract service Medicaid therapies	7,459
Therapy-Part B	55,920
Barber & Beauty	3,958
Personal hygiene items	3,392
Contract service - x-ray	24,091
Contract service - lab	32,728
Contract service - ambulance	19,180
Total Other Services	748,131
Food purchases	114,940
Food supplements	16,727
Employee benefits	20,706
Salaries/wages - PTO	8,150
Total Other Patient Care Services	1,213,703

BRINTON WOODS HEALTH CARE CENTER, LLC

Schedule of Expenses (continued)
Year Ended December 31, 2016

Routine Services	
Dietary	
Salaries/wages - dietary	255,995
Dietary supplies	17,414
Total Dietary	273,409
Laundry and Linen	
Salaries/wages - laundry	48,827
Laundry supplies	6,177
Diaper/disposable purchase	19,447
Linen purchases	12,321
Total Laundry and Linen	86,772
Housekeeping	
Salaries/wages - housekeeping	84,772
Housekeeping supplies	17,194
Total Housekeeping	101,966
Plant Operation/Maintenance	
Salaries/wages - maintenance	93,472
Supplies - maintenance	26,673
Repairs and maintenance	22,215
Contract service - maintenance	25,597
Minot Equipment	150
Gas and electric	53,380
Fuel oil	19,502
Trash removal	4,897
Total Plant Operation/Maintenance	245,886
Employee benefits	89,562
Salaries/wages - PTO	35,252
Total Routine Services	832,847

BRINTON WOODS HEALTH CARE CENTER, LLC

Schedule of Expenses (continued)
Year Ended December 31, 2016

Administrative	
Salaries/wages - administrators	72,906
Salaries/wages - administrative	139,289
Salaries/wages - admissions	60,503
Management fee	309,487
Advertising	2,965
Automobile	2,142
Bank charges	209
Consulting services	420
Data processing	70,958
Dues and subscriptions	6,734
Insurance - non property	33,220
Office supplies	25,699
Employee background check	3,347
Licenses and permits	8,131
Legal services	7,791
Telephone & postage	16,638
MA TPL Fees	547
Miscellaneous expense	1,686
Meeting and seminars	6,685
Total Administrative	769,357
Employee benefits	52,161
Salaries/wages - PTO	20,531
Total Administrative Services	842,049
Capital/Property Services	
Taxes real estate	23,756
Taxes tangible property	2,605
Insurance property	5,627
Officers life insurance	-
Assessment Tax	335,306
Total Capital/Property Services	367,294

BRINTON WOODS HEALTH CARE CENTER, LLC

Schedule of Expenses (continued)
Year Ended December 31, 2016

Capital Value Rental	
Other nursing rental expense	13,398
Depreciation	38,570
Rental - facility	420,000
Rental - equipment	12,920
Total Capital Value Rental	484,888
Other Services	
Advertising - other	8,998
Bad debt expense	83,248
Contributions	1,040
Total Other Services	93,286
Total Expenses	$ 6,117,177

BRINTON WOODS
HEALTH CARE CENTER, LLC

FINANCIAL STATEMENTS

Year Ended December 31, 2017

BRINTON WOODS HEALTH CARE CENTER, LLC

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McGibney & Associates, LLC

To the Board of Directors
Brinton Woods Health Care Center, LLC
Sykesville, Maryland

INDEPENDENT ACCOUNTANT'S REVIEW REPORT

We have reviewed the accompanying financial statements of Brinton Woods Health Care Center, LLC (the "Company"), which comprise the balance sheet as of December 31, 2017, and the related statement of income, members' equity, and cash flow for the year then ended, and the related notes to the financial statement. 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 these 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 the financial statements that are free from material misstatement 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 review, 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.

McGibney and Associates, LLC

McGibney and Associates, LLC
March 12, 2018

BRINTON WOODS HEALTH CARE CENTER, LLC

Balance Sheet
December 31, 2017

ASSETS

Current Assets	
Cash	$ 120,868
Accounts receivable, net of allowance for doubtful accounts of $73,657	985,422
Prepaid expenses	52,604
Due from Medicaid/Medicare	30,579
Total Current Assets	1,189,473
Property and Equipment	
Leasehold improvements	28,537
Furniture, fixtures, and equipment	384,675
	413,212
Less Accumulated Depreciation and Amortization	349,687
Net Property and Equipment	63,525
Total Assets	$ 1,252,998

LIABILITIES AND MEMBERS' EQUITY

Current Liabilities	
Accounts payable	$ 189,498
Accrued liabilities	102,686
Accrued payroll	153,797
Accrued payroll taxes	14,533
Accrued vacation	85,058
Working Capital Loan - DHMH	31,388
Due to BWSL III	150,000
Due to Brinton Woods Management Company, LLC	38,493
Total Current Liabilities	765,453
Members' Equity	
Members' contributions	100,000
Cumulative earnings	487,545
Distributions	(100,000)
Total Members' Equity	487,545
Total Liabilities and Members' Equity	$ 1,252,998

See accompanying notes and independent accountant's review report.

BRINTON WOODS HEALTH CARE CENTER, LLC

Statement of Income and Members' Equity
Year Ended December 31, 2017

Revenue	
Private	$ 921,714
Managed Care	271,476
Medicaid	2,628,670
Medicare	2,559,376
Non-operating revenue	6,909
Total Revenue	6,388,145
Expenses	
Nursing care services	2,449,758
Other patient care services	1,335,178
Routine services	807,527
Administrative services	864,391
Capital/property services	386,666
Capital value rental	514,640
Other services	139,629
Total Expenses	6,497,789
Net Income	(109,644)
Members' Equity - December 31, 2016	697,189
Distributions	(100,000)
Members' Equity - December 31, 2017	$ 487,545

See accompanying notes and independent accountant's review report.

BRINTON WOODS HEALTH CARE CENTER, LLC

Statement of Members' Equity
Year Ended December 31, 2017

	Members' Contributions	Cumulative Earnings	Total
Balance - Beginning of Year	$ 100,000	$ 597,189	$ 697,189
Net income	-	(109,644)	(109,644)
Distributions	-	(100,000)	(100,000)
Balance - End of Year	$ 100,000	$ 387,545	$ 487,545

See accompanying notes and independent accountant's review report.

BRINTON WOODS HEALTH CARE CENTER, LLC

Statement of Cash Flows
Year Ended December 31, 2017

Cash Flows From Operating Activities	
Net income	$ (109,644)
Adjustments to reconcile net income to net cash provided by operating activities	
Amortization/depreciation	33,998
Changes in assets and liabilities	
Increase in receivables	(163,194)
Increase in prepaid expenses	(6,288)
Decrease in due from Medicare and Medicaid	15,010
Decrease in accounts payable	(1,285)
Increase in other current liabilities	33,250
Net Cash Flows Provided by Operating Activities	(198,153)
Cash Flows from Investing Activities	
Loan due to related party	150,000
Capital expenditures	(15,793)
Net Cash Flows Used in Investing Activities	134,207
Cash Flows from Financing Activities	
Distributions	(100,000)
Net Cash Flows Used in Financing Activities	(100,000)
Net Increase (Decrease) in Cash and Cash Equivalents	(163,946)
Cash and Cash Equivalents - Beginning of Year	284,814
Cash and Cash Equivalents - End of Year	$ 120,868
Supplementary Cash Flow Information	
Cash paid for interest	$ -

See accompanying notes and independent accountant's review report.

NOTE A - THE COMPANY AND ITS SIGNIFICANT ACCOUNTING POLICIES

Nature of Business

Brinton Woods Health Care Center, LLC (the "Company") was organized in Maryland in 2005 and began operations on May 1, 2005, primarily to provide skilled nursing for seniors on an inpatient basis. Brinton Woods Health Care Center, LLC (BWHCC) and its members sold and conveyed a 55% interest in the Company to LBH Carroll County and Rehabilitation, LLC (LBH).

Basis of Accounting

The financial statements have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. Under this method of accounting, revenue is recognized when amounts are earned and when the amount and timing of the revenue can be reasonably estimated. Expenses are recognized when they occur.

Cash and Cash Equivalents

For the purposes of the Statement of Cash Flows, the Company considers all highly liquid debt instruments purchased with a maturity of three months or less to be cash equivalents.

Credit Risk

The Company maintains its cash balances at a financial institution. Accounts are insured by the Federal Deposit Insurance Corporation ("FDIC") up to $250,000. At various times, the Company maintained deposits in excess of FDIC limitations. The Company believes it is not exposed to any significant credit risk on its cash balances.

Accounts Receivables - Allowance for Doubtful Accounts

The Organization provides for estimated losses on accounts receivable based on prior bad debt experience and a review of existing receivables. Based on these factors, management determined the allowance for doubtful accounts at the year ended December 31, 2017 was $73,657.

Property and Equipment

Property and equipment are carried at cost. Depreciation is computed using the straight-line method over the estimated useful lives of the assets ranging from five to fifteen years.

Income Taxes

The Company is organized as a limited liability company. As such, the Company pays no income taxes direct. The applicable income (loss) is allocated to the members and reported on their tax returns.

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 revenues and expenses during the reporting period. Actual results could differ from those estimates.

NOTE B - ACCOUNTS RECEIVABLES

Accounts receivables consist of the following at December 31, 2017:

Accounts Receivables	
Private/insurance	$ 292,538
Medicaid	374,383
Medicare	392,158
Total Accounts Receivables	1,059,079
Less allowance for doubtful accounts	73,657
Net Accounts Receivables	$ 985,422

NOTE C - PROPERTY AND EQUIPMENT

Property and equipment consists of the following at December 31, 2017:

Assets	
Building improvements	$ 28,537
Furniture and equipment	384,675
Total Assets	413,212
Less Accumulated Depreciation and Amortization	349,687
Net Property and Equipment	$ 63,525

Depreciation expense was $33,998 for the year ended December 31, 2017.

NOTE D - LINE-OF-CREDIT

The line of credit was eliminated in November 2017, with the occurrence of the sale of 55% member interest to LBH.

Interest expense was $0 for the year ended December 31, 2017.

NOTE E - RELATED PARTY TRANSACTIONS

Operating Lease

The Company leases the long-term care center from Brinton Woods Senior Living, LLC, a related company. The lease is for twenty years and expires April 30, 2026. Total rent expense was $450,000 for the year ended December 31, 2017. Effective November 2017, the rent was increased to $50,000 from $35,000 per month, per the First Amendment to the Lease, pursuant to the Acquisition Agreement with LBH. Future minimum lease rentals are as follows:

2018	$ 600,000
2019	600,000
2020	600,000
2021	600,000
2022	600,000
Thereafter	2,000,000
Total	$ 5,000,000

Due from Brinton Woods Senior Living, LLC	$ -

There is $0 due from Brinton Woods Senior Living, LLC, a related company as of December 31, 2017.

Management Services

The Company has an agreement with Brinton Woods Management Company, LLC, an entity related to the partners to provide management services. The management agreement is for 3 years and expires on April 30, 2018. The term of this agreement shall thereafter continue for successive three year periods unless terminated upon the expiration of the initial term or any successive term by either party, with or without cause, upon not fewer than ninety days prior written notice to the other party. The management fee is equal to five percent of the gross revenue.

Management fee expense was $321,934 for the year ended December 31, 2017.
Due to Brinton Woods Management Company, LLC at year ended December 31, 2017 was $38,493.

Other

A member of the Company receives commissions for services rendered as an insurance broker. The Company purchased insurance using this service from this related party.

Other Related Party Transactions

Due to Brinton Woods Senior Living III	$ 150,000

NOTE F – RETIREMENT PLAN

The Company adopted a 401(K) qualified deferred compensation plan in 2012. Per the plan, an employee can elect to make tax deferred contributions to the plan. The Company has no obligation to make contributions to the plan, but can make contributions at the discretion of the Company, determined on an annual basis. For the year ended December 31, 2017, the company matched contributions based on 25% of the employee deferrals, up to 3% of compensation. The Company matching contributions was $6,905.

NOTE G - MAJOR CUSTOMER

During the year ended December 31, 2017, sales to the Maryland Medicaid Program represented 41% of total sales. At December 31, 2017, accounts receivables from this customer represented 35% of total accounts receivables.

During the year ended December 31, 2017, sales to the Medicare Program represented 40% of total sales. At December 31, 2017, accounts receivables from this customer represented 37% of total accounts receivables.

Both of these programs rely on government financing (Federal and/or state), which future funding could be subject to budgetary controls.

The Medicare program is subject to a final settlement based on cost report prepared after the year end that reflects their applicable rules and regulations. Interim calculations for these final settlements have been made and amounts due to/from the programs have been considered and reflected in the financial statements.

NOTE H - COMMITMENT AND CONTINGENCIES

Brinton Woods Senior Living, LLC has obtained a promissory note from BB&T Bank. The Note Payable is $1,729.736 at 12/31/17. The note is collateralized by all the assets of the Brinton Woods Senior Living, LLC, Brinton Woods Health Care Center, LLC, and is also personally guaranteed by the Daren Cortese, by Brinton Woods Management Company, LLC and all the members interest in in the Companies. The borrower has specific covenants relating to any outstanding revolving line of credit: to maintain a debt service coverage ratio of not less than 1.25 to 1, occupancy equal to eighty-five percent (85%), and the borrower shall at all time maintain a combined net worth of at least $500,000.

NOTE I – SUBSEQUENT EVENTS

The company has evaluated subsequent events through March 12, 2018, the date which the financial statements were available to be issued. No significant subsequent events have been identified that would require adjustment of the accompanying financial statements.

It is the intention of LBH to submit to the MHCC in the spring of 2018, a letter of intent and an application for a Certificate of Need (CON) for relocation of the 60 beds. If the Relocation CON is approved and LBH determines to proceed with the construction of a new facility, the real property and equipment owned by Brinton Woods Senior Living, LLC (BWSL) and Brinton Woods Health Care Center, LLC (BWHCC) that is not transferred to the new facility, shall be sold.

If LBH submits a Relocation CON application and a Relocation CON is issued, LBH shall be obligated to purchase and acquire the remaining 45% interest in BWSL and BWHCC.

BRINTON WOODS
HEALTH CARE CENTER, LLC

SUPPLEMENTARY INFORMATION

Year Ended December 31, 2017

BRINTON WOODS HEALTH CARE CENTER, LLC

Schedule of Expenses
Year Ended December 31, 2017

Nursing Care Services	
Salaries/wages - DON	$ 83,066
Salaries/wages - administration	198,835
Salaries/wages - RN	300,911
Salaries/wages - LPN	372,538
Salaries/wages - CMA	108,376
Salaries/wages - aides	766,771
Salaries/wages - orientation	1,676
Nursing Supplies	89,873
Oxygen supplies	4,827
Tubefeeding Nutrition	1,930
Contract nursing services	15,549
Contract service IV Therapy	12,695
Contract service respiratory	40,673
Employee benefits	324,188
Salaries/wages - PTO	127,850
Total Nursing Care Services	2,449,758
Other Patient Care Services	
Pharmacy	
Contract service - pharmacy	12,482
OTC drugs	14,262
Prescription drugs	238,360
Total Pharmacy	265,104
Recreational Activities	
Salaries/wages - activities	67,211
Activities supplies	4,723
Cable TV	8,846
Contract service - activities	2,390
Total Recreational Activities	83,170
Other Services	
Salaries/wages - social service	51,537
Contract service - social service	2,892
Contract service - medical director	33,600
Contract service - medical other	20
Contract service - swallowing tests	395
Physical therapy	241,305
Occupational therapy	220,910
Speech therapy	101,299
Contract service Medicaid therapies	13,958
Therapy-Part B	65,573
Barber & Beauty	4,235
Personal hygiene items	4,780
Contract service - x-ray	23,236
Contract service - lab	31,681
Contract service - ambulance	20,655
Total Other Services	816,076
Food purchases	133,880
Food supplements	7,511
Employee benefits	21,111
Salaries/wages - PTO	8,326
Total Other Patient Care Services	1,335,178

See independent accountant's review report.

BRINTON WOODS HEALTH CARE CENTER, LLC

Schedule of Expenses (continued)
Year Ended December 31, 2017

Routine Services	
Dietary	
Salaries/wages - dietary	218,836
Salaries/wages - dieticians	36,003
Dietary supplies	16,133
Total Dietary	270,972
Laundry and Linen	
Salaries/wages - laundry	56,739
Laundry supplies	4,891
Diaper/disposable purchase	21,377
Linen purchases	10,197
Total Laundry and Linen	93,204
Housekeeping	
Salaries/wages - housekeeping	74,346
Housekeeping supplies	14,235
Total Housekeeping	88,581
Plant Operation/Maintenance	
Salaries/wages - maintenance	93,802
Supplies - maintenance	19,938
Repairs and maintenance	25,100
Contract service - maintenance	27,720
Minor Equipment	332
Gas and electric	50,988
Fuel oil	21,552
Trash removal	5,343
Total Plant Operation/Maintenance	244,775
Employee benefits	78,885
Salaries/wages - PTO	31,110
Total Routine Services	807,527

BRINTON WOODS HEALTH CARE CENTER, LLC

Schedule of Expenses (continued)
Year Ended December 31, 2017

Administrative	
Salaries/wages - administrators	95,856
Salaries/wages - administration	47,545
Salaries/wages - admissions	53,969
Salaries/wages - finance	55,861
Salaries/wages - human resources	34,426
Management fee	321,934
Advertising	1,764
Automobile	3,371
Consulting services	180
Data processing	75,091
Dues and subscriptions	13,115
Insurance - non property	35,818
Office supplies	24,620
Employee background check	4,514
Licenses and permits	1,050
Legal services	44
Telephone & postage	14,640
Miscellaneous expense	290
Meeting and seminars	6,853
Total Administrative	790,941
Employee benefits	52,676
Salaries/wages - PTO	20,774
Total Administrative Services	864,391
Capital/Property Services	
Taxes real estate	24,305
Taxes tangible property	2,644
Insurance property	17,538
Assessment Tax	342,179
Total Capital/Property Services	386,666

BRINTON WOODS HEALTH CARE CENTER, LLC

Schedule of Expenses (continued)
Year Ended December 31, 2017

Capital Value Rental	
Other nursing rental expense	17,888
Depreciation	33,998
Rental - facility	450,000
Rental - equipment	12,754
Total Capital Value Rental	514,640
Other Services	
Advertising - other	3,330
Bad debt expense	136,199
Contributions	100
Total Other Services	139,629
Total Expenses	$ 6,497,789

EXHIBIT 15

LIFEBRIDGE
HEALTH

Last updated 4/4/2018

CON History

2003

Docket No. 02-24-2098 (Expansion of bed capacity of **Levindale** Hebrew Geriatric Center and Hospital by 20 Beds); issued April 22, 2003 – Project completed in accordance with CON

2005

Docket No. 04-24-2160 (Expansion of operating room and PACU capacity, expansion/renovation of pathology lab, family waiting area, and relocate hemodialysis unit at **Sinai** Hospital); issued October 13, 2005; CON relinquished.

2006

Docket No. 06-06-2166 (Construction of 5 North and 5 West, fit out 5 South for inpatient med/surg beds, and construction of four new operating rooms at **Carroll** Hospital Center); issued March 6, 2006 – Project completed in accordance with CON.

2008

Docket No. 07-24-2199 (Renovation of surgery department of **Sinai** Hospital of Baltimore, including the addition of four operating rooms); issued February 21, 2008 – Project completed in accordance with CON.

Docket No. 08-24-2247 (Construction of new 3-story addition and renovation of existing building space by **Levindale** Hebrew Geriatric Center and Hospital); issued October 16, 2008 – Project completed in accordance with CON.

2009

Docket No. 08-03-2233 (Expansion of Home Health Agency Services into Baltimore County by **Carroll** Hospital Center d/b/a Carroll Home Care); issued July 16, 2009 – Project completed in accordance with CON.

2012

Docket No. 12-06-2330 (Expansion and relocation of cancer center by **Carroll** Hospital Center); issued June 21, 2012, modified December 20, 2012 – Project completed in accordance with CON.

EXHIBIT 16

Exhibit _____

Data Sources

Certificate of Need Application for Brinton Woods:
Replacement and
Relocation to the Carroll Hospital Center Campus

Maryland Comprehensive Care Facilities: Utilization data
- Maryland Long Term Care Survey, Maryland Health Care Commission, Public Use Files, 2011-2015
  http://mhcc.maryland.gov/public_use_files/compdownload.html

- Minimum Dataset, 2011-2015; obtained through the Maryland Health Care Commission by special request (August-September, 2017)

Comprehensive Care Bed Need Projections, State of Maryland
- Maryland Register, Volume 43, Issue 9, Friday, April 29, 2016

Nursing home placements from Carroll Hospital Center
- Department of Case Management, Carroll Hospital Center

Acute Care Admissions of Brinton Woods patients, CY2015
- CMS Standard Analytic Claims File, CY2015
- Brinton Woods: Internal performance reports (?)

Maryland hospitals: Discharge data
- HSCRC Discharge Abstract Database
- HSCRC Non-Confidential Revisit File

Operating performance, Brinton Woods
- Brinton Woods, Administration

Population data
- Nielsen Claritas demographic database