IN THE MATTER OF	*	**BEFORE THE**
	*	
GENESIS BAYVIEW	*	**MARYLAND**
	*	
JOINT VENTURE, LLC	*	**HEALTH CARE**
	*	
DOCKET NO. 11-24-2323	*	**COMMISSION**

*** ***

Staff Report and Recommendation

March 15, 2012

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I. INTRODUCTION

Project Description

Genesis Bayview Joint Venture, L.L.C. proposes to establish a new 132-bed nursing home on a 4.02 acre site located on the 130-acre campus of the Johns Hopkins Bayview Medical Center in Baltimore City. The newly-formed joint venture is a collaboration between Johns Hopkins Bayview Medical Center and Genesis Bayview JV Holdings, a subsidiary of Genesis HealthCare. The proposed facility will be named Genesis Bayview SNF ("GBSNF").

The joint venture will purchase and replace, in part, beds currently owned by the 172-bed Johns Hopkins Bayview Care Center ("Care Center") on the Medical Center grounds. Of this bed complement, 80 beds are currently operated by the Care Center, and 92 beds are temporarily delicensed. The Joint Venture will purchase all of the delicensed beds plus 40 of the currently-operated beds at the Care Center, with the remaining 40 of the operational beds to be transferred or temporarily delicensed.

The new four-floor, 76,193 square foot facility will include two 34-bed Transitional Care Units (each with 32 private rooms plus one semi-private room), a 24-bed Dementia Care Unit (4 private plus 10 semi-private rooms), a 20-bed Ventilator Care Unit (4 private and 8 semi-private rooms) and a 20-bed Long-term Care Unit (4 private and 8 semi-private rooms). Each unit in the facility will have a separate café and lounge, allowing for a private, personalized living experience and small group interaction, and each floor will have a dedicated rehabilitation and therapy space. Each bedroom will have its own bathroom, with a centralized shower facility on each floor. The ground-floor Dementia Unit will feature an enclosed "wander garden" for supervised outdoor activity, and the other units will share a secure rooftop garden for that purpose.

The applicant projects that, in its first year of full utilization, Medicare will account for 44.0 % of GBSNF's patient days, and 55.3% of its gross revenue. In FY2011, the applicant reports that Medicare reimbursements accounted for 32.0% of patient days and 48.4% of revenues at the Care Center.

Under a complex financing structure, the facility would be built upon land owned by, and leased from, FSK Land Corporation. Johns Hopkins Real Estate would oversee the development and construction of the building through a third-party developer, who would lease the land and

own the building. The developer would then lease the facility to Genesis Bayview Joint Venture, which would own the licensed beds, furniture, fixtures and equipment. The applicant estimates total project costs of $26,150,769, including $25,605,769 in total capital costs, $45,000 in legal and consultant fees and $500,000 in working capital costs. Included within the capital costs is the $1,320,000 purchase price of the beds from the Care Center. Sources of funds for the project include $1,150,769 in cash, and $25,000,000 to be arranged through the Johns Hopkins Real Estate Annual development effort. Annual land lease and building lease costs are estimated to be $200,000 and $2,250,000, respectively.

Summary of Staff Recommendation

Staff analyzed the proposed project's compliance with the applicable State Health Plan criteria and standards in COMAR 10.24.01.08, State Health Plan: Long Term Care Service, and the remaining criteria at COMAR 10.24.01.08G(3) and recommends **APPROVAL,** with the following condition.

At the time of first use review, Genesis Bayview SNF shall provide the Commission with a completed Memorandum of Understanding with the Maryland Medicaid Assistance Program agreeing to maintain the minimum required proportion of Medicaid patient days required for a comprehensive care facility located in Baltimore City.

II. PROCEDURAL HISTORY

Review of Record

GBSNF filed a letter of intent for this project on July 8, 2011 (Docket Item ["D.I."] #1).

GBSNF filed a revised letter of intent for this project on September 6, 2011 (D.I. #2).

On September 6, 2011, a CON application was filed by GBSNF (D.I. #3)

On September 9, 2011: MHCC staff acknowledged receipt of the letter of intent (D.I. #4).

On September 9, 2011staff requested that the *Baltimore Sun* publish notice of receipt of the application. (D.I #5) and requested that the *Maryland Register* publish notice of receipt of the application. (D.I #6). On September 20, 2011, a classified proof of the publication of the notice of receipt of the application scheduled for publication on September 17, 2011 was received from the *Washington Examiner*. (D.I. #7).

Staff asked completeness questions on September 20, 2011. (D.I. #8).

On September 29, 2001, MHCC staff communicated with counsel to the applicant with regards to preservation of the temporary de-licensed bed capacity. (D.I. #9).

On October 7, 2011 GBSNF responded to completeness questions. (D.I #10).

On November 4, 2011 MHCC staff sent GBSNF a notice of docketing. (D.I. #11).

On November 4, 2011staff requested that the *Baltimore Sun* publish notice docketing. (D.I #12) and the *Maryland Register* publish a notice of docketing. (D.I #13). On that same date, staff requested review and comment on the application by the Baltimore City Health Department (D.I.#15)

On November 15, 2011, a classified proof of the publication of the notice of docketing of the application published November 11, 2011 was received from the *Baltimore Sun*. (D.I. #15).

On November 22, 2011 MHCC staff corresponded with Anne Langely, confirming that Johns Hopkins Bayview Care Center had complied with regulations COMAR 10.24.01.03(5)(b) in regards to the issue of temporary delicensed beds. (D.I. #15)

Local Government Review and Comment

No comments on this project have been received from the Baltimore City Department of Health and Human Services or other local government entities.

Interested Parties in Review

There are no interested parties in this review.

III. DEMOGRAPHIC BACKGROUND

Baltimore City's Population: Growth Patterns and Age Composition

2010 census data show that while the elderly currently comprise approximately the same percentage of the overall population in Baltimore as throughout the state (11.7% and 12.2% respectively), the actual number of residents over 65 decreased markedly in Baltimore between the 2000 and 2010 censuses (See Table 1 below). This 15.3 percent *decrease* in the City stands in stark contrast to the 18.1% *increase* in the elderly population throughout the state during the decade. Immediately prior to the publication of the most recent census results, however, the Department of Planning had actually projected Baltimore's elderly population to grow by 1.5% to over 87,000 residents in 2010. The Department's projection for the growth of the over-65 population throughout the state was more accurate, with an expected growth of the population to 735,660 compared to the actual head count of 707,642.

Table 1: Trends in Population by Age Group
Baltimore City and Maryland, 2000 - 2020

Baltimore City	Population			
	2000 (Census)	2010 (Census)	2015 (Proj.)	2020 (Proj.)
0-64	565,233	548,149	563,580	564,378
% Change		**-3.0%**	**+2.8%**	**+0.2%**
65+	85,921	72,812	96,670	106,572
% Change		**-15.3%**	**+32.8%**	**+10.2%**
TOTAL	651,154	620,961	660,250	670,950
% Change		**-4.6%**	**+6.3%**	**+1.6%**
Maryland				**Population**
	2000 (Census)	**2010 (Census)**	**2015 (Proj.)**	**2020 (Proj.)**
0-64	4,697,179	5,065,910	5,156,352	5,240,222
% Change		**+7.9%**	**+1.8%**	**+1.6%**
65+	599,307	707,642	882,088	1,036,088
% Change		**+18.1%**	**+2.5%**	**+1.7%**
TOTAL	5,296,486	5,773,552	6,038,440	6,276,310
% Change		**+9.0%**	**+4.9%**	**+3.9%**

SOURCE: 2015 and 2020 data from Maryland Department of Planning, 2010 Total Population Projections by Age, Sex and Race, November 2010; 2000 and 2010 data from US Census Bureau

In the absence of updated projections following the surprising 2010 census results, it is difficult to rely on the 2015 and 2020 projections of very strong elderly population growth in Baltimore as shown in Table 1. The cumulative projection of a 46.4% increase in senior citizens between 2010 and 2020, following such a steep decline in the City's elderly population over the past decade appears to be implausible. This is particularly true in view of the continued decline of this age cohort since the 1980 census, when the elderly numbered just over 100,000 in Baltimore.

Long-Term Care Facilities and Services in Baltimore City

There are currently 32 operational nursing facilities in Baltimore City, with a total of 4,345 licensed beds. There are 5 CON-approved but unlicensed beds, 50 authorized waiver beds[1] and 117 temporarily delicensed beds (92 of which are at the Johns Hopkins Bayview Care Center). The following table profiles demand for comprehensive care beds located at the 4 CCFs owned by Genesis Healthcare in Baltimore City, the Care Center, and the City of Baltimore and statewide. As shown, Genesis facilities, like all CCFs in Baltimore, experienced a slight decline in demand over the four year period similar to that experienced in Maryland and throughout the country. The Care Center witnessed a dramatic decline in utilization, falling from over 69% occupancy of 200 beds in 2006 to less than 37% of 172 beds in 2009.

[1] "Waiver" beds are a small increment (no more than 10 total) of additional beds that Maryland nursing homes can obtain without Certificate of Need authorization on a periodic basis, so long as a nursing facility has the physical space to accommodate the waiver beds, and the facility has maintained all of its beds in operation for at least two years prior to requesting waiver beds.

Table 2: Comprehensive Care Facility Beds (Current) and Average Annual Bed Occupancy Rate (2006-2009)
Table 2: Selected Facilities in Baltimore City, and Maryland

Facility	Beds (Current)	2006	2007	2008	2009
Caton Manor – Genesis Healthcare	138	89.49%	88.87%	87.38%	90.52%
Hamilton Center – Genesis Healthcare	99	89.20%	91.28%	90.27%	88.75%
Homewood Center - Genesis Healthcare	112	81.89%	88.06%	82.00%	83.58%
Long Green Center – Genesis Healthcare	135	96.26%	94.63%	91.90%	90.21%
Johns Hopkins Bayview Care Center	172*	69.25%	64.42%	60.70%	36.55%
Total Genesis Healthcare (Baltimore City)	**484**	**89.32%**	**90.82%**	**87.99%**	**88.38%**
Baltimore City	4,345	89.66%	88.96%	88.95%	**88.23%**
Maryland	27,778	89.82%	89.26%	88.79%	**89.09%**

Source: MHCC Public Use Database
*Johns Hopkins Bayview Care Center reduced CCF bed capacity from 200 beds to 190 beds in 2008, and to 172 beds in 2009. It temporarily delicensed 92 CCF beds in FY 2011

The trend in Maryland in recent years has been one of growth in per capita demand for CCF beds by the population younger than 75 and declining use rates for the population aged 75 and older, with the overall effect of gradually declining total patient census, as longer-term admissions are replaced by much shorter-staying patients. This pattern primarily reflects greater use of CCF beds for transitional care (short-term rehabilitation and skilled nursing care) and less demand for comprehensive care facilities as a setting for long-term care. The long term care sector of the market has seen development of alternatives to CCFs, such as assisted living facilities and in-home care, which can accommodate lower levels of morbidity and extensive limitation of independent functioning among the elderly, delaying the point in time where CCF care becomes necessary. Overall, this pattern has tended to result in flat to declining trends in overall demand for CCF beds in most parts of the state, as well as nationally, in recent years.

IV. PROJECT CONSISTENCY WITH REVIEW CRITERIA AND STANDARDS

A. STATE HEALTH PLAN

COMAR 10.24.01.08G(3)(a)State Health Plan. An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

The applicable section of the State Health Plan for this review is COMAR 10.24.08, the State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services. The specific standards to be addressed include COMAR 10.2408.05A and .05B, the Nursing Home General Standards and Standards for New Construction or Expansion of Beds or Services for nursing home projects.

PART ONE: STATE HEALTH PLAN STANDARDS

COMAR 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 the letter of intent for the application will be the need projection applicable to the review.

The proposed project is the establishment of a new 132-bed CCF bed facility in Baltimore City. No need for additional CCF bed capacity is currently identified in the State Health Plan for this jurisdiction. The 132 beds at this facility will be purchased from the Johns Hopkins Bayview Care Center, including 92 temporarily delicensed beds and 40 operational beds. The remaining 40 operational beds at the Care Center will be transferred or delicensed. Therefore, no new beds will be added to the State's bed inventory.

The proposed project is consistent with the standard.

(2) Medical Assistance Participation. 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 documents a written Memorandum of Understanding with Medicaid to maintain the proportion of Medicaid patient days required by .05A2(b) of this Chapter.

(a) 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 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.

(b) 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.

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

(i) Achieve or maintain the level of participation required by .05A2(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.

GBSNF has agreed to the requirement for executing a Memorandum of Understanding (MOU) to participate in the Medicaid Assistance Program at the most recently published minimum level of participation for Baltimore City (currently 48.99%). Based on this agreement, Staff recommends that approval of this application, should that be the result of this review, be conditioned on documentation that the MOU is in place when the project is complete and first use approval is requested. The proposed condition is as follows:

At the time of first use review, Genesis Bayview SNF shall provide the Commission with a completed Memorandum of Understanding with the Maryland Medicaid Assistance Program agreeing to maintain the minimum required proportion of Medicaid patient days required for a comprehensive care facility located in Baltimore City.

(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 services waiver programs and other initiatives to promote care in the most appropriate settings.

(b) Initiating discharge planning on admission; and

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

The applicant states that "GBSNF will provide information to all prospective residents about the existence of alternative community-based services" and notes that both the Care Center and all Genesis facilities currently comply with this requirement. The applicant has provided a copy of the material that is currently provided to residents regarding long term care resources in the community, including state government, advocacy and legal resources.

The applicant states that discharge planning will begin upon admission, consistent with the current policies and procedures maintained by both the Care Center and all Genesis facilities.

GBSNF will also permit access to the facility for all "Olmstead" efforts approved by the Department of Health and Mental Hygiene to provide education and outreach for residents and their families, continuing the existing policies of both the Care Center and Genesis facilities.

The project meets the standard.

(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.

The applicant states that Genesis has "extensive experience caring for younger individuals who need long-term care placement," and "will initiate 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."

GBSNF has provided an outline of an in-service training program that will be presented to staff of the new facility that addresses the physical, psychological, social, emotional, vocational and spiritual needs of this resident population. It also states that it will locate the nonelderly patients in rooms near to each other whenever possible, and will hold "55 and younger" meetings each week to plan events, outings and gatherings of specific interest to this population.

Staff recommends that the project be found to be consistent with the standard.

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

(a) In a new construction project:

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

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

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

The proposed project will be a 132-bed, 5-level building with a total of 76 private rooms and 28 semi-private rooms in five distinct "neighborhoods," including two Transitional Care Units of 34 beds each, a Dementia Care Unit of 24 beds, a Ventilator Care Unit of 20 beds and a Long-term Care Unit with 20 beds. The applicant notes that the room configuration of the new facility would greatly improve upon the living environment of the current Care Center, where 31 of the rooms are designed for more than two residents. All bedrooms will have bathrooms, assuring that toilets are not shared by more than two residents, and a "spa," or centralized shower facility, will be located on each floor. Each room will have individually controlled heating and air conditioning.

GBSNF meets the standard.

(b) In a renovation project:

(i) Reduce the number of patient rooms with more than two residents per room;
(ii) Provide individual temperature controls in renovated rooms; and
(iii) Reduce the number of patient rooms where more than two residents share a toilet.

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

Standards (b) and (c) do not apply to this project.

(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.

The proposed project meets this standard. GBSNF will be served by a public water supply.

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

(a) Identification of the types of residents it proposes to serve and their diagnostic groups;
(b) Citation from the long term care literature, if available, on what types of design features have been shown to best serve those types of residents;
(c) An applicant may show evidence as to how its proposed model, which is not otherwise documented in the literature, will best serve the needs of the proposed resident population.

As discussed under Standard 5, above, GBSNF has identified the types of residents it proposes to serve, and their diagnostic groups.

The applicant asserts that GBSNF will incorporate the fundamentals of the Long-Term Care Enhancements or "Culture Change" movement, which "creates living situations for nursing home residents that are in line with the Nursing Home Reform Act of 1987," part of the Omnibus Budget Reconciliation Act of that year. This law requires that each nursing home "care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident." This requires transformation from an acute-care, medical model managed by physicians and nurses to a consumer-directed model. This

transformation or "culture change" de-emphasizes the institution and emphasizes person-centered care. It encourages thinking about long-term care facilities as places that people can call home, where people live and also can get good care, rather than primarily as places that deliver care. Facilities that operate under this paradigm try to honor residents' desires and allow flexibility in sleeping and eating schedules, preferences in bathing, and choices of activities. They focus on quality of life and offer dignity, privacy and autonomy along with quality care.

GBSNF's "Neighborhood" design decentralizes traditional nursing home services and functions, creating smaller communities within the facility that promote an interactive and healing environment for residents. Each of the neighborhoods is designed to attend to the needs of residents within specific diagnostic groups. Features of the facility design and therapeutic environment include: an emphasis on private rooms; secure outdoor spaces conducive to ambulation; freedom from the limitations of institutional schedules governing dining, activities of daily living, waking and retiring at night; a more homelike décor including small neighborhood dining areas/cafes, home-like lighting, non-institutional furnishings and finishes, telephone and computer access; and resident-centered social activities.

The proposed project is consistent with the standard.

(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.

The applicant states that "none of GBSNF's principals have been convicted of either felony or fraud." Based on this assertion, the project is consistent with this standard.

(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

GBSNF will utilize relationships that have been established by Johns Hopkins Bayview Care Center to develop transfer agreements and establish collaborative working relationships with other types of long-term care providers to assure that residents have access to different aspects of the long term care continuum. Such relationships currently exist with hospitals, other nursing homes, assisted living facilities, physicians, hospice providers, adult day care programs, home-care agencies and advocacy groups.

The proposed project meets the standard.

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 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 how access to, and/or quality of, needed services will be improved.

Rather than an expansion of beds or services, the proposed project would result in a reduction of 40 beds in the Commission's overall CCF inventory, from 172 to 132 beds, or no change. Thus, criterion 1(a) does not apply to the project.

While the project may be construed as a "relocation" of existing beds at the Care Center, the move to a new site on the campus of Johns Hopkins Bayview Medical Center would not impact the need for CCF beds in the City, utilization trends or nursing facility accessibility, which are the focus of this criterion. Therefore, Criterion 1(b) does not apply to the project.

(2) Facility Occupancy.

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

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

The standard is not applicable, as the proposed project is for construction of a replacement facility and will reduce or leave unchanged, the bed inventory.

(3) Jurisdictional Occupancy.

(a) The Commission may approve a CON application for a new nursing home only if the jurisdictional occupancy for all nursing homes in that jurisdiction equals or exceeds a 90 percent occupancy level for at least the latest fiscal year, or the latest Maryland Long Term Care Survey, if no Medicaid Cost Report is filed. Each December, the Commission will issue a report on nursing home occupancy.

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

GBSNF argues that although the average occupancy rate of all free-standing CCFs in Baltimore City was 87.9% in 2009 (the most recent Medicaid Cost Report data available), this rate is artificially lowered by the inclusion of the 92 Care Center beds that were temporarily delicensed in FY 2011, two years later. It reasons that, if only the 80 beds that are *currently* fully-licensed were factored into the occupancy rate calculation, the average occupancy rate in Baltimore City would have been 90.13% in 2009. Therefore, the applicant implies, the project should be deemed to be consistent with the standard.

The applicant prefaces its rationale for the project being deemed consistent with the Jurisdictional Occupancy standard with an assertion that the standard should not apply to the project. It argues that, "While it is arguable that, technically, GBSNF must address this standard because GBSNF is structured as a new nursing home and not a simple replacement of the Care Center, this rule should not apply. While structured as a new facility, with a new ownership entity, one of the partners in the new entity is the owner of the Care Center. GBSNF is on the same campus as the Care Center and all of the beds to be implemented in the new facility will be purchased from the Care Center. This standard should not apply because in its most fundamental form, this project does not involve the establishment of a new facility as contemplated by the regulations. Rather, it simply allows continued operation of existing beds, on the same campus, with expanded ownership under (new) auspices."

The GBSNF project is, essentially, a proposal to replace an existing facility, albeit with expanded ownership and new clinical management. The six standards of COMAR 10.24.08.05A, however, including this Jurisdictional Occupancy standard, specifically apply to all "…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…"*

Staff finds that, in the particular fact situation presented by this application, the applicant's case for not applying this rule as a basis for denying the project is acceptable. This project resurrects mothballed CCF bed capacity on the JHBMC project but does not represent a new facility with new additional bed capacity that has not been part of the City's licensed bed inventory. The project is, based on the information provided, the culmination of a recent process by which JHBMC has reduced the number of CCF beds it operates on its campus. This plan reconfigures most of the remaining bed capacity in a way that will probably allow for the bed capacity to be more effectively marketed and utilized.

(4) Medicaid Assistance Program Participation.

(a) An applicant for a new nursing home must agree in writing to serve a proportion of Medicaid residents consistent with .05A2(b) of this Chapter.

(b) An applicant for new comprehensive care facility beds has three years during which to achieve the applicable proportions 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.

(c) An application 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 the Certificate of Need.

(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 percentage rate.

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

Genesis Bayview SNF agrees to sign a Memorandum of Understanding with the Medical Assistance Program committing to the required minimum rate of Medicaid participation. As previously noted, a condition stating that this MOU will be put in place prior to first use approval is recommended.

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

The applicant notes that the Care Center has continually maintained both its licensure and accreditations, and has received only minor citations in Quality Indicator Surveys conducted in 2011 by OHCQ, all immediately corrected or with corrective action in progress. The applicant further notes that there are no outstanding G Level or higher deficiencies in any Genesis facility. This has been confirmed by MHCC staff.

(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.

The standard is inapplicable. The project calls for the construction of a new CCF on the same campus where the current Care Center is located.

PART TWO: REMAINING CERTIFICATE OF NEED REVIEW CRITERIA

The project's compliance with the five remaining general review criteria in the Regulations governing Certificate of Need is outlined below:

B. NEED

COMAR 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.

The current State Health Plan projects the need for CCF beds through 2011 and does not identify a net need for additional CCF beds in Baltimore City. In the proposed project, the new joint venture will purchase and replace, in part, beds currently owned by the 172-bed Johns Hopkins Bayview Care Center on the Medical Center grounds. Of this bed complement, 80 beds are currently operated by the Care Center, and 92 beds are temporarily delicensed. The Joint Venture will purchase all of the delicensed beds plus 40 of the currently-operated beds at the Care Center, with the remaining 40 of the operational beds to be transferred or temporarily delicensed. The net effect of this plan would thus be to *increase* the number of operational CCF beds on the campus from 80 to 132, but *decrease* the number of temporarily delicensed beds from 92 to 40.

The applicant has provided an analysis of bed need which suggests that, while the total number of CCF patient days has admittedly declined by 3.14% in the past 4 years in the City of Baltimore, the number of CCF beds per 1,000 persons over the age of 65 has declined at a faster rate of 6.93%, based upon Department of Planning population projections and utilization data for 2006 - 2009. Furthermore, with the projected sharp increases in elderly population of more than 10% every five years through 2020, the applicant argues that the bed/population ratio will decrease proportionally into the foreseeable future. This, combined with the fact that occupancy rates have declined only slightly in recent years, leads GBSNF to the conclusion that the 132 beds proposed for the new facility, which are already in the state's CCF inventory, should be maintained and modernized.

As previously noted, 2010 Census figures showed a 4.6% decline in the overall population of Baltimore City for the preceding decade, and a far more significant decline of 15.3% in the number of residents over the age of 65. While the City's overall population decline was projected by the State Department of Planning, the sharp drop in the elderly population was unexpected, with the Department having projected a growth of 1.5% for this age cohort during the decade. This reversal renders unreliable the use of the Department's pre-census projections of the elderly Baltimore resident population in 2015 and 2020 for planning purposes.

We can assume with a high degree of certainty that the elderly population numbers in Baltimore from 2006 to 2009, as estimated by the Department of Planning, are erroneous. The census populations for this age cohort in 2000 and 2010 were 85,921 and 72,812, respectively. Assuming that the decrease occurred steadily over the ten years, this would mean that the City lost 1,311 seniors per year over the decade, and would result in a stable but marginally *increased* bed/population ratio over that span (despite a significant decrease in the number of licensed CCF beds in the City) as shown in Table 3 below.

It appears clear from the data presented in Table 3 that an argument for the reintroduction of a net 52 beds to Baltimore City's CCF inventory, based upon a clearly

disproven projection of a decline in bed/population ratios, is unsubstantiated. Staff again cautions, however, that in the absence of reliable projections of future population growth or decline, quantitative projections of need for CCF beds should be viewed as less reliable than demand-based projections or other qualitative assessments of need.

Table 3: Baltimore City CCF Bed/ Population Ratios, 2006-2009
MDP Population Estimates Compared with Census Estimates

	2005	2006	2007	2008	2009
Beds	4,310	4,176	4,078	4,123	4,035
65+ Population (MDP est.)	86,553	86,680	86,807	86,935	87,062
Beds/1,000 Pop MDP est.)	**49.8**	**48.2**	**47.0**	**47.4**	**46.4**
65+ Population (Census Revision)	79,366	78,055	76,744	75,433	74,122
Beds/1,000 Pop (Census Revision)	**54.3**	**53.5**	**53.1**	**54.7**	**54.4**

Sources: Bed totals from MHCC Public Use Databases; MDP population estimates from Maryland Department of Planning; Census Revision population estimates extrapolated by MHCC Staff from US Census Bureau data, 2000 and 2010.

GBSNF also provides a detailed description of the expected primary service area for the new facility, which it expects to mirror that of the Care Center. This area comprises 4 zip codes in the City of Baltimore and 5 in its eastern suburbs – Sparrows Point, Middle River, Essex, Dundalk and Rosedale.

The applicant has used population projections provided by Claritas (a consultant demographic data provider) to forecast the growth of the elderly population in the service area, and although not specifically cited, these data appear to be based upon actual 2010 census figures, as the 4 Baltimore suburbs included all showed significant population loss between 2000 and 2011. Inexplicably, however, these same zip codes are projected to reverse the downward trend between 2011 and 2016, with growth rates of between 5.21% and 12.81% in that 5-year period. With the exception of Dundalk, each of the suburban zip codes in the service area experienced growth in the 65+ age cohort between 2000 and 2011, and are projected to see very significant growth ranging from 5.21% to 14.36% by 2016.

GBSNF provides 2009 utilization data for 9 of the existing CCF facilities in the primary service area, excluding the Care Center. While 6 of these 9 nursing homes experienced occupancy rates in excess of 90%, the average rate of 87.72% fell slightly below that threshold. Had the applicant included the 172 licensed beds at the Care Center in 2009, that rate would have been only 77.55%. In fact, if only the *currently* operated 80 beds were factored into the utilization of the primary service area CCFs, the occupancy rate would still have been 81.97%, still far below the 90% occupancy threshold.

From the discussion above, it is apparent that there is no clear need for the reintroduction of 52 currently delicensed beds into the inventories of either the City of Baltimore or GBSNF's primary service area, using quantitative need assessment methodologies.

As also expressed in this standard, however, the Commission must "consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs."

GBSNF asserts that, in its current configuration, the Care Center building is unable to meet the needs of the population it serves. It states, "The central need for this project is to provide a physical environment conducive to today's standard of high quality nursing care and provide the residents with a new, state of the art environment. The building where the comprehensive care program resides was built in 1991, prior to advances in long term care culture change initiatives. The facility includes several elements that are not consistent with today's skilled nursing facility design standards and that take away from both the residents' experience and the ability of the staff to provide the highest level of care possible. The following features of the building pose challenges for enhancing a home-like environment:

- Long hallways with 3 wings per unit; very institutional;
- Each unit houses one central nurses station;
- Long term care program with three residents per room;
- Multi-purpose rooms, in which activities and dining take place in one space;
- No garden or outside facilities for pleasure, wandering or other activities;
- No beauty or barber shops; services provided in resident rooms;
- Shower room with combined shower and tub; and
- One rehabilitation suite utilized for all units (not unit based).

Despite the outdated and undersized condition of the current facility, the existing Care Center's staff continues to provide a high quality of care to the residents… GBSNF will replace the current outdated, undersized facility with a new, modern facility offering services and space consistent with today's standard of care."

As discussed previously, the therapeutic model of the proposed facility will be based upon the "Culture Change" system of care that evolved over the years following the Nursing Home Reform Act of 1987. This resident-centered system of care, which emphasizes the active participation of residents and their families in the development and implementation of their plans of care, requires a home-like, non-institutional, and personalized treatment environment that the applicant argues cannot be achieved in the current Care Center.

As the trend toward higher-acuity transitional care in CCFs continues, the emphasis on shorter-term, discharge-focused treatment environments will be likely to expand. GBSNF reports that in the past two years alone, the percentage of skilled nursing and rehabilitative (transitional) patient days at the Care Center have grown from 30.0% to 44.0% of total patient days, reflecting this trend. It becomes increasingly difficult, they assert, to implement culture change in a physical environment that is not designed to support it.

Staff believes that GBSNF has presented a persuasive argument that the current lack of an appropriate physical environment at the Care Center that promotes healing and recuperation constitutes a significant unmet need of the population it serves. While quantitative need-assessment methodologies suggest that the availability of CCF beds in the City of Baltimore may be marginally adequate to house residents in need of long term care, staff concludes that the treatment environment at the current Care Center is inadequate to meet their treatment needs, and recommends that the application be found to be consistent with the Need criterion.

C. AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

COMAR 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.

No CON applications have been submitted to compete with the GBSNF proposal.

The applicant's initial CON submission stated that Johns Hopkins Bayview Medical Center considered three alternatives in addressing the need for CCF beds: do nothing; construct a 132 bed new facility on the same or adjacent site; and construct a 132 bed new facility on a different site. The first option was rejected because maintaining the existing Care Center did not benefit its residents. Once the decision was made to replace the facility, the first approach was to attempt to build on the JHBMC campus, and two sites were identified. The Care Center then contacted Genesis HealthCare about being a joint venture partner in the new facility, and once that interest was established, no further action on the third option was needed.

MHCC staff requested additional information regarding alternatives to building a new facility, particularly in light of the fact that Genesis operates 4 CCFs in Baltimore City, two of which have 112 or fewer beds, and expansion of one or more of these facilities may present a more cost-effective alternative to new construction on the JHBMC campus.

In response to the request, GBSNF notes that each of the 4 Genesis facilities in Baltimore is located at a significant distance from the JHBMC campus, and none is located within the primary service area of the Care Center. Relocating these beds to distant CCFs would create undue hardship on residents and their families, and on their referring personal physicians, who strive to maintain a continuum of care between the hospital, the facility and the residents' homes. Such an argument appears to be reasonable, considering that in excess of 92% of the referrals to the Care Center are generated from JHBMC discharges by physicians practicing there.

Further, the applicant notes that such an alternative would negatively impact the teaching mission of JHBMC, as the new facility will continue to provide a training and education site for Johns Hopkins School of Medicine interns, residents and fellows. Finally, given the importance of the above objectives to JHBMC, the applicant notes that it did not undertake an assessment of the ability of other Genesis facilities in the City to accommodate the expansion of bed capacity that would be required by this alternative, and the associated substantial construction costs.

Commission staff finds that the applicant has reasonably addressed the cost and effectiveness of alternatives for achieving the objectives of the proposed project and demonstrated that developing a new facility through bed replacement and relocation on the Bayview campus is the most cost effective alternative for achieving those objectives.

D. VIABILITY OF THE PROPOSAL

COMAR 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.

Project Cost

Genesis Bayview SNF estimates the cost of the project to be $26,150,769, with $25,000,000 of this funding coming from Hopkins Realty and the balance of $1,150,769 being supplied by Genesis Bayview SNF. The budget estimate and sources for funds for the proposed project are outlined in the following table.

Table 4: Project Budget Estimate - Uses and Sources of Funds

A. Uses of Funds	Cost Estimate
Building	$12,982,566
Land Purchase	$0
Site Preparation	$3,262,503
Architect/Engineering Fees	$1,063,324
Permits	$50,000
Subtotal	$17,358,393
Major Movable Equipment	$800,000
Minor Movable Equipment	700,000
Other Capital Costs	2,494,552
Contingencies	2,005,795
Subtotal	$6,000,347
Total-Current Capital Costs	$23,358,740
Inflation	$747,029
Capitalized Interest	1,500,000
Subtotal	$2,247,029
Total Capital Costs	**$25,605,769**
Loan Placement Fee	
Legal Fees (CON related)	25,000
Legal Fees (Other)	
CON Application Assistance	20,000
Subtotal-Financing and Other Cash	**$45,000**
Working Capital/ Startup Costs	$500,000
Total Uses of Funds	**$26,150,769**
B Sources of Funds	
Cash	$1,150,769
Mortgage	
Working Capital Loans	
Hopkins Realty	25,000,000
Total Sources of Funds	**$26,150,769**

Source: CON application (D.I #3)

The applicant provided a letter from Johns Hopkins Real Estate, indicating its interest arranging the financing for the construction as well as Audited financial statements for Genesis HealthCare for Years ending December 31, 2008 through 2010 and for John Hopkins Bayview Medical Center for Years ending June 30, 2010 and June 30, 2009. JHBMC financial statements indicate cash and cash equivalents at end of years 2010 and 2009 to be 22 million and 20 million respectively. Genesis financial statements indicate cash and cash equivalents at end of years 2010, 2009 and 2008 to be 123 million, 110 million and 73 million respectively.

During the review process MHCC staff was made aware that Johns Hopkins and Genesis Bayview contemplated changing the financing plans for this project and expressed their concern to Johns Hopkins. Ultimately the Applicant and Johns Hopkins decided to stick with the original financing plans stated above.

Construction Cost

The following table summarizes an evaluation of the applicant's estimated construction cost, using the MVS guidelines.

Table 5: MVS Construction Cost Analysis, Genesis Bayview SNF

	New Construction
Building	$12,982,566
Normal Site Preparation	$3,262,503
Architect/Engineering Fees	$1,063,324
Permits	$50,000
Capitalized Construction Interest	$850,000
Total Project Costs	$18,208,393
Cost Adjustments	
Demolition	53,927
Storm Drains	145,610
Deforestation	350,000
Rough Grading	174,000
Sediments & Erosion Control	64,961
Offsite Costs	771,931
Signs	100,000
Landscaping	1,725,500
Elevators	155,000
Wander Garden	166,404
Canopies	35,000
Total Adjustments	**$3,742,333**
Net Project Costs	**$**14,466,060
Square Feet of Construction	76,193
Adjusted Project Cost Per SF	$189.86
MVS Cost/SF	$170.23
Over(Under)	**$19.63**

Source: CON application (D.I #3)

Genesis Bayview SNF construction cost estimates for the project are 11.5% above the MVS benchmark cost equivalent projects. GBSNF does state in the application that while the cost per square foot is above the MVS benchmark, no public payers will be affected. The Medicare Part A rate will be set without reference to the constructions costs. Under the Maryland Medical Assistance Program, costs in excess of the MVS level will not be reimbursed under the capital cost center. The rates for the minority of residents who are private pay will be governed by market forces, not construction costs.

Revenues and Expenses

The projects per diem projected revenues and expenses for the first two years of operation of the replacement facility, FY 2015 to 2016, are as follows:

Table 6: Projected Performance
Genesis Bayview SNF, First Two Years of Operation FY 2015-2016

	2015	2016
Beds	132	132
Admissions	1,140	1,140
Patient Days	45,260	45,260
Average Annual Occupancy Rate	93.94%	93.94%
Gross Revenue/Patient Day	$411.50	$411.50
Net Revenue/Patient Day	$407.05	$407.05
Expense/Patient Day	$400.30	$400.30
Income/Patient Day	$6.75	$6.75
Assumed Payor Mix (Patient Days)		
Medicare	32%	32%
Medicaid	50%	50%
Commercial Insurance	14%	14%
Self Pay	4%	4%

Source: CON application pages 60-63. (DI #3)
Note: Revenue and expenses presented in current year dollars, in conformance with application instructions.

As shown in the above table, Genesis Bayview SNF still projects the ability to reach profitability in the first year of operation at a payor mix of 32% Medicare patient days and 50% Medicaid days.

Given that the proposed CCF will replace most of the existing licensed and temporarily delicensed CCF bed capacity of JHBMC, MHCC staff requested that applicant provide a revised Table 1 and Table 3 of the original application that shows two years of historical utilization information for Table 1 and revenue, expense, and income data for Table 3, for the CCF beds operated at the JHBMC Care Center, a current year projection, and projections for CCF revenue, expenses, and income for FY 2012 to FY 2014. The following is the summary:

Table 7: Historical and Projected Performance
JHBMC, FY 2010-2014

	Recent Years		Current Estimate	Projected Years	
	2010	**2011**	**2012**	**2013**	**2014**
Beds	172	80	80	80	80
Admissions	400	431	614	612	612
Patient Days	21,484	19,876	18,707	18,656	18,656
Average Annual Occupancy Rate	34.2%	68.1%	64.1%	63.9%	63.9%
Gross Revenue/Patient Day	543.64	599.63	599.63	599.63	599.63
Net Revenue/Patient Day	280.38	310.30	292.92	292.92	292.92
Expense/Patient Day	451.11	500.02	500.87	500.91	500.91
Income/Patient Day	(170.73)	(189.72)	(207.95)	(207.99)	(207.99)
Assumed Payor Mix (Patient Days)					
Medicare	30%	32%	44%	44%	44%
Medicaid	56%	49%	38%	38%	38%
Commercial Insurance	8%	13%	14%	14%	14%
Self Pay	0%	0%	0%	0%	0%

Source: Response to Completeness questions Exhibit#1 and #3. (DI #10)

Staffing

Genesis Bayview SNF projected the following staffing pattern and cost for its payroll employees for FY 2015.

Table 8: Projected FY 2014 Staffing – Payroll Staff Employees Only
Genesis Bayview SNF Project

	Position	Current No. FTEs	Employee/ Contractual	Average Salary	Total Cost
Administration	*Administrator*	1	Employee	140,262	140,262
	Adm. Staffing	8.8	Employee	41,258	363,070
Sub Total					503,332
Direct Care	*Registered Nurse*	26.2	Employee	85,432	2,238,318
	LPN	12.6	Employee	64,396	811,390
	Aids	53.2	Employee	30,151	1,604,033
Sub Total					4,653,741
Support	Nursing Adm. Staffing	7.6	Employee	64,550	490,580
	Maintenance Staffing	2	Employee	39,512	79,024
	Dietary Staffing	14.1	Employee	32,190	453,879
	Housekeeping Staffing	11.3	Employee	25,725	290,693
	Laundry Staffing	3.2	Employee	24,287	77,718
	Activities / Rec. Staffing	5.3	Employee	38,586	204,506
	Social Service Staffing	5.5	Employee	43,554	239,547
Sub Total					1,835,947
Total Without Benefits					**6,993,020**
Benefits					**1,250,352**
Total		**150.8**			**8,243,372**

Source: Source: Response to Completeness questions Exhibit #5. (DI #10)

Genesis projects the following nurse staffing pattern for its nursing units.

Table 9: Nurse Staffing by Shift
Genesis Bayview SNF Facility

Special Unit	Day	Evening	Night
RN	7	4	3
LPN	2	3	2
Aides	14	11	8

LTC unit	Day	Evening	Night
RN	1	0	1
LPN	1	1	0
Aides	2	2	1

Source: CON applications (DI#3)Note: Schedules are based on 8 hour shifts. Weekend/holiday staffing is the same as for week days.

The applicant has projected a direct care staffing schedule that will deliver an overall average ratio of 3.8 nursing hours per bed per day of care for all units. These staffing ratios are consistent with those required in COMAR 10.07.02.12, a minimum of two hours per bed per day.

With respect to the standard of community support, GBSNF provided copies of 15 letters of support for the project:

- Johns Hopkins Bayview Medical Center Community Advisory Board;
- Harbel Community Organization, Inc.;
- Bayview Business Association, Inc.;
- Bayview Community Association, Inc.;
- Dundalk Renaissance Corporation;
- Chesapeake Gateway Chamber of Commerce;
- Southeast Community Development Corporation;
- Frankford Improvement Association, Inc.;
- Bowleys Quarters Improvement Association, Inc.;
- Millers Island Edgemere Business Association;
- Union Baptist Church, Turner Station;
- Perry Hall/White Marsh Business Association;
- Baltimore Medical System;
- Overlea Fullerton Business and Professional Association; and
- Eastfield Stanbrook Civic Association

Summary

The applicant has reasonably demonstrated it can obtain the resources necessary for project development and its assumptions with respect to utilization, revenues, expenses, staffing and payor mix are within acceptable ranges. Staff recommends a finding that the project is viable.

E. COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED

COMAR 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.

Strictly speaking, as a new corporate entity, Genesis Bayview SNF has no previous certificates of need. Genesis record of complying with terms and conditions of CONs has been acceptable.

F. IMPACT ON EXISTING PROVIDERS AND THE HEALTH CARE DELIVERY SYSTEM

COMAR 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.

Table 10 below, provided by the applicant, summarizes the most common CCFs to which patients from Johns Hopkins Bayview Medical Center patients were referred in 2011. Each of these facilities is within the previously-described primary service area of the Care Center.

As the table shows, 399 referrals were received by the Care Center from JHBMC, constituting 92.6% of its total of 431 admissions last year, but only 14.5% of the total of 2,752 referrals from the Medical Center. Only two other CCFs received more than 10% of JHBMCs referrals, those being FutureCare – Northpoint and Heritage Center – MD, and it is these two facilities that would potentially impacted the most by the project. Both operated in excess of 90% occupancy in 2009.

Table 10: Referrals to CCFs from JHBMC
In Primary Service area of Johns Hopkins Bayview Care Center 2011

Facility	Referrals FY 2011	Percent	Licensed Beds	FY 2009 % Occupancy
JHB Care Center	399	14.50%	172	36.6%
FutureCare Northpoint	444	16.03%	150	91.59%
Heritage Center – MD	431	15.66%	177	93.49%
FutureCare Canton Harbor	222	8.07%	160	90.92%
Riverview Care Center	182	6.61%	238	91.75%
Frankford Nursing & Rehab Center	178	6.47%	232	88.38%
HCR Manor Care Rossville	78	2.83%	172	74.03%
All Others	818	29.72%		
Total	2,752	100%	1,129	88.31%

Source: Applicant CON application (D.I #3)

The applicant notes that GBSNF projects that it will admit 1,140 residents in 2016, meaning that an additional 741 admissions per year would be expected above current levels, and if 92.6% of those referrals come from JHBMC as is currently the case, it would mean that an additional 656 admissions would be from that source. While it is expected that the referral of these residents to GBSNF would clearly have an impact on other area CCFs, the applicant notes that neither FutureCare – Northpoint nor Heritage Center (a Genesis facility) operate dementia or ventilator units, which would constitute a significant percentage of GBSNF admissions. Further, it is expected that a large percentage of the new referrals would be derived from the almost 30% of the Medical Center discharges that are sent to facilities outside the service area.

Commission staff notes that MHCC has received no letters of objection to the proposed project from potentially-affected CCFs, and does not find that the proposed project is likely to have a significant negative impact on these existing providers or the health care delivery system that should bar its approval.

V. SUMMARY AND STAFF RECOMMENDATION

Staff has analyzed the proposed project's compliance with the applicable State Health Plan criteria and standards in COMAR 10.24.01.08.05A and B, and with Certificate of Need review criteria, COMAR 10.24.01.08G(3)(a)-(f).

The applicant has provided, however, a reasoned argument that the physical plant of the Johns Hopkins Bayview Care Center is inadequate to meet the needs of an increasingly transitional resident population that requires skilled nursing and rehabilitative care in a resident-centered, discharge-focused therapeutic environment. Staff finds that the applicant has demonstrated that a new 132-bed CCF, designed with diagnosis-specific treatment units would better meet the needs of this growing resident population, would not impact geographic or financial access to care in the service area, and would not be likely to have a significant negative impact on other service providers.

Accordingly, Staff recommends that the Commission **APPROVE** the application of the Genesis Bayview Joint Venture, L.L.C. for a Certificate to establish a new 132-bed nursing home on a 4.02 acre site located on the 130-acre campus of the Johns Hopkins Bayview Medical Center in Baltimore City at a total estimated cost of $26,150,769, with the following condition:

> *At the time of first use review, Genesis Bayview SNF shall provide the Commission with a completed Memorandum of Understanding with the Maryland Medicaid Assistance Program agreeing to maintain the minimum required proportion of Medicaid patient days required for a comprehensive care facility located in Baltimore City.*

IN THE MATTER OF	*	**BEFORE THE**
	*	
GENESIS BAYVIEW	*	**MARYLAND**
	*	
JOINT VENTURE, LLC	*	**HEALTH CARE**
	*	
DOCKET NO. 11-24-2323	*	**COMMISSION**

* *

FINAL ORDER

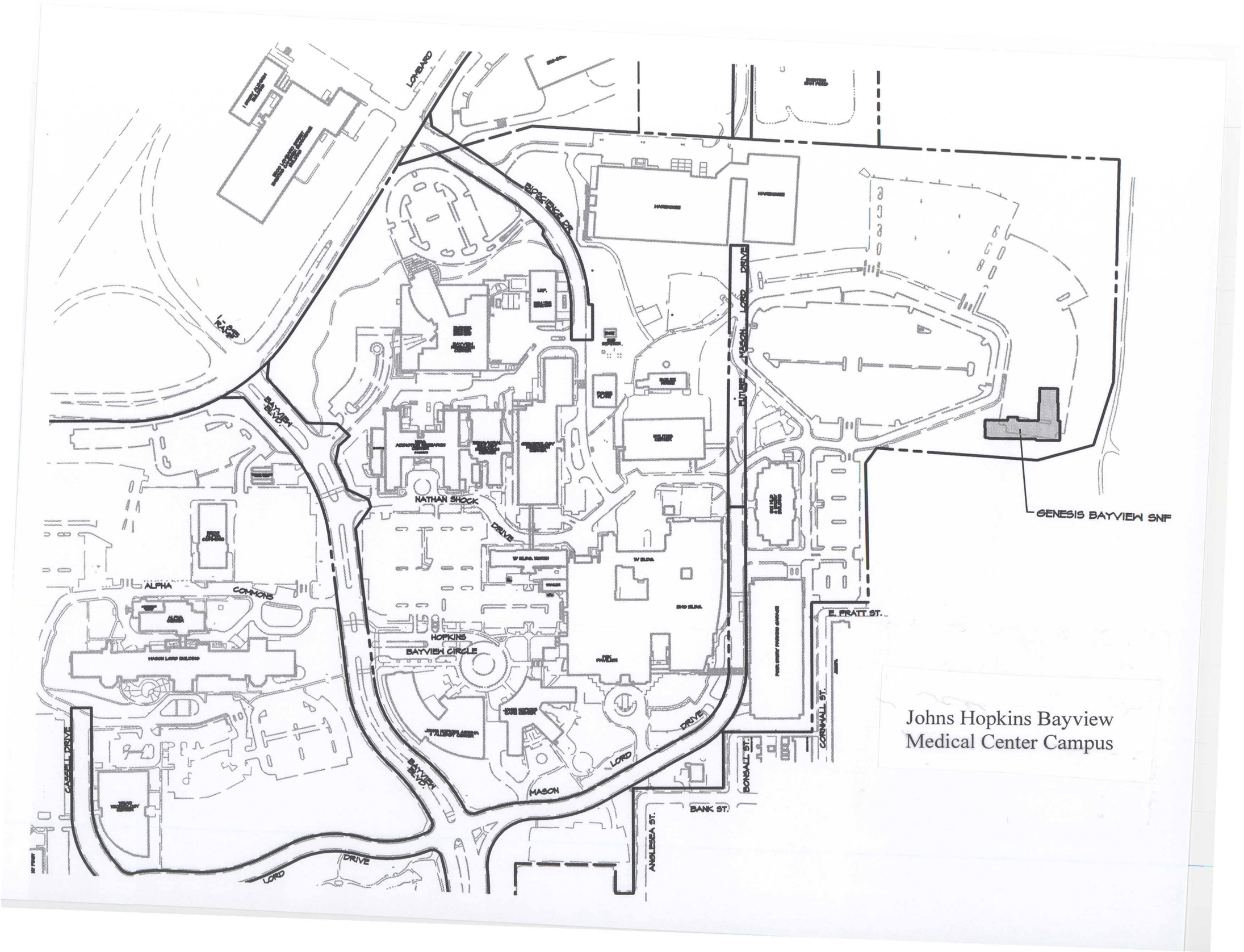
Based on Commission Staff's analysis and findings, it is this 15th day of March, 2012, **ORDERED** that:

The application for Certificate of Need submitted by Genesis Bayview Joint Venture, L.L.C., Docket No. 11-04-2323, to establish a new 132-bed nursing home on a 4.02 acre site located on the 130-acre campus of the Johns Hopkins Bayview Medical Center in Baltimore City, is **APPROVED,** subject to the following condition:

> Prior to first use review, Genesis Bayview shall provide to the Commission an updated Memorandum of Understanding with the Maryland Medical Assistance Program agreeing to maintain the proportion of Medicaid patient days required by Nursing Home Standard COMAR 10.24.08.05A(2).

Appendix A

Site Plan


LOMBARD
BIOSCIENCE DR.
MASON LORD DRIVE
FUTURE
BAYVIEW BLVD.
NATHAN SHOCK
DRIVE
GENESIS BAYVIEW SNF
ALPHA
COMMONS
HOPKINS
BAYVIEW CIRCLE
E. FRATT ST.
CORNHILL ST.
BONSALL ST.
BANK ST.
ANGLESEA ST.
CASSELL DRIVE
LORD
MASON
DRIVE
Johns Hopkins Bayview
Medical Center Campus

Appendix B

Floor Plan

KANN PARTNERS
33 SOUTH GAY STREET, SUITE 400 - BALTIMORE, MD 21202
P 410-234-0900
F 410-539-4921
WWW.KANNPARTNERS.COM

BAYVIEW SKILLED NURSING FACILITY

JOHNS HOPKINS BAYVIEW CAMPUS

Milestone	Date
PRELIMINARY DESIGN	8/1/11

KANN Project Number:	11031.03
SM	CWG
PM	VT
© KANN Partners registered trade name of Kann & Associates, Inc.	2011

Sheet Title:

GROUND FLOOR PLAN

A100

GROSS FLOOR AREA

NAME	AREA
GROUND FLOOR	9,273 SF
FIRST FLOOR (24 DEMENTIA CARE BEDS)	17,075 SF
SECOND & THIRD FLOORS (34 TCU BEDS / FLOOR)	17,141 SF
SECOND & THIRD FLOORS (34 TCU BEDS / FLOOR)	17,141 SF
FOURTH FLOOR (20 LTC BEDS & 20 VENT BEDS)	15,563 SF
	76,194 SF

N

0 8' 16' 32'

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

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BAYVIEW SKILLED NURSING FACILITY
JOHNS HOPKINS BAYVIEW CAMPUS

Milestone	Date
PRELIMINARY DESIGN	8/1/11

KANN Project Number:	1103.03
SM	CWG
PM	VT
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Sheet Title:

FIRST FLOOR PLAN

A101

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BAYVIEW SKILLED NURSING FACILITY
JOHNS HOPKINS BAYVIEW CAMPUS

Milestone	Date
PRELIMINARY DESIGN	7/27/11

KANN Project Number:	1103.1.03
SM	CWG
PM	VJ
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Sheet Title
SECOND & THIRD FLOOR PLAN

A102

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BAYVIEW SKILLED NURSING FACILITY

JOHNS HOPKINS BAYVIEW CAMPUS

Milestone	Date
PRELIMINARY DESIGN	7/27/11

KANN Project Number	11031.03
SM	CWG
PM	VT
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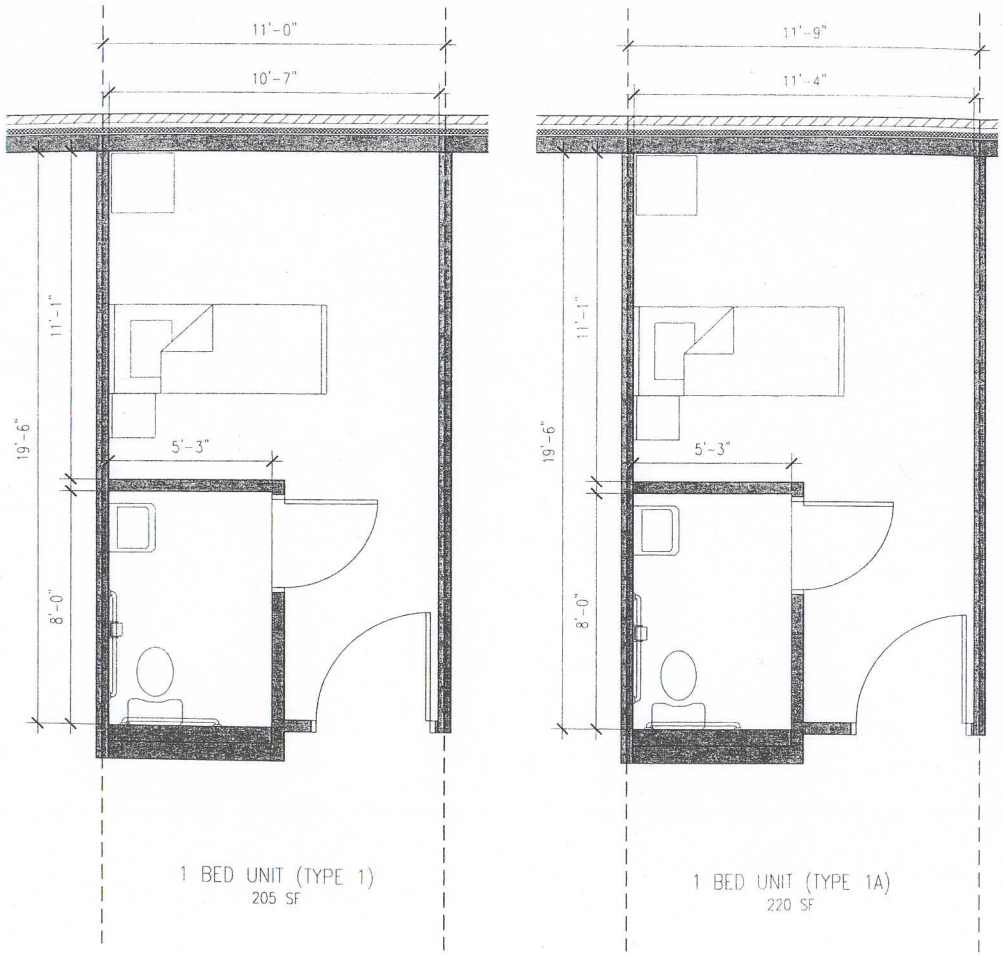
Sheet Title

FOURTH FLOOR PLAN

A104

Appendix C

Room Plans



TYPICAL ONE BED ROOM UNIT LAYOUTS

0 8' 16' 32'
SCALE: 1/4"=1'-0"

KANN PARTNERS
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BAYVIEW SKILLED NURSING FACILITY
JOHNS HOPKINS BAYVIEW CAMPUS

Milestone	Date
PRELIMINARY DESIGN	7/27/11

KANN Project Number:	11031.03
SM	CWG
PM	VJ
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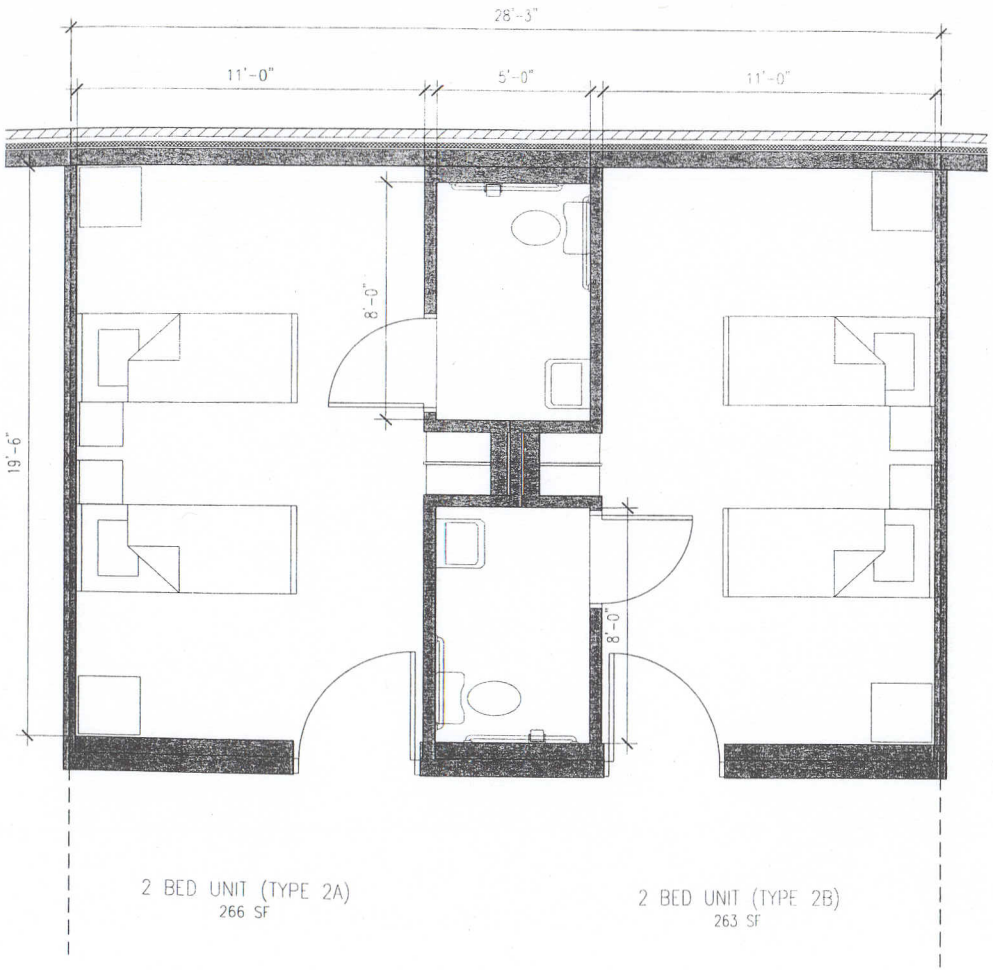
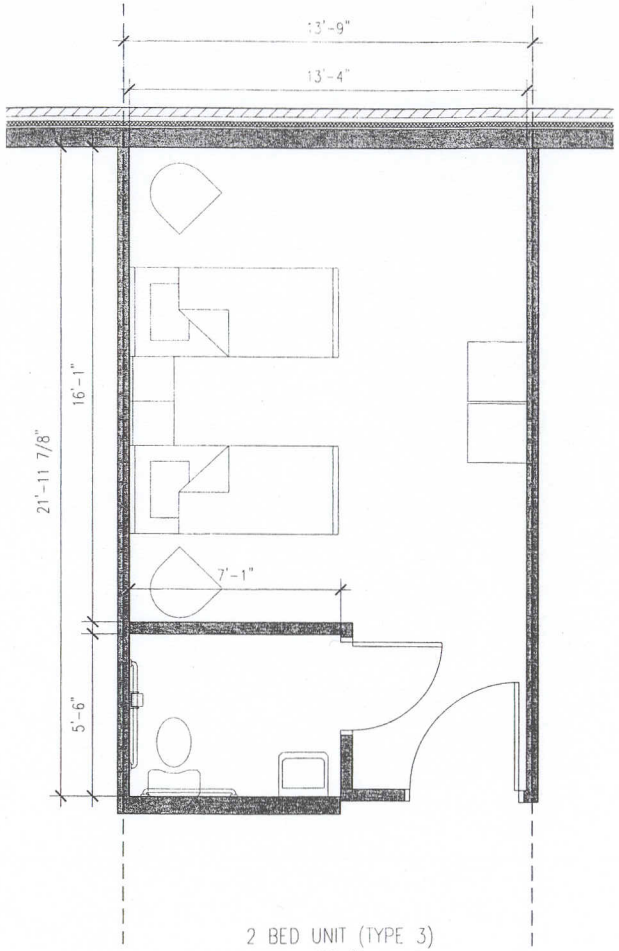
Sheet Title:
TYPICAL UNIT LAYOUTS

A421.1



2 BED UNIT (TYPE 2A)
266 SF

2 BED UNIT (TYPE 2B)
263 SF



2 BED UNIT (TYPE 3)
292 SF

TYPICAL TWO BED ROOM UNIT LAYOUTS

SCALE: 1/4" = 1'-0"

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BAYVIEW SKILLED NURSING FACILITY
JOHNS HOPKINS BAYVIEW CAMPUS

Milestone	Date
PRELIMINARY DESIGN	7/27/11

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Sheet Title:
TYPICAL UNIT LAYOUTS

A421.2

Appendix D

The Star Quality Rating System

Strengths and Limitations of the Five-Star Ratings
Like any information, the Five-Star rating system has strengths and limits. Here are some things to consider as you compare nursing homes.

Health Inspection Results
Strengths:

- Comprehensive: The nursing home health inspection process looks at all major aspects of care in a nursing home (about 180 different items).
- Onsite Visits by Trained Inspectors: It is the only source of information that comes from a trained team of objective surveyors who visit each nursing home to check on the quality of care, inspect medical records, and talk with residents about their care.
- Federal Quality Checks: Federal surveyors check on the state surveyors' work to make sure they are following the national process and that any differences between states stay within reasonable bounds.

Limits:

- Variation between States: There are some differences in how different states carry out the inspection process, even though the standards are the same across the country.
- Medicaid Program Differences: There are also differences in state licensing requirements that affect quality, and in state Medicaid programs that pay for much of the care in nursing homes.

TIP: The best comparisons are made by looking at nursing homes within the same state. You should be careful if you are trying to compare a nursing home in one state with a nursing home in another state.

Staffing
Strengths:

- Overall Staffing: The quality ratings look at the overall number of staff compared to the number of residents and how many of the staff are trained nurses.
- Adjusted for the Population: The ratings consider differences in how sick the nursing home residents are in each nursing home, since that will make a difference in how many staff are needed.

Limits:

- Self-Reported: The staffing data are self-reported by the nursing home, rather than collected and reported by an independent agency.
- Snap-Shot in Time: Staffing data are reported just once a year and reflect staffing over a 2 week period of time.

TIP: Quality is generally better in nursing homes that have more staff who work directly with residents. It is important to ask nursing homes about their staff levels, the qualifications of their staff, and the rate at which staff leave and are replaced.

Quality Measures
Strengths:

- In-Depth Look: The quality measures provide an important in-depth look at how well each nursing home performs on ten important aspects of care. For example, these measures show how well the nursing home helps people keep their ability to dress and eat, or how well the nursing home prevents and treats skin ulcers.
- National Measures: The ten quality measures we use in the Five-Star rating are used in all nursing homes.

Limits:

- Self-Reported Data: The quality measures are self-reported by the nursing home, rather than collected and reported by an independent agency.
- Just a Few Aspects of Care: The quality measures represent only a few of the many aspects of care that may be important to you.

TIP: Talk to the nursing home staff about these quality measures and ask what else they are doing to improve the care they give their residents. Think about the things that are most important to you and ask about them, especially if there are no quality measures that focus on your main concerns.