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July 20, 2015

VIA FIRST CLASS MAIL AND HAND DELIVERY

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

Re: **St. Mary's Long Term Care, LLC d/b/a**
Blue Heron Nursing and Rehabilitation Center
Docket No. 13-18-2348
Exceptions to Recommended Decision

Dear Mr. McDonald:

With this letter, we are submitting six copies of the Exceptions to Recommended Decision on behalf of the applicant in the above-referenced matter. I hereby certify that a copy of these Exceptions has also been forwarded to the appropriate local health planning agency, as noted below.

Sincerely,

Howard L. Sollins

HLS/lam
Enclosures

cc: Mr. Paul Parker
Ms. Linda Cole
Mr. Joel Riklin
Meenakshi Brewster, Health Officer
Suellen Wideman, Assistant Attorney General
Marta D. Harting, Esquire
Henry E. Schwartz, Esquire
Mr. Mark Fulchino
Ms. Melissa Warlow
Mr. Andrew L. Solberg
John J. Eller, Esquire

IN THE MATTER OF	*	**BEFORE THE**
ST. MARY'S LONG TERM CARE, LLC	*	**MARYLAND HEALTH**
BLUE HERON NURSING AND	*	**CARE COMMISSION**
REHABILITATION CENTER	*	**DOCKET NO. 13-18-2348**

* * * * * * * * * * * *

EXCEPTIONS

St. Mary's Long Term Care, LLC d/b/a Blue Heron Nursing and Rehabilitation ("Blue Heron"), through undersigned counsel, takes exception to findings in the Recommended Decision on the above-captioned certificate of need ("CON") application (the "Recommended Decision"). Blue Heron submits these exceptions because its CON application is in compliance with the Maryland Health Care Commission's ("MHCC") CON review criteria under COMAR 10.24.01.08G(3) (the "CON Criteria") and the applicable Long Term Care Chapter at COMAR 10.24.08 (the "Chapter") in the State Health Plan ("SHP"), and therefore should be approved.

Denying the Blue Heron application means that St. Mary's County residents will be deprived of a new, state-of-the-art 90-bed comprehensive care facility ("CCF") with a continuum of care including 30 on-site assisted living beds, that offers a range of post-acute services not presently available in the County. Its services are completely congruent with, and an enhancement of, efforts to reduce reliance on hospital services and to reduce readmissions. The Recommended Decision denies approval even though the two existing facilities are occupied in excess of 90% and the overall and aging population in St. Mary's County is growing.

OVERVIEW

Blue Heron submitted its CON application on the basis of the MHCC's seven-year precedent in the manner in which the agency identified the need for CCF beds, resulting in an updated, published need for 192 CCF bed and a notice inviting CON applications to meet it. That notice was bolstered by MHCC regulatory language that mandated that the need projection in effect when the letter was filed would govern the review. This led to Blue Heron expending substantial resources to acquire site control, prepare a CON application, navigate the completeness process, and respond to all Interested Party comments. This CON was nearly complete when a new bed need projection was published and a ruling given that this changed projection would be applied in the current review. Blue Heron then voluntarily modified its project to remove 50 proposed beds from its original application in an effort to reach out to the Interested Parties. Even after the discussion about the bed need projection commenced, a site visit was conducted, which demonstrated the differences between the project Blue Heron proposes and the existing facilities.

The Recommended Decision's approach to the changed bed need projection is not only unfair; it is in inconsistent with the MHCC's own regulations. Acceptance of Blue Heron's exception on the need projection would not only ensure a result that is consistent with the applicable regulation, but would allow the MHCC to evaluate the true needs of St. Mary's County residents for the specific 90-bed CCF Blue Heron proposes.

The Recommended Decision suggests that all CCFs operating as Medicare and Medicaid skilled nursing facilities are alike, irrespective of their services, physical

plants, age or other aspect and that need is simply an arithmetic exercise. Blue Heron proposes to augment the local health care delivery system with a third choice for CCF services, in a way that the two existing CCFs do not provide. This was evident from the newly revised bed need projection is no barrier to the MHCC considering and confirming the need for the Blue Heron project.

The Recommended Decision properly finds Blue Heron to be in compliance with many of the CON Criteria and Chapter standards. Where the Recommended Decision asserts noncompliance, it is apparent that this flows from a misapplication of the Chapter's bed need projection provision. The Recommended Decision, on page 2 of the Summary of Recommendations," describes these as "reinforcing factors" flowing from the bed need projection. The need projection ties to the finding on "cost effectiveness" as well as to the "financial feasibility" analysis.

Blue Heron filed a CON application for a 140-bed CCF, in reliance on the 192-bed need identified by the MHCC for St. Mary's County. While it justifiably is within its rights to receive CON approval for that facility, in an effort to compromise and address Interested Party concerns about the size of its facility, Blue Heron modified its project to seek only 90 CCF beds, in a facility that would also offer 30 assisted living beds. Not only do these 90 beds offer an array of high acuity services and physical plant and service amenities not available in either of the other two CCFs, but the number of beds is substantially less than the applicable bed need.

As explained in its initial application on pages 8-9, 33-34, 43 and 62-63 (Exhibit 1) and as reiterated on Replacement Pages 33b and 34 of its modified application, Blue Heron will offer St. Mary's County senior services related to:

- Cardiac Rehabilitation/ Pulmonary Rehabilitation
- Integumentary/Chronic Wound Care
- Orthopedic Rehabilitation following:
    - Joint Replacement
    - Spinal Surgery
    - Amputation
- Management of chronic disease, renal disease, respiratory disease
- Management of cardiac disease
- Management of complex medical or surgical conditions, such as:
    - Transplant
    - General surgery
    - Polytrauma
- IV Therapy
- Rehabilitation relating to Neurological conditions, such as:
    - Head injury
    - Stroke
    - Traumatic brain injury
    - Alzheimer's / Parkinson's
- Oncology
- Pain management
- Infectious disease
- Diabetes Management
- The MSU Model

- Your Choice 365, providing personal choice in important aspects of daily life, such as meals.

The Recommended Decision, on pages 17 and 18, summarizes substantial service and design amenities Blue Heron will offer. Blue Heron will provide this array of post-acute services in a one-story building with multiple day rooms, outside, accessible, protected areas and a large therapy space with state-of-the-art equipment. Its facility will include piped-in gases and a medical vacuum, providing the capability to provide high acuity respiratory therapy. Blue Heron includes rooms with private bathrooms and showers, an internet café, and small refrigerators and microwaves in some rooms to facilitate resident choice and nutrition in a more home-like setting. This is a configuration not otherwise available at other St. Mary's County facilities. Of its 90 CCF beds, 46 will be in private rooms, not only providing an important personal choice for residents seeking that setting, but also enhancing the availability of infection control in a post-acute setting. Hospitals have moved to private rooms for this reason and, so too, Blue Heron offers a facility that has the capability to accept hospital discharges and prevent readmissions due to infection control issues. By co-locating 30 assisted living beds alongside 90 CCF beds, Blue Heron also provides a capability for couples with differing needs to be in the facility together and for easier transition to assisted living after a CCF stay.

Blue Heron's position on the bed need projection provides the MHCC with an opportunity to provide the residents of St. Mary's County with a third option for CCF services in a way that expands access and choice, and offers an array of beneficial, high-acuity services with many amenities enhancing quality of life. Rather than ignoring

realities, the Blue Heron application addresses the reality of how CCF services are being, and could be, delivered in St. Mary's County.

Blue Heron takes exception to findings that it does not comply with the Chapter's Bed Need Standard under COMAR 10.24.08.05A(1) and the CON Criterion addressing need under COMAR 10.24.01.08G(3).

The Recommended Decision notes that the CON Criterion under "need" requires that the Commission consider the SHP's applicable need projection. It states, on page 35, that the basis for a finding of inconsistency is tied to the applicable need projection. Thus, it is evident from the Recommended Decision that if the Commission's own SHP Chapter identifies a need for the 90 CCF beds Blue Heron is seeking to implement as part of a new facility with an additional 30 assisted living beds, the need criterion is also met.

As stated on page 9 of the Recommended Decision, this CON review is based on the bed need projection in effect when the letter of intent ("LOI") is filed with the MHCC, which reflects the regulatory requirements governing CON reviews. Blue Heron substantially relied upon this rule, as well as the MHCC's notice inviting proposal for CCF beds in St. Mary's County because a need exists.

The MHCC identified a substantial need for CCF beds in St. Mary's County for 7 years. It published in the March 16, 2007 Maryland Register a notice that 124 beds were needed in the jurisdiction. The MHCC accepted, docketed and approved a prior CON application for a new CCF on the identical site for which Blue Heron now seeks approval. On September 18, 2008, the MHCC awarded a CON to the Point Lookout project, Docket No. 07-18-2201, approving the construction of a 124-bed CCF. The MHCC successfully defended its determination in the face of opposition by the same

Interested Parties as in the current CON review, up to and including obtaining a favorable ruling of the Maryland Court of Special Appeals. The Point Lookout project was withdrawn by that applicant, for reasons it then explained relating to the major downturn in the economy.

Blue Heron filed its LOI on February 26, 2013. By letter dated April 12, 2013, over two years ago, the MHCC advised Blue Heron that an updated bed need projection would be published in the April 19, 2013 Maryland Register showing 192 CCF beds are needed in St. Mary's County by 2016, that a CON review schedule would be established and the MHCC would hold the Blue Heron Letter of Intent for review under that schedule. The MHCC published its notice on April 19, 2013. Blue Heron resubmitted a LOI on August 2, 2013, seeking only a portion of the needed beds, proposing a [140 bed] CCF.

Under the MHCC's rules in the SHP Chapter, which have been adopted as regulations, the 192-bed need projection governs the current CON review.

Blue Heron rightly has continued to rely substantially on the MHCC's published need projection. Blue Heron:

- Devoted internal and external resources to developing its CON application which was filed on October 4, 2013.
- Responded to three sets of questions from the MHCC seeking additional information leading to the docketing of its application on February 7, 2014. The need projection remained at 192 beds.
- Responded to Interested Party comments on March 25, 2014. The need projection remained at 192 beds.

It was not until June 27, 2014 that Blue Heron was advised that the MHCC identified an error in its bed need projections, i.e. long after the LOI was filed, after the MHCC had published a notice of bed need set a CON review schedule for projects to meet that need, and only after the MHCC accepted and docketed the Blue Heron application based on the substantial work and expenditure of resources expended to complete it.

Uncertainty about the revised bed need projection going forward remains; Adoption of the change through regulatory amendment would be required.

Uncertainty about the MHCC's position on the bed need number has continued. In the Reviewer's June 27, 2014 letter, he indicated the bed need was 39 beds, not 192 beds. The MHCC published a new notice of bed need in the July 25, 2014 Maryland Register, asserting that the bed need was 39 beds. Thereafter, the bed need projection changed yet again. In the October 3, 2014 Maryland Register, a year after Blue Heron filed its CON application, the MHCC published a new notice finding a need for 14 beds. In a September 8, 2014 memo from Mr. Paul Parker to Commissioner Fronstin, Mr. Parker identified six separate errors that had been made in the projections. Some of these were "typographical errors" that Mr. Parker said would be corrected in the next iteration of the SHP chapter. Blue Heron filed a letter on November 19, 2014 (Exhibit 2) explaining that the MHCC's new projection of a need for 14 beds continued to be incorrect, as the MHCC failed to follow the narrative description of its methodology in respect to inmigration from out-of-state. Blue Heron demonstrated that, had the MHCC not made the error, the need would be 23 beds. This error is explained as well in the modification to its application at Replacement Page 33 (Exhibit 3) that Blue Heron filed on February 9, 2015.

As Blue Heron explained, the MHCC has continued to make an error in its newer calculation in Step 4(d), which states:

> Step (4)(d) When the jurisdiction of residence is an adjacent state,
> 1. sum the base year patient days for each age group and Jurisdiction of residence for a given jurisdiction of care,
> 2. multiply the base year patient days for each age group by the population growth rate in that age group, and ...

The MHCC only counted the change in patient days, not the net result of that change. In the description of the methodology on page 21 of the State Health Plan section, the Methodology Assumptions are listed. Under (3) Migration Assumptions, it says:

> (b) Migration into Maryland from the adjacent states of Delaware, the District of Columbia, Pennsylvania, Virginia, and West Virginia is taken into account in estimating bed need, by assuming that the current pattern of migration from these adjacent states into Maryland will increase in the future at their projected rate of population growth.

This confirms that the MHCC's SHP Chapter clearly intended that the rate of change in population be applied to the base year's volume, and use adjusted base year's volume as the projected volume. The MHCC did not do that. The MHCC clearly left out a step in applying its methodology. BHNRC calculated that the actual need is 23 beds. However, whereas the MHCC stated that it would apply the errors that it had identified (even though they must be corrected in the next iteration of the SHP chapter), it refused to correct the projection error identified by Blue Heron.

Consequently, on December 2, 2014, Commissioner Fronstin wrote to the parties (Exhibit 4) indicating no further changes in bed need projections can be made in response to Blue Heron's November 19, 2014 letter and memorandum because such changes would not entail correction of computational errors, but instead would require amendments to the State Health Plan need projection formula. Blue Heron takes

exception to this ruling. It likewise takes exception to the finding that Blue Heron has not demonstrated need, as stated on page 27 on the Recommended Decision. Blue Heron's November 19, 2014 letter identified a misapplication of the formula the MHCC claimed to be using to change the bed need projection from 192 beds. If the errors identified its November 19, 2014 letter represent changes that would require an amendment to the SHP Chapter, the same is true of the other corrections being made to the bed need number; i.e., then all of the changes to the bed need number should have been part of a prospective amendment to the bed need projection in the Chapter. The change cannot rightly be made in a piecemeal manner. Blue Heron is not asserting that the bed need is 23 beds, nor does it accept that it is 14 beds, or 39 beds. The key point is that if the MHCC believes that a change to the MHCC bed need projection to address the issues Blue Heron raised requires a change to the Chapter, the same is true for the change to the approach to the bed need projection that was used consistently and defended by the MHCC for 7 years.

It is also clear that the Chapter dictates that the 192 bed need projection that was in effect when Blue Heron filed its LOI remains in effect. Blue Heron takes exception to the Recommended Decision's conclusion, summarized on page 13, that the applicable bed need projection in this CON review is 14 beds.

The Recommended Decision's Analysis and Findings on this issue, found on pages 11-13, is based on the plain meaning of the relevant provisions of the Chapter, which is itself a regulation under COMAR 10.24.08. By no means is Blue Heron seeking to lock the MHCC into a "mechanical" application of the bed need projection rules. Rather, as Blue Heron demonstrated in its initial and modified application, the data support a bed need in excess of the 90 beds sought for this project. By using a portion of the 192 bed need to approve the 90 beds requested, the MHCC will be

meeting the community need for the services Blue Heron will offer to St. Mary's County residents. The MHCC is not locked into a 14 bed need projection and it has the present opportunity to approve a new facility offering a deep range of post-acute services.

A ruling in favor of Blue Heron based on an appropriate, valid application of the plain language of the SHP Chapter will rectify a unique situation, enabling the MHCC to exercise its judgement about the needs of the community for the type of CCF Blue Heron proposes to offer. In two places under COMAR 10.24.08.05A(1) and 10.24.08.07K(4), the Chapter assured Blue Heron that the 192 bed need projection in effect when its LOI was filed will govern this CON review (Exhibit 5).

COMAR 10.24.08.05A(1) provides expressly that the "bed need in effect when the Commission receives a letter of intent for the application will be the bed need projection applicable to the review." Blue Heron acknowledges the language of COMAR 10.24.08.07K(3), which states: "Published projections remain in effect until the Commission publishes updated nursing home bed need projections, and will not be revised during the interim other than to incorporate inventory changes or to correct errors in the data or computation."

However, immediately following that provision, the Chapter reiterates, at COMAR 10.24.08.07K(4): "Published projections and Commission inventories in effect at the time of submission of a letter of intent will control projections of need used for that Certificate of Need review."

A cardinal rule of regulatory (and statutory) construction requires reliance on the plain language of the regulation, and ordinary, popular understanding of the English language dictates interpretation of its terminology. *Kushell v. Dep't of Natural Res.*, 385

Md. 563, 576-77 (2005) (citation omitted). The plain language of a provision is analyzed within the regulatory scheme as a whole to harmonize provisions dealing with the same subject so that each may be given effect. *Kushell*, 385 Md. at 577 (citations omitted). Further, as declared in *Farmers & Merchants Nat. Bank of Hagerstown v. Schlossberg*, 306 Md. 48, 63 (1986), "[i]t is well settled that when two statutes [or here, provisions within the same chapter of regulations], one general and one specific, are found to conflict, the specific statute will be regarded as an exception to the general rule." (Citations omitted).[1]

By its own language, the regulation on which SMNC and Chesapeake Shores rely refers to revisions that are made "during the interim." Based on the context of this term, it is abundantly clear that "interim" refers to the period between CON reviews, not the midst of a CON review. Second, the regulations state a second time, immediately following and in the same part of the same regulation, that applicants may rely on the published CCF bed need projection when the LOI is filed. Thus, the plain reading of the regulation makes clear that the assurance governs all CCF CON reviews. Otherwise, this assurance would not have been reiterated twice, for the avoidance of doubt, once specifically and then, separately, as part of the methodology description. The only logical and consistent way to harmonize the provisions stating that the bed need projection will be maintained with that allowing for revision or correction is to

[1] In their comments, the Interested Parties relied on *Schlossberg* in stating that one provision of a regulation must be harmonized with the others to avoid nullifying that provision, suggesting that COMAR 10.24.08.07K(3) should not be nullified (ignoring that their interpretation calls for nullification of the specific exception provided in COMAR 10.24.08.07K(4), whereas under the correct interpretation both can exist and be given effect). Even so, that case is inapposite; there, the court found that two distinct statutes were irreconcilable, and applied the rule that the statute whose relevant provisions were enacted most recently repeals, by implication, any conflicting provisions of the earlier statute. Here, however, the language exists within the very same part of the same regulation as an exception to the general rule, purposefully complementing the regulatory scheme, and so it is not irreconcilable therewith.

recognize the former for what it is - - a separate, binding part of the application of the methodology. This specific, separate assurance governs irrespective of the general language on updates of the methodology. The plain language of the methodology is that, even if there are updates to published need projections during the course of a review, those changes do not apply to a pending CON review where applicants filed in reliance on the projection in effect on the LOI date.

Adhering to the plain language of the MHCC's own Chapter in no way divests the MHCC of its authority to assess the need for the Blue Heron project. It simply means the MHCC is not hamstrung by the newer bed need projection published finally a year after Blue Heron filed its CON application. It is not Blue Heron that seeks a mechanical application of the bed need projection. Rather, it is the Recommended Decision that would have the Commission wrongly impose upon itself a mechanical application of a new bed need projection to foreclose any ability to assess what St. Mary's County residents need.

Need for the Blue Heron Project Was Established

In this regard, Blue Heron did not rest only on the 192 bed need projection. To the contrary, it provided a bed need analysis in its initial application as well as on pages 33a-35 of its modified application (Exhibit 5). As Blue Heron explained, there is a need for 115 beds in St. Mary's County:

> Table 2 shows that the number of Comprehensive Care Days in the two relevant St. Mary's County existing facilities in FY 2011 was 93,714. When divided by 2011 St. Mary's County's 65+ population[2], this converts to 8.3 days per person.[3] When this is

[2] Interpolated from the MDP 2010 and 2015 population using the Compound Average Growth Rate ("CAGR").

[3] Blue Heron recognizes that this is not a true use rate. However, patient origin data do not exist.

multiplied by the MDP projected population for 2020, there is a projected need for 418 beds (at 90% occupancy), 115 more beds than exist today.

Table 2
2011 St. Mary's County Comprehensive Care Use Rates
Applied to 2020 Population, Age 65+
St. Mary's County

2011 65+ Pop.	11,244
2011 Comp Care Days	93,714
Days/Person	8.3
2020 65+ Pop	16,460
2020 Comp Care Days	137,184
ADC	376
Beds	418
Existing Beds	303
Net Needed	115

Sources: Population based on MDP population estimates and projections
Patient days are from the MHCC Public Use Data for 2011

In its Background discussion, commencing on page 5, the Recommended Decision acknowledges that St. Mary's County's population grew at a much faster rate than the overall State population, i.e. 22% vs. 9%. It noted the substantial historical growth of the population age 85+ over the period 2001-2010, i.e. at 65.8%, and characterized a future change to 2010 as a "slowing" to 39%. But, the chart supplied with the narrative notes that that even at that rate the St. Mary's population age 85+ will still exceed the State population growth rate. Moreover, simply because the 85+ population used nursing home beds at a greater rate, it is the population 65+ that is most relevant, particularly given the increasing use of CCFs to avoid hospitalizations and rehospitalizations including for rehabilitation patients. The narrative provided does not note that the population from 65-74 is projected to increase from a historical 45.3% to 79.2% and for the population from 75-84 there is a projected increase from a historical 17.7% to

56.9%. This trend means there will be substantially increased numbers of St. Mary's County residents age 65+ seeking CCF services.

The Recommended Decision asserts that these data are "baked into" the bed projections. But, the Recommended Decision did not address the fact that the data show that the St. Mary's County CCF use rate of 8.3 has historically been suppressed based on a comparison for the entire State. As noted on page 35 of its modified application:

Table 3 shows that the statewide 2011 "use rate" was 12.4, compared to 8.3 for St. Mary's County.

Table 3
2011 Comprehensive Care Use Rates
State of Maryland

2011 Comp Care Days	9,092,292
2011 65+ Pop.	732,419
Days/Person	12.4

There are no indications that a use rate that is 33% lower than the statewide average is appropriate. (12.4-8.3 =4.1; 4.1/12.4 = 0.331) These data suggest that the need for beds is, and will be, higher than the current usage indicates. If the statewide use rate is applied to the St. Mary's 2020 65+ population, the use rate is considerably larger.

Table 4
2011 Statewide Comprehensive Care Use Rates
Applied to 2020 Population, Age 65+
St. Mary's County

Days/Person	12.4
2020 65+ Pop	16,460
2020 Comp Care Days	204,335
ADC	560
Beds	622
Existing Beds	303
Net Needed	319

This conclusion that the St. Mary's County use rate is out of kilter is supported by Table 3 on page 8 of the Recommended Decision, which shows how the occupancy percentages in St. Mary's County are materially lower than the Southern Maryland Region and the State as a whole. These data support the conclusion that St. Mary's County has a rising population overall, and a rising population among 65+ at rates that are faster than the State of Maryland while its use rates for CCF services are lower. This validates Blue Heron's assertion that the two existing, older, St. Mary's County facilities are not sufficiently meeting community needs and that there is a need for a third, modern, CCF equipped to handle high acuity patients with complex medical needs in a setting with greater numbers of private rooms, private baths with showers, co-located with assisted living beds.

Blue Heron acknowledges the Recommended Decision's discussion on page 26 about differences in demand among the various bands of the elderly. It notes the higher utilization of CCF services among the population age 85+. This simply means that the utilization of CCF services is mainly driven by that portion of the senior population, whether in St. Mary's County (although, in St. Mary's County, the population age 75-84 generates almost the same number of patient days as the 85+ population) or Statewide. Thus, whether one uses the population age 65+ or only the population age 85+, the disparity in use rates would remain. The Recommended Decision refers to a "slowing" of the rate of growth among the population age 85+, but that is only a slowing in the rate of increase. Moreover, that St. Mary's County rate of increase still is projected to exceed the statewide projected rate of increase for seniors age 85+.

With respect to outmigration, the data referenced on page 27 of the Recommended Decision was only for 2009. There was no trending of migration data over a period of years. What is known from Table 2 and 3 on pages 7 and 8 of the Recommended Decision is that occupancy rates in St. Mary's County were historically lower than the region or State, even when the population at 65+ including age 85+ was rising faster than the state. That this growing population in need of CCF services was using St. Mary's County CCFs at a lower rate is reliable evidence that the existing CCFs were not meeting the county need for such services. One year's migration data is no trend.

Neither do those data undermine Blue Heron's commitment to provide a wider range of post-acute, high acuity services versus traditional long term care services, i.e. making Blue Heron a greater resource for a younger population than 85+, so a simple equating of Blue Heron's projected utilization with those of the two existing facilities is not fully comparable. It would simply assume that all CCFs, of whatever age, design and services, are completely alike.

Moreover, the Recommended Decision uses data that go back to 2006 to consider occupancy rates, without any reference to the MHCC's own decision in the Point Lookout decision that lower occupancies at the two Interested Party facilities were no barrier to approval of that CON.

In the Point Lookout decision, the MHCC found that the applicant's introduction of programs that are new to the County were a valid consideration in finding a need for the project. Moreover, in the Point Lookout approval, the MHCC approved the CON even though the occupancy standard was not met (which standard is met in this CON

review). The Commission previously held that the lower occupancy of the two Interested Party facilities is no barrier to issuance of a CON for a 3rd CCF that would be larger than the one Blue Heron is proposing. In fact, in the Point Lookout review the MHCC found that the average number of unoccupied beds in the exact same Interested Party facilities supported need for a new CCF. The Commission held:

> In the three year period of FY2005-2007, this number has increased to 22. However, I believe that the long term pattern of population growth in St. Mary's County warrants favorable consideration of this project, which will bring to the jurisdiction a modern comprehensive care facility with programs that foster advancement in treating medically compromised and/or disabled individuals as well as members of the general public whose health has declined to the point where they require long term care.

This finding was valid in the Point Lookout review and it is valid now for Blue Heron. It would be wrong for the MHCC to now use the same occupancies for the same facilities in the same county to conclude that they demonstrate a lack of need for the Blue Heron project.

It would surely represent a mechanical application of the Chapter for the Commission to conclude that because the two, existing, older facilities are not meeting the needs of a fast-growing senior population, a lower bed need projection is appropriate or warranted. It would represent the MHCC locking into a suppressed bed need projection, during a period when the population of seniors is rising fast in the County and there is a statewide initiative to avoid hospitalizations and readmissions, which is a need Blue Heron is developed to meet. It would mean that, unless seniors in the County are willing to use the two, existing, older facilities that lack comparable services and amenities, they will never be allowed the choice of a third, newer facility offering services not available in the County.

Even now, as Table 2 of the Recommended Decision documents, the two existing CCFs are both at nearly 95% and 91% occupancy respectively for 2014.

Acceptance of Blue Heron's position that the 192 bed need projection applies, does not mean the MHCC will need to award 192 CCF beds at all. In fact, given the new, October 3, 2014 bed need projection, no other applicant can in the future assert that the 192 bed need projection applies. Blue Heron reduced its application from 140 to 90 beds. Approving that application complies with the applicable bed need projection according to the plain meaning of the Chapter, enables the MHCC to make a judgement that there is a need for the smaller, high acuity, CCF Blue Heron proposes.

Blue Heron takes exception to the finding on page 38 of the Recommended Decision that its application is not the most cost-effective alternative to meet the projected need for 14 CCF beds in St. Mary's County.

First, the cited standard, under COMAR 10.24.01.08G(3)(c) requires the MHCC to compare the cost effectiveness of the proposed project with the cost-effectiveness of providing the service through alternative existing facilities. The finding on page 38 was that Blue Heron failed to demonstrate it is the "most" cost effective alternative. That is not the applicable standard. Blue Heron's proposal is a cost effective alternative.

Second, whatever the standard, the Recommended Decision did not make any comparison between Blue Heron and the existing facilities based on the services Blue Heron would offer. This is because Blue Heron proposes to offer services that are not available at the other two CCFs in the jurisdiction. It is not enough for the MHCC to simply assume that all CCFs are alike when that is clearly not the case, nor is it in the interest of consumers and the health care delivery system for that to be used as the metric.

The Recommended Decision explained clearly that the major question considered under cost-effectiveness is whether the applicant's project is needed. Thus, the 14 bed need projection, which Blue Heron submits is inapplicable, effectively blocked a cost-effectiveness comparison. The Recommended Decision did not analyze the respective facilities based on their submissions and the site visits, resulting in the absence of an analysis of what it will mean for consumers and the health care delivery system for Blue Heron not to be built.

The only metrics used under the cost-effectiveness standard were satisfaction surveys and licensing and certification survey data. This implies that all CCFs are alike, all meet the same needs of all patients, and all are equally able to take all types of CCF patients and work with local hospitals to prevent admissions and readmissions in the same way. This is not the case. The services Blue Heron outlined in its application and as summarized above in this filing, demonstrate that St. Mary's County would benefit substantially from the availability of the proposed new facility.

Blue Heron takes exception to the finding on page 44 of the Recommended Decision that the applicant has not shown that the project is viable.

On page 43, the Recommended Decision speculates on whether the proposed lender is aware of certain information identified in the decision. In contrast, the Recommended Decision does not ask whether a lender would be interested in funding a 90 bed CCF co-located with 30 assisted living beds, in a market with a population of seniors growing faster than the state (including those age 85+), where there are only two CCFs the newest of which was built more than 30 years ago, where the new facility will have a substantial ratio of private to semi-private rooms, private baths and showers, kitchenette amenities in various rooms, high acuity services not otherwise provided by

other CCFs, all in a setting with significant amenities enhancing the quality of life and services for residents. Simply put, if a lender will not finance the project, it will not be built.

There is simply no reliable basis on which the MHCC should reasonably conclude that the financial experience of other CCFs in the County are a measure of Blue Heron's projected performance. There is nothing in the record to support the use of the revenues and expenses and margins of those two, existing, older facilities with more limited services than what Blue Heron is proposing. The Recommended Decision simply took information from the Medicaid cost reports of the Interested Parties, but the CON review did not include any sort of analysis of the financial operations of the Interested Parties.

Frankly, the fundamental concerns of the Interested Parties have not been that Blue Heron will not be viable, but rather that its success may have implications for the Interested Parties. Blue Heron disagrees because there is need for its 90-bed CCF along with the existing CCFs. Blue Heron presented a strong, comprehensive proposal that offers a third and very desirable choice for CCF care to St. Mary's County residents.

Blue Heron takes exception to the finding, on page 47 of the Recommended Decision that its proposed project will likely have a significant adverse impact on the existing nursing home providers and the county's health care delivery system.

Here too, the Recommended Decision's finding is linked to the applicable need projections. The Recommended Decision rightly concludes that Medicare and Medicaid charges to consumers would not be affected by development of the Blue Heron project. It does find that existing facilities' "unit costs" would suffer a significant negative impact. However, there was nothing in the record to support this finding. There was no

evidence on the Interested Parties' fixed versus variable unit costs. Neither was there any analysis of their ability to manage the effects of competition from a third, smaller CCF in the County. Moreover, the Recommended Decision considered 2007 utilization even though in the Point Lookout decision, utilization during that period was no barrier to the CON approved by the MHCC.

The Recommended Decision noted on page 47, Chesapeake Shores, one of the interested parties, indicated that if its occupancy rate falls below 80%, it would not be able to meet its expenses and would not be viable as a going concern. But, nowhere was it established that Chesapeake Shores' occupancy would fall below 80% occupancy. It is not a valid criticism that Blue Heron did not offer a "contrary analysis" of a completely separate, competing CCF. On what basis could Blue Heron have analyzed another provider's operations? If, as was stated, the Reviewer preferred a more thorough quantification of impact from Chesapeake Shores, the Reviewer had the authority to require Chesapeake Shores to produce one. Blue Heron takes exception to a finding that its project would have such a negative impact on the basis that the Reviewer had no reason to question the Interested Party's claim.

Blue Heron take exception to the finding on page 47 that a reduction of revenue resulting from the development of its project would result in a substantial negative impact. Revenue alone is no valid measure of impact without a consideration of fixed and variable expenses. Nor was there any basis upon which the Reviewer could speculate on the possibility of closure and dislocation of patients. Indeed, the reasonable inference from the Recommendation is that even Chesapeake Shores anticipated that it

could sustain and adjust to an impact up to 80% occupancy, even though Blue Heron does not believe there will be such a negative impact.

The Recommended Decision made no findings that there would be a negative impact on the other Interested Party, St. Mary's Nursing Center.

Moreover, the Recommended Decision made no findings about the implications of approval of the Blue Heron project on MedStar St. Mary's Hospital, which wrote to the MHCC about the Blue Heron project. Not only did the local hospital not oppose the Blue Heron project; the hospital affirmatively advised the MHCC it would work with Blue Heron.

Blue Heron detailed the high-acuity, post-acute services it would be able to provide based on its clinical programs and design. These include ample private rooms, facilitating better infection control without hospitalization, piped in medical gases and medical vacuuming facilitating respiratory care that enables hospital discharges and avoids rehospitalizations, and the other, as well as the array of high acuity services outlined in the introduction to this submission. The Recommended Decision nowhere evaluates how the development of Blue Heron will benefit the health care delivery system by enhancing the ability of the local hospital to achieve its goals under the Health Services Cost Review Commission's Global Budget Revenue agreements.

The MHCC was provided a letter of support from Vinod Shah, M.D., leader of the largest multi-site, multi-specialty medical practice in Southern Maryland. (Exhibit 6). Support from such a major health care provider which plays a key role in the health care delivery system also illustrates the favorable impact of the Blue Heron project. Blue Heron urged review the Shah group's website since it describes the extensive medical

practice Dr. Shah leads, at www.shah-associates.com. As it indicates, Shah Associates is a substantial provider of primary and specialty medical services throughout Southern Maryland. It lists 13 separate practice locations in St. Mary's County and all of the surrounding Southern Maryland jurisdictions. According to a Washington Post article from 2007, "They built the largest private specialty practice in Southern Maryland, Shah Associates, which has treated about 90,000 of St. Mary's 110,000 residents."[4] According to the website, today there are over 100 health care practitioners providing services across an array of specialties. This practice is noted for its participation in both accountable care organization and physician centered medical home models. Dr. Shah is one of Maryland's most prominent practitioners. In Dr. Shah's letter of support, he independently reinforces that Blue Heron's facility will improve the quality of care, clinical outcomes and overall experience of residents, families and employees while reducing hospital readmissions and length of stay. We also note that subsequent to this expression of support, Shah Associates affiliated with MedStar Health. http://www.medstarhealth.org/mhs/2015/05/26/medstar-health-and-shah-associates-sign-agreement-to-expand-collaboration-in-southern-md/#q={}

Blue Heron would augment and support the integration of the health care delivery system in St. Mary's County in ways not addressed by the two existing facilities. This support and coordination with the Shah medical group is nowhere substantively addressed in the Recommended Decision.

Blue Heron submits that the Recommended Decision's consideration of impact on revenues (which are not mentioned in Criterion .08G(3)(f) on two competing CCFs is

[4] The Washington Post article is found at http://www.washingtonpost.com/wp-dyn/content/article/2007/12/06/AR2007120602851.html

not the cost effectiveness analysis the CON Criterion anticipates. Blue Heron will improve geographic and demographic access by adding a third, smaller CCF to St. Mary's County. It will provide access to services in a CCF setting not otherwise available to the community. There was no basis for any finding that non-variable costs of any provider in the community would have a material impact on other providers. The Recommended Decision finds no negative impact on the charges to Medicare and Medicaid, the principal payers, and increased competition will help control private pay rates with only two CCFs now operating both of which at more than 90% occupancy. To the contrary, Blue Heron represents an opportunity for a favorable impact on the health care delivery system by beneficial competition introducing enhanced choice, access, amenities and services, for the benefit of consumers and the health care delivery system as a whole.

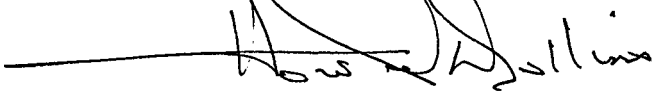
CONCLUSION

St. Mary's County seniors, their families and the health care delivery system will benefit greatly if Blue Heron is permitted to offer a third choice to this fast-growing County. Blue Heron seeks to offer a smaller, 90-bed CCF that will be designed, equipped and staffed to provide a deep array of high acuity services that will avoid hospitalizations, enable effective discharges to its facility and prevent readmissions. This will be done in a facility with greater access to private rooms, private baths with showers, in a setting that enhances personal choice and freedom, with an onsite continuum of care that includes assisted living.

The revised SHP bed need projection is inapplicable to Blue Heron's application, and is not a barrier to approval of the application. It would not only violate the MHCC's

own regulations to apply it in this CON review, it would be deeply unfair to do so. The proper application of the SHP opens the door to a full and fair consideration of the Blue Heron application and all the benefits it provides to the St. Mary's County community and health care delivery system. An assessment of Blue Heron's application leads to the conclusion that it is needed, compliant with all applicable standards and awarded a CON.

Respectfully submitted,



Howard L. Sollins
John J. Eller
OBER, KALER, GRIMES & SHRIVER
A Professional Corporation
100 Light Street
Baltimore, MD 21202

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 20th day of July, 2015, a copy of the foregoing St. Mary's Long Term Care, LLC d/b/a Blue Heron Nursing and Rehabilitation Center's Exceptions was sent via email and first class mail to:

Henry E. Schwartz, Esquire
Henry E. Schwartz LLC
901 Dulaney Valley Road, Suite 500
Towson, Maryland 21204

Marta D. Harting, Esquire
Venable, LLP
750 E. Pratt Street, Suite 900
Baltimore, MD 21202

Suellen Wideman, Esq.
Assistant Attorney General
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Howard L. Sollins

Exhibit 1

MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

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

ALL PAGES THROUGHOUT THE APPLICATION SHOULD BE NUMBERED CONSECUTIVELY.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1.a. St. Mary's Long Term Care, LLC
Legal Name of Project Applicant (ie. Licensee or Proposed Licensee)

b. 920 Ridgebrook Road
Street

c. Sparks | 21152 | Baltimore
City | **Zip** | **County**

d. 410-773-1000
Telephone

e. Kam McGavock
Name of Chief Executive

2.a. St. Mary's Healthcare Realty, LLC
Legal Name of Project Co-Applicant (ie. if more than one applicant)

b. 920 Ridgebrook Road
Street

c. Sparks | 21152 | Baltimore
City | **Zip** | **County**

d. (410) 773-1000
Telephone

e. Ken Tabler (Manager)
Name of Owner/Chief Executive

3.a. Blue Heron Nursing and Rehabilitation Center
Name of Facility

b. 20877 Point Lookout Road
Street (Project Site)

c. Callaway | 20620 | St. Mary's
City | **Zip** | **County**

4.
Name of Owner (if different than applicant)

5.a. Ken Tabler
Representative of Co-Applicant

b.
Street

c. | |
City | **Zip** | **County**

d.
Telephone

developed a full range of services and programs tailored to the needs of the residents. The facility's mission is to provide superior rehabilitative medical care through the use of technologically advanced, clinically sophisticated and scientifically based rehabilitation approaches with integrity, professionalism and compassion while striving to be the provider and employer of choice to the communities.. BHNRC's vision is to be the premier provider of healthcare services; to be the industry leader through innovation of programs and adapting our approaches to the ever changing needs of our communities; and to exceed the expectation of those we serve. BHNRC is dedicated and committed to delivering quality care and a rewarding experience to the individuals and communities we serve. BHNRC will work diligently to treat residents, employees, customers, partners and communities with respect and sensitivity. BHNRC respects all individuals and values their contributions. BHNRC values integrity, compassion, enthusiasm and dedication; focusing on the patients' needs and goals in a holistic model.

Clinical Services

BHNRC will employ talented registered and licensed practical nurses experienced in the fields of sub-acute and long-term care. These skilled professionals work closely with nurse practitioners and certified nursing assistants to provide round-the-clock care and can meet the most complex medical needs.

As the market demands, BHNRC will offer the following programs to St. Mary's County:

- Cardiac Rehabilitation/ Pulmonary Rehabilitation
- Integumentary / Chronic Wound Care
- Orthopedic – Rehabilitation following:
    - Joint Replacement
    - Spinal Surgery
    - Amputation

- Chronic Disease Management
  - Renal disease
  - Respiratory disease
  - Cardiac
- Management of complex medical or surgical conditions, such as:
  - Transplant
  - General surgery
  - Polytrauma
  - IV Therapy
- Rehabilitation relating to Neurological conditions, such as:
  - Head injury
  - Stroke
  - Traumatic brain injury
  - Alzheimer's/ Parkinson's
- Oncology
- Pain management
- Infectious disease
- Diabetes Program

In addition to the above programs, FCOS has implemented a clinical program for Diabetes that is unique in the LTC industry. St. Mary's will participate in this Diabetes program which educates both facility nursing staff and residents on diabetes with a goal of increasing awareness and managing the disease more aggressively to achieve better clinical outcomes e.g. fewer amputations, strokes, loss of vision, neuralgia, and also to reduce rehospitalizations.

The FCOS Diabetes program has two levels of accomplishment to be achieved by a facility; (1) a Diabetes Specialty Facility (DSF) where the facility practices focused diabetic care, staff education and resident awareness and (2) a Diabetes Center of Excellence (DCOE) where the facility raises the bar by improving clinical outcomes through the utilization of clinical outcome goals, requiring advanced nursing education; involving primary care providers and family and providing community outreach. Program components include the utilization of Insulin Pens during a Medicare A / MC stay and the reduction of Insulin Sliding Scale Orders during long term stays. Both components provide better clinical care at a lower cost.

projects that the population in the county will grow by 8.3% between 2010 and 2015 and another 9.9% between 2015 and 2020. However, the 65 years and older age group (the population most in need of nursing home care) is projected to grow at a rate which is two to three times the rate for all age groups (23.5% between 2010 and 2015 and another 23.7% between 2015 and 2020).

Table 1
Population
St. Mary's County
2000, 2010, 2015, and 2020

Age Cohort	2000	2010	% Change 2000-2010	2015	% Change 2010-2015	2020	% Change 2015-2020
0-4	6,237	7,580	21.5%	7,800	2.9%	8,550	9.6%
5-19	20,383	23,220	13.9%	24,400	5.1%	26,140	7.1%
20-44	33,239	35,340	6.3%	37,060	4.9%	41,140	11.0%
45-64	18,527	28,240	52.4%	31,340	11.0%	32,870	4.9%
65+	7,825	10,780	37.8%	13,310	23.5%	16,460	23.7%
Total	86,211	105,150	22.0%	113,900	8.3%	125,150	9.9%

Source: Maryland Department of Planning web site; http://planning.maryland.gov/MSDC/County/stma.pdf; Accessed 09/13/13

In addition, as the market demands BHNRC will offer the following programs to St. Mary's County:

- Cardiac Rehabilitation/ Pulmonary Rehabilitation
- Integumentary / Chronic Wound Care
- Orthopedic – Rehabilitation following:
  - Joint Replacement
  - Spinal Surgery
  - Amputation
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  - General surgery
  - Polytrauma

    - IV Therapy
- Rehabilitation relating to Neurological conditions, such as:
    - Head injury
    - Stroke
    - Traumatic brain injury
    - Alzheimer's/ Parkinson's
- Oncology
- Pain management
- Infectious disease
- Diabetes Management
- The MSU Model
- Your Choice 365

Furthermore, data suggest that residents will need an additional facility in the county. Table 2 shows that the number of Comprehensive Care Days in the two relevant St. Mary's County existing facilities in FY 2011 was 93,714. When divided by 2011 St. Mary's County's 65+ population[1], this converts to 8.3 days per person.[2] When this is multiplied by the MDP projected population for 2020, there is a projected need for 418 beds (at 90% occupancy), 115 more beds than exist today.

Table 2
2011 St. Mary's County Comprehensive Care Use Rates
Applied to 2020 Population, Age 65+
St. Mary's County

2011 65+ Pop.	11,244
2011 Comp Care Days	93,714
Days/Person	8.3
2020 65+ Pop	16,460
2020 Comp Care Days	137,184
ADC	376
Beds	418
Existing Beds	303
Net Needed	115

Sources: Population based on MDP population estimates and projections
Patient days are from the MHCC Public Use Data for 2011

While 115 beds is lower than the MHCC projected, there is evidence that either

[1] Interpolated from the MDP 2010 and 2015 population using the Compound Average Growth Rate ("CAGR").
[2] BHNRC recognizes that this is not a true use rate. However, patient origin data do not exist.

2011 Comprehensive Care Use Rates
State of Maryland

2011 Comp Care Days	9,092,292
2011 65+ Pop.	732,419
Days/Person	12.4

There are no indications that a use rate that is 33% lower than the statewide average is appropriate. (12.4-8.3 =4.1; 4.1/12.4 = 0.331) These data suggest that the need for beds is, and will be, higher than the current usage indicates.

In addition, as the market demands BHNRC will offer the following programs to St. Mary's County:

- Cardiac Rehabilitation/ Pulmonary Rehabilitation
- Integumentary / Chronic Wound Care
- Orthopedic – Rehabilitation following:
  - Joint Replacement
  - Spinal Surgery
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- Your Choice 365

For more information on these services, please see the Project description.

10.24.01.08G(3)(f). Impact on Existing Providers.

For evaluation under this subsection, an applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers.

Indicate the positive impact on the health care system of the Project, and why the Project does not duplicate existing health care resources. Describe any special attributes of the project that will demonstrate why the project will have a positive impact on the existing health care system.

If this project is not approved, residents who require the additional 192 beds that the Commission has projected to be needed in 2016 will clearly have to leave St. Mary's county in order to seek nursing home care.

As stated previously, this project will not have any impact on the costs or charges at other facilities. Given that the additional need is for 192 beds is actually calculated at a percent occupancy of 90%, there should be enough volume of patient days to accommodate BHNRC without affecting existing facilities.

Also, as stated previously, as the market demands BHNRC will offer the following programs to St. Mary's County:

- Cardiac Rehabilitation/ Pulmonary Rehabilitation
- Integumentary / Chronic Wound Care
- Orthopedic – Rehabilitation following:
    - Joint Replacement
    - Spinal Surgery
    - Amputation
- Chronic Disease Management
    - Renal disease
    - Respiratory disease
    - Cardiac
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    - Traumatic brain injury
    - Alzheimer's/ Parkinson's
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- Infectious disease
- Diabetes Management
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- Your Choice 365

For more information on these services, please see the Project description.

In addition, as the market demands BHNRC will offer the following programs to St. Mary's County:

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    - General surgery
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- Rehabilitation relating to Neurological conditions, such as:
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    - Stroke
    - Traumatic brain injury
    - Alzheimer's/ Parkinson's
- Oncology
- Pain management
- Infectious disease
- Diabetes Management
- The MSU Model
- Your Choice 365

Furthermore, data suggest that residents will need an additional facility in the county. Table 2 shows that the number of Comprehensive Care Days in the two relevant St. Mary's County existing facilities in FY 2011 was 93,714. When divided by 2011 St. Mary's County's 65+ population[1], this converts to 8.3 days per person.[2] When this is multiplied by the MDP projected population for 2020, there is a projected need for 418 beds (at 90% occupancy), 115 more beds than exist today.

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Beds	418
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Sources: Population based on MDP population estimates and projections
Patient days are from the MHCC Public Use Data for 2011

[1] Interpolated from the MDP 2010 and 2015 population using the Compound Average Growth Rate ("CAGR").
[2] BHNRC recognizes that this is not a true use rate. However, patient origin data do not exist.

Exhibit 2

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Offices In
Maryland
Washington, D.C.
Virginia

November 19, 2014

Paul Fronstin, Ph.D.
Commissioner Reviewer
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: **St. Mary's Long Term Care, LLC d/b/a**
Blue Heron Nursing and Rehabilitation Center
Docket No. 13-18-2348

Dear Dr. Fronstin:

Thank you for your September 8, 2014 letter in which you provided the detail we had requested supporting the second correction to the comprehensive care facility ("CCF") bed need projection for St. Mary's County, which was subsequently published in the Maryland Register on October 3, 2014 We asked Andrew L. Solberg, the consultant assisting on the pending certificate of need ("CON") application, to evaluate the information provided and to validate the calculations used to update the CCF be need projection.

Attached is a memorandum from Mr. Solberg. In it, he explains why the St. Mary's County CCF bed need projection remains inaccurate. We are copying Paul Parker and Linda Cole on this letter, as they have been involved the prior CCF bed need updates. Our November 10, 2014 letter indicates the applicant's intention to modify its CON application, and requested a 60 day extension of the deadline to do so. We did reserve our position that the bed need projection on the Letter of Intent date remains in effect in this CON review, advising that the modification will include a smaller CCF bed complement. The modified application will address why its bed need projection is valid and approvable. By the same token, we are mindful of your September 8, 2014 letter's reference to the revised CCF bed need projection. Accordingly, we wish to provide this attached memorandum for your consideration, which explains why a further St. Mary's County CCF bed need correction is warranted.

Sincerely,

Howard L. Sollins

Enclosures

cc: Mr. Paul Parker
Mr. Kevin McDonald
Ms. Linda Cole
Mr. Joel Riklin
Meenakshi Brewster, Health Officer
Suellen Wideman, Assistant Attorney General
Marta D. Harting, Esquire
Henry E. Schwartz, Esquire
Mr. Mark Fulchino
Mr. Melissa Warlow
Mr. Andrew L. Solberg
John J. Eller, Esquire

A.L.S. HEALTHCARE CONSULTANT SERVICES
5612 THICKET LANE, COLUMBIA, MARYLAND 21044

MEMORANDUM

TO: Howard Sollins
FROM: Andrew L. Solberg
RE: MHCC Recalculation of Bed Need
DATE: November 13, 2014

I have applied the nursing home bed need methodology as it is described in the State Health plan using the data provided to BHNRC by the MHCC. My calculations matched the MHCC's calculations for every step in their revised projections, except one step. The MHCC has continued to make an error in its calculation in Step 4(d), which states:

Step (4)(d) When the jurisdiction of residence is an adjacent state,

1. **sum the base year patient days for each age group and Jurisdiction of residence for a given jurisdiction of care,**
2. **multiply the base year patient days for each age group by the population growth rate in that age group, and**

Using the age group 0-64 as an example, the MHCC's data show that the only other state from which residents were admitted to nursing homes in St. Mary's County was Washington, D.C.

The MHCC has only counted the change in patient days, not the net result of that change. For example, there were 31 days in 2009. The population of Washington, D.C. in this age group is expected to decline by 7%. This would result in 2,2 fewer days. (31 X -0.07 = -2.17) However, the MHCC has considered the -2.17 the total number of patient days that St. Mary's County can expect from D.C. in 2016, not the net impact of the change. The projected number of days should have been 28.83. (31 - 2.17 = 28.83) The MHCC cannot have intended this.

This error is repeated for all of the out of state admissions to every county.

(410) 730-2664
FAX (410) 730-6775
E-MAIL asolberg@earthlink.net

URATEP33	AGE GROUP	PROJ POP	BASEPOP 2009	SUMLOS 2009	RETRATE	PROJDAY 2016	URATE 200965	OUTDAY 2009	MIGFLAG	DAYS	JurCare	JurRes
8471.752	0-64	439553	472656	118137		104369.9839		31	4D	-2.17112	ST MARYS	WASHINGTON DC
						A	Base Year Pop	472656				
						B	ProjPop	439553				
						C	Growth Rate	-0.07003614				
						D	Base Year Days	31				
						E	D X C	-2.17112022				

In the description of the methodology on page 21 of the State Health Plan section, the Methodology Assumptions are listed. Under (3) Migration Assumptions, it says:

> (b) Migration into Maryland from the adjacent states of Delaware, the District of Columbia, Pennsylvania, Virginia, and West Virginia is taken into account in estimating bed need, by assuming that the current pattern of migration from these adjacent states into Maryland will increase in the future at their projected rate of population growth.

This confirms that the MHCC clearly intended to apply the rate of change in population to the base year's volume, and use adjusted base year's volume as the projected volume. The MHCC did not do that. The methodology clearly left out a step. As stated previously, it should be 28.83, not -2.17.

The table below shows that the total impact of this correction would result in more than ten times the projected number of patient days in St. Mary's County by Out of State residents than the MHCC projected.

URATEP33	AGE GROUP	PROJPOP	BASEPOP 2009	SUMLOS 2009	PROJDAY 2016	OUTDAY 2009	MIGFLAG	DAYS	JurCare	JurRes	Pop Growth Rate	Change in PDs	Total PDs
8471.752	0-64	439553	472656	118137	104370	31	4D	-2.17112	ST MARYS	WASHINGTON DC	-0.07004	-2.17112	28.82888
8471.752	65-74	728604	535013	12080	15628.52	395	4D	142.9282	ST MARYS	VIRGINIA	0.361844	142.9282	537.9282
8471.752	65-74	34661	32148	72727	74491.45	2	4D	0.156339	ST MARYS	WASHINGTON DC	0.07817	0.156339	2.156339
8471.752	75-84	629062	669714	23997	21413.35	365	4D	-22.1557	ST MARYS	PENNSYLVANIA	-0.0607	-22.1557	342.8443
8471.752	75-84	344911	302243	24135	26165.06	730	4D	103.055	ST MARYS	VIRGINIA	0.141171	103.055	833.055
8471.752	75-84	17706	19643	111134	95166.3	365	4D	-35.9927	ST MARYS	WASHINGTON DC	-0.09861	-35.9927	329.0073
8471.752	85+	364942	329133	42628	44902.55	156	4D	16.97248	ST MARYS	PENNSYLVANIA	0.108798	16.97248	172.9725
8471.752	85+	43955	39631	38755	40834.25	365	4D	39.82388	ST MARYS	WEST VIRGINIA	0.109107	39.82388	404.8239
8471.752	85+	158766	130338	51830	59977.9	365	4D	79.61009	ST MARYS	VIRGINIA	0.21811	79.61009	444.6101
8471.752	85+	9413	9755	139131	127540.6	413	4D	-14.4793	ST MARYS	WASHINGTON DC	-0.03506	-14.4793	398.5207
										Total		307.7471	3494.747

Step (5) Calculate the total target year patient days for each jurisdiction of care by summing the target year patient clays for each age group in the jurisdiction of care over all age groups.

The MHCC totaled the number of projected patient days in facilities in St. Mary's County in 2016 at 109,913. If we subtract the 308 patient days that the MHCC calculated for residents from out of state and substitute the 3,495 days that I believe was intended, we arrive at 113,100.

Step (6) Calculate the gross bed need for each jurisdiction of care by dividing the target year patient days for the jurisdiction by the product of 365 and 0.95.

113,100 patient days calculates to 326.2 beds at 95% occupancy.

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

According to Paul Parker's memo to Dr. Fronstin, there are 285 existing beds in St. Mary's County. 326 – 285 = 41 net need.

Step (8) Calculate the number of nursing home beds for which community based services (CBS) will substitute in each jurisdiction of care.

Step (8)(a) Calculate the proportion of total nursing home patient days represented by the patients appropriate for CBS by dividing the CBS days by the total patient days for each jurisdiction of care in the base year.

TOTLOS	LIGHTDAYS	Proportion
95,860	5,325	0.05554976

Step (8)(b) Calculate the number of target year patient days appropriate for CBS by multiplying the target year patient days by the proportion of total nursing home patient days calculated in Step 8(a).

Proj. Days	CBS Proportion	CBS Days
113,100	0.05555	6,282.7

Step (8)(c) Calculate the number of nursing home beds for which CBS will substitute for nursing home beds in each jurisdiction of care by dividing the target year patient days appropriate for CBS by the result of the product of 365 and 0.95.

CBS Days	/365	/.95
6,282.7	17.2	18.1

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

$41 - 18 = 23$

Exhibit 3

February 9, 2015

Via Hand Delivery or First Class Mail
Kevin McDonald, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: St. Mary's Long Term Care, LLC d/b/a
Blue Heron Nursing and Rehabilitation Center
Docket No. 13-18-2348
Modification to Certificate of Need Application

Dear Mr. McDonald:

Pursuant to the December 2, 2014 letter from Commissioner Paul Fronstin, Ph.D., Reviewer in the above-referenced matter, enclosed please find six copies of the Modification to the above-referenced Certificate of Need ("CON") application (the "Modification") being filed on behalf of St. Mary's Long Term Care, LLC d/b/a Blue Heron Nursing and Rehabilitation Center to establish a new comprehensive care facility in St. Mary's County. The Modification provides replacement pages amending the original CON application materials you previously received and Affirmations pertinent to this filing. Duplicates of the drawings in large sizes will be sent under separate cover. A copy of the enclosed materials is also being sent to you in electronic form.

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

Thank you.

Sincerely,

Melissa Warlow

Enclosures

cc: Mr. Paul Parker
Paul Fronstin, Ph.D.
Ms. Linda Cole
Mr. Joel Riklin
Meenakshi Brewster, Health Officer
Suellen Wideman, Assistant Attorney General
Marta D. Harting, Esquire
Henry E. Schwartz, Esquire
Mr. Mark Fulchino
Mr. Andrew L. Solberg
John J. Eller, Esquire

Exhibits

1. CON Application Replacement Pages
2. Affirmations
3. Floor Plan
4. Site Plan
5. Enlarged Resident Room Types

Exhibit 1
CON Application Replacement Pages

Register, Volume 41, Issue 15, Friday, July 25, 2014).. Following a filing by BHNRC, the MHCC, on September 9, 2014, informed BHNRC that the need was only 14 beds (published in *The Maryland Register*, Volume 41, Issue 20, Friday, October 3, 2014). BHNRC requested that the MHCC provide it with the data and calculations on which the 14 bed projected need is based, and the MHCC provided it. On November 19, 2014, BHNRC informed the MHCC that, after reviewing the data and the MHCC's calculations, it found that the MHCC has continued to make an error in its newer calculation in Step 4(d), which states:

Step (4)(d) When the jurisdiction of residence is an adjacent state,

1. **sum the base year patient days for each age group and Jurisdiction of residence for a given jurisdiction of care,**
2. **multiply the base year patient days for each age group by the population growth rate in that age group, and**

The MHCC had only counted the change in patient days, not the net result of that change. In the description of the methodology on page 21 of the State Health Plan section, the Methodology Assumptions are listed. Under (3) Migration Assumptions, it says:

> (b) Migration into Maryland from the adjacent states of Delaware, the District of Columbia, Pennsylvania, Virginia, and West Virginia is taken into account in estimating bed need, by assuming that the current pattern of migration from these adjacent states into Maryland will increase in the future at their projected rate of population growth.

This confirms that the MHCC's State Health Plan clearly intended that the rate of change in population be applied to the base year's volume, and use adjusted base year's volume as the projected volume. The MHCC did not do that. The MHCC clearly left out a step in applying its methodology. BHNRC calculated that the actual need is 23 beds. However, the MHCC refused to make this correction.

Exhibit 4

STATE OF MARYLAND

Craig Tanio, M.D.
CHAIR

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

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

December 2, 2014

By E-Mail and U.S. Mail

Howard L. Sollins, Esquire
John J. Eller, Esquire
Ober, Kaler, Grimes & Shriver
100 Light Street
Baltimore, Maryland 21202

Marta D. Harting, Esquire
Venable LLP
750 Pratt Street, Suite 900
Baltimore, Maryland 21202

Henry E. Schwartz, Esquire
Henry E. Schwartz, LLC
901 Dulaney Road, Suite 400
Towson, Maryland 21204

Re: St. Mary's Long Term Care, LLC
d/b/a Blue Heron Nursing & Rehabilitation Center
Docket No. 13-18-2348
Request for Extension of Filing Date for Modified Application;
Comments re Corrected CCF Bed Need Projection for St. Mary's County

Dear Counsel:

I have reviewed the request for extension of the date for filing a modified CON application made by St. Mary's Long Term Care, LLC d/b/a Blue Heron Nursing & Rehabilitation Center ("Blue Heron") and the response filed by interested party LP Lexington Park, LLC d/b/a Chesapeake Shores ("Chesapeake Shores") opposing this request. I have also considered the November 19, 2014 filing by Blue Heron that encloses a memorandum from its consultant, Andrew L. Solberg, in which he concluded that the corrected and updated comprehensive care facility (CCF) bed need projection published in the *Maryland Register* on October 3, 2014 (Corrected CCF Projections) were inaccurate.

I will first address Mr. Solberg's conclusion, regarding the Corrected CCF Projections. The Corrected CCF Projections published in 41:20 *Maryland Register* 1180 (Oct. 3, 2014) accurately reflect the treatment of migration specified in the formula, COMAR 10.24.08.07J(2)(d), and described in COMAR 10.24.08.07I(4)(d) of the Chapter. The interpretation that Mr. Solberg urges would require amendments to both the description of the

formula and to the formula itself. Such substantive regulatory amendments require action by the full Commission. Thus, I cannot make such changes during the course of this review because, unlike the correction of the 2013 Erroneous Projection for St. Mary's County, the proposed changes would not constitute the correction of computational errors permitted by Subsection .07K(3).

Regarding Blue Heron's request for an additional 60 days in which to file a modified application, I will grant the requested extension despite the objection of Chesapeake Shores. I will grant Blue Heron until February 9, 2015 to file a modified application.

If you have any questions regarding procedural matters, please put your questions in writing by email to Suellen Wideman, Assistant Attorney General, copying all parties.

Sincerely yours,

Paul Fronstin
Commissioner/Reviewer

cc: Paul E. Parker
Kevin McDonald
Joel Riklin
Suellen Wideman, AAG
Meenakshi Brewster, MD, MPH, St. Mary's County Health Officer

Exhibit 5

STATE OF MARYLAND

MARYLAND HEALTH CARE COMMISSION

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

STATE HEALTH PLAN FOR FACILITIES AND SERVICES:

NURSING HOME AND HOME HEALTH AGENCY SERVICES

COMAR 10.24.08

Effective
October 14, 2013

TOLL FREE
1-877-245-1762

TDD FOR DISABLED
MARYLAND RELAY SERVICE
1-800-735-2258

.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.

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

(b) Each applicant shall agree to serve a proportion of Medicaid patient days that is at least equal to the proportion of Medicaid patient days in all other nursing homes in the jurisdiction or region, whichever is lower, calculated as the weighted mean minus 15.5%[3] based on the most recent Maryland Long Term Care Survey data and Medicaid Cost Reports available to the Commission as shown in the ***Supplement to COMAR 10.24.08: Statistical Data Tables***, or in subsequent updates published in the *Maryland Register*.

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

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

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

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

[3] For explanation of the derivation of this percentage, see Statement of Issues and Policies, 3. Consumer Choice above.

K. Update, Correction, Publication, and Notification Rules.

(1) The Commission will update nursing home bed need projections at least every three years and publish them in the *Maryland Register*, including:

(a) Utilization data from the Long Term Care Facility Resident Assessment Instrument's Minimum Data Set for Maryland; and

(b) The most recent inventory prepared by the Commission.

(2) Updated projections published in the *Maryland Register* supersede any previously published projections in either the *Maryland Register* or any Plan approved by the Commission.

(3) Published projections remain in effect until the Commission publishes updated nursing home bed need projections, and will not be revised during the interim other than to incorporate inventory changes or to correct errors in the data or computation.

(4) Published projections and Commission inventories in effect at the time of submission of a letter of intent will control projections of need used for that Certificate of Need review.

Exhibit 6

FUNDAMENTAL®

February 9, 2015

Via Hand Delivery or First Class Mail
Kevin McDonald, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: St. Mary's Long Term Care, LLC d/b/a
Blue Heron Nursing and Rehabilitation Center
Docket No. 13-18-2348
Modification to Certificate of Need Application

Dear Mr. McDonald:

Pursuant to the December 2, 2014 letter from Commissioner Paul Fronstin, Ph.D., Reviewer in the above-referenced matter, enclosed please find six copies of the Modification to the above-referenced Certificate of Need ("CON") application (the "Modification") being filed on behalf of St. Mary's Long Term Care, LLC d/b/a Blue Heron Nursing and Rehabilitation Center to establish a new comprehensive care facility in St. Mary's County. The Modification provides replacement pages amending the original CON application materials you previously received and Affirmations pertinent to this filing. Duplicates of the drawings in large sizes will be sent under separate cover. A copy of the enclosed materials is also being sent to you in electronic form.

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

Thank you.

Sincerely,

Melissa Warlow

Enclosures

cc: Mr. Paul Parker
Paul Fronstin, Ph.D.
Ms. Linda Cole
Mr. Joel Riklin
Meenakshi Brewster, Health Officer
Suellen Wideman, Assistant Attorney General
Marta D. Harting, Esquire
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Mr. Mark Fulchino
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John J. Eller, Esquire

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Exhibit 1
CON Application Replacement Pages

According to the State Health Plan Standard 10.24.01.08G(3)(a)(.05)(A)(1), "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." That was 192 beds. In the original application, BHNRC demonstrated the need for 140 beds. BHNRC believes that all of the subsequent projections of nursing home bed need that the MHCC has published are still not yet completely consistent with its own methodology and are inapplicable to the current review. However, in an effort to compromise, BHNRC is modifying its application to propose a new facility with 90 beds.

Strong population growth in St. Mary's County is still projected to occur. Overall, the Maryland Department of Planning ("MDP") projects that the population in the county will grow by 8.3% between 2010 and 2015 and another 9.9% between 2015 and 2020. However, the 65 years and older age group (the population most in need of nursing home care) is projected to grow at a rate which is two to three times the rate for all age groups (23.5% between 2010 and 2015 and another 23.7% between 2015 and 2020).

Table 1
Population
St. Mary's County
2000, 2010, 2015, and 2020

Age Cohort	2000	2010	% Change 2000-2010	2015	% Change 2010-2015	2020	% Change 2015-2020
0-4	6,237	7,580	21.5%	7,800	2.9%	8,550	9.6%
5-19	20,383	23,220	13.9%	24,400	5.1%	26,140	7.1%
20-44	33,239	35,340	6.3%	37,060	4.9%	41,140	11.0%
45-64	18,527	28,240	52.4%	31,340	11.0%	32,870	4.9%
65+	7,825	10,780	37.8%	13,310	23.5%	16,460	23.7%
Total	86,211	105,150	22.0%	113,900	8.3%	125,150	9.9%

Source: Maryland Department of Planning web site; http://planning.maryland.gov/MSDC/County/stma.pdf; Accessed 09/13/13

In addition, as the market demands BHNRC will offer the following programs to St. Mary's County:

- Cardiac Rehabilitation/ Pulmonary Rehabilitation
- Integumentary / Chronic Wound Care
- Orthopedic – Rehabilitation following:
    - Joint Replacement
    - Spinal Surgery
    - Amputation
- Chronic Disease Management
    - Renal disease
    - Respiratory disease
    - Cardiac
- Management of complex medical or surgical conditions, such as:
    - Transplant
    - General surgery
    - Polytrauma

    - IV Therapy
- Rehabilitation relating to Neurological conditions, such as:
    - Head injury
    - Stroke
    - Traumatic brain injury
    - Alzheimer's/ Parkinson's
- Oncology
- Pain management
- Infectious disease
- Diabetes Management
- The MSU Model
- Your Choice 365

Furthermore, data suggest that residents will need an additional facility in the county. Table 2 shows that the number of Comprehensive Care Days in the two relevant St. Mary's County existing facilities in FY 2011 was 93,714. When divided by 2011 St. Mary's County's 65+ population[1], this converts to 8.3 days per person.[2] When this is multiplied by the MDP projected population for 2020, there is a projected need for 418 beds (at 90% occupancy), 115 more beds than exist today.

Table 2
2011 St. Mary's County Comprehensive Care Use Rates
Applied to 2020 Population, Age 65+
St. Mary's County

2011 65+ Pop.	11,244
2011 Comp Care Days	93,714
Days/Person	8.3
2020 65+ Pop	16,460
2020 Comp Care Days	137,184
ADC	376
Beds	418
Existing Beds	303
Net Needed	115

Sources: Population based on MDP population estimates and projections
Patient days are from the MHCC Public Use Data for 2011

[1] Interpolated from the MDP 2010 and 2015 population using the Compound Average Growth Rate ("CAGR").
[2] BHNRC recognizes that this is not a true use rate. However, patient origin data do not exist.

- Diabetes Management
- The MSU Model
- Your Choice 365

While 115 beds is lower than the MHCC projected, there is evidence that either St. Mary's County residents' use of Comprehensive Care may be suppressed for some reason or that residents are having to travel outside of the County for care. Table 3 shows that the statewide 2011 "use rate" was 12.4, compared to 8.3 for St. Mary's County.

Table 3
2011 Comprehensive Care Use Rates
State of Maryland

2011 Comp Care Days	9,092,292
2011 65+ Pop.	732,419
Days/Person	12.4

There are no indications that a use rate that is 33% lower than the statewide average is appropriate. (12.4-8.3 =4.1; 4.1/12.4 = 0.331) These data suggest that the need for beds is, and will be, higher than the current usage indicates. If the statewide use rate is applied to the St. Mary's 2020 65+ population, the use rate is considerably larger.

Table 4
2011 Statewide Comprehensive Care Use Rates
Applied to 2020 Population, Age 65+
St. Mary's County

Days/Person	12.4
2020 65+ Pop	16,460
2020 Comp Care Days	204,335
ADC	560
Beds	622
Existing Beds	303
Net Needed	319

These projections indicate the need for an additional Comprehensive Care provider in St. Mary's County and support the Commission's own findings of a need for 192 beds in 2016.

Exhibit 7

OBER KALER
Attorneys at Law

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Baltimore, MD 21202
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410.347.7369 / Fax: 443.263.7569

Offices In
Maryland
Washington, D.C.
Virginia

May 20, 2014

VIA ELECTRONIC TRANSMISSION AND REGULAR MAL

Paul Fronstin, Ph.D.
Commissioner Reviewer
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Blue Heron Nursing and Rehabilitation Center
Docket No. 13-18-2348

Dear Dr. Fronstin:

Attached for inclusion in the record of the above-referenced certificate of need review is a strong letter of support from Dr. Vinod Shah. Dr. Shah both expresses support for the project and indicates an interest in developing collaborative relationships with this new facility.

To place this letter in context, we urge you to review the website for the extensive medical practice Dr. Shah leads, at www.shah-associates.com. As it indicates, Shah Associates is a substantial provider of primary and specialty medical services throughout Southern Maryland. It lists 13 separate practice locations in St. Mary's County and all of the surrounding Southern Maryland jurisdictions. According to a Washington Post article from 2007, "They built the largest private specialty practice in Southern Maryland, Shah Associates, which has treated about 90,000 of St. Mary's 110,000 residents."[1] According to the website, today there are over 100 health care practitioners providing services across an array of specialties. This practice is noted for its participation in both accountable care organization and physician centered medical home models. Dr. Shah is one of Maryland's most prominent practitioners.

[1] The Washington Post article is found at http://www.washingtonpost.com/wp-dyn/content/article/2007/12/06/AR2007120602851.html

Dr. Shah's support represents an important endorsement of the facility the applicant is seeking to establish in St. Mary's County, further demonstrating that this additional long term care choice for the community will succeed.

Sincerely,

Howard L. Sollins

Enclosure

cc: Kevin McDonald
Suellen Wideman, Assistant Attorney General
Ms. Ruby Potter
Mr. Mark Fulchino
Mr. Melissa Warlow
Marta Harting, Esq.
Henry Schwartz, Esq.
Mr. Andrew L. Solberg
John J. Eller, Esquire

April 25, 2014

Mr. Kevin McDonald
Chief, Certificate of Need
State of Maryland
Maryland Healthcare Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. McDonald:

I am writing in strong support of the application of St. Mary's Long Term Care, LLC ("St. Mary's") for the Certificate of Need ("CON") for the construction of a 140 bed comprehensive care facility in St. Mary's County. This new facility will be located at 20877 Point Lookout Road and will offer significant value to residents including Medicaid and Medicare beneficiaries while satisfying the need of a rapidly growing population. The proposed design, systems and clinical programs will improve the quality of care, clinical outcomes and overall experience for the residents, family members and employees while reducing hospital readmissions and length of stay.

St. Mary's will be a welcomed addition to our community while creating additional jobs in the county. If the CON is approved, we look forward to establishing certain collaborative relationships with St. Mary's team.

Sincerely,

Dr. Vinod Shah