

OBER KALER
Attorneys at Law

Ober, Kaler, Grimes & Shriver
A Professional Corporation

100 Light Street
Baltimore, MD 21202
410.685.1120 Main
410.547.0699 Fax
www.ober.com

October 4, 2013

Howard L. Sollins
hlsollins@ober.com
410.347.7369 / Fax: 443.263.7569

VIA HAND DELIVERY, EMAIL AND FIRST CLASS MAIL

Joel Riklin, Acting Chief
Hospital Services Policy & Planning/Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2229

Offices In
Maryland
Washington, D.C.
Virginia

Re: **Certificate of Need Application for Establishment
of New Comprehensive Care Facility in St. Mary's County**

Dear Mr. Riklin:

Enclosed please find six copies of a Certificate of Need Application being filed on behalf of St. Mary's Long Term Care, LLC to establish of a new comprehensive care facility in St. Mary's County. Full size copies of the drawings are included with this filing, and smaller copies are included in each CON application. A full copy of the application will also be emailed to you in PDF form.

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

Thank you.

Sincerely,



Howard L. Sollins

JJE/tjr
Enclosures

cc: Meenakshi Brewster, Health Officer
St. Mary's County

Joel Riklin, Acting Chief
Hospital Services Policy & Planning/Certificate of Need
Center for Hospital Services
August 4, 2013
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O B E R K A L E R

cc: Ms. Ruby Potter
Health Facilities Coordination Office
Melissa Warlow, Vice President
Fundamental Administrative Services, LLC
John J. Eller, Esquire

**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

- | | |
|---|---|
| <p>1.a. <u>St. Mary's Long Term Care, LLC</u>
Legal Name of Project Applicant
(ie. Licensee or Proposed Licensee)</p> <p>b. <u>920 Ridgebrook Road</u>
Street</p> <p>c. <u>Sparks</u> <u>21152</u> <u>Baltimore</u>
City Zip County</p> <p>d. <u>410-773-1000</u>
Telephone</p> <p>e. <u>Kam McGavock</u>
Name of Chief Executive</p> | <p>3.a. <u>Blue Heron Nursing and Rehabilitation Center</u>
Name of Facility</p> <p>b. <u>20877 Point Lookout Road</u>
Street (Project Site)</p> <p>c. <u>Callaway</u> <u>20620</u> <u>St. Mary's</u>
City Zip County</p> <p>4. _____
Name of Owner (if different than applicant)</p> |
| <p>2.a. <u>St. Mary's Healthcare Realty, LLC</u>
Legal Name of Project Co-Applicant
(ie. if more than one applicant)</p> <p>b. <u>920 Ridgebrook Road</u>
Street</p> <p>c. <u>Sparks</u> <u>21152</u> <u>Baltimore</u>
City Zip County</p> <p>d. <u>(410) 773-1000</u>
Telephone</p> <p>e. <u>Ken Tabler (Manager)</u>
Name of Owner/Chief Executive</p> | <p>5.a. <u>Ken Tabler</u>
Representative of Co-Applicant</p> <p>b. _____
Street</p> <p>c. _____
City Zip County</p> <p>d. _____
Telephone</p> |

6. Person(s) to whom questions regarding this application should be directed: (Attach sheets if additional persons are to be contacted)

<p>a. <u>Melissa Warlow, Senior Vice President - Transactions and Regulatory Affairs</u> Name and Title Fundamental Administrative Services, LLC</p> <p>b. <u>920 Ridgebrook Road</u> Street</p> <p>c. <u>Sparks 21152 Baltimore</u> City Zip County</p> <p>d. <u>410-773-1176</u> Telephone</p> <p>e. <u>410-773-1321</u> Fax No. Email: melissa.warlow@fundltc.com</p>	<p>a. _____ Name and Title</p> <p>b. _____ Street</p> <p>c. _____ City Zip County</p> <p>d. _____ Telephone</p> <p>e. _____ Fax No. Email:</p>
<p>a. <u>Howard L. Sollins, Esq.</u> Name and Title Ober, Kaler, Grimes, & Shriver</p> <p>b. <u>100 Light Street</u> Street</p> <p>c. <u>Baltimore 21202 Baltimore</u> City Zip City</p> <p>d. <u>410 347-7369</u> Telephone</p> <p>e. <u>443-263-7569</u> Fax No. Email: hlsollins@ober.com</p>	<p>a. <u>Andrew L. Solberg</u> Name and Title A.L.S. Healthcare Consultant Services</p> <p>b. <u>5612 Thicket Lane</u> Street</p> <p>c. <u>Columbia 21044 Howard</u> City Zip County</p> <p>d. <u>410-730-2664</u> Telephone</p> <p>e. <u>410-730-6775</u> Fax No. Email: asolberg@earthlink.net</p>

7. Brief Project Description (for identification only; see also item #14):

Establishment of a new 140 bed nursing home.

8. Legal Structure of Licensee (check one from each column):

<p>a. Governmental <input type="checkbox"/></p> <p> Proprietary <input checked="" type="checkbox"/></p> <p> Nonprofit <input type="checkbox"/></p>	<p>b. Sole Proprietorship <input type="checkbox"/></p> <p> Partnership <input type="checkbox"/></p> <p> Corporation <input type="checkbox"/></p> <p> Subchapter "S" <input type="checkbox"/></p> <p> LLC <input checked="" type="checkbox"/></p>	<p>c. To be Formed <input type="checkbox"/></p> <p> Existing <input checked="" type="checkbox"/></p>
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9. Current Licensed Capacity and Proposed Changes:

Service	Unit Description	Currently Licensed/ Certified	Units to be Added or Reduced	Total Units if Project is Approved
Comprehensive Care	Beds	<u> 0 </u> / <u> 0 </u>	140	140
Assisted Living	Beds	<u> </u> / <u> </u>		
Extended Care	Beds	<u> </u> / <u> </u>		
Adult Day Care	"Slots"	<u> </u> / <u> </u>		
Other (Specify)		<u> </u> / <u> </u>		
		<u> </u> / <u> </u>	140	140

10. Community Based Services Provided by Facility:

	Existing/Proposed
Respite Care Program (Yes/No)	<u> </u> / <u> Yes </u>
Dedicated Respite Beds (Number)	<u> </u> / <u> No </u>
Congregate Meals (Yes/No)	<u> </u> / <u> No </u>
Telephone Reassurance (Yes/No)	<u> </u> / <u> No </u>
Child Day Care (Yes/No)	<u> </u> / <u> No </u>
Transportation (Yes/No)	<u> </u> / <u> No </u>
Meals on Wheels (Yes/No)	<u> </u> / <u> No </u>

11. Project Location and Site Control:

- A. Site Size 6 acres
- B. Have all necessary State and Local land use approvals, including zoning, for the project as proposed been obtained? YES X NO (If NO, describe below the current status and timetable for receiving necessary approvals.)

 Zoning is VMX. A nursing home is permitted in a VMX zoning by right.

- C. Site Control:

- (1) Title held by: Purchase and Sale Agreement is currently being negotiated by St. Mary's Healthcare Realty, LLC (Buyer) and St. Mary's Nursing Home, LLC.
- (2) Options to purchase held by: _____
 (i) Expiration Date of Option _____
 (ii) Is Option Renewable? _____ If yes, Please explain
-
- (iii) Cost of Option _____
- (3) Land Lease held by: _____
 (i) Expiration Date of Lease _____
 (ii) Is Lease Renewable? _____ If yes, please explain
-
- (iii) Cost of Lease _____
- (4) Option to lease held by: _____
 (i) Expiration date of Option _____
 (ii) Is Option Renewable? _____ If yes, please explain
-
- (iii) Cost of Option _____
- (5) If site is not controlled by ownership, lease, or option, please explain how site control will be obtained St. Mary's Long Term Care, LLC will lease the facility for St. Mary's Healthcare Realty, LLC

Project Description

1. Fundamental

St. Mary's Long Term Care, LLC ("St. Mary's") d/b/a Blue Heron Nursing and Rehabilitation Center ("BHNRC") will be the operator/licensee of the new comprehensive care facility to be built. The property on which the facility will be located will be under contract to St. Mary's Healthcare Realty, LLC who will build the facility and lease it to St. Mary's. Both lease costs and construction costs are provided in this application to allow appropriate Commission review of the project.

BHNRC will be operated by St. Mary's and all staff of the facility will be employees of St. Mary's. St. Mary's will contract with Fundamental Administrative Services, LLC ("FAS") for administrative support services, including all financial services and back office functions. BHNRC will contract with Fundamental Clinical and Operational Services, LLC ("FCOS") for clinical support services, including development of clinical policies and procedures, clinical education and health information management services. The relationship with FAS and FCOS will enable the facility to contract for services that will improve clinical outcomes and operating and financial efficiency.

FAS and FCOS are privately-held companies that provide administrative and clinical consulting services to skilled nursing facilities, long-term acute care hospitals, hospices, out-patient clinics and other health care service providers. FAS and FCOS are active members of the American Healthcare Association (AHCA) and all state healthcare associations in which their clients operate.

FAS and FCOS represent over 100 years of combined experience in the following sectors:

- Skilled Nursing Facilities (SNFs)
- Home Nursing
- Home Oxygen and DME
- Sub-Acute Centers
- Long Term Acute Care Hospitals (LTACs)
- Assisted Living Facilities
- Institutional Pharmacy
- Geriatric Psychology
- Hospice
- Durable Medical Equipment

The Fundamental family of companies consists of approximately 10,475 beds in 12 states and over 10,250 employees.

Certain subsidiaries within the Fundamental family of companies operate Skilled Nursing Facilities in the following states:

Texas	38
South Carolina	12
Nevada	7
New Mexico	4
Kansas	3
Pennsylvania	3
Missouri	12
All Other States*	<u>4</u>
Total:	83

* Other states include IL (1), MI (1), NH (1), WI (1)

Certain subsidiaries within the Fundamental family of companies operate a continuum of care model encompassing the following business lines:

Operating Units:

Skilled Nursing Facilities	83
Assisted Living Facilities	2
Group Home (MR)	1
Long-Term Acute Care Hospital	8
Geri-psych facilities	1
Outpatient Rehab Clinics	7
Hospice	<u>2</u>
Total:	104

Programs at FCOS client facilities are resident-centered. FAS and FCOS have

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.

The philosophy of providing the best comprehensive care to residents is employed through the Medical Specialty Unit Model (“MSU”). FCOS will assist St. Mary’s in establishing a “MSU”. The MSU is designed to provide specialty physical medicine services at a high level of clinical sophistication in a setting that is innovatively designed, technologically advanced and aesthetically pleasing to patients, employees and their caregivers. The MSU can take many structural forms and provide a variety of specialized clinical programs but the core mission is always the same: to provide to our clients superior rehabilitative medical care through the use of technologically advanced, clinically and scientifically based physical medicine approaches with integrity, professionalism and compassion. An MSU is based on an acute physical medicine model of care where treatment is delivered to address a specific complex medical or rehabilitative condition. The care provided with a comprehensive and holistic focus that aims to improve the patient’s overall health and wellness over the long term. The MSU is designed for short-term stay patients that require comprehensive, complex care and rehabilitation services. Another important component of the MSU is the comprehensive outcome tracking, the analysis and reporting of outcomes to continuously strive for improvement. To accomplish this goal, the MSU must expand its focus beyond that of a traditional healthcare facility that focuses on a disease process in a patient from admission through discharge and instead focus on the individual patient’s overall wellness from the precondition stage through the post discharge stages. The model also includes the use of Nurse Practitioners to identify and assess changes in a resident’s condition, to act quickly and decisively. The Nurse Practitioner can respond to changes by writing orders for treatments, medications and other medical interventions, as necessary. The Program

provides a consistent and solid process to monitor treatment adjustments, changes in condition and the overall well being of each resident on a daily basis. Utilizing Nurse Practitioners improves clinical care and services by treating issues in the facility before they become acute.

Positive outcomes translate into:

- A shorter length of stay and a faster, safer return to the most appropriate level of care
- Reduced hospital readmissions
- Enhanced functional abilities that allow the patient to be discharged and remain at the least restrictive and most appropriate setting

Rehabilitation Services

The FCOS Physical Medicine Departments (PMD) provide specialty physical medicine services at a high level of clinical sophistication in a setting that is most conducive to full physical, cognitive and spiritual healing for clients and their caregivers. These PMDs can take many structural forms and provide a variety of specialized clinical programs depending on individual client and community needs but the core mission is always the same: to provide to clients superior rehabilitative medical care through the use of technologically advanced, clinically expert and scientifically based physical medicine approaches. The FCOS physical medicine model of care is physician specialist driven and multidisciplinary in nature where person centered treatment is delivered to address a specific complex medical or rehabilitative challenge but provided with a comprehensive and holistic focus that aims to improve the patient's overall health and wellness.

To this end, all clients admitted to an FCOS PMD program are collaboratively assessed by all Physical Medicine Team members to include physician, nursing, social

services and the full complement of rehabilitation therapy specialists - Physical Therapy (PT), Occupational Therapy (OT) and Speech Language Pathology (SLP). The collaborative Rehabilitation Team assessment focuses on establishing a comprehensive plan of care that will achieve the most efficient and effective amelioration of the primary and secondary conditions, impacting comorbidities, primary symptoms, functional impairments and psychosocial challenges. Each client's treatment program is carefully and collaboratively designed with input from primary team members, client and client caregivers and external medical consultants as indicated. Treatment programs are carefully monitored relative to goals established and precisely adjusted as needed to achieve the most satisfactory transition to the next appropriate level of care and/ or discharge to community with full resolution of presenting challenges.

Your Choice 365

Your Choice 365 is a person-centered care program designed by FCOS. St. Mary's will utilize this program at BHNRC. The program focuses on the residents and their caregivers, enabling them to transform the facility into not just a "home-like" environment but actually making it "home" within a community environment. In person-centered care, relationships between staff and residents are at the heart of care. The facility will honor those relationships through consistent assignments in which teams of staff work together with groups of residents on a steady, on-going basis. In supporting normal life for residents, staff help people get up according to their life-long patterns, eat their meals as they have been accustomed to at home, and go about their daily activities in a way that feels and is "at-home" for them. Person-centered care empowers residents to direct their own care and empowers the caregivers to be

responsive to the needs of the residents. Person-centered care takes the decision-making of everyday activities away from the institution and places it in the hands of the residents and the staff who care for them. For people to awake on their own accord requires a reorientation of the systems for the nursing staff, housekeeping, food service and laundry. The facility will typically experience a reduction in anti-anxiety meds when people have a better start to their day, better nutritional status, and numerous other health improvements associated with adapting to residents' natural rhythms.

The core person-centered values of *Your Choice 365 Program* are:

- Choice
- Respect
- Purposeful living
- Traditions
- Dignity
- Self-determination
- Community
- Customs

The *Your Choice 365* program includes some common elements but also allows the facility to develop special projects that will be unique to them. The program focuses on the following areas:

- The Language of Culture
- Culinary Services
- Community Life
- Environment
- Workplace Practices
- Special Projects

Examples of programming within the 365 Your Choice program include the

following:

- Welcome Center (Lobby)
- Welcome Program for New Residents
- Community Outreach
- Community Partners
- Culinary Options
- Family Social Events
- Indoor Garden Space
- Intergenerational Programming
- Neighbor Volunteer Program
- Developing Neighborhoods within the facility
- Neighbors' Rooms
- Outdoor Environment (simple to more complex such as mobility or healing garden)
- Peer Mentoring
- Recruitment and Retention
- Sleep, awake at residents requests.
- Spa-Style Bathing

Dietary Services – Culinary Element of the Your Choice 365

Within the Your Choice 365 program is the culinary element. Maintaining a healthy diet is important to the residents' quality of life. The Registered Dietician will work with culinary experts to meet individual resident requirements. At the center of every home is **FOOD!** A large part of the program focuses on socialization around an easily accessible, selective, liberalized meal with more freedom of dining timeframes in a more pleasant environment. Resident satisfaction is key.

The Culinary Element of the 365 Day Program includes the following:

- Provide Culinary Options: Family-style dining service, Buffet-style dining service, Restaurant-style dining service, Room service
- Liberalize restrictive diet orders (requires physician approvals*).

- Dining rooms with attractive china and flatware, tablecloths or placemats, centerpieces, decorations, enhanced lighting.
- Provide an “Always Offered” list of food choices available daily.
- Provide homemade soup as a choice at lunch and/or dinner.
- Provide mobile snack carts with a variety of snacks and beverages.
- Extend dining hours at one or more meals per day or per week. Extend meal hours over at least a 2-hour period to allow neighbors the opportunity to eat on demand at a time of their choosing.
- Allow neighbors to rise and eat a “No Rush” breakfast at a time of their choosing.
- Prepare and serve vegetables and/or herbs grown in gardens tended by residents.

The facility will provide a more homelike style of dining, offering more choices and flexibility. Food is often the heart of our home, one of life’s daily pleasures, which nourishes the soul as well as the body. This means there is a strong connection between the concept of home and food. To prepare a satisfying meal, both the ingredients and the individual consuming it must be respected in order to strive to serve “home cooking.”

Person-centered culinary programs are all about ensuring there are choices based on the interests and preferences of the resident. This can foster independence, encourage friendships and enhance nourishment. The quality of the dining experience can affect satisfaction with overall community living. Noise control is an important component of dining enhancement since most people find noise distressing, especially during mealtime.

House-Keeping and Laundry Services

Housekeeping and laundry is also an integral part of Your Choice 365 program.

The coordination of preparing rooms, maintaining a clean environment, providing linens and caring for resident's clothing is all centered on the residents schedule not the staff's schedule.

Social Services

The support of a social worker can assist residents and their families in easing the transition from home or acute setting to the facility. Individual conferences and support groups offer everyone a time to become familiar with the resident's treatment plan.

For those residents and patients who are able to return home or to a setting of lesser care, the social worker will coordinate home care services and the delivery of needed medical equipment and medical prescriptions any other service that is prescribed by the resident's physician.

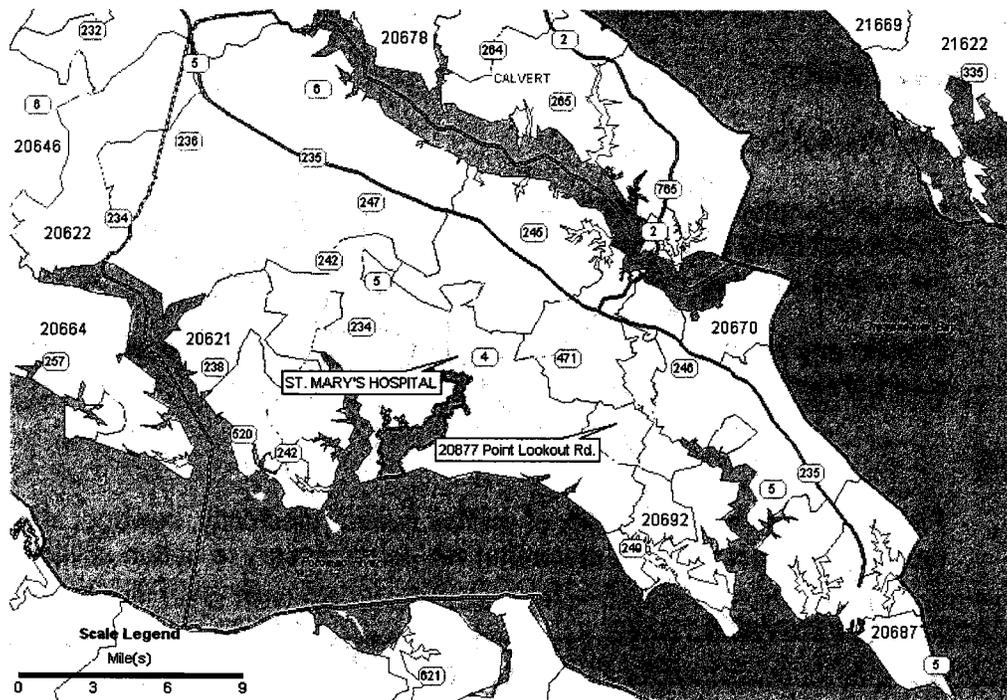
Recreation Services

Being a resident does not mean being inactive. BHNRC will offer a variety of recreational and social programs. Activities and outings are scheduled each week and include arts and crafts, musical events, Wi games, church services, and more. Residents can develop a new hobby or interest. The Restorative program is also an essential part to activities. Aides participate with residents in activities so that they can assess their activities in daily living (ADLs) to ensure that residents maintain the strength and endurance they need.

Resident Councils give each resident a voice in the life of the facility. From making suggestions for menu selections to holiday parties, BHNRC will encourage residents to shape their world through the Your Choice 365 program.

2. The Project

BHNRC will be a new 140 bed nursing home, located in Callaway, approximately 8 miles and 11 minutes driving time from St. Mary's Hospital which is in Leonardtown.



BHNRC will be comprised of 140 Comprehensive Care beds and will include:

- post-operative care
- infusion therapy
- tube feedings
- wound care
- pain management
- diabetic management
- dementia care
- palliative care

BHNRC will provide the clinical, rehabilitation, and other FCOS programs described previously. BHNRC will benefit from the experience, systems and programs available to it through its contracts with FAS and FCOS.

15. Project Drawings:

Projects involving renovations or new construction should include architectural schematic drawings of plans outlining the current facility (if applicable), the new facility (if applicable) and the proposed new configuration. These drawings should include:

- 1) the number and location of nursing stations,

- 2) approximate room sizes,
- 3) number of beds to a room,
- 4) number and location of bath rooms,
- 5) any proposed space for future expansion, and
- 6) the "footprint" and location of the facility on the proposed or existing site.

Please see Exhibit 1.

16. Features of Project Construction:

A. Please Complete "**CHART 1. PROJECT CONSTRUCTION CHARACTERISTICS**" describing the applicable characteristics of the project, if the project involves new construction.

B. Explain any plans for bed expansion subsequent to approval which are incorporated in the project's construction plan.

None

C. Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities.

All utilities are available on site.

Chart 1. Project Construction Characteristics and Costs		
Base Building Characteristics	Complete if Applicable	
	New Construction	Renovation
Class of Construction		
Class A		
Class B		
Class C		
Class D		
Type of Construction/Renovation		
Low		
Average		
Good		
Excellent		
Number of Stories		
Total Square Footage	63,990	
Basement		
First Floor	63,990	
Second Floor		
Third Floor		
Fourth Floor		

Perimeter in Linear Feet		
Basement		
First Floor	2,748	
Second Floor		
Third Floor		
Fourth Floor		
Wall Height (floor to eaves)		
Basement		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Elevators		
Type	<i>Passenger</i>	
<i>Freight</i>		
Number		
Sprinklers (Wet or Dry System)	Wet in facility. Dry in porte-cocheres	
Type of HVAC System	Resident Rooms (and some appropriate perimeter spaces) will have through-wall PTACs. Corridors, activity areas, and most other spaces will have split-systems.	
Type of Exterior Walls	Wood or Metal studs with a combination of brick veneer and vinyl siding.	
Chart 1. Project Construction Characteristics and Costs (cont.)		
	Costs	Costs
Site Preparation Costs (Total)	1,450,000	\$
Normal Site Preparation*	760,000	
Demolition		
Storm Drains	185,000	
Rough Grading	125,000	
Hillside Foundation		
Terracing		
Pilings		
Offsite Costs (Site Costs)		\$
Roads	100,000	
Utilities		

Jurisdictional Hook-up Fees	10,000	
Signs (Site Costs)	20,000	\$
Landscaping (Site Costs)	250,000	\$
Porte-cocheres (Building-3 of them)	125,000	

*As defined by Marshall Valuation Service. Copies of the definitions may be obtained by contacting staff of the Commission.

PART II - PROJECT BUDGET

(INSTRUCTION: All estimates for 1.a.-d., 2.a.-h., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. Use of Funds

1. Capital Costs:

a. New Construction

(1)	Building	<u>\$8,650,000</u>
(2)	Fixed Equipment (not included in construction)	<u>\$0</u>
(3)	Land Purchase	<u>\$1,675,000</u>
(4)	Site Preparation	<u>\$1,450,000</u>
(5)	Architect/Engineering Fees	<u>\$380,000</u>
(6)	Permits (Building, Utilities, Etc.)	<u>\$30,000</u>

SUBTOTAL \$12,185,000

b. Renovations

(1)	Building	<u> </u>
(2)	Fixed Equipment (not included in construction)	<u> </u>
(3)	Architect/Engineering Fees	<u> </u>
(4)	Permits (Building, Utilities, Etc.)	<u> </u>

SUBTOTAL \$0

c. Other Capital Costs

(1)	Major Movable Equipment	<u>\$325,000</u>
(2)	Minor Movable Equipment	<u>\$1,100,000</u>
(3)	Contingencies	<u>\$500,000</u>
(4)	Other (Specify)	<u>\$10,000</u>

SUBTOTAL \$1,935,000

TOTAL CURRENT CAPITAL COSTS (a - c) \$14,120,000

d. Non-Current Capital Costs

(1)	Inflation	<u>\$400,000</u>
(2)	Capitalized Construction Interest	<u>\$400,000</u>

TOTAL PROPOSED CAPITAL COSTS \$14,920,000

(a - e)

2. Financing Cost and Other Cash Requirements:

a. Loan Placement Fees	\$150,000
b. Bond Discount	<u> </u>
c. Legal Fees, Printing, etc.	\$70,000
d. Consultant Fees	<u> </u>
CON Application Assistance	\$25,000
Other (Purchase bed rights)	<u> </u>
e. Liquidation of Existing Debt	<u> </u>
f. Debt Service Reserve Fund	<u> </u>
g. Principal Amortization Reserve Fund	<u> </u>
h. Other	<u> </u>
TOTAL (a - h)	<u> \$245,000 </u>
3. <u>Working Capital Startup Costs</u>	<u> \$1,000,000 </u>
TOTAL USES OF FUNDS (1 - 3)	<u> \$16,165,000 </u>

B. Sources of Funds for Project:

1. Cash	<u> \$1,565,000 </u>
2. Pledges:Gross less allowance for uncollectable = Net	<u> </u>
3. Gift, bequests	<u> </u>
4. Interest income (gross)	<u> </u>
5. Authorized Bonds	<u> </u>
6. Mortgage	<u> \$13,600,000 </u>
7. Working capital loans	<u> \$1,000,000 </u>
8. Grants or Appropriation	<u> </u>
(a) Federal	<u> </u>
(b) State	<u> </u>
(c) Local	<u> </u>
9. Other (Specify)	<u> </u>
TOTAL SOURCES OF FUNDS (1 - 9)	<u> \$16,165,000 </u>

Lease Costs:

a. Land	\$ <u> </u> x <u> </u> = \$ <u> </u>
b. Building	\$ <u> \$112,500 </u> x <u> 12 </u> = \$ <u> \$1,350,000 </u>

- c. Major Movable Equipment
- d. Minor Movable Equipment
- e. Other (Specify)

\$ _____	x _____	= \$ _____
\$ _____	x _____	= \$ _____
\$ _____	x _____	= \$ _____

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

(INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G(3). Each criterion is listed below.)

10.24.01.08G(3)(a). The State Health Plan.

List each standard from the Long Term Care chapter of the State Health Plan (COMAR 10.24.08) and provide a direct, concise response explaining the project's consistency with that standard. In cases where standards require specific documentation, please include the documentation as a part of the application. (Copies of the State Health Plan are available from the Commission. Contact the Staff of the Commission to determine which standards are applicable to the Project being proposed.)

.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.

COMAR 10.24.08, "State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services," identifies a need for 192 Comprehensive Care beds in St. Mary's County in 2016.

(2) *Medical Assistance Participation.*

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

Maryland Long Term Care Survey data and Medicaid Cost Reports available to the Commission as shown in the Supplement to COMAR 10.24.08: Statistical Data Tables, or in subsequent updates published in the Maryland Register.

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

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

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

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

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

BHNRC will participate in the Medical Assistance Program. Prior to licensure, BHNRC will 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. On December 28, 2012, the MHCC published the Required Maryland Medical Assistance Participation Rates for Nursing Homes by Region and Jurisdiction: Fiscal Year 2011 in the *Maryland Register*, requiring a Medicaid percentage of 44.72 percent.

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

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

(b) Initiating discharge planning on admission; and

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

BHNRC will provide information to all prospective residents about the existence of alternative community-based services, including but not limited to Medicaid home and community-based waiver programs, home care, medical day care, assisted living, and other initiatives to promote care in the most appropriate settings. Please see Exhibit 2 for examples of such material distributed at other FCOS client facilities. (NOTE: These will be submitted at a future date.)

BHNRC will initiate discharge planning on admission as part of its development of the Patient Care Plan. Please see Exhibit 3, which includes FCOS Discharge Planning Policy.

BHNRC will 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.

(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.

Recognizing the unique health care requirements and preferences of citizens in their earlier years of growth FCOS/Department of Physical Medicine employs a full and comprehensive age appropriate, person centered evaluation process to precisely

identify all areas of resident needs to include various aspects of the physical, spiritual, cognitive, functional and psychosocial domains. The process of precisely identifying all areas of resident need for age appropriate and person centered care is conducted with the primary goal of delineating upon admission, in collaboration with each resident, the most clinically efficient pathway to the least restrictive and psychosocially conducive setting possible.

To achieve this end FCOS/Department of Physical Medicine will deploy a variety of internal facility and external community resources that address challenged areas identified for each resident upon admission and included immediately in the discharge planning pathway. Each resident will participate in the process of identifying care priorities that will allow him or her to achieve full recovery while maintaining autonomy through self-expression and choice - a primary tenet of person centered care delivery models. Physical and functional challenges will be addressed through one on one therapeutic programs delivered by Physical, Occupational and Speech Therapists in an environment that is condition appropriate and exclusive on a age specific level. Spiritual health will be managed collaboratively through internal resources, family and caregiver participation as well as community advisors and spiritual health practitioners. Cognitive health will be managed through a variety of mechanisms to include physician directed care provided by Social Services, Occupational Therapy and Speech Therapy as well as by consulting team members from the community to include psychiatry, psychology and other behavioral health practitioners. Similar to cognitive and spiritual health, psychosocial health will be addressed by a variety of physician directed internal services and external consultants. Psychosocial health will also be addressed using a fully developed plan for community reintegration established jointly between

rehabilitation therapists, therapeutic recreation specialists, social service practitioners and various other specialists as needed such as vocational rehabilitation counselors, lifestyle guides and practitioners of spiritual health.

All aspects of care will be carefully planned for each individual resident, comprehensively mapped from admission through discharge, precisely accounted for through individual clinician notes/ team care conferences and routinely referenced to resident goals with the ever present objective being to optimize citizen recovery and expedite transition to the next most appropriate stage of recovery and setting.

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

(a) In a new construction project:

- (i) Develop rooms with no more than two beds for each patient room;**
- (ii) Provide individual temperature controls for each patient room;**
- and**
- (iii) Assure that no more than two residents share a toilet.**

(b) In a renovation project:

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

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

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

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

water system.

BHNRC's site is served by a public water system.

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

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

(b) Citation from the long term care literature, if available, on what types of design features have been shown to best serve those types of residents;

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

BHRNC's core mission is to provide specialized and comprehensive medical rehabilitative services and as such the facility aesthetic is specifically designed to be conducive to providing a motivating, inspiring and comforting environment that facilitates healing. This is achieved through the use of natural light, open air spaces, incorporation of nature and the purposeful use of materials, fabrics, textures and designs that appeal to the various senses. Recognizing that patient autonomy, privacy and connectivity are paramount to all citizens but particularly those in this demographic, the physical plant elements are designed from the citizen's perspective which starts from the citizen's bed and extends outward toward the bathrooms, the hallways around the citizens' room, the rehabilitation gym, the nurses station and finally the entrance to and exit from the unit and/or facility. To achieve the most autonomous, private and connected environment, citizens have access to various areas that allow for small group activities, quiet areas for reflection/ solace, private areas for family or care giver gatherings and areas for independent pursuit of preferred leisure activities. Natural

elements are included in care processes to the degree desired by each citizen through the availability of outdoor spaces and coordinated activities. Connectivity is encouraged through the provision of private, small group and large group spaces that can accommodate a variety of events and activities. Connectivity is also facilitated through the provision of wireless internet services and access to various other multimedia. Various other important structural elements are addressed below to include specific facility lay out features as well as specific measures to address safety, comfort of visitors and noise.

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

None of BHNRC's principals have ever pled guilty to, or been convicted of, a criminal offense in any way connected with the ownership, development, or management of a health care facility.

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

FAS is working on establishing collaborative relationships with local providers and physicians. Prior to opening, BHNRC will also make efforts to establish relationships with other providers in St. Mary's County, such as the Local Area Office on Aging and:

Assisted Living

- Schuyler House
- Charlotte Hall Veterans Home
- Del-Ros Place of Care
- Praise Housing Network

- St. Mary's Home for the Elderly Inc
- Taylor Farm Assisted Living Home,
- Taylor Farm Assisted Living, Inc.
- Taylor Farm Assisted Living, Inc.

Hospice

- Hospice of St. Mary's at St. Mary's Hospital

Home Health Agencies Serving St. Mary's County

- Chesapeake Potomac Home Health Agency, Inc.
- HomeCall Prince George's County
- Johns Hopkins Pediatrics at Home
- Southern Maryland Home Health Services, Inc.

Adult Medical Day Care Facilities

- St. Mary's Cty Medical Adult Day - V. Ripple Ctr

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(l)-(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.

In 2007, the Commission promulgated nursing home projections as part of its State Health Plan chapter, COMAR 10.24.08, "State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services." The MHCC

identified a need for 124 Comprehensive Care beds in St. Mary's County in 2011. A Certificate of Need was approved for 124 beds, despite the opposition of the two existing providers in the county. (See In the Matter of Point Lookout Nursing Center, Docket No. 07-18-2201) The Commission determined that there was need for an additional nursing home in St. Mary's County.

"I find that the proposed project is a reasonable and consistent response to the applicable need analysis established by the State Health Plan and, as such, conforms with the requirements of this criterion. As previously discussed, the SHP's case for more nursing home beds in St. Mary's County can be called into question by the average number of unoccupied beds in the jurisdiction in the two facilities that serve the general public. In the three year period of FY2003-2005, the average number of empty CCF beds in the county was 11. 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."

See Final Decision, pg. 27

The existing providers in the county then filed a judicial appeal of the MHCC's approval. After a protracted court review of the decision, the MHCC's decision was upheld. Prior to the end date of the first performance requirement, however, the applicant determined to not proceed with the project and relinquished the CON.

In November 2012, the MHCC promulgated an update of its need projections for Comprehensive Care beds to 2016. It found that there is a need for 192 Comprehensive Care beds in St. Mary's County, 54.8% more need than it found in 2007. ($192/124 = 1.548$) The Commission has emphatically affirmed its continuing position that there is a continuing need for more nursing home beds in the county.

The population growth that was one of the clear bases of Point Lookout decision 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			% Change 2000-2010		% Change 2010-2015		% Change 2015-2020	
	2000	2010	2010	2015	2015	2020	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+ population¹, 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.

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.

(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.

Not applicable. BHNRC is not an existing facility.

(3) Jurisdictional Occupancy.

(a) The Commission may approve a CON application for a new nursing home only if the average jurisdictional occupancy for all nursing homes in that jurisdiction equals or exceeds a 90 percent occupancy level for at least the most recent 12 month period, as shown in the Medicaid Cost Reports for the latest fiscal year, or the latest Maryland Long Term Care Survey, if no Medicaid Cost Report is filed. Each December, the Commission will issue a report on nursing home occupancy.

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

According to the Commission's most recent Public Use Database FY 2011, The two facilities in St. Mary's County have the following occupancy³:

**Table 5
2011 Comprehensive Care % Occupancy
Nursing Homes in St. Mary's County**

	Lic Beds (BDO2011)	Lic Beds (EDO2011)	Total Patient Days_Comp	Calculation for Comp Care Patient Days	% Occupancy
St. Mary's Nursing Center, Inc.	180	180	53,655	65,700	81.7%
Chesapeake Shores	120	123	40,059	44,802	89.4%
Total	300	303	93,714	110,502	84.8%

³ Charlotte Hall Veterans Home is not included because of the specialty nature of the facility. It accepts only veterans and their spouses. Further, Charlotte Hall accepts residents from all over the state and is not a local St. Mary's County nursing home.

Chesapeake Shores is nearly at 90 percent occupancy, and the Commission has found in the past that such cases essentially meet the standard.

BHNRC believes that this standard should not apply for the following reasons:

1. The Commission recently found a need for an additional 192 beds.
2. The difference between the St. Mary's County occupancy (84.8%) and 90% is less than 16 beds. (110,502 (Calculation for Comp Care Patient Days) X .9 = 99,452; 97,452 – 93,714 (Total Patient Comp. Days) = 5,738; 5,738/365 = 15.7)
3. The fact that 16 beds were not filled should not deprive the residents of St. Mary's County of a state of the art, new nursing home that will meet the Commission's projected need for 192 beds.
4. Both existing facilities are older facilities.
5. Approval of this application will enhance availability of choice for St. Mary's County residents in this fast-growing county.

(4) Medical Assistance Program Participation.

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

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

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

(d) An applicant for nursing home expansion or replacement of an existing facility must modify its MOU upon expansion or replacement of its facility to encompass all of the nursing home beds in the expanded facility, and to

include a Medicaid percentage that reflects the most recent Medicaid participation rate.

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

Please see the response to Standard A. (2) "Medical Assistance Participation."

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

Not applicable. BHNRC is not an existing facility.

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

Not applicable. BHNRC is not relocating.

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

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

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

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

Not applicable. BHNRC is not renovating an existing facility.

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

(a) Shall participate in the Medicaid Program;

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

programs or an, innovative nursing home model of care;

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

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

Not applicable. BHNRC is not renovating an existing facility.

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

Not applicable. BHNRC is not renovating an existing facility.

10.24.01.08G(3)(b). Need.

For purposes of evaluating an application under this subsection, 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.

Please discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. For applications proposing to address the need of special population groups identified in this criterion, please specifically identify those populations that are underserved and describe how this Project will address their needs.

In 2007, the Commission promulgated nursing home projections as part of its State Health Plan chapter, COMAR 10.24.08, "State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services." The MHCC identified a need for 124 Comprehensive Care beds in St. Mary's County in 2011. A Certificate of Need was approved for 124 beds, despite the opposition of the two existing providers in the county. (See In the Matter of Point Lookout Nursing Center, Docket No. 07-18-2201) The Commission determined that there was need for an additional nursing home in St. Mary's County.

"I find that the proposed project is a reasonable and consistent response to the applicable need analysis established by the State Health Plan and, as such, conforms with the requirements of this criterion. As previously discussed, the SHP's case for more nursing home beds in St. Mary's County can be called into question by the average number of unoccupied beds in the jurisdiction in the two facilities that serve the general public. In the three year period of FY2003-2005, the average number of empty CCF beds in the county was 11. 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.”
See Final Decision, pg. 27

The existing providers in the county then filed a judicial appeal of the MHCC’s approval. After a protracted court review of the decision, the MHCC’s decision was upheld. Prior to the end date of the first performance requirement, however, the applicant determined to not proceed with the project and relinquished the CON.

In November 2012, the MHCC promulgated an update of its need projections for Comprehensive Care beds to 2016. It found that there is a need for 192 Comprehensive Care beds in St. Mary’s County, 54.8% more need than it found in 2007. (192/124 = 1.548) The Commission has emphatically affirmed its continuing position that there is a continuing need for more nursing home beds in the county.

The population growth that was one of the clear bases of Point Lookout decision is still projected to occur. Overall, the Maryland Department of Planning 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 (Reproduced from Above)
Population
St. Mary’s County
2000, 2010, 2015, and 2020**

Age Cohort			% Change 2000-2010			% Change 2010-2015			% Change 2015-2020
	2000	2010	2010	2015	2015	2020	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

Furthermore, data suggest that residents will need an additional facility in the county. Table 4 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+ population⁴, this converts to 8.3 days per person.⁵ 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 4 (Reproduced from Above)
 2011 Comprehensive Care Use Rates
 Applied to 2020 Population
 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 addition, there is evidence that either St. Mary's County residents' use of Comprehensive Care may be suppressed for some reason or that residents have 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 (Reproduced from Above)

⁴ Interpolated from the MDP 2010 and 2015 population using the Compound Average Growth Rate ("CAGR").

⁵ 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
 - 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

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

[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]

TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY

CY or FY (Bold)	Two Most Actual Ended Recent Years		Current Year Estimated	Projected Years (Ending with first full year at full utilization)	
				Yr 1	Yr 2
1. Admissions					
a. ECF					
b. Comprehensive				77	130
c. Assisted Living					
d. Respite Care*					
e. Adult Day Care					
f. Other (Patial Psych Hosp.)					
f. Other (Chronic)					
g. TOTAL	-	-	-	77	130
2. Patient Days					
a. ECF					
b. Comprehensive				28,024	47,450
c. Assisted Living					
d. Respite Care*					
e. Adult Day Care					
f. Other (Patial Psych Hosp.)					
f. Other (Chronic)					
g. TOTAL	-	-	-	28,024	47,450
3. Occupancy Percentage					
a. ECF					
b. Comprehensive				54.8%	92.9%
c. Assisted Living					
d. Respite Care*					
e. Adult Day Care					
f. Other (Patial Psych Hosp.)					
f. Other (Chronic)				54.8%	92.9%
f. TOTAL					

	Two Most Actual Ended	Current Year	Projected Years
--	-----------------------	--------------	-----------------

CY or FY (Bold)	Recent Years		Estimated	(Ending with first full year at full utilization)	
				Yr. 1	Yr. 2
4. Number of Beds					
a. ECF					
b. Comprehensive				140	140
c. Assisted Living					
d. Respite Care*					
e. Adult Day Care					
f. Other (Patial Psych Hosp.)					
f. Other (Chronic)					
g. TOTAL	-	-	-	140	140

* Number of beds and occupancy percentage should be reported on the basis of licensed beds. Respite care admissions, patient days and number of beds should **not** be included in "comprehensive care" or "domiciliary care" categories.

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT

(INSTRUCTION: All applicants should complete this table.)

NOTE: BHNRC has not completed this table, based on guidance from the CON Director on previous CON applications.

CY or FY (Circle)	Projected Years (Ending with first full year at full utilization)			
	20	20	20	20
1. Admissions				
a. ECF				
b. Comprehensive				
c. Assisted Living				
d. Respite Care*				
e. Adult Day Care				
f. Other (Specify)				
g. TOTAL				
2. Patient Days				
a. ECF				
b. Comprehensive				
c. Assisted Living				
d. Respite Care*				
e. Adult Day Care				
f. Other (Specify)				
g. TOTAL				
3. Occupancy Percentage				
a. ECF				
b. Comprehensive				
c. Assisted Living				
d. Respite Care*				
e. Adult Day Care				
f. Other (Specify)				
g. TOTAL				

Table 2 cont.	Projected Years (Ending with first full year at full utilization)			
	20	20	20	20
4. Number of Beds				
a. ECF				
b. Comprehensive				
c. Assisted Living				
d. Respite Care*				
e. Adult Day Care				
f. Other (Specify)				
g. TOTAL				

* Respite care admissions, patient days, and number of beds should **not** be reported under "comprehensive" or "assisted living" categories.

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

For purposes of evaluating an application under this subsection, the Commission shall compare the cost-effectiveness of providing the proposed service through the proposed project with the cost-effectiveness of providing the service at alternative existing facilities, or alternative facilities which have submitted a competitive application as part of a comparative review.

Please explain the characteristics of the Project which demonstrate why it is a less costly or a more effective alternative for meeting the needs identified.

For applications proposing to demonstrate superior patient care effectiveness, please describe the characteristics of the Project which will assure the quality of care to be provided. These may include, but are not limited to: meeting accreditation standards, personnel qualifications of caregivers, special relationships with public agencies for patient care services affected by the Project, the development of community-based services or other characteristics the Commission should take into account.

Providing The Service At Alternative Existing Facilities

As stated above, the Commission has found a need for 192 beds. There are two existing facilities in St. Mary's County, neither of which has submitted competing CON applications to accommodate these beds. Neither facility would be able to meet the need of 192 additional beds without a major construction project. As kitchen and other facilities would need to be expanded to accommodate 192 additional beds, BHNRC suggests that the cost of construction per square foot would be comparable, no matter who is the applicant. If one of the existing facilities had chosen to replace their existing structures, as well, the project costs would have been even higher.

Since neither existing facility submitted a CON application to build these beds, it is difficult to know what they might have proposed. Therefore, it is difficult to determine if St. Mary's County residents would have the benefits that BHNRC would offer. For example, one does not know if the existing facilities would have proposed a facility with multiple private rooms with private showers to allow maximum patient privacy; multiple dining and activity rooms, multiple entrances and state of the art rehab gym and

mobility gardens such as that proposed for BHNRC.

Cost Effectiveness of Construction

BHNRC’s Project Costs are Reasonable.

As shown below, the cost per square foot for new construction in this project is lower than the MVS benchmark for Convalescent Hospitals. A complete Marshall Valuation Service (“MVS”) analysis is included as Exhibit 4.

**I. Marshall Valuation Service
Valuation Benchmark**

Type	Convalescent Hospital
Construction Quality/Class	D/Good
Stories	2
Perimeter	1,374
Height of Ceiling	10.10
Square Feet	63,990
f.1 Average floor Area	63,990
A. Base Costs	
Basic Structure	158.79
Elimination of HVAC cost for adjustment	0
HVAC Add-on for Mild Climate	0
HVAC Add-on for Extreme Climate	0
Total Base Cost	\$158.79
B. Additions	
Elevator (If not in base)	\$0.00
Other	\$0.00
Subtotal	\$0.00
Total	\$158.79
C. Multipliers	
Perimeter Multiplier	0.95658787
Product	151.8965879

Height Multiplier (plus/minus from 12')	0.953
Product	\$144.76

Multi-story Multiplier (0.5%/story above 3)	1
Product	\$144.76

D. Sprinklers

Sprinkler Amount	2.89
Subtotal	\$147.65

E. Update/Location Multipliers

Update Multiplier	1.09
Product	\$160.94

Location Multiplier	1.04
Product	\$167.38

Final Square Foot Cost Benchmark \$167.38

II. Cost of New Construction

II. The Project

A. Base Calculations	Actual	Per Sq. Foot
New Construction	\$8,650,000	\$135.18
Fixed Equipment	In Building	
Site Preparation	\$1,450,000	\$22.66
Architectural Fees	\$380,000	\$5.94
Capitalized Construction Interest + Loan Placement Fee	\$452,664	\$7.07
Permits	\$30,000	\$0.47
Subtotal	\$10,962,664	\$171.32

However, there are costs that are not included in the MVS benchmark that have to be deducted from the \$10,962,664.

B. Extraordinary Cost Adjustments

	Project Costs	Associated A&E Fees	Associated Cap Interest	Total	
Storm Drains	\$185,000	\$6,960		\$191,960	Site
Rough Grading	\$125,000	\$4,703		\$129,703	Site

Demolition/Deforestation		\$0		\$0	
Site Improvements		\$0		\$0	Site
Landscaping	\$250,000	\$9,406		\$259,406	Site
Roads	\$100,000	\$3,762		\$103,762	Site
Utilities		\$0		\$0	
Jurisdictional Hook-up Fees	\$10,000	\$376		\$10,376	Permits
Signs	\$20,000	\$752		\$20,752	Building
Canopy	\$125,000.00	\$4,703	\$5,384	\$135,087	Building
Total Cost Adjustments	\$815,000	\$30,663	\$5,384	\$851,047	
Per Square Foot				\$13.30	
C. Adjusted Project Cost	\$10,111,617				
Per square foot	\$158.02				

III. Comparison

A. Adjusted Project Cost/Sq. Ft.	\$158.02
B. Marshall Valuation Service Benchmark	\$167.38

The project is consistent with the MVS benchmark.

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

For purposes of evaluating an application under this subsection, the Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frame set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Please include in your response:

- a. Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. The availability of each source of funds listed in Part II, B. Sources of Funds for Project, must be documented.**
- b. Existing facilities shall provide an analysis of the probable impact of the Project on the costs and charges for services at your facility.**
- c. A discussion of the probable impact of the Project on the cost and charges for similar services at other facilities in the area.**
- d. All applicants shall provide a detailed list of proposed patient charges for affected services.**

As BHNRC is a new facility, there are no audited financial statements for prior years.

Exhibit 5 includes a letter attesting to the bank's interest in financing this project.

Exhibit 6 includes a letter attesting that the funds proposed for the equity contribution for this project are available.

This project will have no impact on existing costs or charges at BHNRC, as it is a new facility.

Nor will it have an impact on the costs or charges at other facilities. Given that the additional need for these 140 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.

A list of proposed patient charges is included as Exhibit 7.

Letters of support will be provided as they are received.

FAS/FCOS offers recruiting services to assist in recruitment of management personnel as well as line staff through on-line recruitment, print advertising, job fairs, radio ads, direct mail and the unemployment office. Relocation assistance and education reimbursement are provided where needed for specific positions and there are a number of educational opportunities provided through in-house learning on Silverchair, attending seminars..

(INSTRUCTIONS: Table 3, "Revenue and Expenses - Entire Facility (including the proposed project)" is to be completed by existing facility applicants only. Applicants for new facilities should not complete Table 3. Table 4, "Revenues and Expenses - Proposed Project," is to be completed by each applicant for the proposed project only. Table 5, "Revenues and Expenses (for the first full year of utilization", is to be completed by each applicant for each proposed service in the space provided. Specify whether data are for calendar year or fiscal year. All projected revenue and expense figures should be presented in current dollars. Medicaid revenues for all years should be calculated on the basis of Medicaid rates and ceilings in effect at the time of submission of this application. Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses.)

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY

	Two Most Actual Ended		Current Year Estimated	Projected Years (Ending with first full year at full utilization)	
	Recent Years			Yr. 1	Yr. 2
CY or FY (Bold)					
1. Revenues					
a. Inpatient Services				\$8,827,884	\$14,823,099
b. Outpatient Services					
c. Gross Patient Service Revenues				\$8,827,884	\$14,823,099
d. Allowance for Bad Debt				\$176,558	\$296,462
e. Contractual Allowance					
f. Charity Care					
g. Net Patient Care Service Revenues				\$8,651,326	\$14,526,637
h. Other Operating Revenues (Specify)					
i. Total Operating Revenues				\$8,651,326	\$14,526,637
2. Expenses					
a. Salaries, Wages and Professional Fees (including fringe benefits)				\$3,920,049	\$6,047,321
b. Contracted Services (Medical Director, Therapy, Consulting, Housekeeping, Laundry)				\$1,637,489	\$2,492,979
c. Interest on Current Debt					
d. Interest on Project Debt					
e. Current Depreciation					
f. Project Depreciation					
g. Current Amortization					
h. Rent				\$1,350,000	\$1,350,000

i. Supplies				\$617,527	\$1,005,448
j. Other (Specify)				\$1,040,844	\$1,466,560
k. Total Operating Expenses	\$0	\$0	\$0	\$8,565,909	\$12,362,308

Table 3 Continued	Two Most Actual Ended		Current Year Estimated	Projected Years (Ending with first full year at full utilization)	
	Recent Years			Yr. 1	Yr. 2
CY or FY (Bold)					
3. Income					
a. Income from Operations				\$85,417	\$2,164,329
b. Non-Operating Income (Specify)					
c. Subtotal				\$85,417	\$2,164,329
d. Income Taxes					
e. Net Income (Loss)—not incl. depreciation				\$85,417	\$2,164,329
4. Patient Mix:					
A. Percent of Net Patient Service Revenues					
1) Medicare				39.5%	39.2%
2) Medicaid				36.7%	39.3%
3) Commercial Insurance				6.5%	6.1%
4) Self-Pay				17.3%	15.4%
5) Other (HMO)					
6) TOTAL	0.0%	0.0%	0.0%	100.0%	100.0%
B. Percent of Patient Days by Payor Source					
1) Medicare				21.9%	21.5%
2) Medicaid				52.1%	55.4%
3) Commercial Insurance				4.1%	3.8%
4) Self-Pay				21.8%	19.2%
5) Other (HMO)					
6) TOTAL	0.0%	0.0%	0.0%	100.0%	100.0%

Note: Other Expenses include Cable/Internet Expense, Transportation Costs, Travel, Training/Education, Advertising and P.R., Forms and Printing, Postage, Overnight Service, Telephone, Wireless Telephone, Minor Furniture & Fixtures, Heat, Power and Light, Infectious Waste Removal, Trash and Refuse Disposal, Water & Sewer, Repairs and Maintenance, Licenses, Real Estate Taxes, Taxes - Non-property, Insurance - Property/Other, Insurance-Automobile, Insurance-Other, Employee Hiring/Moving, Dues/Subscriptions, Background, Checks, Equipment Rent

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTION: Each applicant should complete this table for the proposed project only)

NOTE: BHNRC has not completed this table, based on guidance from the CON Director on previous CON applications.

CY or FY (Circle)	Projected Years (Ending with first full year at full utilization)			
	20	20	20	20
1. Revenues				
a. Inpatient Services				
b. Outpatient Services				
c. Gross Patient Service Revenue				
d. Allowance for Bad Debt				
e. Contractual Allowance				
f. Charity Care				
g. Net Patient Care Service Revenues				
i. Total Net Operating Revenues				
2. Expenses				
a. Salaries, Wages and Professional Fees (including fringe benefits)				
b. Contracted Services				
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation				
f. Project Depreciation				
g. Current Amortization				
h. Project Amortization				
i. Supplies				
j. Other Expenses (Specify)				
k. Total Operating Expenses				

Table 4 cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20	20	20	20
3. Income				
a. Income from Operation				
b. Non-Operating Income				
c. Income				
d. Income Taxes				
e. Net Income (Loss)				
4. Patient Mix:				
A. Percent of Total Revenue				
1) Medicare				
2) Medicaid				
3) Commercial Insurance				
4) Self-Pay				
5) Other (Specify)				
6) TOTAL	100%	100%	100%	100%
B. Percent of Patient Days/Visits/Procedures (as applicable)				
1) Medicare				
2) Medicaid				
3) Commercial Insurance				
4) Self-Pay				
5) Other (Specify)				
6) TOTAL	100%	100%	100%	100%

TABLE 5. REVENUES AND EXPENSES - (for first full year at full utilization)

(INSTRUCTION: Group revenues and expenses by service category)

	Comp Care	Assisted Living	Extended Care	Respite Care	Adult Day Care	Community Based Services	TOTAL
CY or FY (Bold)	Yr. 2						
1. Revenues							
a. Inpatient Services	\$14,823,099						\$14,823,099
b. Outpatient Services							
c. Gross Patient Service Revenue	\$14,823,099						\$14,823,099
d. Allowance for Bad Debt	\$296,462						\$296,462
e. Contractual Allow.							\$0
f. Charity Care							\$0
g. Net Patient Care Services Revenue	\$14,526,637						\$14,526,637
h. Other Operating Revenue (Specify)							\$0
i. Total Operating Revenues	\$14,526,637	\$0	\$0	\$0	\$0	\$0	\$14,526,637
2. Expenses							
a. Salaries, Wages and Professional Fees (including fringe benefits)	\$6,047,321						\$6,047,321
b. Contracted Serv.	\$2,492,979						\$2,492,979
c. Interest on Current Debt							\$0
d. Interest on Project Debt							\$0
e. Current Depreciation							\$0
f. Project Depreciation							\$0
g. Current Amortization							
h. Rent	\$1,350,000						\$1,350,000
i. Supplies	\$1,005,448						\$1,005,448

Table 5 cont.	Comp Care	Assisted Living	Extended Care	Respite Care	Adult Day Care	Community Based	TOTAL
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						Services	
j. Other Expenses	\$1,466,560						\$1,466,560
k. Total Operating Expenses	\$12,362,308	\$0	\$0	\$0	\$0	\$0	\$12,362,308
3. Income							
a. Income from Operations before depreciation	\$2,164,329	\$0	\$0	\$0	\$0	\$0	\$2,164,329
b. Non-Operating Income							\$0
c. Subtotal	\$2,164,329	\$0	\$0	\$0	\$0	\$0	\$2,164,329
d. Income Taxes							
e. Net Income (Loss)	\$2,164,329	\$0	\$0	\$0	\$0	\$0	\$2,164,329
4. Patient Mix:							
A. Percent of Gross Patient Service Revenue							
1. Medicare	39.2%						39.2%
2. Medicaid	39.3%						39.3%
3. Commercial Insur.	6.1%						6.1%
4. Self-Pay	15.4%						15.4%
5. Other (Specify)							
6. TOTAL	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%

Table 5 cont.	Comp Care	Assisted Living	Extended Care	Respite Care	Adult Day Care	Community Based Services	TOTAL
B. Percent of Patient Days by Payor Source							
1. Medicare	21.5%						21.5%
2. Medicaid	55.4%						55.4%
3. Commercial Insur.	3.8%						3.8%
4. Self-Pay	19.2%						19.2%
5. Other (Specify)							
6. TOTAL	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%

C. Medicaid Analysis		
	Patient Days	Daily Rates
a. Light	2,365	\$ 200.00
b. Moderate	12,352	\$ 220.00
c. Heavy	9,461	\$ 223.00
d. Heavy Special	2,102	\$ 250.00
e. TOTAL	26,280	

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

To meet this subsection, an applicant shall demonstrate compliance with all conditions applied to previous Certificates of Need granted to the applicant.

List all prior Certificates of Need that have been issued to the project applicant by the Commission since 1990, and their status.

The applicant is a new entity and does not have any prior CONs.

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
- 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

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

TABLE 6. MANPOWER INFORMATION

(INSTRUCTION: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project.)

Position	Current No FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractua l	Total Cost
Administration					
Administrator		1.0	\$57.69	Employee	\$119,995
Reception		1.0	\$15.38	Employee	\$31,990
Business Office Manager		1.0	\$21.63	Employee	\$44,990
Payroll Personnel		1.0	\$19.23	Employee	\$39,998
Admissions		1.0	\$25.00	Employee	\$52,000
Marketing		1.0	\$30.00		\$62,400
Staffing Coordinator		1.0	\$17.61	Employee	\$36,733
Medical Records		1.0	\$20.00	Employee	\$41,600
Staff Development		0.7	\$22.93	Employee	\$32,397
MDS Coordinator		3.0	\$34.35	Employee	\$214,906
Direct Care					
DON		1.0	\$50.48	Employee	\$105,287
ADON		1.0	\$37.50	Employee	\$78,214
RN Unit Manager		2.0	\$35.04	Employee	\$146,146
RN		14.0	\$35.53	Employee	\$1,037,330
LPN		9.8	\$27.40	Employee	\$560,128
LPN Wound Nurse		1.0	\$28.00	Employee	\$58,400
CAN		50.0	\$14.21	Employee	\$1,478,195
Therapy Aide		2.3	\$23.50	Employee	\$110,287
Support					
Activities		2.5	\$16.61	Employee	\$86,362
Social Service		2.0	\$23.52	Employee	\$97,822
Maintenance		2.0	\$19.44	Employee	\$80,850
Dietary		12.2	\$13.79	Employee	\$349,931
Laundry		4.5	\$12.69	Contracted	\$119,023
Housekeeping		11.1	\$7.73	Contracted	\$178,534
TOTAL					
		Total Salaries			\$4,865,961
		PTO for replacement positions			\$290,146
		Total Salary & Wages			\$5,156,107
		Benefits			\$891,214
		Total Salaries & Benefits			\$6,047,321
		Professional Fees			\$0
		Total Salaries, Benefits, & Professional Fees			\$6,047,321

(INSTRUCTION: Indicate method of calculating benefits percentage): 18.315%

TABLE 7. NURSING STAFFING PATTERN

(INSTRUCTION: On the chart below, delineate the proposed nursing staffing pattern for patient care units or services. If your staffing pattern varies among units or services, complete a separate chart for each unit)

Scheduled Staff for Typical Work Week

	WEEKDAY			WEEKEND/HOLIDAY		
	D	E	N	D	E	N
Staff Category						
R.N.	4	3	3	4	3	3
L.P.N.	3	3	1	3	3	1
AIDES	15	14	9	15	14	9
MEDICINE AIDE						
OTHER (Specify)						
DON	1					
Assistant DON	1					
Unit Manager RN	1.2			1	1	
Restirative Aides	3			2		
Wound Nurse	1					

If staff will not differ between "weekday" and "weekend/holiday", please indicate _____.

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

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

Bronz Peterson is responsible for implementing this development project. The address is 7001 Boulevard 26, Suite 201, N. Richland Hills, TX 76180.

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

St. Mary's Healthcare Realty, LLC has not been involved with another health care facility. Bronz Peterson has been involved with implementing other development projects for FAS.

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

No

4. Are any facilities with which the applicant is involved, or have any facilities with which the applicant has in the past been involved (listed in response to Question 2, above) ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to actions to suspend the licensure or certification at the applicant's facility or facilities listed in response to Question 2? If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition reached by the applicable governmental authority.

No

5. Have the applicant, owners or responsible individuals listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

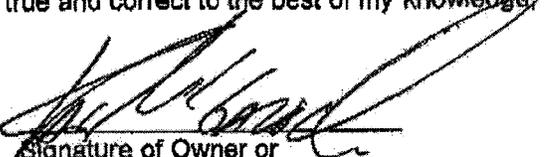
No

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

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

Date

10/4/13

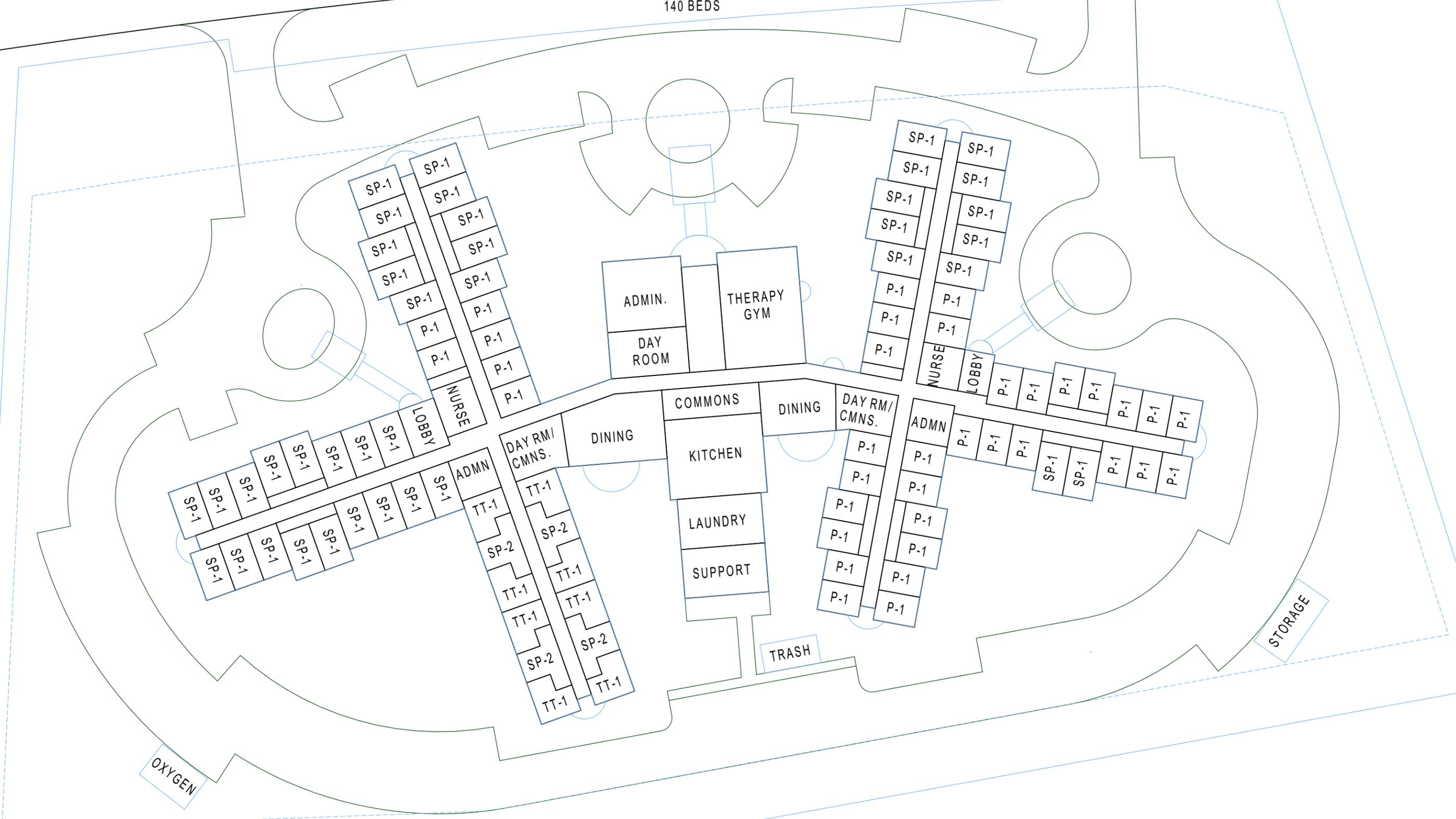

Signature of Owner or
Board-designated Official

Exhibits

1. Project Drawings
2. Examples of Handouts Regarding Community Based Services
3. Discharge Planning Policy
4. Marshall Valuation Service Worksheets
5. Letter Attesting To Interest In Financing This Project
6. Letter Attesting That The Funds Proposed For The Equity Contribution For This Project Are Available
7. List Of Proposed Patient Charges
8. Affirmations

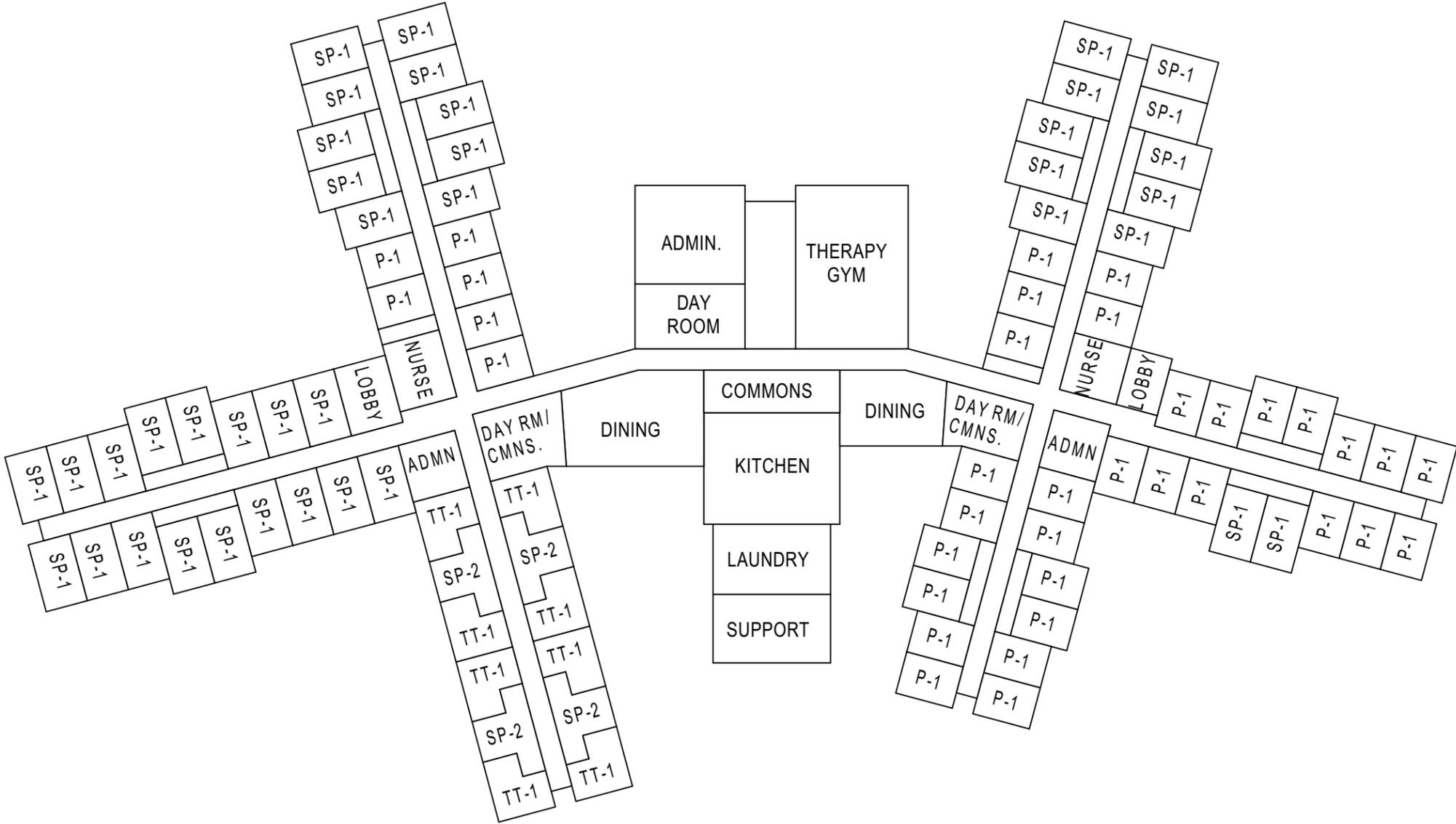
Exhibit 1
Project Drawings

63,990SF
140 BEDS



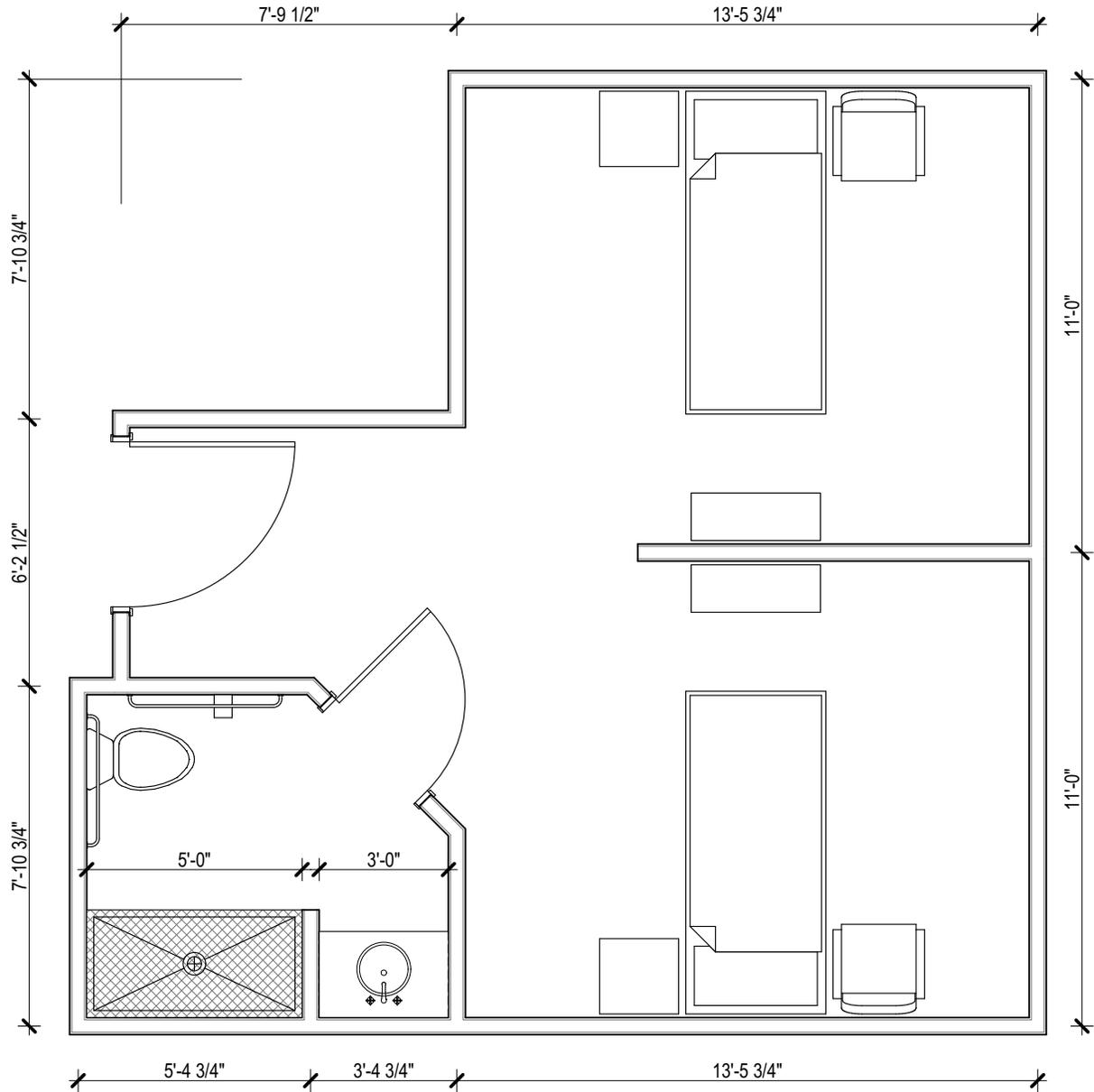
1 SITE PLAN
SCALE: 1" = 50'

63,990SF
140 BEDS



1 FLOOR PLAN
SCALE: 1" = 50'

BLUE HERON NURSING AND REHABILITATION CENTER
20877 POINT LOOKOUT ROAD
CALLAWAY, MD 20620

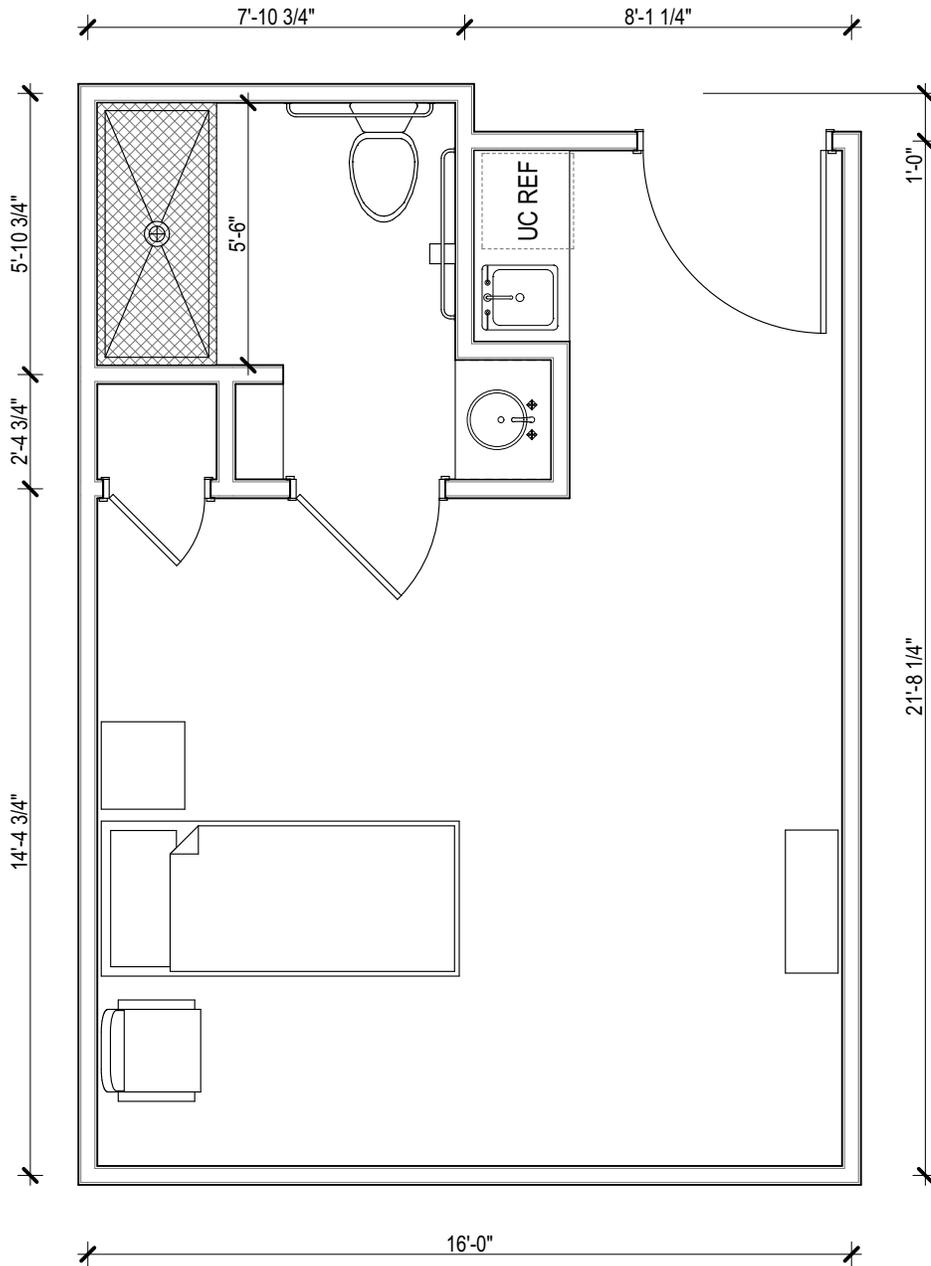


1

ROOM TYPE TT-1

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

BLUE HERON NURSING AND REHABILITATION CENTER
20877 POINT LOOKOUT ROAD
CALLAWAY, MD 20620

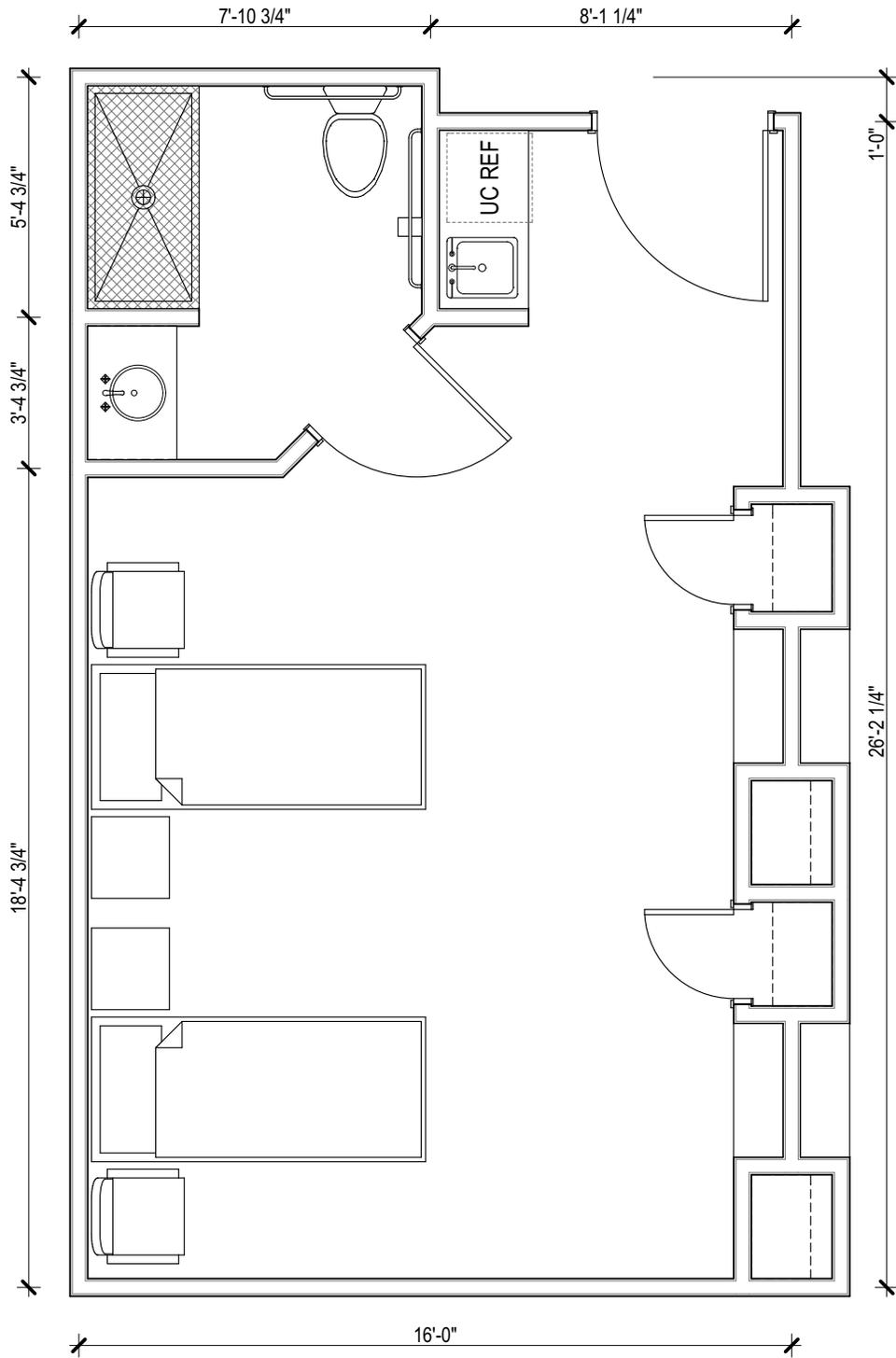


1

ROOM TYPE P-1

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

BLUE HERON NURSING AND REHABILITATION CENTER
20877 POINT LOOKOUT ROAD
CALLAWAY, MD 20620

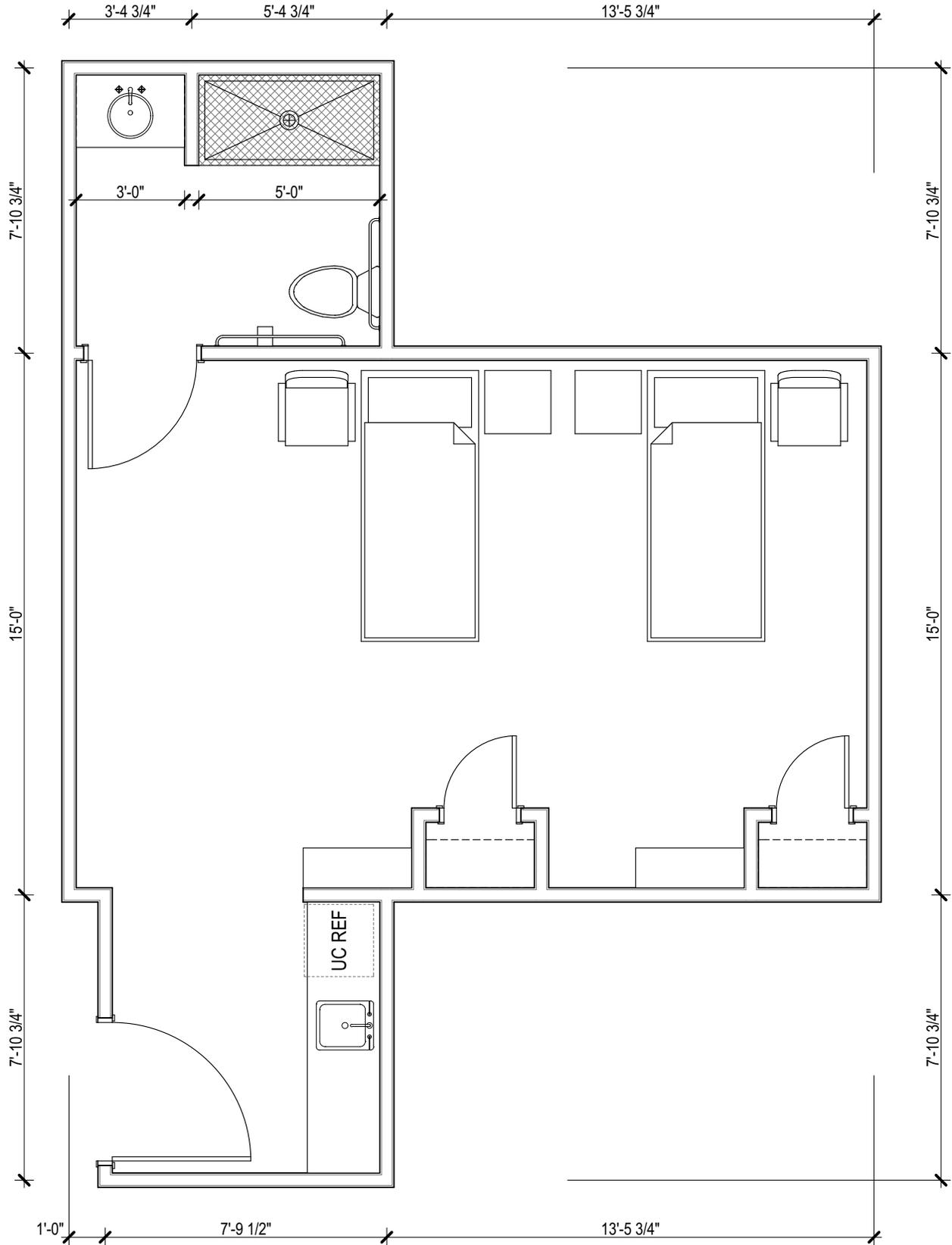


1

ROOM TYPE SP-1

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

BLUE HERON NURSING AND REHABILITATION CENTER
20877 POINT LOOKOUT ROAD
CALLAWAY, MD 20620



1

ROOM TYPE SP-2

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

Exhibit 2
Examples of Handouts Regarding Community Based Services

To Be Submitted

Exhibit 3
Discharge Planning Policies

SOCIAL SERVICES POLICIES AND PROCEDURES

SUBJECT: DISCHARGE PLANNING AND NOTIFICATION

POLICY:

Social Services staff, as members of the Interdisciplinary Team, will participate in the development of a discharge plan for patients/residents with a potential for discharge to a private residence, another nursing facility or to another type of residential facility. This policy applies to both voluntary and involuntary transfers/discharges.

All patients/residents will be discharged/transferred from the Facility by order of his/her attending physician, in a safe, secure and correct manner.

PROCEDURES:

1. Discharge planning begins at time of admission and any changes in a patient's/resident's discharge plan will be documented in Social Service progress notes.
2. The discharge plan is used to assist the patient/resident in preparing for discharge and to address continuing care needs after discharge.
3. When the Interdisciplinary Team determines that a patient/resident has potential for discharge, Social Services staff addresses the following information utilizing Discharge Evaluation and Plan Form #MP5423 (This form may serve as your care plan for discharge):
 - A. Necessary supportive relationships in the community to meet the patient's/resident's emotional needs.
 - B. The cost of needed services and financial resources necessary to pay for those services.
 - C. The patient/resident and family's educational needs regarding available community resources and how to access those services.
 - D. Needs for emotional support to assist in adjustment to the new living environment.
4. The discharge plan is incorporated into the patient's/resident's interdisciplinary care plan and addressed quarterly in Social Services progress notes.
5. In compliance with federal and state regulations, all transfers and discharges require proper notification to the patient/resident and, if known, a family member or legal representative.
6. A patient/resident can be transferred/discharged from the facility when:
 - A. The transfer or discharge is necessary for the patient's/resident's welfare and the patient's/resident's needs cannot be met in the facility;
 - B. The patient's/resident's health has improved sufficiently so that he/she no longer needs the services of the facility;
 - C. The safety of the individuals in the facility is in danger;

- D. The health of individuals in the facility is otherwise in danger;
 - E. The patient/resident has refused to pay his/her bill after reasonable and appropriate notice to pay or to have paid under Medicare or Medicaid; and
 - F. The facility ceases to operate.
7. The Social Services Staff is charged with ensuring that systems are in place to provide written notification to the patient/resident and, if known, a family member or legal representative prior to the patient's/resident's transfer. The transfer/discharge notice must comply with federal and state regulations and must contain the following information.
- A. The reason for transfer or discharge;
 - B. The effective date of transfer or discharge;
 - C. The location to which the resident is transferred or discharged;
 - D. A statement that the resident has the right to appeal the action to the State;
 - E. When appropriate, the name, address and telephone number of the State long term care ombudsman;
 - F. When appropriate, for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and
 - G. When appropriate, for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.
8. Contact the FAS Legal Department for guidance on specific state regulations and requirements for written discharge notices.
9. A copy of the transfer/discharge notice must be included in the patient's/resident's record.
10. Some states allow for emergency discharges of patients/residents needing psychiatric care. Such discharges can be voluntary or involuntary. All such discharges will be made pursuant to state regulations and the facility should contact FAS Legal Department for guidance regarding emergency discharges for psychiatric care.
11. The Social Services Staff provides and coordinates sufficient preparation and orientation for the patient/resident prior to and during the transfer or discharge. This includes:
- A. Providing information about alternative living areas (ALF's, Retirement Communities, other nursing facilities, etc.);
 - B. Meeting with patients/residents, their legal representatives and/or family members so they can make informed choices before choosing an alternate living area;
 - C. If possible, arranging tours of the new living area and meeting their staff; and
 - D. Assisting with referrals and applications as needed.
12. Social Services Staff will document in Social Service Progress Notes ALL discharge planning efforts, including but not limited to conversations with the

patient/resident/responsible party, home health, and other supportive services in the community.

13. Facility staff will contact the FAS Legal Department for guidance relating to any additional questions or concerns regarding patient/resident discharges.

FORMS:

Discharge Evaluation & Plan - MP5423

CROSS REFERENCE:

1. Leadership Policies and Procedures: #20, "Organizational Ethics, Transfer/Discharge".
2. Social Services Policies and Procedures: #30, "Transfers Discharges Outside of the Facility".

SOCIAL SERVICES POLICIES AND PROCEDURES

SUBJECT: DISCHARGE SUMMARY

POLICY:

The Social Services staff, as part of the Interdisciplinary Team, will participate in the development of a discharge summary when a patient/resident is discharged to a private residence, another nursing facility or another type of residential facility according to the following time frames and Facility procedures. A discharge summary is completed when a resident is fully discharged from the facility (i.e. to another nursing facility, to the community or death).

PROCEDURES:

1. The Discharge Summary is completed when the patient/resident is permanently discharged for any reason and return to the facility is not anticipated. The completed Interdisciplinary Discharge Summary is part of the patient/resident's closed medical record.
2. The Discharge Summary provides for a recapitulation of the patient's/resident's stay and the patient's/resident's status at the time of discharge to verify continuity of care.
3. The Social Services staff is responsible for the following information in the recapitulation of the patient's/resident's stay.
 - A. Sensory Impairment: glasses, hearing aids, language barriers.
 - B. Mental and psychosocial status at the time of discharge: was the patient/resident able to make his/her needs known?
 - C. Patient's/Resident's attitude about discharge.
 - D. Cognitive status at the time of discharge.
 - E. Discharge potential.
 - F. What services were arranged for the patient/resident? Did patient/resident or his/her qualified legal representative decline any services?
 - G. What happened to the patient's/resident's personal belongings?
 - H. In cases of patient's/resident's death, what gestures of bereavement were made? Sympathy card and/or flowers?
3. The Discharge Summary is available for release to the patient/resident and to other persons or agencies as provided in Facility's policies and procedures for the release of medical records (*See Health Information Management Services Manual*).

SOCIAL SERVICES POLICIES AND PROCEDURES

SUBJECT: DISCHARGE INSTRUCTIONS FOR CARE

POLICY:

Social Service staff, as member of the Interdisciplinary Team will participate in the development of the Discharge Instructions for Care.

PROCEDURES:

1. The Discharge Instructions for Care is completed for any patient/resident returning to the community (e.g. home or an assisted living facility).
2. The Discharge Instructions for Care provides written instructions for the provision and coordination of care after discharge and a smooth transition and adjustment to the new living environment.
3. Social Services, as part of the Interdisciplinary Team, documents the availability of the care and services required to maintain maximum patient/resident psychosocial functioning upon discharge and how to access them. This includes, at a minimum, the following:
 - A. Home health care.
 - B. Case management service.
 - C. Food and meal services.
 - D. Community mental health.
 - E. Transportation services.
 - F. Lifeline services.
 - G. Personal care needs services.
 - H. Durable medical equipment services.
4. Social Services staff provides assistance to the patient/resident and family in coordinating these needed services.
5. The Social Services staff communicates the arrangements made, the referrals and the recommended care and services to the patient/resident and legal representative in a clear and concise manner, ensuring they comprehend the information.
6. A signed copy of the Discharge Instructions for Care is sent with the patient/resident upon discharge and copies may be released to other persons and agencies as provided in Facility's policies and procedures for the release of medical records (*See Health Information Management Services Manual*).

SOCIAL SERVICES POLICIES AND PROCEDURES

SUBJECT: TRANSFERS AND DISCHARGES OUTSIDE OF THE FACILITY

POLICY:

The patient/resident will be discharged/transferred from the Facility by order of his/her attending physician in a safe, secure and correct manner.

PROCEDURES:

1. Nursing will obtain a discharge order from the patient's/resident's physician.
2. Social Services staff or designated staff will notify the patient/resident and, if known, a family member or legal representative and will document the discharge.
3. A patient/resident may be discharged for the following reasons:
 - A. The transfer or discharge is necessary for the patient's/resident's welfare and the patient's/resident's needs cannot be met in the facility;
 - B. The patient's/resident's health has improved sufficiently so that he/she no longer needs the services of the facility;
 - C. The safety of the individuals in the facility is in danger;
 - D. The health of individuals in the facility is otherwise in danger;
 - E. The patient/resident has refused to pay his/her bill after reasonable and appropriate notice to pay or to have paid under Medicare or Medicaid; and
 - F. The facility ceases to operate.
4. Discharge Scenarios:
 - A. **For planned discharges home/private residence:**
 - 1) Provide the patient/resident and, if known, a family member or legal representative with written Discharge Instructions for Care in a language that they can understand, utilizing current forms, prior to the patient's/resident's discharge;
 - 2) Review and discuss the Discharge Instructions with the patient/resident;
 - 3) Document the discussion in the patient's/resident's Plan of Care, which should include a notation of who it was reviewed with; and
 - 4) Place a copy of the completed form in the patient's/resident's medical record;
 - B. **For planned discharges to an Assisted Living Facility ("ALF"),**
 - 1) Provide the patient/resident and, if known, a family member or legal representative with written Discharge Instructions for Care in a language that they can understand, utilizing current forms, prior to the patient's/resident's discharge;
 - 2) Review and discuss the Discharge Instructions with the patient/resident;
 - 3) Document the discussion in the patient's/resident's Discharge Plan of Care which should include a notation of who it was reviewed with.
 - 4) Place a copy of the completed forms in the patient's/resident's medical record; and
 - 5) Provide requested information (Advanced Directives, History & Physical, most recent MAR, TAR, etc.) to the receiving agency. This information is usually requested and provided pre-discharge.

SUBJECT: TRANSFERS AND DISCHARGES OUTSIDE OF THE FACILITY (Continued)

C. For emergency transfers:

- 1) Nursing will complete a Resident Transfer sheet, utilizing the current form, or other form specific to facility; and
- 2) Facility staff will send with the patient/resident his/her face sheets, Advance Directives, bed-hold policy, MAR and TAR, and any state specific records according to regulations. If staff is unable to complete the information before the patient/resident is transferred, staff will provide an oral report to the receiving agency and fax it when the information is complete.

D. For planned discharges to another healthcare facility (e.g., Hospital/Nursing Facility):

- 1) Nursing will complete a Resident Transfer form.
- 2) Facility staff will send the resident's face sheet, advance directives, copies of MAR and TAR, and any state specific records according to regulations.
- 3) Facility will maintain copies of all completed discharge/transfer forms in the patient's/resident's permanent medical record.

E. Discharge against medical advice: Refer to the *Against Medical Advice (AMA) – Day Outings/Therapeutic Leaves of Absence* Policy and Leadership Policies and Procedures: #20, "Organizational Ethics, Transfer/Discharge".

F. Involuntary Discharge:

- 1) To process an involuntary discharge, the Facility Designee will:
 - a) Contact the FAS Legal Department for guidance regarding state specific requirements for involuntary discharges;
 - b) Develop a safe discharge plan, including but not limited to securing an alternate location, and will have the plan approved by the patient's/resident's physician;
 - c) Obtain a physician's order for the discharge; and
 - d) Complete and provide a written notice of transfer/discharge to the patient/resident and, if known, a family member or legal representative.

5. Refer to the *Discharge Planning and Notification* Policy for discharge notice requirements.

6. Resident deaths will be documented in Nursing Progress Notes and documentation shall include disposition of body and personal effects.

CROSS REFERENCE:

1. Leadership Policies and Procedures: #20, "Organizational Ethics, Transfer/Discharge".
2. Social Services Policies and Procedures: #30, "Discharge Planning and Notification".

Complete Revision:
4/2012
Email Revision:
7/16/2013

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SS - SECTION IV - 6

NURSING POLICIES AND PROCEDURES

SUBJECT: DISCHARGE/TRANSFER

POLICY:

The patient/resident will be discharged/transferred (home/another entity) by order of his/her attending physician. Facility will include the patient/resident and family in developing a safe discharge plan to address the patient's/residents individual needs.

PROCEDURES:

1. Obtain a discharge/transfer order from the physician.
2. Notify the patient/resident, his/her legal representative, if any, or an interested family member and document the discharge.
3. Types of discharges:
 - A. Planned discharge to the patient's/resident's home/private residence or assisted living facility:
 - 1) Obtain an order for discharge/transfer from the patient's/resident's physician.
 - 2) Arrange community resources identified by the interdisciplinary team/patient/resident and/or family.
 - 3) Provide written Discharge Instructions for care to the patient/resident and/or family when discharging the patient home or to a community setting such as assisted living.
 - 4) Complete the Discharge Summary, documenting the patient's/resident's assessment at time of discharge and a summation of the patient's/resident's stay.
 - 5) Place copy of completed forms in the patient's/resident's medical record.
 - B. Emergency:
 - 1) Complete emergent transfer form.
 - 2) Send the patient's/resident's face sheet, Advance Directives, bed-hold policy, MAR and TAR, and any state specific records in accordance with state regulations with the patient/resident. If unable to complete the information, verbally communicate the necessary information and fax when complete.
 - C. Planned to Another Healthcare Facility:
 - 1) Complete the Resident Transfer Form when the patient/resident is discharged to another health care agency such as a hospital or nursing facility.
 - 2) Send copies of the patient's/resident's face sheet, advance directives, copies of MAR and TAR, and any state specific records in accordance with state regulations.
 - 3) Maintain copies of all completed discharge/transfer forms in patient's/resident's permanent medical record.
 - D. Death:
 - 1) Document in Nursing Progress Notes (Include disposition of body and personal effects).
 - 2) Complete Interdisciplinary Discharge form and maintain in the patient's/resident's closed permanent medical record.
 - E. Involuntary Discharge:
 - 1) To process an involuntary discharge:

SUBJECT: DISCHARGE/TRANSFER (Continued)

- a) Contact the FAS Legal Department for guidance regarding state specific requirements for involuntary discharges.
 - b) Develop a safe discharge plan, including but not limited to securing an alternate location, and have the discharge plan approved by the patient's/resident's physician.
 - c) Obtain a physician's order for the discharge.
 - d) Complete and provide a written notice of transfer/discharge to the patient/resident and, if known, a family member or legal representative.
- F. Against Medical Advice:
- 1) If the patient/resident wishes to discharge him/herself from the facility without a physician's order or the patient's/resident's legal representative informs the facility that he/she plans to discharge the patient/resident without a physician's order, Facility staff will immediately notify the patient's/resident's treating physician and attempt to schedule a care conference by and between the patient/resident/legal representative and the treating physician, the director of nursing, administrator and social services director. Other personnel may attend as needed.
 - 2) During the care conference, the treating physician/appropriate Facility staff will inform the patient/resident/legal representative of the risks and consequences associated with his/her decision to discharge from the facility against medical advice. Facility staff will document all care conference discussions in the medical record.
 - 3) If the patient/resident/legal representative still wishes to proceed with the discharge, Facility staff will contact the FAS Legal Department and complete the appropriate form and present it to the patient/resident/legal representative for execution.
 - a) If the patient/resident has the ability to make his/her own healthcare decisions, as documented in the medical record by the treating physician, patient/resident will sign appropriate form.
 - b) If the patient/resident is not able to make his/her own health care decisions, the patient's/resident's qualified legal representative (as defined by state law) will sign the appropriate form. **NOTE: BEFORE HAVING THE LEGAL REPRESENTATIVE SIGN THIS FORM, FACILITY STAFF WILL ENSURE PROPER DOCUMENTATION IS ON FILE TO EVIDENCE THE INDIVIDUAL'S LEGAL AUTHORITY TO ACT ON THE PATIENT'S/RESIDENT'S BEHALF.**
 - 3) If the patient/resident/legal representative refuses to wait for a care conference, all attempts should be made to have him/her sign the form. If the patient/resident/legal representative refuses to sign, Facility staff should write "refused to sign" on the form and provide the patient/resident/legal representative with a copy. Two staff members should thoroughly document the occurrence and refusal in the resident's medical record.
 - 4) Facility staff may contact the FAS Legal Department if additional guidance/assistance is needed.

CROSS REFERENCE

Leadership Policies and Procedures - # 20, Section III

Complete Revision: 9/2011
Email Revision: 7/15 /2013

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NP-D-9

NURSING POLICIES AND PROCEDURES

SUBJECT: CARE PLAN PROCESS

POLICY:

The Interdisciplinary Team will coordinate with the resident and their legal representative an appropriate care plan for the resident's needs or wishes based on the assessment and reassessment process within the required time frames.

PROCEDURES:

1. Initiate an Interim Plan of Care and complete within twenty-four (24) hours of admission based on the physician's orders and nursing admission data collection. The Interim Plan of Care will direct the residents care until a comprehensive care plan is developed.
2. Initiate an Acute Plan of Care when the resident's clinical status dictates the need such as but not limited to falls and pressure sore development.
3. Interdisciplinary Team meets and creates/reviews the Care Plan as follows:
 - A. Within Seven (7) days after the closure date (V0200 B 2) of an initial, annual or significant change MDS, and at least. The resident and/or the family must be invited to care plan meeting
 - B. Quarterly.
4. The actual paper copy of the care plan should be reprinted yearly with all the updates added.
5. The Plan of Care should include:
 - A. Date
 - B. Problem
 - C. Goals, measurable and realistic
 - D. Time frames for achievement
 - E. Interventions, discipline specific services, and frequency
 - F. Resolution/Goal analysis
 - G. Discharge options

Exhibit 4
Marshall Valuation Service Worksheets

I. The Marshall and Swift Guideline

Type		Convalescent Hospital	
Construction Quality/Class		D/Good	
Stories		2	
Perimeter		1,374	
Height of Ceiling		10.10	
Square Feet		63,990	
f.1	Average floor Area	63,990	
A. Base Costs			
	Basic Structure	158.79	
	Elimination of HVAC cost for adjustment	0	
	HVAC Add-on for Mild Climate	0	
	HVAC Add-on for Extreme Climate	0	
Total Base Cost		\$158.79	
B. Additions			
	Elevator (If not in base)	\$0.00	
	Other	\$0.00	
Subtotal		\$0.00	
Total		\$158.79	
C. Multipliers			
Perimeter Multiplier		0.95658787	From AreaPerimeter
	Product	151.8965879	Interpolation
Height Multiplier (plus/minus from 12')		0.953	See
	Product	\$144.76	Interpolation
Multi-story Multiplier (0.5%/story above 3)		1	
	Product	\$144.76	
D. Sprinklers			
	Sprinkler Amount	2.89	
Subtotal		\$147.65	
E. Update/Location Multipliers			
Update Multiplier		1.09	
	Product	\$160.94	

Location Multiplier	1.04
Product	\$167.38
Final Square Foot Cost Benchmark	\$167.38

M&S Method for Interpolating Area and Perimeter Factor

To use this, substitute the perimeter and average floor area measures that apply. Then substitute the M&S multipliers from the table on page 15-37 for the sizes just above and below the actual measures.

Perimeter		Below	Actual	Above	Calculated:	Below	Actual	Above
Area		1,200	1,374	1,400		1,200	1,374	1,400
Below	30,000	0.949		0.965	Below	0.949		0.965
Actual	31,995				Actual	0.943015	0.9565879	0.958616
Above	35,000	0.934		0.949	Above	0.934		0.949

Area Interpolation

1	0.949	-	0.934	=	0.015
2	31995	-	30000	=	1995
3	35000	-	30000	=	5000
4	1995	/	5000	=	0.399
5	0.015	*	0.399	=	0.005985
6	0.949	-	0.005985	=	0.943015
7	0.965	-	0.949	=	0.016
8	0.016	*	0.399	=	0.006384
9	0.965	-	0.006384	=	0.958616

Perimeter Interpolation

10	1400	-	1200	=	200
11	1374	-	1200	=	174
12	174	/	200	=	0.87
13	0.958616	-	0.943015	=	0.015601
14	0.015601	*	0.87	=	0.0135729
15	0.943015	+	0.0135729	=	0.9565879

	Perimeter	Area
1	2,748	64,630
2		0.04
Total	2,748	63,990
Avg	2,748	63,990
	1374	31995
Height		
1	10	646300
2		0

646300

Wall Height Interpolation

10.00 0.953

11 0.977

10.00 0.953

12 1

1	0.977	-	1	=	-0.023
2	10	-	11	=	-1
3	12	-	11	=	1
4	-1	/	1	=	-1
5	-0.023	*	-1	=	0.023
6	0.977	-	0.023	=	0.953

Capitalized Construction Allocation

	New	Renovation	Total	Cap	Fin Fees
Building Cost	\$ 8,650,000				
Subtotal Cost	\$10,510,000		\$10,510,000		
Cap Interest	\$ 550,000			\$400,000	\$150,000
Building/Subtotal	82.3%				
Building Cap Interest	\$ 452,664				

	Sprinkler	Interpolation			
		50,000	3		
		63,990	2.893676		
		75,000	2.81		
1	3	-	2.81	=	0.19
2	63,990	-	50000	=	13990
3	75000	-	50000	=	25000
4	13990	/	25000	=	0.5596
5	0.19	*	0.5596	=	0.106324
6	3	-	0.106324	=	2.893676

<i>Consolidated Benchmark</i>	A	B	
	Benchmark	Sq. Feet	A x B
Building	\$167.38	63,990	\$10,710,474
Basement	N/A	N/A	N/A
Consolidated	\$167.38	63,990	\$10,710,474

II. The Project

A. Base Calculations		Actual	Per Sq. Foot
cc	New Construction	\$8,650,000	\$135.18
dd	Fixed Equipment	In Building	
ee	Site Preparation	\$1,450,000	\$22.66
ff	Architectural Fees	\$380,000	\$5.94
gg	Capitalized Construction Interest + Loan Placement Fee	\$452,664	\$7.07
hh	Permits	\$30,000	\$0.47
ii	Subtotal	\$10,962,664	\$171.32

B. Extraordinary Cost Adjustments

	Project Costs	Associated A&E Fees	Associated Cap Interest	Total	
	Storm Drains	\$185,000	\$6,960	\$191,960	Site
	Rough Grading	\$125,000	\$4,703	\$129,703	Site
	Demolition/Deforestation		\$0	\$0	
	Site Improvements		\$0	\$0	Site
	Landscaping	\$250,000	\$9,406	\$259,406	Site
	Roads	\$100,000	\$3,762	\$103,762	Site
	Utilities		\$0	\$0	
	Jurisdictional Hook-up Fees	\$10,000	\$376	\$10,376	Permits
	Signs	\$20,000	\$752	\$20,752	Site
	Canopy	\$125,000.00	\$4,703	\$5,384	\$135,087 Building
oo	Total Cost Adjustments	\$815,000	\$30,663	\$5,384	\$851,047
pp	Per Square Foot				\$13.30
qq	C. Adjusted Project Cost	\$10,111,617			
rr	Per square foot	\$158.02			

III. Comparison

ss	A. Adjusted Project Cost/Sq. Ft.	\$158.02
tt	B. Marshall ValuationService Benchmark	\$167.38

Exhibit 5
Letter Attesting To Interest In Financing This Project



October 2, 2013

St. Mary's Healthcare Realty, LLC
920 Ridgebrook Road
Sparks, MD 21152
Attn: Mark Fulchino

Re: Construction of a 140 bed skilled nursing facility located at 20877 Point Lookout Road, Callaway, Maryland

Dear Mr. Fulchino:

This letter will confirm that F&M Bank is interested in providing financing to St. Mary's Healthcare Realty, LLC ("Borrower") for an amount up to \$13,600,000. This amount will be used for the purchase of the land and construction costs incurred by Borrower in connection with the development of a 140 bed skilled nursing facility located at 20877 Point Lookout Road, Callaway, Maryland.

Please feel free to contact Kevin Howell at (214) 780-2091 or via e-mail at KHowell@fmbanktexas.com if you need any further information regarding the anticipated financing of this project.

Yours very truly,

THE F&M BANK & TRUST COMPANY

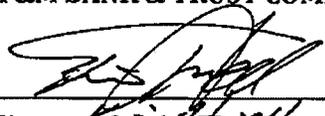
By: 
Name: Kevin Howell
Title: SVP

Exhibit 6
**Letter Attesting That the Funds Proposed For The Equity Contribution For This
Project Are Available**

Greenspring Consulting Services, LLC

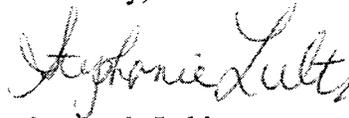
8202 Bellona Avenue • Ruxton, Maryland 21204

October 3, 2013

To Whom It May Concern:

I am an independent accountant and I am familiar with the finances of the developers of Blue Heron Nursing and Rehabilitation Center. The aforementioned entity has sufficient liquidity to invest the proposed equity contribution of approximately \$1,600,000 identified in the Application for Certificate of Need.

Sincerely,



Stephanie Lubitz

Director

Greenspring Consulting Services, LLC

Exhibit 7
List of Proposed Patient Charges

Private Pay Rate: \$250 per day

Most ancillaries for private pay are billed directly to the resident by the vendor...Pharmacy, Lab, Respiratory Therapy, Radiology

The follow ancillaries the facility bills the resident

Therapy PT, OT, ST- billed at the same rate as the Medicare Fee schedule

Specialty Beds: \$10-110 per day

Specialty Wound Equip: \$25-100 per day

Cable TV included in Room & Board

Phone included in Room & Board

Exhibit 8
Affirmations

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

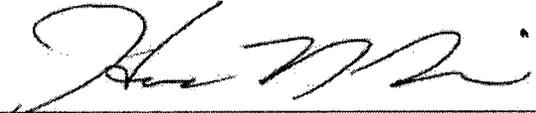


Signature

10/3/2013

Date

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

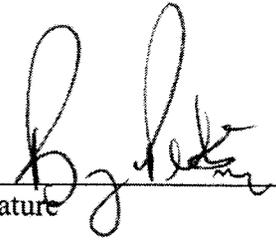


Signature

10-3-13

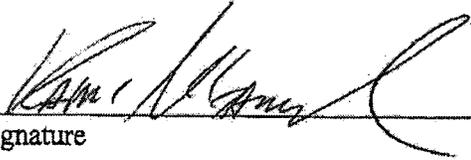
Date

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


Signature

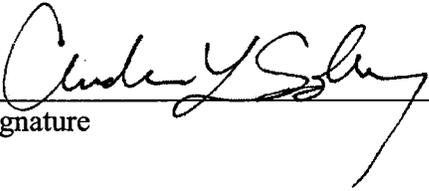
10/03/13
Date

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


Signature

10/3/13
Date

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


Signature

10/1/2013
Date