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October 17, 2014

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

RE: Follow-up Response to "Letter of Completeness"
CON Application
Brooke Grove Rehabilitation and Nursing Center
Brooke Grove Foundation

Thank you for the opportunity to answer questions about Brooke Grove's pending request for approval of Certificate of Need for a proposed 70-bed replacement facility on Brooke Grove's Sandy Spring campus. This letter and accompanying documents is the response to the MHCC's initial questions.

As these documents were assembled they reinforced Brooke Grove's belief that while the health care system is changing dramatically and a lot of uncertainty exists about the end result there will continue a strong need for skilled and comprehensive beds in Montgomery County. Among the factors that Brooke Grove believes will play a major role is the significant projected increase in the elderly population. As the boomers grow older their impact on the provision of health services will result in increased utilization, including utilization in skilled and comprehensive care facilities. Brooke Grove understands this position may be considered bold and even possibly contrary to other's projections. Still, Brooke Grove requests the commission to consider the information in this proposal from Brooke Grove's market position, its experience, perspective and market objectives in its immediate market area.

Brooke Grove continues to run at high occupancies. The demand for its beds is increasing, even as other facilities struggle to maintain occupancies at much lower levels.

Brooke Grove Retirement Village

The Cottages Independent Living
301-260-2300

The Meadows Assisted Living
301-924-1228

The Woods Assisted Living
301-924-3877

*Brooke Grove Rehabilitation
and Nursing Center*
301-924-5176

Other Campuses

Williamsport Retirement Village
154 North Artizan Street
Williamsport, MD 21795
301-223-7971

Rest Assured Living Center
1137 Shirley's Hollow Road
Meyersdale, PA 15552
814-634-0567

The proposed 70-bed replacement facility will replace a 48-bed wing at BGRNC and also include the transfer of 22-CON beds purchased from National Lutheran/Village at Rockville. The proposed project would result in a 22 bed net increase in licensed beds at BGRNC, increasing the license from 168 to 190 beds.

The enclosed/attached package(s) includes 6 binders. In each binder is a table of contents, the response to "Letter of Completeness" and revised application, and assorted supporting exhibits.

Thank you for your continued consideration of Brooke Grove's application. Please let me know if I can answer any further questions or clarify information. My contact information is as follows.

Direct Phone 301 388-7202

Email dhunter@bgrf.org

A handwritten signature in black ink, appearing to read "Dennis Hunter", written over a horizontal line.

Sincerely,

Dennis Hunter, VP

A Response to Letter of Completeness
CON Application, Revised 10/17/2014 (revisions in yellow)

B Mini Basement Plan

C MOU (2000)

D Medicaid Participation Policy

E Information about Community-Based Services

F Psychosocial Training, LIFE Illustrated

G Occupancy Rates, 5-Year History

H Population Growth Expected in Montgomery County, 65+

I Trends in Functional Limitations (CBO Report, 2013)

J Admissions by Source Hospital

K Letters of Support

L Quality Assurance Plan & Examples of Improvements Made

M Map of MC, Hospitals and Primary/Secondary Markets

N Pay for Performance Rankings, 2014

O Impact of Alzheimer's Disease

P FINANCIAL TABLES

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R

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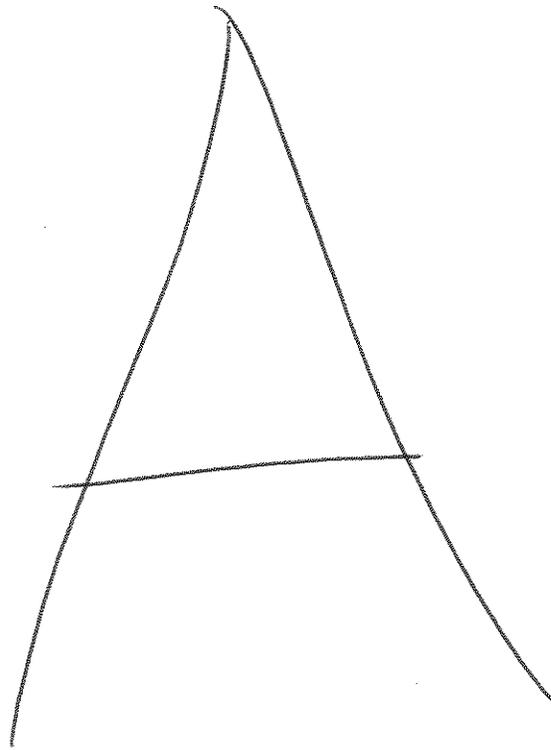
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**RESPONSE TO “COMPLETENESS LETTER” AND REVISED CON APPLICATION
PREPARED 10/17/2014**

PROJECT DESCRIPTION

1. Provide more specific detail/reasons to demolish the existing 48-bed wing

BGRNC is comprised of two sections, a newer section completed in 2000 and an older section originally constructed in the 1800's as a home. The older section was added to and renovated over the years since its original construction. The proposed demolition is of the building/wing that was originally constructed in the mid-late 1800's. When the home was originally converted to use as a skilled/comprehensive care facility the existing rooms, corridors and stairways were adapted as best could be done at the time but, of course, did not consider today's higher acuity resident population or conform to today's building codes. In 1970 an addition to the older building/wing was added but the structural design preempts the ability to create contemporary features such as ADA toileting/bathrooms. The resident rooms were also built to exact minimum dimensions making very tight accommodations when considering the in-room equipment needs of residents. The remnant 1800's design elements were never updated. And for good reason. For example, one can imagine the extreme challenge and cost to changing multiple load bearing walls in a 4 story building such that corridor widths could meet current code. All of the inherent inadequacies of a building constructed in the 1800's remain intact, e.g., narrow corridors, steep stairways, stone foundation, knob and tube electrical wiring, poor ventilation, inadequate space for bathrooms and toileting, lack of support spaces and storage, 3 and 4-person rooms.

About 10 years ago Brooke Grove approached Montgomery County about a renovation to add a country kitchen/cooking battery on the main level of the old wing. After a couple of meetings with the code interpreters for life and safety issues it was clear that Montgomery County would require whole building upgrades to the electrical, mechanical and fire suppression/sprinkler systems. Even after millions of dollars of expense Brooke Grove would still have an antiquated structure with non-complaint corridors and stairs, inadequate resident rooms with non-ADA toileting, insufficient storage and support spaces. Montgomery County basically asserted to Brooke Grove that any proposed major renovation would trigger comprehensive County reviews and require complete systems upgrades.

A small case study might serve as an example. About three years ago Brooke Grove updated a former residence/home that is on its campus to serve as an office building. Originally, the residence consisted of a basement and three upper stories. Due to code

requirements the renovation cost was approximately \$100 per sq. ft. and resulted in a net loss of half the space because of fire separation issues, i.e., lost use of the basement and the upper floor.

Here are a few specific issues in the building proposed for demolition. Some of these items are simply not changeable. Others may seem simple enough when isolated by themselves but the domino effect becomes staggering.

- a. Resident Corridors between 4 and 5' wide in portions of the building
- b. Non-ADA toileting/bathrooms in all resident rooms coupled with the inability to create them
- c. 3 and 4-person rooms
- d. Original old knob and tube electrical wiring is still in sections of the existing building of which creates concern for insurers related to resident safety.
- e. Aging plumbing systems
- f. Mechanical systems that do not meet fresh air requirements
- g. Non-compliant circulating stairs, rise and run too steep to meet current code
- h. An original stone foundation that is problematic in spite of numerous "fixes"
- i. Inadequate insulation in exterior walls which require supplemental heat and AC most months of the year
- j. Ingress and egress from the building cannot be safely self-managed by most residents.

2. Discrepancy in Approximate Sq. Ft.

The correct square footage of the proposed building is 78,473 and is corrected on Page 4 of the application.

3. Number of Beds Serving LTC Residents

130 beds projected to be LTC based on the proposed resident/patient mix of Medicare, Medicaid and Private Pay.

4. Describe "Short Stay Med A Patients"

"Short Stay Med A Patients" as used in the application is intended to mean short stay residents receiving rehabilitation under Medicare, or meeting other Medicare qualifying criteria for skilled care, with the intent of returning to the community after the Medicare stay. BGRNC's short stay residents are all post-acute with many needs, e.g., coronary, neuro, wound care, IV antibiotics, etc. Length of stay tends to be between 20-30 days but lengths of stay vary significantly.

5. Inconsistency in Exhibits 5 and 6

Exhibit 5 of the application was revised and included with this response. A mini basement plan is provided with this response. The first and second floors are included as well for easy reference. See **Exhibit B**.

PROJECT BUDGET

6. Expense for Purchase of CON Beds

The appropriate table(s) was revised to show the expense for purchasing the 22 beds. The cost is shown as a separate line item in the project summary of costs.

7. Site Preparation Cost

The discrepancy was corrected and the correct amount of \$2,015,000 is shown in the project cost.

8. Architectural Fees and Permit Fees

Design fees include architectural design fees, MEP design fees, civil engineering fees, kitchen design (country kitchens and pantries), third party building/contractor consultant, construction management fees for architectural/MEP, and field engineering fees for civil engineering. Brooke Grove already has expensed \$1.2M dollars toward the \$1.8. The remainder of the projected cost relates to architectural and engineering services during the remainder of the project, e.g., bid analysis, construction management, design fees associated with change in scope and due to field conditions. The projected architectural/engineering/construction management fees remaining to complete the job may seem a bit high but based on Brooke Grove's experience the projected amount is reasonable.

Permit Fees

Permit fees are inclusive of building permits and utility permits, which also include the utility companies' own engineering and design fees, i.e., PEPCO, Washington Gas, Verizon, WSSC. Each of these utilities' fees is expected to approach \$100K and the fee for WSSC alone is expected to be above \$150K.

9. Contingency

Contingency allowance was reviewed and decreased slightly to \$1,339,000 from the previous amount of \$1.39M. The total contingency was based on a contingency for the general contractor and a contingency for the owner. The GC's contingency was based on 3.5% of the building and site costs. The owner's contingency was based on 3.5% of the total project cost.

The contractor's contingency is designated for required adjustments due to field conditions and required changes in scope due to conflicts in the plans and/or due to code compliance/interpretation by field inspectors. The owner's contingency is designated for owner requested changes, e.g., revisions, specification changes, materials, layout/design.

Once the official bid is in place the contractor will tend to adjust the contractor's contingency downward to 3% but rarely below that. It is too early in the project to reduce the contingency. Owner's contingency won't change even after the official bids are received.

10. Bond Fees/Loan Placement Fees

Bond fees are comprised of a cluster of fees, e.g., commitment, placement, remarketing, trustee, construction monitoring, appraisal, legal, title and survey. These fees will be capitalized and are actually financed as part of the overall financing. So the payment will be to M&T Bank. There are a couple of these fees that will be paid directly to other providers as yet not known, i.e., appraisal, title work.

11. Debt Financing

Brooke Grove discussed financing options with M&T Bank and considered three options, i.e., traditional taxable financing, HUD financing and tax exempt financing. Taxable financing was more expensive. HUD financing required that all existing debt be in place for 2 years before refinancing. (Brooke Grove continues to consider HUD refinancing for its Williamsport campus, separate from financing related to this proposed project.) Tax exempt financing was considered the best option because it provided the best combination of rate and term available.

Additionally, M&T Bank advised that Brooke Grove view its debt as a debt portfolio, similar to how an investment portfolio would be viewed. Part of the objective was to balance the debt in ways that would protect against inflation fluctuations but also not lock in all the debt into higher rates for too long at one time.

STATE HEALTH PLAN STANDARDS

12. Memorandum of Understanding (MOU)

A copy of the MOU is included with this response. See **Exhibit C**.

13. Policy to Maintain Level of Participation

A written policy is attached to this response stating BGRNC's willingness to maintain its required level of participation when attained. See **Exhibit D**. Historically, it was the practice of Brooke Grove's executive team to review its level of participation during each fiscal year.

14. Sample of Information Regarding Alternative Community-based Services

BGRNC provides information about available community services prior to admission and at time of discharge. Samples of information distributed are provided. See **Exhibit E**.

Generally speaking, there are two broad groups of prospective residents at BGRNC, short-stay rehab residents and LTC residents. Short-stay residents are post-acute residents and are referred from a hospital for specific reasons. Length of stay (LOS) is expected to be short, usually around 3 weeks. The other group is comprised of residents intending to remain at the skilled/comprehensive care facility, true LTC residents.

Many prospective LTC residents come to BGRNC uncertain as to the appropriate level of care for their loved one. The initial discussion(s) with prospective residents or their responsible parties is one in which information is gathered to evaluate whether or not the skilled/comprehensive care facility is the correct placement. In instances where placement is appropriate at a lower level of care, for example assisted living, is more appropriate, information is provided and guidance provided to assist with an alternate placement.

Examples of information/pamphlets/brochures discussed and/or provided to prospective residents or residents being discharged are as follows.

A comprehensive list providers of all types, including home care, home health, transportation, aging services (Guide to Retirement Living and Montgomery County Seniors' Guide), resource information about support organizations such as the Alzheimer's Association, specific information about transport services, assisted living, senior housing, senior day care programs, veterans' assistance, case management, home care, home health, home delivery of groceries, etc. See **Exhibit E**. Exhibit E contains copies of some of the front covers of pamphlets and brochures provided to potential resident and residents being discharged.

15. Psychosocial Needs of Non-Elderly

BGRNC trains its staff on an ongoing basis to serve people of all ages. Training is provided within the context of its LIFE Principles/LIFE Illustrated training. (**LIFE** is Living well together, Individual discovery, Family matters, Enriching experiences.) These training sessions focus on basic needs that each person experiences at the various stages of life, e.g., inclusion, belonging, self-esteem and self-directedness and sense of purpose. The most basic needs, the ones that drive our motives, actions and emotions are not age related but span each stage in life. Our staff is trained to attend to these issues and in so doing unresolved age-related issues come to light and the caregiving team can deal with them directly. Additional training, if needed, would be provided at that time and be directed to specific situations.

Training about the psychosocial needs of non-elderly and elderly is consistently and frequently addressed throughout the organization. It is more than a policy. It is a way of life in the culture of BGRNC. The LIFE Principles are the foundational value(s) of BGRNC's corporate culture initiative called LIFE Illustrated. A copy of the LIFE

Principles PowerPoint and the LIFE Illustrated standards are included with this response. See **Exhibit F**.

The core values of the LIFE Principles are as follows.

Living Well Together
Individual Discovery
Family Matters
Enriching Experiences

LIFE Illustrated standards are behaviors that support each of the LIFE Principle values.

The training is solely focused on the importance of relationships and connecting with people, i.e., understanding each person's value, affirming their unique strengths and contributions, embracing the whole person and their family, and providing experiences that are meaningful to each person. These are universal needs at every age. It is the belief of BGRNC that these are the most essential ingredients to understanding the human experience no matter the age.

Every department at BGRNC provides education and/or examples of how these values are to be expressed in action at a minimum of once a month. BGRNC's general expectation is that every department meeting should begin with some discussion of the LIFE Principles/LIFE Illustrated and how they apply in daily life of BGRNC's residents. In addition, there are two leadership team meetings each month that highlight these values, one of which spends 1 ½ hours focused totally on training related to LIFE Principles/LIFE Illustrated.

In addition to the ongoing training BGRNC provides a LIFE Enrichment staff tasked to provide meaningful programming to each resident. At times this calls for distinctive programming for different populations, e.g., rehab vs. LTC, or in the case of this particular standard, age differences. Staff members are available to all residents and, as needed, address the needs of each population, e.g., short-stay, LTC, elderly and non-elderly. Some times this calls for more personalized and/or one-on-one engagement to provide age-appropriate interaction, relationships and meaningful activities.

Historically people under the age of 65 who contact BGRNC are insured and usually their insurer requires them to admit to a contracted facility. Brooke Grove is not a preferred provider for any HMO or a party in any other contractual relationship that directs under-65 patients/residents to BGRNC. However, BGRNC is prepared in the unlikely occurrence of a younger than expected resident.

16. Design Features to Meet Needs of Future Residents

Health Care is a moving target. Brooke Grove believes that the needs of future residents/patients of rehab facilities will differ from those needs of today's patients, just as today's patients are different from those of comprehensive care facilities of 20 years ago. While one can't necessarily predict the exact nature of those needs one can possibly make some generalizations.

- a. People are bigger today than they were a couple of decades ago. In the proposed addition there are four bariatric rooms planned which will include ceiling lifts for lifting and transporting into the bathroom and larger bathrooms.
- b. Not only are people getting bigger, today's patients are discharged more quickly from the acute setting and more acutely ill upon admission to the skilled setting. It is common for older, smaller rooms to be cluttered with equipment. The proposed replacement facility, while it could always be larger budget permitting, provides more accessible space in each room and enough space for more equipment and personal items.
- c. Larger Support Spaces. The pace of resident/patient turnover on short-stay units intensifies the number of staff working at the same time on the rehab units. Larger support spaces are needed to accommodate staff needs, e.g., care base, medical supplies on the unit.
- d. The proposed building also will house a new rehab area which will include space for some higher tech but space intensive equipment, e.g, zero gravity treadmill. This equipment won't fit into any of the existing buildings spaces and it will allow residents to more aggressively participate in physical therapy.
- e. Each resident room in the proposed replacement facility will have piped in oxygen at their bed side. This will facilitate therapies for pulmonary patients, e.g., COPD.
- f. And while it doesn't take a new building to have an electronic health record Brooke Grove purchased one this year in anticipation of expanded rehab services to better track, monitor and prevent hospital readmissions.

17. Criminal Offenses

No officer or Board Member of the corporation has ever pled guilty to a criminal charge or ever been convicted of a criminal offense in any way connected with the ownership, development, or management of a health care facility.

18. Collaborative Relationships

Examples of BGRNC's collaborative relationships are as follows.

- a. Referral Relationships with other providers to provide care. BGRNC commonly refers to other community-based, outpatient, assisted living and other LTC providers. BGRNC also discharges short-stay residents to home care and home health agencies so that care continues in a lower cost environment after discharge.
- b. Consulting with other providers to discover best practices, e.g., BGRNC currently has a consulting relationship with a physician specializing in pain management. The relationship was promoted so that BGRNC could become better at managing residents' pain, especially in the short-stay residents.
- c. Sharing Best Practices. BGRNC occasionally contacts other facilities to confer about issues and problem-solve. BGRNC encourages and expects its team of leaders to tour other facilities, to share and learn from other facilities in hopes of establishing better ways of caring for residents at BGRNC.
- d. BGRNC encourages its leaders to be active in other organizations, e.g., board and committee membership at LifeSpan/MANPHA, community civic involvement. Currently, BGRNC has staff members active in the following capacities, i.e., board member of LifeSpan/MANPHA, board member of Grass Roots Organization for the Wellbeing of Seniors (GROWS), committee member/board member of the Board of Registered Nursing Home Administrators, President of Olney Chamber of Commerce. In addition, BGRNC has consistent representation at major events in its industry, anything from meet-and-greets to educational seminars and other member/professional organizations. Each of these opportunities promotes relationships with leaders of other providers and community resources and gives rise to discussions of common professional points of interest/concern.
- e. BGRNC has transfer agreements in place with other comprehensive care and care providers
- f. BGRNC has multiple nurse liaisons whose primary task is relationship building with other providers. Those providers include community-based providers, hospitals, other comprehensive care facilities, assisted living facilities, physicians, and just about any kind of company for which BGRNC might provide a service or that in some way might provide a service to the residents at BGRNC.

19. Address 05(B)(1)

a. Occupancy Data for Last 5 Years

See **Exhibit G**. BGRNC operated with an occupancy above 90% for the last two years. Please note that the percent occupancy in the newer section of BGRNC increased each of the last 4 years. The overall occupancy of BGRNC is dragged down by the sagging occupancy of the older building which in 2014 was only 81%. The older wing is very hard to sell to prospective residents because of its physical limitations. The proposed replacement facility and demolition of the old wing would result in an even higher percent occupancy of BGRNC.

b. Growing Demographic of Over 80 Population

See **Exhibit H**. Every source available projects significant population growth in Montgomery County for ages 65 and up, across the nation for that matter. Between 2010 and 2040 each segment of the senior population is projected to significantly increase. The 70+ age groups each will more than double. The Boomers are becoming seniors. The older Boomers are already turning 70. The “silver wave,” as it sometimes is referred, is projected to have dramatic impact on health care as this group of people begin to progressively need more care. The “unmet need” refers to the potential lack of capacity within the health care continuum. See **Exhibit I**. An important fact in BGRNC’s case is that the population is that the senior population is not necessarily distributed evenly throughout the county. Leisure World, with a population of 8K seniors is only 4 miles from BGRNC.

c. Increased Referrals/Admissions by Source

See **Exhibit J**. It documents the number of admissions from each hospital. A couple of tidbits are worth mentioning. Holy Cross now accounts for 10.6 percent of BGRNC admissions. This is significant growth. Howard County General Hospital represents only 2.6% but a couple of years ago BGRNC admitted next to none from Howard County. BGRNC expects the number of admissions from Howard County General to double next year. (Note the letter of support in Exhibit K from the Director of Case Management of Howard County General.) Brooke Grove expects continued growth from all the neighboring hospitals. The fewest admissions from local hospitals was from National Rehab but the relationship is growing and the pain management consulting from an affiliated physician adds credibility to BGRNC’s services, which will ultimately lead to increased referrals.

Letters of support are in **Exhibit K**. Time permitting a greater number of letters would have been received.

20. Quality Assurance Program

A copy of the Quality Assurance Program and examples of changes implemented as a result of actions taken by the QA Committee is attached. See **Exhibit L**.

CERTIFICATE OF NEED CRITERIA

21. Jurisdictional Occupancy

Jurisdictional occupancy of Montgomery County is much lower than the current occupancy of BGRNC. This fact raises the question why does BGRNC operate at such a high occupancy? As the supporting reasons to approve the transfer of these 22 beds are presented it is important to remember that the intended use of these beds is short-stay rehabilitation, not LTC.

BGRNC's request to transfer 22 beds from Village at Rockville to BGRNC is warranted for a number of reasons.

First, BGRNC's census for the last 2 years is above 90%. See **Exhibit G**. It's operated at above 90% even though the older section of the facility operated at a much lower occupancy, 81.4% in FY2014. The age of the older section, lack of space, basic lack of functionality and code-related issues make it very hard to sell. The proposed replacement facility is anticipated to run a higher occupancy than the existing old section, thus raising current overall occupancy levels even higher. The newer part of the building, the 120-bed section constructed in 2000 increased percent occupancy in each of the last four years, i.e., 89.5% (FY2011), 90% (FY2012), 93.7% (FY2013), 94.3% (FY2014).

Second, the demand and support for BGRNC's beds/services is high. (Letters of support are shown in **Exhibit K**). The beds at BGRNC, with the exception of the "old" wing, are frequently full. BGRNC frequently denies access due to lack of available beds. Last year BGRNC denied 60 admissions from MedStar Montgomery Medical Center alone because of lack of bed availability. MedStar Montgomery Medical Center is the primary referring hospital to BGRNC. Demand for BGRNC's beds continues to build in its primary service area but with perimeter hospitals as well. Holy Cross Hospital now represents 10% of admissions to BGRNC. A few years ago BGRNC only received a handful of admissions from Holy Cross per year. Admissions from Shady Grove Adventist (6%) and Suburban (4%) are not as great but the increase in their admissions represents significant impact on the availability of BGRNC's beds and the increased revenue resulting from the admissions.

Third, there is a concentration of seniors and physician services close to BGRNC. The seniors create the demand and the health care providers create the referrals to BGRNC.

Leisure World, a retirement community of 8K seniors is only 4 miles away. MedStar Montgomery Medical Center is only 2 miles away. There are two major medical office buildings on the campus of MedStar Montgomery Medical Center and one other large medical office complex less than three miles from the hospital and BGRNC. Numerous other medical office buildings are within 4 miles of BGRNC. The concentration of seniors and providers and their proximity to BGRNC is an ideal scenario to support current and future occupancy, especially coupled with the projected future growth of the senior population.

Fourth, there are numerous assisted living homes and senior housing apartments close to BGRNC. In addition to Brooke Grove's own 7 assisted living facilities located on its Sandy Spring campus others include Solana, a 92-bed assisted living home, located about 1.5 miles away, Olney Assisted Living, a 64-bed assisted living that opened October 2014, located about 3 miles away, and Alfred House, Marian Assisted Living, Andrew Kim House/Victory Housing, Friends House. All of these assisted living homes are within 4 miles of BGRNC. Again, proximity to MedStar Montgomery Medical Center and BGRNC create an ideal scenario, i.e., MedStar Montgomery for acute care and BGRNC for rehab services.

Fifth, BGRNC's census is high due to its reputation, outcomes, Pay for Performance rankings, 5-Star rating, impressive physical plant and high customer satisfaction ratings. While the connections between these performance indicators are difficult to directly correlate with the high census at BGRNC these are simple facts which BGRNC leverages heavily in its marketing efforts. At face value it makes sense that these factors would influence prospective customers' opinions and the opinions of referral sources. Which discerning prospective customer would not want to receive their rehab at the facility ranked number one in its service area by the State of Maryland three years running and also has a 60-year community presence and has one of the newest physical plants of any freestanding skilled/comprehensive care facility in the area? BGRNC believes these factors play a significant role in BGRNC's continued increase in census/percent occupancy.

Sixth, BGRNC has experienced significant growth, especially in its rehab/short-stay census. BGRNC also projects the trend for increased rehab utilization to continue. Of course, demand for future health care services is uncertain and assumptions about the future of the health care system vary greatly. BGRNC's assumptions are as follows.

a. As aging “Boomers” reach retirement there will be, at a minimum, sustained demand for LTC services and an increased demand for post-acute rehab services. Younger Boomers may elect to receive their therapies in outpatient settings but older ones with less family support and more fragile health will still rely on inpatient rehab stays at comprehensive/skilled care settings.

b. The anticipated elimination of the 3-day hospital stay as a requisite for skilled care will result in lower hospital census but will not necessarily result in lower skilled admissions. It is more likely to result in direct admissions to the skilled setting and overall increased skilled admissions, yet at an overall lower cost to the health care system.

c. Current reimbursement incentivizes hospitals to discharge patients earlier than ever and at the same time challenges them to lower their readmission rate. BGRNC believes the option that will prove to be the most cost effective for hospitals will be to discharge patients as quickly as reasonably possible to a skilled environment so as to minimize the risk of readmission. This would be particularly true of frail elderly patients at risk for post- acute complications, medication-related falls and little to no family support.

d. The overall increase in the over 80 year old population will result in higher utilization in the health care system. Hospitals will direct patients to the lowest cost level of care that poses the least financial risk to the hospitals. In many cases that choice will be a skilled/rehab facility demonstrating the highest clinical competencies.

The State’s projections for decreased need for beds is interesting in light of the proposed population explosion of the Boomers/seniors but also in light of the anticipated explosion of Alzheimer’s Disease, especially mid to late stage. The frail elderly will still need skilled/rehab/comprehensive care beds and mid to late stage Alzheimer’s is very challenging to manage at home. Either or both of these trends would tend to increase utilization.

The seventh and last reason that warrants transfer of beds to BGRNC is that the final result of providers adapting to market conditions will be an increase in the jurisdictional occupancy, e.g., delicensing beds to convert semi-private rooms to private. But if rehab utilization increases due to the needs of the aging Boomers there will be a need for greater capacity, especially short-stay rehab capacity. The volume will naturally shift to those providers who have rehab capacity. Those providers that are delicensing beds and converting semi-private to private rooms are doing so to create a more competitive product and keep pace with their own market conditions. BGRNC should be allowed to accommodate its own market realities, the increased demand for its beds and services.

22. Location of Hospitals and Primary Market Area

- a. Map of Montgomery County with Hospitals Shown
See **Exhibit M.**
- b. List of Zip Codes/Primary Market Area (75% of Admissions)
List is attached and additional map showing primary market area is attached as **Exhibit M.**

23. Factors Influencing Need for Additional Beds

BGRNC did not complete primary market research to establish to what extent how each of the factors listed influenced prospective customers' purchase decisions. However, at face value one can understand that each of the factors would positively influence a decision to place a member of one's family at BGRNC for rehabilitation or LTC.

Reputation

BGRNC has been a care facility since its inception in 1950, beginning with only 2 residents, now corporate-wide almost a daily census of 450. Though not family owned or affiliated with any religious denomination it began under the leadership of a Christian woman whose family members have been involved in operating the business since its beginning. A few years after beginning the business the founder's son, Carl Howe, joined the team, soon becoming president of Brooke Grove and remaining so for 50 years. The current president of Brooke Grove has been president for 20 years. There have only been three presidents of the company in its 64-year history. The long tenured leadership of Brooke Grove gave a consistency in values and mission that is the cornerstone of its corporate culture and reputation in the community. All leaders at Brooke Grove are encouraged to participate in community organizations and committees. For example, the current administrator of BGRNC is the president of the Olney Chamber of Commerce.

Carl Howe, the longest tenured president of Brooke Grove was also chair of the committee that initially wrote the standards for licensing of nursing home administrators in the State of Maryland and until his death held license number 1. Brooke Grove was also the first to operate an assisted living home in Montgomery County. BGRNC and MedStar Montgomery have been neighbors and have been referring patients to each other for 64 years. Brooke Grove's provision of high quality care, involvement in community affairs and being a large employer in the area is highly respected. The point is that BGRNC has been around a long time and has been a prominent provider of health care, a significant employer and fully committed, active member of the community. Its reputation is meaningful.

Pay for Performance Rankings

Since Pay for Performance Rankings were initiated 3 years ago BGRNC has been the #1 ranked facility in Montgomery County. Its overall ranking in the state the first year was #6. The second year it was #6. The third year it was ranked #2 in the state. BGRNC is highly ranked and has demonstrated a track record of consistency and quality. BGRNC leverages its high ranking in marketing efforts, e.g., print advertising, web/online advertising, banners at its main entrance during significant stretches of time for the three years. A color flyer of the Pay for Performance rankings is also given to each prospective resident. See **Exhibit N**.

5-Star Rating

BGRNC is a 5-Star rated provider by CMS. There's been a lot of negative and positive publicity about the 5-Star Ratings but this ranking still tends to be important to hospitals. One local hospital recently held a meeting for community/nurse liaisons of the surrounding comprehensive care providers. The hospital announced that it intended to only work with facilities that were either 4 or 5-Star rated. A 5-Star rating is exceptional and in the minds of hospital discharge planners and case managers very meaningful.

Physical Plant

BGRNC's newer section was constructed in 2000. Even though it is 15 years old it remains one of the newer freestanding facilities in Montgomery County. The overall appearance and feel of a newer building is emotionally more uplifting than older facilities. There is more natural light and fresher air in the building at all times of year. Spaces tend to be larger. BGRNC has very generous spaces for social functions, family get-togethers, community meetings and connecting times such as these. There are two spaces of about 2000 square in it. One is used as a party and community room, which residents and their families enjoy greatly. The other room is an activity room but is used as flex space for many resident functions. These spaces are in addition to the usual dining/activity spaces of older facilities. The reality is that BGRNC is still a relatively new facility with contemporary spaces. It is well maintained and in general just feels good to enter. For potential residents it just feels like a better place than most others.

Outcomes

Outcomes and quality indicators are closely monitored by DHMH. BGRNC consistently ranks well in quality indicators. Quality measures are considered in the calculations of Pay for Performance and the 5-Star Rankings which were summarized above.

Corporate Culture

Brooke Grove's corporate culture is an ongoing strong emphasis. Each leadership meeting focuses on culture, vision and mission. At one monthly leadership meeting it is the total focus of the meeting. Each department addresses culture, vision and mission in its department meetings at least once a month. Culture is a constant discussion point.

The culture is based on the LIFE Principles of Living Well Together, Individual Discovery, Family Matters and Enriching Experiences. This is a relatively simple mantra. What makes the culture of BGRNC different isn't necessarily the messaging or how it is packaged. BGRNC doesn't let the words stay on a page or on the wall. BGRNC intentionally sets about to operationalize those words in as many ways as possible.

The current promise in BGRNC's advertising is "Simply Different. Because what surrounds you really matters." The BGRNC marketing team created the messaging but the words originated from our customers. Those words were close to direct quotes from hundreds of customers over the years. They are words we simply repeated in advertising. They are the words our customers used to share their stories about the care they received while at BGRNC.

24. Post-Acute Services/Comorbidities in the Elderly

Identify Comorbidities

BGRNC will continue to provide the same services as it does now, i.e., short-stay rehab, LTC for alert and oriented, LTC for residents with cognitive deficits and memory loss. The main consideration heading into the future is that future residents admitted to skilled/comprehensive care facilities will be more medically complex than now, e.g., increased tracheostomies, traumatic brain injuries, extensive wounds/wound care, TPN. The structural and reimbursement changes now occurring in the health care system necessitate caring for residents at the lowest cost level of care at which the most appropriate medical care can be delivered. This transformation will result in quicker discharges from hospitals to skilled facilities for care management. And if the Medicare requirement for a 3-day hospital stay is eliminated then skilled facilities will likely see direct admits that previously would have been directly admitted to the hospital. Skilled facilities/comprehensive care facilities will upgrade their competencies to care for more acutely ill residents. In addition, as admission and qualifying criteria are revised by regulatory agencies residents/patients that are less medically complex will be more appropriate for lower levels of care.

A discussion of co-morbidities ranges far and wide. Diagnostic groupings potentially have co-morbidities shared in common with each other but also unique ones. As people age with their disease(s) it is common for other related issues to manifest themselves. The

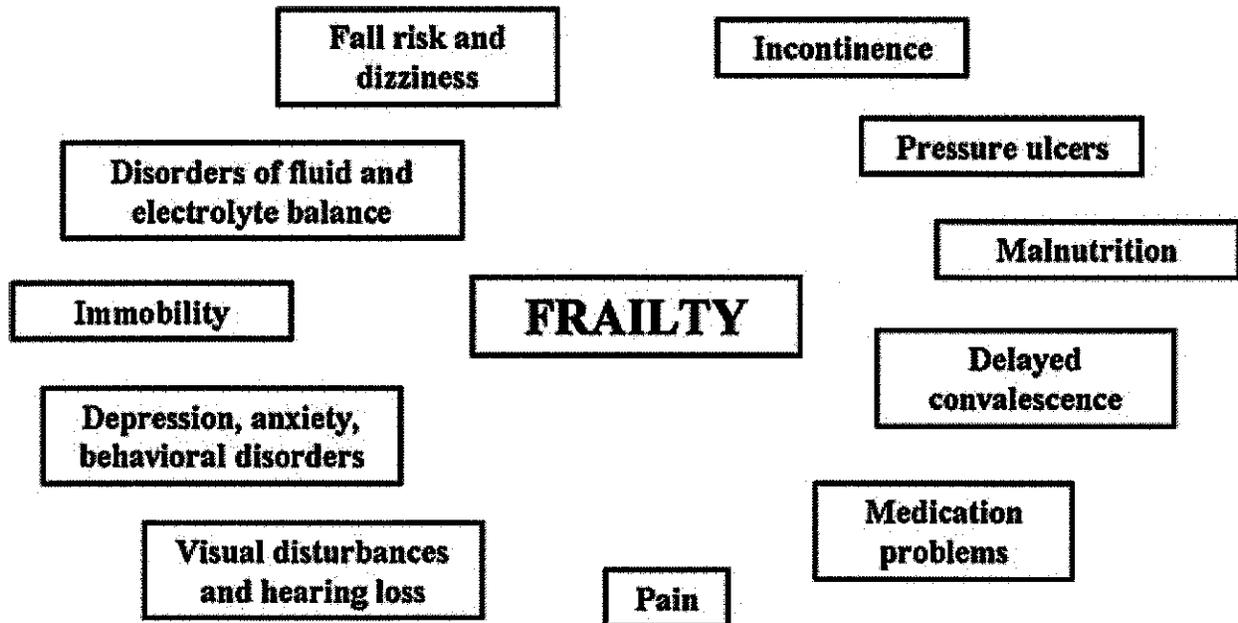
population of America is aging. The projected growth of the senior population is expected to increase disproportionately compared to other age groups. The Boomers are coming of age. Since they are expected to live longer than the previous generation they will tend to exhibit multiple co-morbidities, possibly even more than previous generations, and live with them longer.

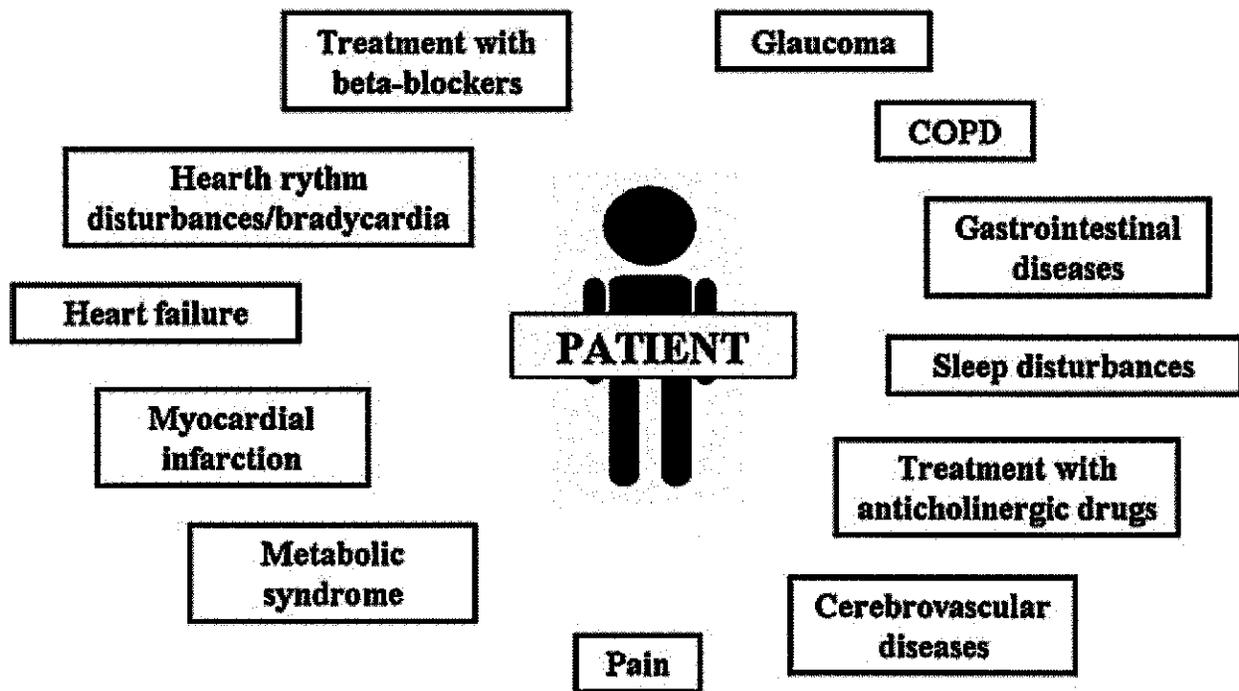
Below is a table of co-morbidities for COPD. The typical COPD resident/patient usually has more than one medical complication, creating complexity in treatment and treatment planning. The table simply serves as an example of co-morbidities. It is a list of the most prominent co-morbidities with COPD. This is just one example of the types of health-related issues that skilled facilities must be prepared to deal with on an increasing level.

Cardiovascular disease
Hypertension
Coronary artery disease
Systolic and/or diastolic left ventricular dysfunction
Pulmonary hypertension
Peripheral vascular disease
Cerebrovascular disease
Stroke
Skeletal muscle dysfunction and loss of muscle mass
Osteoporosis, osteopenia or osteoarthritis
Psychological disturbances
Depression
Anxiety
Cognitive impairment
Anemia
Obstructive sleep apnea
Diabetes/metabolic syndrome
Renal insufficiency
Gastro-esophageal reflux disease
Lung cancer
Infections

Each disease that today challenges American society has co-morbidities, e.g., pulmonary/respiratory diseases, cancers, cardiac diseases, diabetes, Alzheimer's obesity. Co-morbidities make treatment more costly and more medically complex. Each has to be managed. As Americans age and live longer they will most likely exhibit more co-morbidities associated with disease processes. And co-morbidities will be a consideration when determining level of care. BGRNC contends that the aging of the population combined with increased medical complexity will result in increased utilization of skilled/comprehensive care facilities.

Following are two images as additional examples published in Neurological Sciences (2013) and appearing on NIH's web site displaying some of the common issues that accompany the frail elderly and the dementia/Alzheimer's patient/resident.





Again, Brooke Grove contends that the aging of America will result in greater utilization in the health care system and that the presence of multiple co-morbidities will drive sustained need of LTC beds and an increasing demand for short-stay rehabilitation beds, simply because the greater the number of co-morbidities the more complex the patient/resident. The health care system will manage many of the younger Boomers in lower cost settings than skilled/comprehensive care facilities. The more elderly, frail Boomers however will need more highly skilled settings to manage their multiple disease processes. This will be true for both LTC and short-stay rehab residents.

a. Need for Dementia Services

Improving the short-stay program at BGRNC does not directly address the jurisdiction's need of services for mid to late stage dementia residents. Brooke Grove, the parent company of BGRNC, is aware of the need for dementia services and in its own way is attempting to address that need at BGRNC and on its Sandy Spring campus.

Ten years ago Brooke Grove immersed itself in a strategic planning process. During its attempt to peek into the future Brooke Grove concluded that short stay rehab would increase, mid to late stage dementia needs would increase and that the traditional alert and oriented LTC resident would, in as much as possible, shift to other care settings, e.g., assisted living.

After reaching those conclusions Brooke Grove tactically began reallocating resources to accommodate what it saw as the future of skilled/comprehensive care facilities and assisted living facilities. At this point 5 of its 7 assisted living facilities on the Sandy Spring campus are Level 3 memory care homes. In BGRNC the number of memory care beds is 108 of the 168 beds, not counting some of the residents who are confused but can still be cared for in a mixed population. It may be that Brooke Grove in the future will convert more assisted living and LTC beds to Alzheimer's care. Bed utilization can change based on need/demand.

Brooke Grove also now staffs some of its assisted living memory care homes similar to nursing home staffing so customers have a choice between receiving care at an assisted living home or the comprehensive care facility. Residents can also remain in assisted living longer than in the past and possibly avoid admission to a skilled/comprehensive care facility, or at least delay admission.

So, while the proposed increase of 22 beds to BGRNC doesn't directly address the jurisdiction's needs for dementia services in a comprehensive care facility Brooke Grove is aware of the coming wave of dementia/Alzheimer's residents and is preparing for them. See **Exhibit O**.

25. Assumptions Underlying Utilization Tables

See Financial Tables, **Exhibit P**

26. Cost Effectiveness of Proposed Replacement Facility

Cost effectiveness of the proposed project can be viewed from a number of perspectives. BGRNC assumes that at some point in the history of a building the cost to repair and renovate becomes great enough that replacement makes the most sense from an investment and long term perspective. This is particularly true if the purpose of the building changes and/or if the population using the building changes significantly.

First, the cost of renovating the existing wing originally constructed in the 1800's is formidable and even if possible to renovate the end result would still be a structure with features that are incompatible with today's building and care standards. BGRNC also

assumes that while there is currently a struggle for facilities to maintain jurisdictional occupancy, market forces and facilities' adaptations will resolve this issue for underperforming facilities. BGRNC assumes that demand for LTC residents will be sustained by the population explosion of the Boomers and the continued rise in Alzheimer's disease. It also believes that the aging of the Boomers will result in a net

increase in utilization for short-stay rehab. In each of these scenarios buildings will need replacing. The reality is that construction costs will continue to rise and now is the least expensive time to build.

Second, BGRNC already being one of the newest facilities in the State is well over the allowable cap for reimbursement related to building cost. So, in this sense a new building does not cost the health care system any additional dollars.

Third, it is true that one could propose the idea that if this proposed expansion was denied that somehow the health care system would be spared expense by forcing patients to go to underperforming facilities. However, even in this scenario one would balance that value with the opportunity to provide the highest level of services in modern buildings that are conducive to healing, recovery and wellness. This would be true of any patient type, true of LTC residents but equally true for short-stay rehabilitation residents.

27. Viability of Proposal

- a. Expand Financial Tables to Add 2019 Projections
See Financial Tables, **Exhibit P**
- b. Define Time Frame of Tables
Fiscal Year, Beginning July 1
- c. Tables/Numbering Format
Yes, the numbers in the financial tables were intended to be read as in thousands (000).

28. Replace Table 2 with Projections for Entire 70 Beds

See Financial Tables, **Exhibit P**

29. For Table 3...

- a. See Supporting Table tied to Payer/Inpatient Revenue in **Exhibit P**, Financial Tables

- b. Assumptions Regarding Payers (Commercial Insurance & Self-Pay)
Commercial insurance is combined with private pay in Brooke Grove's record systems. While commercial insurance has shown some growth over the past several years, self-pay continues to decline. We assume that Private Pay / Commercial Insurance will decline, both in numbers of patient days and as a percentage of total days.
- c. Explain Calculation of Contractual Allowances
Contractual allowances are calculated by Brooke Grove's financial system, and are 22.0% of Inpatient Services Revenue in 2013, and 24.8% in 2014. Years 2015 through 2019 are projected at 24.4% of Inpatient Services Revenue.
- d. Explain Increase in Allowance for Bad Debt, 2013 – 2014
Bad Debt increased significantly in 2014, due to increased difficulty in collecting self-pay balances, and fewer short stay residents with secondary insurances to pay Medicare A co-pays. 2015 through 2019 are projected at 1.66% of Inpatient Services Revenue.
- e. Explain Increase in Contractual Services, 2017-2018
The largest component of Contractual Services is purchased Rehabilitation Services. We anticipate increases in contractual services expense in 2018, as a result of increased Medicare A (rehabilitation) admissions and patient days.

30. Medicare and Medicaid Projections

- a. There a number of factors combining to make the Medicare projections tenable. First, growing demand for Brooke Grove's beds and increasing denials to BGRNC. Second, an aging population that will increase short-stay rehab utilization. Third, Brooke Grove's proximity to a concentrated population of seniors and health care providers.
The proposed project is for a 70-bed replacement wing. The success of the project will be judged on BGRNC's ability to use the larger component of these beds for short-stay rehab. The sheer number of beds in the new unit as a percentage of total beds would preempt a 25% Medicare utilization, especially when combined with a 43% Medicaid participation. That would mean a Private Pay census of 32%. BGRNC sees Private Pay remaining approximately the same at best and the Medicare census increasing significantly, e.g., population growth and aging population, Medicaid sustaining but decreasing Private Pay.
- b. Compliance of Medicaid Participation
The financial tables/projections were revised to reflect a 43% Medicaid participation.

BGRNC is fully willing and committed to participating in the Medicaid program. It currently makes, and will continue to make, a good faith effort at serving all those potential Medicaid residents that meet admission criteria.

31. Impact on Other Providers

BGRNC believes that the impact of transferring 22 beds from Village of Rockville to BGRNC will have a negligible impact on other providers. The requested increased capacity is a relatively small number of beds. In addition, BGRNC attracts admissions from hospitals throughout the county so any impact, if at all, would be distributed. However, the impact of a changing health care system and continued decreasing reimbursement will be disrupting. The impact of a changing system will far outweigh the

transfer of 22 beds in inventory within the same jurisdiction. Each facility must strategically plan on how best it can adapt to the future. Some will delicense beds. Some already have done so. Others may join ACOs or enter into contractual agreements with other providers in an attempt to drive more admissions. Some may improve and/or develop specialty services in an effort to increase census. These actions will be the result of the changing health care system as opposed to the small contingent of licensed beds added to BGRNC.

32. Breakdown of Projected FTEs by Job Titles

RN 11.7 FTE

LPN 23.4 FTE

Aides 65.3 FTE

Medicine Aides 9.2 FTE

33. Nursing Staff for Replacement Facility

Yes, 16.8 FTE nursing staff will be hired to provide care to additional patient volumes created by the 70 bed replacement facility and they will work in the proposed replacement facility.

APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

34. Ownership of Other Facilities

Brooke Grove Foundation, Inc. owns and operates the following comprehensive care facilities.

Brooke Grove Rehabilitation and Nursing Center
18131 Slade School Road
Sandy Spring, MD 20860

Williamsport Nursing home
154 N. Artizan
Williamsport, MD 21795

It also operates 9 assisted living homes in Maryland and a group home in Pennsylvania.
They are as follows.

The Meadows 1635
1635 Hickory Knoll Road
Sandy Spring, MD 20860

The Meadows 1637
1637 Hickory Knoll Road
Sandy Spring, MD 20860

The Meadows 1639
1639 Hickory Knoll Road
Sandy Spring, MD 20860

The Meadows 1641
1641 Hickory Knoll Road
Sandy Spring, MD 20860

Twin Oaks 40
40 East Village Lane
Williamsport, MD 21795

Twin Oaks 44
44 East Village Lane
Williamsport, MD 21795

Rest Assured Living Center
1170 Shirley Hollow Road
Meyersdale, PA

Brooke Grove Foundation also operates a CCRC on its Sandy Spring, Maryland campus. Its address is as follows.

Brooke Grove Retirement Village
18100 Slade School Road
Sandy Spring, MD 20860

35. Signature Page

The signature page is the last page of the revised CON Application. See **Exhibit A**.

**MARYLAND
HEALTH
CARE
COMMISSION**

MATTER/DOCKET NO.

DATE DOCKETED

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

***ALL PAGES THROUGHOUT THE APPLICATION
SHOULD BE NUMBERED CONSECUTIVELY.***

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

- | | | | |
|------|---|------|--|
| 1.a. | Brooke Grove Foundation, Inc.
Legal Name of Project Applicant
(ie. Licensee or Proposed Licensee) | 3.a. | Brooke Grove Retirement Village
Name of Facility |
| b. | 18100 Slade School Road
Street | b. | 18131 Slade School Road
Street (Project Site) |
| c. | Sandy Spring, 20860, Montgomery
City Zip County | c. | Sandy Spring, 20860, Montgomery
City Zip County |
| d. | 301 924-2811
Telephone | 4. | _____
Name of Owner (if different than
applicant) |
| e. | Keith Gibb, CEO
Name of Owner/Chief Executive | | |
| 2.a. | _____
Legal Name of Project Co-Applicant
(ie. if more than one applicant) | 5.a. | _____
Representative of
Co-Applicant |
| b. | _____
Street | b. | _____
Street |
| c. | _____
City Zip County | c. | _____
City Zip County |
| d. | _____
Telephone | d. | _____
Telephone |
| e. | _____
Name of Owner/Chief Executive | | |

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

- a. Dennis Hunter, Vice President
Name and Title
- b. 18100 Slade School Road
Street
- c. Sandy Spring, 20860, Montgomery
City Zip County
- d. 301 388-7202
Telephone No.
- e. 301 924-1200
Fax No.

a. _____
Name and Title

b. _____
Street

c. _____
City Zip County

d. _____
Telephone No.

e. _____
Fax No.

7. Brief Project Description (for identification only; see also item #14):
Construct a 70-bed replacement unit to the existing Brooke Grove Rehabilitation and Nursing Center (BGRNC) with a net increase of 22 beds, increasing the licensed capacity from 168 to 190 beds. The proposed 70 beds are comprised of 48 existing beds, currently located in a wing to be demolished and 22 CON-approved beds already in MHCC's inventory and purchased from National Lutheran/Village at Rockville.

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

- a. Governmental _____
Proprietary _____
Nonprofit
- b. Sole Proprietorship _____
Partnership _____
Corporation
Subchapter "S" _____
- c. To be Formed _____
Existing _____

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	168/168	+22	190
Assisted Living	Beds	____/____		
Extended Care	Beds	____/____		
Adult Day Care	"Slots"	____/____		
Other (Specify)		____/____		
		____/____		

- (3) Land Lease held by: Not Applicable
 (i) Expiration Date of Lease _____
 (ii) Is Lease Renewable _____ If yes, please explain

 (iii) Cost of Lease _____
- (4) Option to lease held by: Not Applicable
 (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: Not Applicable

(INSTRUCTION: IN COMPLETING ITEMS 12 & 13, PLEASE NOTE APPLICABLE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

12. Project Implementation Target Dates (for construction or renovation projects):
 A. Obligation of Capital Expenditure 3 months from approval date.
 B. Beginning Construction 2 months from capital obligation.
 C. Pre-Licensure/First Use 24 months from capital obligation.
 D. Full Utilization 8 months from first use.
13. Project Implementation Target Dates (for projects **not** involving construction or renovations):
 A. Obligation of Capital Expenditure _____ months from approval date.
 B. Pre-Licensure/First Use _____ months from capital obligation.
 C. Full Utilization _____ months from first use.
14. Project Description:

Provide a reasonably full description of the project's construction and renovation plan and all services to be provided following completion of the project.

Brooke Grove Foundation, Inc. proposes to construct a 70-bed replacement wing/facility to Brooke Grove Rehabilitation and Nursing Center (BGRNC), its skilled facility in Sandy Spring, Maryland. The proposed 70 beds are comprised of 48 replacement beds, from the demolition of an existing 48-bed unit, and 22 beds purchased from National Lutheran/Village at Rockville. The net result is a proposed 22-bed increase to BGRNC's licensed capacity. The proposed facility is planned as a 78,473 square foot addition with an estimated cost of \$25M.

The proposed 70-bed replacement facility will take approximately 2 years to construct. The anticipated start date is April 2015. Construction is expected to last 24 months/2 years and be completed in March 2017. The proposed project involves a phased sequence, i.e., site work, construction of 56 beds, demolition of existing 48-bed wing, construction of 14-bed pod/wing.

The proposed 70-bed addition will feature many new amenities, including bedrooms, country kitchen serving areas, dining rooms, rehab space, and more. And, of course, the proposed new replacement facility will meet all current codes, replacing an antiquated existing wing, most of which was built in the late 1800's and early 1900's. The newest section of the wing to be demolished was built in the early 1970's but constructed in a way that makes it challenging to renovate and create living environments to meet the needs to today's and tomorrow's resident population

CONSTRUCTION SEQUENCE/SCHEDULE

1. Site Work (3 months)
 - a. Road Improvements
 - b. Side Walks
 - c. Parking Lots
 - d. Walking Trails
 - e. Relocation of Utilities
2. Construction of Replacement Facility (Phase 1, 56 beds, 12 months)
 - a. 8 Private Rooms, 4 of which are bariatric with ceiling lifts
 - b. 24 Companion Suites (semi-private rooms with walls between beds)
 - c. All rooms with ADA bathrooms
 - d. New rehab area
 - e. New mechanical systems, e.g., HVAC
 - f. Compliance to current building codes
 - g. Country kitchen/serving areas on each floor
 - h. Easy access to courtyards
 - i. Patios
3. Demolition of Old Section of Existing Building (1 month)
 - a. Demolish a 48-bed portion of the existing nursing home
 - b. Built in the late 1800's
 - c. Multi-story building with inadequate support spaces upstairs
 - d. Existing 3-bed wards/rooms
 - e. Narrow corridors
 - f. Bathrooms that cannot be renovated to be ADA
 - g. Old HVAC system
 - h. Limited access to outdoors
4. Construction of 14-Bed Pod/Wing (Phase 2, 14 beds, 8 months)
 - a. 2 Private Rooms
 - b. 6 Companion Suites
 - c. Same features as Phase 1

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.

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.
Not Applicable

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 already on site and connected to the existing building, i.e., water, sewer, gas, electricity, communications.

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	15,168,000	60,000
Class D		
Type of Construction/Renovation		
Low		
Average		
Good	Yes	Yes
Excellent		
Number of Stories		
Total Square Footage		
Basement	21,817	None Added
First Floor	30,090	None Added
Second Floor	26,566	None Added
Third Floor		
Fourth Floor		
Perimeter in Linear Feet		
Basement	1,304	
First Floor	1,552	
Second Floor	1,486	
Third Floor		
Fourth Floor		
Wall Height (floor to eaves)		
Basement	33'-9"	
First Floor	21'-9"	
Second Floor	9'-9"	
Third Floor		
Fourth Floor		
Elevators		
Type	<i>Passenger</i>	<i>Freight</i>
Number		Passenger/4500#
		3
Sprinklers (Wet or Dry System)		Wet
Type of HVAC System		VRF w/energy recovery
Type of Exterior Walls		1 hr. rated metal stud bearing w/cement board siding

Chart 1. Project Construction Characteristics and Costs (cont.)		
	Costs	Costs
Site Preparation Costs	\$	\$
Normal Site Preparation*	750,000	
Demolition	300,000	
Storm Drains	400,000	
Rough Grading	250,000	
Hillside Foundation		
Terracing		
Pilings		
Offsite Costs	\$	\$
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Signs	40,000	\$
Landscaping	275,000	\$

*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		15,168,000
(2)	Fixed Equipment (not included in construction)		1,427,000
(3)	Land Purchase		0
(4)	Site Preparation		2,015,000
(5)	Architect/Engineering Fees		1,835,000
(6)	Permits, (Building, Utilities, Etc)		625,000
	SUBTOTAL	\$	21,070,000

b.	<u>Renovations</u>		
(1)	Building	\$	60,000
(2)	Fixed Equipment (not included in construction)		
(3)	Architect/Engineering Fees		
(4)	Permits, (Building, Utilities, Etc.)		
	SUBTOTAL	\$	60,000

c.	<u>Other Capital Costs</u>		
(1)	Major Movable Equipment		0
(2)	Minor Movable Equipment		421,000
(3)	Contingencies		1,339,000
(4)	Other (Specify, FFE)		635,000
	Other (Purchase of Beds)		110,000
	TOTAL CURRENT CAPITAL COSTS	\$	23,635,000
	(a - c)		

d.	<u>Non Current Capital Cost</u>		
(1)	Interest (Gross)	\$	960,000
(2)	Inflation (state all assumptions, including time period and rate)		0
	TOTAL PROPOSED CAPITAL COSTS	\$	24,595,000
	(a - d)		

2. Financing Cost and Other Cash Requirements:

a.	Loan Placement Fees	\$	400,000
----	---------------------	----	---------

b.	Bond Discount	
c.	Legal Fees (CON Related)	0
d.	Legal Fees (Other, Zoning)	30,000
e.	Printing	0
f.	Consultant Fees	0
	CON Application Assistance	0
	Other (Specify)	0
g.	Liquidation of Existing Debt	0
h.	Debt Service Reserve Fund	0
i.	Principal Amortization Reserve Fund	
j.	Other (Specify)	

TOTAL (a - j) \$ 430,000

3. Working Capital Startup Costs \$ _____

TOTAL USES OF FUNDS (1 - 3) \$ 25,076,000

B. Sources of Funds for Project:

1.	Cash	1,052,100
2.	Pledges: Gross _____, less allowance for uncollectables _____ = Net	
3.	Gifts, bequests	
4.	Interest income (gross)	23,900
5.	Authorized Bonds	24,000,000
6.	Mortgage	
7.	Working capital loans	
8.	Grants or Appropriation	
	(a) Federal	
	(b) State	
	(c) Local	
9.	Other (Specify)	

TOTAL SOURCES OF FUNDS (1-9) \$ 25,076,000

Lease Costs: a. Land	\$ _____	x _____	= \$ _____	0
b. Building	\$ _____	x _____	= \$ _____	0
c. Major Movable Equipment	\$ _____	x _____	= \$ _____	0
d. Minor Movable Equipment	\$ _____	x _____	= \$ _____	0
e. Other (Specify)	\$ _____	x _____	= \$ _____	0

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.)**

**State Health Plan
COMAR 10.24.08.05
Nursing Home Standards**

SECTION A, GENERAL STANDARDS

05.A.1, Bed Need

The 70-bed proposed project builds 48 replacement beds and adds 22 CON-approved beds purchased from National Lutheran/Village at Rockville. All beds in the proposed replacement addition already exist as CON beds and are currently in inventory. None of the beds in the proposed project add capacity in the jurisdiction/Montgomery County. However, a more complete description of why Brooke Grove Rehabilitation and Nursing Center (BGRNC) continues to need its current capacity and the proposed increase is explained in later sections of this document. The primary driving factors are increased demand for Short Stay Med A beds at BGRNC, sustained high percentage of occupancy, increased admissions, high percentage of denied admissions based on lack of short term stay Med A beds, elderly population growth with more comorbidities and chronic health conditions resulting in increased utilization.

5.A.2, MEDICAL ASSISTANCE PARTICIPATION

05.A.2.a, MOU

Brooke Grove Rehabilitation and Nursing Center (BGRNC) currently has a MOU. It was originally signed around 1999 or 2000 and requires an approximate 43% participation. It currently serves the Medicaid population at levels proportionate to other providers in its jurisdiction/region. Brooke Grove intends to sign a new MOU, or modify the existing one, to reflect current participation requirements.

05.A.2.b, Proportion of Medicaid Days

BGRNC currently serves and will continue to serve the Medicaid population proportionate to the needs of its jurisdiction/region.

05.A.2. c, Agreement to Admit Medicaid Residents

BGRNC will admit Medicaid residents to maintain levels of participation in the medical assistance program per its updated MOU.

05.A.2.d, MOU

BGRNC will update its current MOU prior to licensing of the proposed addition.

05.A.2.d.i, Maintain Level of Medicaid Participation

BGRNC will maintain the level of participation in the Medical Assistance Program as required.

05.A.2.d.ii, Admit Medicaid Residents

BGRNC will admit residents whose primary source of payment on admission is Medicaid.

05.A.2.d.iii, Evidence to Void Rule of Medical Assistance Participation

Not Applicable

05.A.3, COMMITMENT TO USE COMMUNITY-BASED SERVICES

BGRNC will demonstrate commitment to providing community-based services and to minimizing the length of stay as appropriate for each resident.

05.A.3.a., Providing Information about Community-Based Services

Each prospective resident will be provided appropriate information regarding Community-Based Services, including alternate programming to promote care in the most appropriate setting, e.g., Community-Based Services or Waiver Programs.

05.A.3.b, Initiating Discharge

Each resident, upon admission, will be evaluated and an appropriate discharge plan created.

05.A.3.c, Olmstead Efforts

Persons covered under the Olmstead Decision would be provided education and direction to sources that would best benefit their needs, e.g., community-based services. If presented with a person whose needs were potentially best met at the facility then an assessment would be completed to determine an appropriate placement.

05.A.4, NONELDERLY RESIDENTS

BGRNC will address the needs of its residents under the age of 65.

5.A.4.a, Training

When a nonelderly resident is admitted to BGRNC staff members will be trained in the psychosocial problems facing the nonelderly disabled resident so the resident can live in an environment that fosters the highest level of social experience within the facility.

5.A.4.b, Discharge Planning

Discharge planning will begin immediately after admission with the goal of discharging the resident or placing them in a more appropriate setting as quickly as possible, especially in 90 days or less.

05.A.5, APPROPRIATE LIVING ENVIRONMENT

The proposed project is new construction. The resident living environment will include, but not be limited to, the following.

5.A.5.a, New Construction

- i. Resident rooms will have no more than two beds in each resident/patient room
- ii Individual temperature controls will be provided to each resident room
- iii No more than two residents will share a toilet

5.B.5.b, Renovation Project NOT APPLICABLE

5.B.5.c, Applicability of Standard There is no reason not to meet this standard

05.A.6, PUBLIC WATER

The existing facility is currently on the local public water system, WSSC, and the proposed addition will also be on the public water system.

05.A.7, FACILITY AND UNIT DESIGN

The proposed facility was designed by a team of architects and engineers well respected in the industry. The team used the latest standards and codes for comprehensive care facilities befitting the needs of current patient populations.

5.A.7.a, Types of Residents

The residents/patients expected to use the proposed replacement facility most frequently are post-acute rehabilitation residents, i.e., orthopedic, neuro (stroke), cardiac, pulmonary.

5.A.7.b, Design Features

The proposed replacement facility was designed by Reese, Lower, Patrick, Scott, architects specializing in the health care design, particularly comprehensive care facilities. They designed many facilities in Maryland and other states. All specifications meet current codes.

5.A.7.c, Applicability of Standard NOT APPLICABLE

05.A.8, DISCLOSURE

None of the officers of the corporation or board has ever pled guilty to a criminal offense in any way connected to with the ownership, development, or management of a health care facility.

05.A.9, COLLABORATIVE RELATIONSHIPS

BGRNC collaborates with other facilities and programs as needed to appropriately place individuals at the most appropriate level of care, including assisted living and community-based services.

SECTION B, NEW CONSTRUCTION OR EXPANSION OF BEDS OR SERVICES

05.B.1, BED NEED

The following narrative applies to both sections (a) and (b) of this standard

The bulleted list of responses to bed need is as follows.

- The requested beds are currently in MHCC's bed inventory
- Sustained high percentage of occupancy, above 90%
- 48 of the requested beds are already at BGRNC and currently occupied. The additional 22 purchased beds will be used to meet BGRNC's increasing demand for Short Stay Med A beds.
- Increasing demand for services at BGRNC, particularly Short Stay Med A beds
- Increasing number and significant percentage of Short Stay Med A residents that are denied access to BGRNC because of lack of beds at BGRNC. "Denials" have increased by 71% in the last three years. In FY2014 BGRNC denied access to over 150 Short Stay Med A residents because of lack of available beds. This doesn't even factor in the number of referrals that weren't made to BGRNC because the discharge planner(s) knew that BGRNC was fully occupied.
- Growth in the senior population, particularly the over 80 population with multiple comorbidities and chronic health issues
- A health care delivery system is in transition with great uncertainty. Projections vary but there are proponents that predict sustained need of comprehensive care beds, and even those that project actual increasing demand for skilled care beds.
- Expected elimination of 3-day qualifying hospital stay. This will shorten lengths of stays in hospitals. Those days, for elderly residents/patients, will likely be spent in comprehensive care facilities instead, potentially adding time and opportunity for rehab facilities to maximize the rehab experience.

There are many reasons why the need for beds at BGRNC has increased in recent years. Each supports BGRNC's proposal to replace a portion of its existing facility and add 22 CON-approved beds purchased from National Lutheran/Village at Rockville. BGRNC is fully committed to the things that matter, e.g., passion for resident care/outcomes, cost effective systems that deliver high quality care and relationships.

1. DEMOGRAPHICS

- a. The surrounding area, greater Olney/Sandy Spring, is projected to double or even triple its senior population in the next 10-20 years. This is true of people 80 and over. In addition, the elderly population of the future is expected to reach that age with more comorbidities and chronic health conditions than the current senior population.
- b. An age-restricted community of approximately 10,000 residents is only 4 miles away and is a primary source of patients for Medstar Montgomery Hospital Center as well as BGRNC. Proximity to this community is partially driving the current increased demand for beds at BGRNC.

- c. The proposed replacement facility's intended focus is short term rehab beds. The actual net result of the proposed project results in more rehab beds and slightly fewer long term beds, a move that seemingly matches the projected needs of the coming-of-age boomers in the surrounding area and the reimbursement initiatives of the State to strategically incentivize LTC residents to seek lower levels of care when possible. BGRNC is strategically positioning itself to meet the coming wave of post-acute needs/demand.

2. PROVIDER/HOSPITAL RELATIONSHIPS

- a. Medstar Montgomery Medical Center is less than 2 miles drive and within eye-sight "as the crow flies." Proximity to its primary referral source for Short Stay Med A residents is a key factor.
- b. BGRNC has worked with Medstar Montgomery Medical Center for 60 years. The relationship continues to strengthen as both parties work together on current health care system issues, e.g., hospital readmissions, transitions between levels of care. Teams from each facility have met together numerous times recently and continue to meet to work on patient transitions. In addition, the leadership of BGRNC (CEO and VP) meets annually with the CEO and CMO of Medstar Montgomery to discuss relational issues and how better to work together.
- c. BGRNC has also developed a strong relationship with National Rehab Hospital, meeting numerous times with physicians to discuss patient quality issues. These discussions have strengthened the medical services provided by BGRNC and assisted in developing new referral sources to BGRNC.
- d. Medstar Montgomery is BGRNC's most significant referral source in its primary market area. Medstar Montgomery continues to grow and along with it so does BGRNC's opportunity for rehab, e.g., growth in the joint replacement program and a new orthopedic group started in Sandy Spring/Olney in the last couple of years.
- e. BGRNC contracted with a Medstar National Rehab physician specializing in pain management to rotate through the facility. The physician strengthened BGRNC's pain management program but also strengthened other associated referral sources.
- f. BGRNC is currently working to contract with a Medstar Montgomery infectious disease specialist to see residents and deepen focus on wound care.
- g. BGRNC hired two additional nurse liaisons in the past 18 months which increased admissions from perimeter hospitals multi-fold, i.e., Holy Cross, Suburban. Admissions from one perimeter hospital doubled and the other tripled. BGRNC nurses are in hospitals and doctor offices every day.

3. PERFORMANCE INDICATORS & LOWER COST TO HEALTH SYSTEM

- a. BGRNC has been ranked #1 in the Pay for Performance Rankings for Montgomery County for the last 3 years and was #2 in the State of Maryland for 2013.

BGRNC's Hospital readmission rate is very low, 15% compared to national average of 20+%. Hospital readmissions negatively affect hospital financial performance. They also increase overall cost to the health care system. As a result skilled nursing homes which demonstrate lower than average readmission rates will be attractive clinical and financial partners. Hospitals will seek to discharge patients to rehab and long term care facilities that perform well on performance indicators. BGRNC will continue to be a primary provider of rehab for patients discharged from Medstar Montgomery, Holy Cross and Suburban hospitals. Demand for BGRNC beds will continue to increase because of its performance and alignment with other providers' utilization goals.

- b. High Census: Historical census for BGRNC is excellent and continues to operate above 90%, in the newer portion of BGRNC above 94%. The older wing of the existing nursing facility, the wing to be demolished, contains the beds that negatively effect the overall census. The older portion over the past few years has run in the mid to high 80 percent range. A new replacement facility would increase the overall census of BGRNC.
- c. Demand for Rehab Beds: BGRNC has a demand for more rehab beds. BGRNC's current rehab beds are frequently fully occupied and potential residents are turned away and not admitted. The number of rehab admissions per year at BGRNC has increased significantly. In each of the last 3 fiscal years BGRNC's number of admissions increased. Short Stay Med A Admissions between FY2012 and FY2014 increased by 6% to just under 500 Med A admissions a year. Med A utilization increased by over 40% in the last 4 years. Correspondingly in each of the last 3 fiscal years BGRNC's number of denials based on lack of bed availability went from 89 in FY2012 to 152 in FY2014, a 71% increase. These statistics do not even consider the number of referrals not made to BGRNC because the case managers and discharge planners already knew the rehab unit was full.

4. MARKETING

- a. Two years ago BGRNC expanded its marketing staff to increase awareness of its performance indicators, especially among hospitals, physicians and other providers in the health care continuum. BGRNC has spent two years building relationships and demand for its services/beds.
- b. Marketing staff members focus on business development, e.g., physician offices, other assisted living facilities, nursing homes, and hospital relations. As a result referrals and admissions for rehab have increased significantly. The percentage increase for admissions in the last 3 years is above 6% and the percent increase in denials based on lack of bed availability is 71%.

5. PHYSICAL PLANT/EQUIPMENT

- a. The current old wing, the one to be demolished does not meet today's codes. Annually, BGRNC has to apply for a waiver to DHMH because it does not meet minimum construction standards. The proposed building will replace an antiquated physical plant with one that meets all current codes. The existing

wing to be demolished is very old and no longer adequate to meet the needs of current medically complex residents. The oldest parts of the existing wing were constructed in the late 1800's.

- b. The newer part of the existing physical plant was constructed in 2000 and is one of the newest and most competitive facilities in BGRNC's primary service area. It is in high demand and admissions are frequently turned away. The additional capacity will allow BGRNC to meet the current demand for its rehab beds.
- c. The proposed new addition will include equipment which will improve the effectiveness of treatment, i.e., zero gravity treadmill, which allows hip and knee patients/residents to more aggressively engage in therapy and maximize their benefit from rehab.

05.B.2, FACILITY OCCUPANCY

BGRNC in the past two years exceeded 90% occupancy as required by the State Health Plan. As it currently exists BGRNC is comprised of a newer section built in 2000 and an older section built across a span of time from the late 1800's to the early 1970's. The overall census for the combined sections for the last two years was 91.44% (FY2013) and 90.61% (FY2014).

The newer section of BGRNC ran 93.69% (FY2013) and 94.29% (FY2014). On the other hand the older section of BGRNC ran 85.82% (FY2013) and 81.43% (FY2014). The newer section improved even while the occupancy of the older section fell by over 4%. The older section of the building has numerous physical plant challenges and therefore is difficult to market and creates a huge drag on the overall census of the facility. The overall census of the facility would be even higher, probably above 95%, if not for the older section.

The reasons to expect the census to remain at a high even after adding 22 additional beds are as follows.

- i. Population Growth: Montgomery County projects a significant increase in the total number of county residents over 80 years old, with the immediate area around BGNRC projected to double in the next 10 years. This cohort of people are expected to have more comorbidities and chronic health conditions of the current elderly population. This would indicate that the demand for comprehensive beds will remain strong for the next decade or two. Post-acute short term rehab, especially as the boomers begin to enter retirement ages, should be on the rise. While the State at this point does not project any increased overall need for comprehensive care beds there are sources that project a continued demand for comprehensive care beds based on the changing health care needs of an increasingly aging population. Some experts project that the demand for beds will increase.

- ii. Performance and Reputation: State of Maryland Pay for Performance rankings currently rank BGRNC as the #2 facility in the state and the #1 facility in Montgomery County, as it has been three years running. As consumers become better educated about our industry the higher performing facilities will naturally draw a higher percentage of the total admissions in their primary and secondary markets. BGRNC is well positioned. BGRNC is the provider of choice in its primary service area. The proposed addition will enable BGRNC to meet the growing demand, a demand for beds that it already is experiencing.
- iii. Alignment with Direction of Health Care System: BGRNC has a very low hospital readmission rate for Medicare Part A residents/patients. The national average is 20+%. BGRNC's is currently around 15%, making BGRNC a very strong clinical and financial partner with Medstar Montgomery Medical Center (MMMC) and other local hospitals, e.g., Holy Cross, Suburban. Currently, hospitals are penalized for readmissions that occur within 30 days of discharge from the hospital. The fewer the readmissions the more profitable the hospital will be and the less cost to the health care system. BGRNC is working with MMMC to better manage readmissions and to develop improved communication and processes to lower them further. BGRNC's low readmission rate and its active collaboration with primary referral sources make it an attractive partner. As a result BGRNC's census remains high and demand is growing.
- iv. Physical Plant: "New" is more appealing than old. Brooke Grove added a new 32-bed short term rehab unit to its Williamsport Nursing Home (WNH) in 2011. The unit was operating at capacity within 3 weeks and has sustained a high census. The unit is frequently at or near capacity. It is projected that the proposed replacement facility to BGRNC would also perform extremely well. The newer portion of BGRNC already runs an occupancy rate of just over 94%. In a brand new facility with state-of-the-art equipment for rehab and restorative care it is expected that the occupancy rate would be equal to or greater than the existing building.
- v. Increased Demand and Strong Relationships: Brooke Grove invested in strategic relationship building and marketing initiatives in recent years to build relationships and referral sources, e.g., hiring RN's as nurse liaisons, marketing initiatives, representation on community organizations/boards. One area of focus is new business development to build a stronger referral base, e.g., priming relationships and referrals with physicians, other facilities, home care companies, etc. The other nurse liaison is focused on building relationships with perimeter hospitals. Due to those efforts admissions from Holy Cross and Suburban have increased multi-fold, 2-3 times prior years referrals. Again, the Short Stay Med A admissions increased 6% over the last three years and the Med A denials due to lack of bed availability increased 71% in the same three years.

The proposed replacement facility at BGRNC creates a compelling vision of a leading comprehensive care provider meeting the challenge of today's post-acute and long term care needs by creating and operating a state-of-the-art facility and collaborating with the broader provider community to provide cost efficient, high quality care and smooth transitions from one care setting to another.

05.B.3, JURISDICTIONAL OCCUPANCY

5.B.3,a, Overall Occupancy of the Jurisdiction

BGRNC is not aware of the current jurisdictional occupancy. The latest it found indicated that in recent years the jurisdictional occupancy of Montgomery County appeared to be in the mid 80% range. The overall nursing home occupancy rates in Montgomery County seem to be in a state of transition, having in recent years suffered with relatively weak rates.

5.B.3,b, Applicability of Standard

BGRNC does not believe this standard applies to its proposal. Overall the jurisdictional census in comprehensive care units is lower than 90%. However, the occupancy of BGRNC remained above 90%. BGRNC's newer section actually increased over the last two years. The occupancy was above 94% for the most recent year. Demand at BGRNC continues to increase. The number of admissions at BGRNC increased 6% over the last 3 years and denials because of lack of bed availability increased by 71%. In FY2014 BGRNC denied access to over 150 Short Stay Med A residents because of no bed availability in rehab. While other facilities' census lags a bit BGRNC's census is very healthy.

Also, with the realignment of the reimbursement system the bed demand for higher performing facilities will grow, particularly in those facilities that are actively collaborating with hospitals to improve hospital performance and their own performance, i.e., better outcomes, lower cost. This assumes of course that the higher performing comprehensive care facilities are allowed to expand their capacities so referring sources can shift their volume. Higher performing, higher quality of care facilities will make better partners with referral sources, e.g., participation in shared savings programs with Medicare, more cost effective, better outcomes.

Demographic projections suggest that the 80+ age group in Montgomery County and the immediate area around BGRNC will at least double over the next 10-20 years. The upcoming generation of elderly are expected to have more comorbidities and chronic health conditions than the current elderly population. Hopefully, most facilities will benefit from this trend but BGRNC is very well positioned to serve the increased population because of its location to Medstar Montgomery, reputation and its performance indicators.

5.B.4, MEDICAL ASSISTANCE PROGRAM PARTICIPATION

5.B.4.a, Agreement in Writing

BGRNC agrees to serve a proportion of Medicaid residents consistent with .05A.2(b) as required.

5.B.4.b, Achievement of Required Participation

BGRNC will achieve the applicable proportion of Medicaid participation within a 3-year time frame and will show a good faith effort toward achieving this goal in the first and second year of operating the proposed addition.

5.B.4.c, MOU

BGRNC has an existing MOU but will sign a new one consistent with new guidelines from MHCC.

5.B.4.d, Inclusive MOU/Total Beds

BGRNC will sign a new MOU as required to include the proposed total beds of the approved facility license and to include a Medicaid percentage that reflects the most recent Medicaid participation.

5.B.4.e, Applicability of Standard

NOT APPLICABLE

5.B.5, QUALITY

BGRNC has no outstanding deficiencies. It currently has an approved quality assurance program.

5.B.6, LOCATION

The proposed replacement facility will be constructed on the existing site.

SECTION 5.C, RENOVATION OF FACILITY

NOT APPLICABLE

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.

Service Area: The primary service area does not change. There are approximately 1M residents in Montgomery County. BGRNC is strategically positioned proximal to Medstar Montgomery Medical Center, numerous medical/physician office complexes and a 10,000 member age-restricted community only 4 miles away. What continues to drive an increased number of referrals and admissions to BGRNC is its reputation, excellent rehab outcomes, Pay for Performance rankings, Five Star rating, outstanding physical plant and campus, resident/patient outcomes, collaborative and active relationships with referral sources, corporate culture that emphasizes resident-centered approaches. As a result primary referral sources changed their referral patterns...which in turn resulted in increased admissions to BGRNC...which in turn resulted in more denials to short stay Med A residents based on lack of beds for short stay Med A residents. In addition, perimeter hospitals in BGRNC's secondary markets have increased their referrals and admissions multi-fold, doubling and tripling previous referrals/admissions.

Population Size: The population of Montgomery County in general is projected to grow, particularly the senior population and those over 80 years of age. The over-80 age group in the Olney-Sandy Spring area, BGRNC's immediate surrounding area, is expected to increase multi-fold, at least doubling in the next 10-20 years.

Characteristics: As mentioned above the senior population is expected to have exponential growth in the next couple of decades. The Olney-Sandy Spring area specifically is expected have significant growth in the senior population. Twenty years ago it was a "30-something" community. Now it is a "50/60-something" community and primed for growth in post-acute medical services. In addition, the upcoming population of seniors are expected to have more comorbidities and chronic health conditions that the current senior population.

Projected Growth: In sync with the projected population growth is growth in post-acute medical services. While prognosticators are far from speaking with consensus on the topic of how these services will be distributed within the health care continuum there are proponents that growth in the senior market will continue to drive demand for nursing home beds, particularly short stay rehab beds and mid to late stage dementia beds. There are also proponents that project such strong growth in post-acute services that demand for rehab beds in comprehensive care facilities will actually increase.

BGRNC is already experiencing increased demand for its short stay rehab beds. The increased senior population in BGRNC's surrounding areas is already driving increased demand which goes beyond its current capacity. Approval of the proposed project will keep the gap between its current capacity and demand for increased beds from widening. BGRNC increased its number of denials to Short Stay Med A residents by 71% over the last 3 years. Last fiscal year BGRNC turned away just over 150 short stay rehab residents because of lack of bed availability.

[(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 (Circle)	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	20__	20__	20__	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							

Table 1 cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20	20	20	20	20	20	20
3. Occupancy Percentage*							
a. ECF							
b. Comprehensive							
c. Assisted Living							
d. Respite Care							
e. Adult Day Care							
f. Other (Specify)							
g. TOTAL							
4. Number of Licensed Beds/Slots							
a. ECF							
b. Comprehensive							
c. Assisted Living							
d. Respite Care							
e. Adult Day Care							
f. Other (Specify)							
g. TOTAL							

* 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.)

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)			
CY or FY (Circle)	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.

At some point buildings need to be replaced. The existing facility is so old and so outdated that renovating it is really not a cost effective option. The existing facility was built between the late 1800's and 1970. The cost of the building will be determined through a competitive bid process, ensuring the cost effectiveness of constructing a new building.

The 48-bed wing to be replaced is an antiquated facility with architectural features and mechanical and electrical systems that are out dated and no longer suitable for today's medically complex residents/patients. For example, one of the State's high priorities is to eliminate all resident rooms licensed for more than 2 residents. The proposed building will eliminate those rooms currently existing in the old wing.

There are many features of the existing building that make it challenging to care for residents and provide suitable living environments. They can be simply categorized, i.e., inadequate space, dimensions of features that do not meet current code, safety considerations, living environments that create obstacles to care instead of enhancing care.

Examples of existing features that pose challenges are as follows.

- Multiple person rooms
- Corridor Widths
- No ADA bathrooms or ADA toilet rooms in resident rooms. There is no bathing in bathing facilities in resident rooms.
- Construction assemblies that no longer meet code
- Old HVAC and electrical systems

It is easy to understand how a new building will enhance patient care.

- Elimination of 3 and 4-person rooms
- Addition of ADA bathrooms
- New dining facilities
- New rehab area with state of the art equipment
- Resident rooms with private bedrooms
- Four rooms with ceiling mounted lifts for bariatric residents
- New mechanical (more fresh air) and electrical systems
- Construction assemblies that meet current code
- Architectural designs consistent with today's trends
- More windows, more interior daylight

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.

Audit financials are included with this proposal.

- b. Existing facilities shall provide an analysis of the probable impact of the Project on the costs and charges for services at your facility.

The cost of the project will be paid for by increased volume and Medicare/Medicaid increases over time consistent with the financial projections contained with this application.

- c. A discussion of the probable impact of the Project on the cost and charges for similar services at other facilities in the area.

There is no projected impact on other facilities as a result of this project but BGRNC will be positioned to better serve the future growth and anticipated volume.

There will be regulatory incentives and pressures on all facilities to align with current trends in reimbursement and utilization. Those that perform will be in greater demand. Those facilities that underperform in quality measures and cost effectiveness will continue to struggle with census.

There are many perspectives on how the growth in the senior market will influence the various segments of the health care continuum. While the payor and regulatory systems expect to drive all care to the most cost effective level of care in the health care continuum the achievement of that goal does not preclude the possible accuracy of experts that predict that growth in the aging population will accelerate demand for post-acute comprehensive beds such that current demand is sustained or that future demand outpaces today's available bed capacity.

- d. All applicants shall provide a detailed list of proposed patient charges for affected services.

There are no proposed changes to any charges as a result of this proposed project. The proposed unit is targeted as Short Stay Medicare Part A residents/patients. Charges will be based on the Medicare fee schedule.

(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 (including proposed project)

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	20	20		20	20	20	20
CY or FY (Circle)	20	20	20	20	20	20	20
1. Revenue							
a. Inpatient Services							
b. Outpatient Services							
c. Gross Patient Services Revenues							
d. Allowance for Bad Debt							
e. Contractual Allowance							
f. Charity Care							
g. Net Patient Services Revenue							
h. Other Operating Revenues (Specify)							
i. Net Operating Revenue							

Table 3 cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	20	20		20	20	20	20
2. Expenses							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)							
b. Contractual 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							
3. Income							
a. Income from Operation							
b. Non-Operating Income							
c. Subtotal							
d. Income Taxes							
e. Net Income (Loss)							

Table 3 cont. CY or FY (Circle)	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	20	20	20	20	20	20	20
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%	100%	100%	100%
B. Percent of Patient Days/Visits/Procedures (as applicable)							
1) Medicare							
2) Medicaid							
3) Commercial Insurance							
4) Self-Pay							
5) Other							
6) TOTAL	100%	100%	100%	100%	100%	100%	100%

(INSTRUCTION: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS)

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

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

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 (Circle)							
1. Revenues:							
a. Inpatient Services							
b. Outpatient Services							
c. Gross Patient Service Revenue							
d. Allowance for Bad Debt							
e. Contractual Allow.							
f. Charity Care							
g. Net Patient Care Services Revenue							
h. Other Operating Revenue (Specify)							
i. Total Operating Revenues							
2. Expenses							
a. Salaries, Wages, and Professional Fees (including fringe benefits)							
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							

Table 5 Cont.	Comp Care	Assisted Living	Extended Care	Respite Care	Adult Day Care	Community Based Services	TOTAL
i. Supplies							
j. Other Expenses (Specify)							
k. TOTAL Operating Expenses							
3. Income							
a. Income from Operation							
b. Non-Operating Income							
c. Subtotal							
d. Income Taxes							
e. Net Income (Loss)							
4. Patient Mix							
A. Percent of Gross							
1. Medicare							
2. Medicaid							
3. Commercial Insurance							
4. Self Pay							
5. Other (Specify)							
6 TOTAL	100%	100%	100%	100%	100%	100%	100%

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							
2. Medicaid							
3. Commercial Insur.							
4. Self-Pay							
5. Other (Specify)							
6. TOTAL	100%	100%	100%	100%	100%	100%	100%

C. Medicaid Analysis			
		Patient Days	Daily Rates
a. Light			
b. Moderate			
c. Heavy			
d. Heavy Special			
e. TOTAL			

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 last and only CON since 1990 for BGRNC was in approximately 1998. It was for a 100-bed replacement facility and is located at 18131 Slade School Road, Sandy Spring, MD. The facility is in full compliance with its CON.

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.

There is no direct impact on other providers in the community. The proposed project replaces an existing 48-bed wing of BGRNC. The facility already operates with a high occupancy rate, between 90% and 94%, and already experiences high demand for its beds. The additional 22 beds are currently in inventory in the same jurisdiction.

Every provider has the opportunity to improve its clinical outcomes, quality processes, cost efficiency, build relationships and possibly even build a replacement facility to keep pace with the demand and changing health care environment. The future health care system will reward those providers that respond to the regulatory directives, health system trends, and consumer/resident needs. Providers that do not respond will continue to perform poorly.

The proposal does not duplicate existing health care resources. The 48-replacement beds and the beds purchased from National Lutheran/Village at Rockville are already in inventory. It does replace an antiquated building and creates capacity that BGRNC needs to meet its current customer demand/volume,

The positive aspects of this project are numerous. First and foremost it replaces an aging facility with a new one meeting current codes and suitable for today's care needs. There are many attributes of the proposed project/new building that will enhance services to residents/patients and will allow BGRNC to continue to deliver quality care in a healing environment.

- Private bedrooms in resident rooms
- ADA bathrooms in each resident room
- Semi-private and private rooms only
- Bariatric rooms
- New Dining rooms

- New country kitchens/serving areas
- Rehab area with state-of-the-art equipment
- Large windows, lots of natural lighting
- Mechanical systems, lots of fresh air
- Access to courtyards
- New salon and spa

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 Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration					
Direct Care					
Support					
				Benefits	_____
				TOTAL	_____

(INSTRUCTION: Indicate method of calculating benefits percentage):

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.						
L.P.N.						
AIDES						
MEDICINE AIDE						
OTHER (Specify)						

Key: D - Day Shift
 E - Evening Shift
 N - Night Shift

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.
Dennis Hunter, Vice President
Greg Porter, Administrator
Keith Gibb, President

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.
No

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.

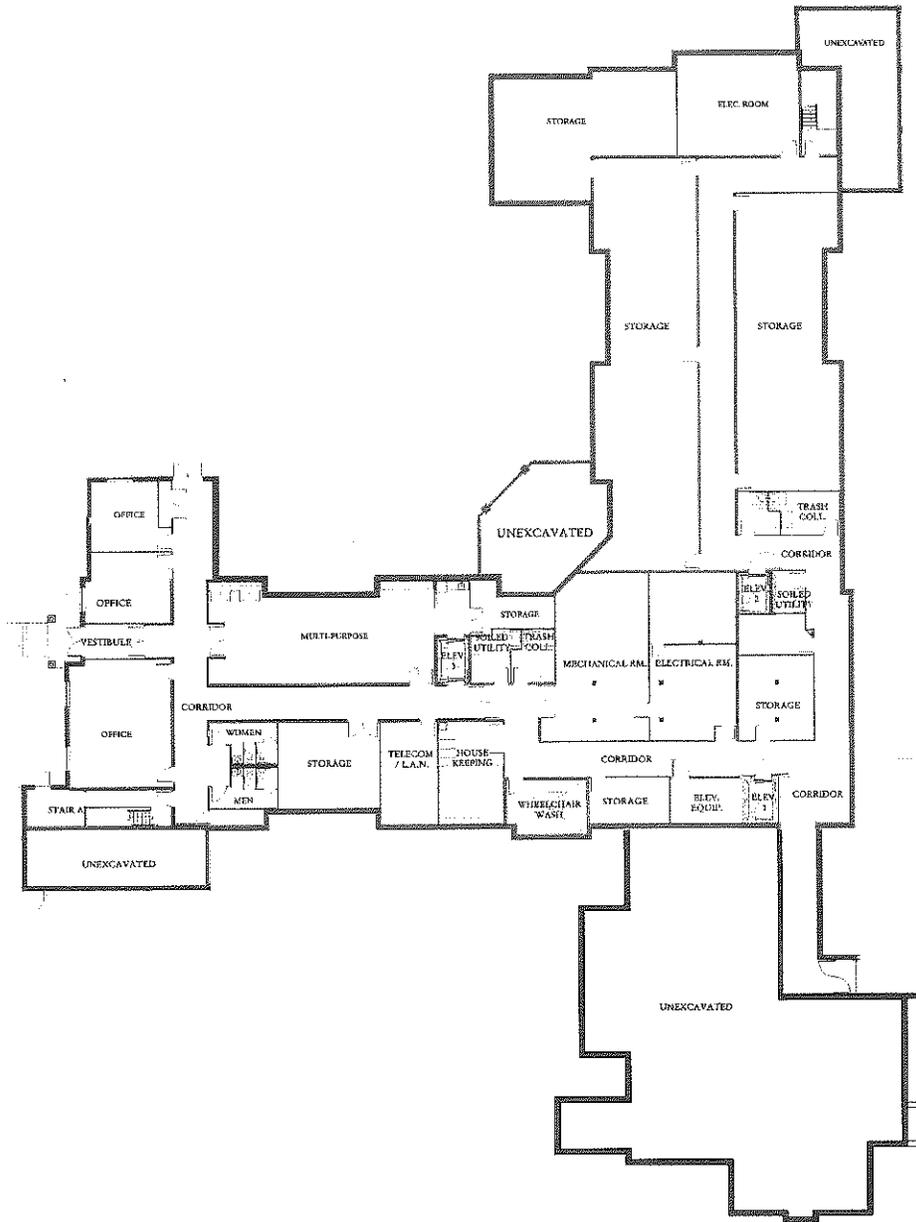
10-17-2014
Date


Signature of Owner or
Board-designated Official



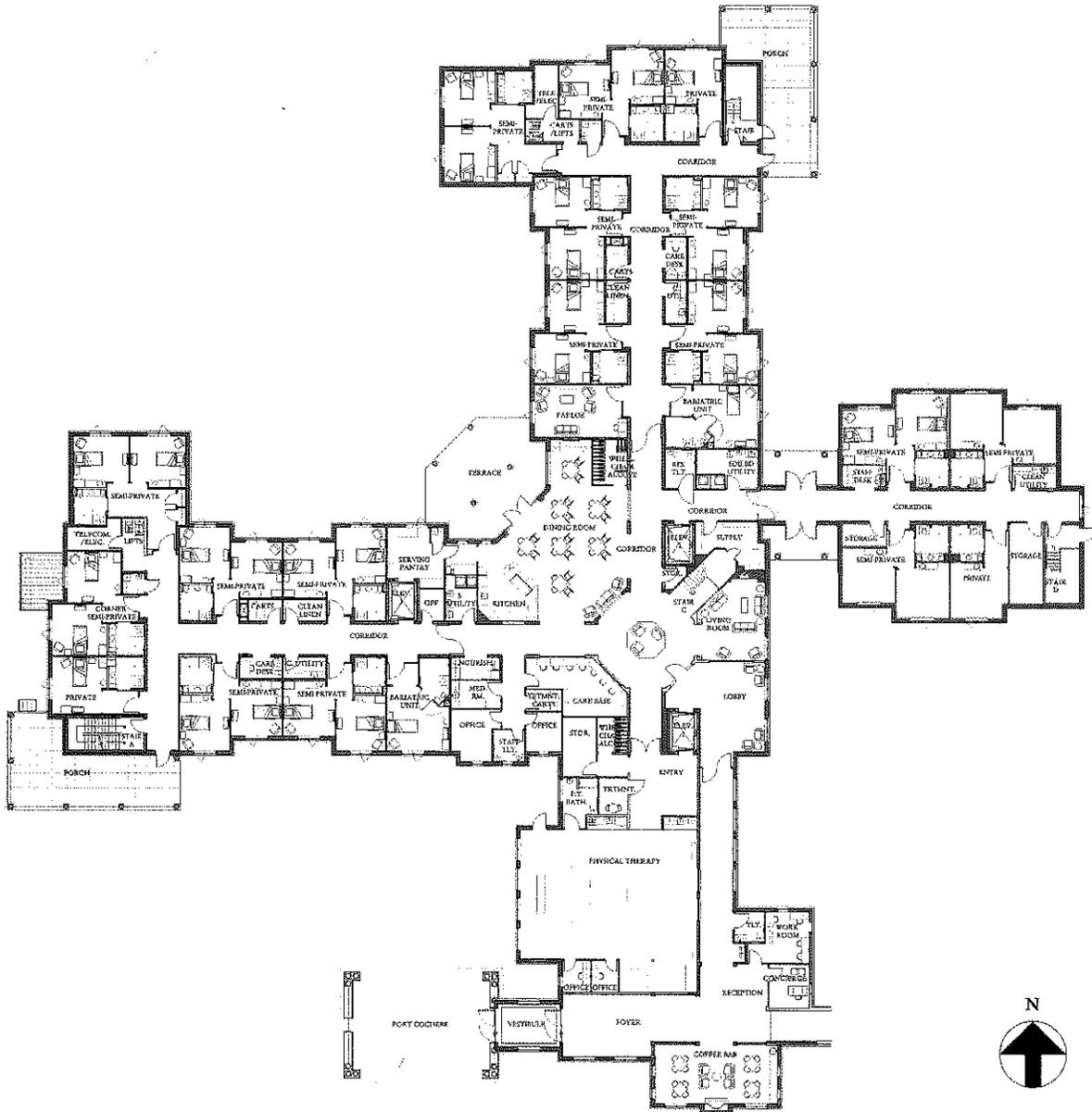
DAVID L SCHEY

B



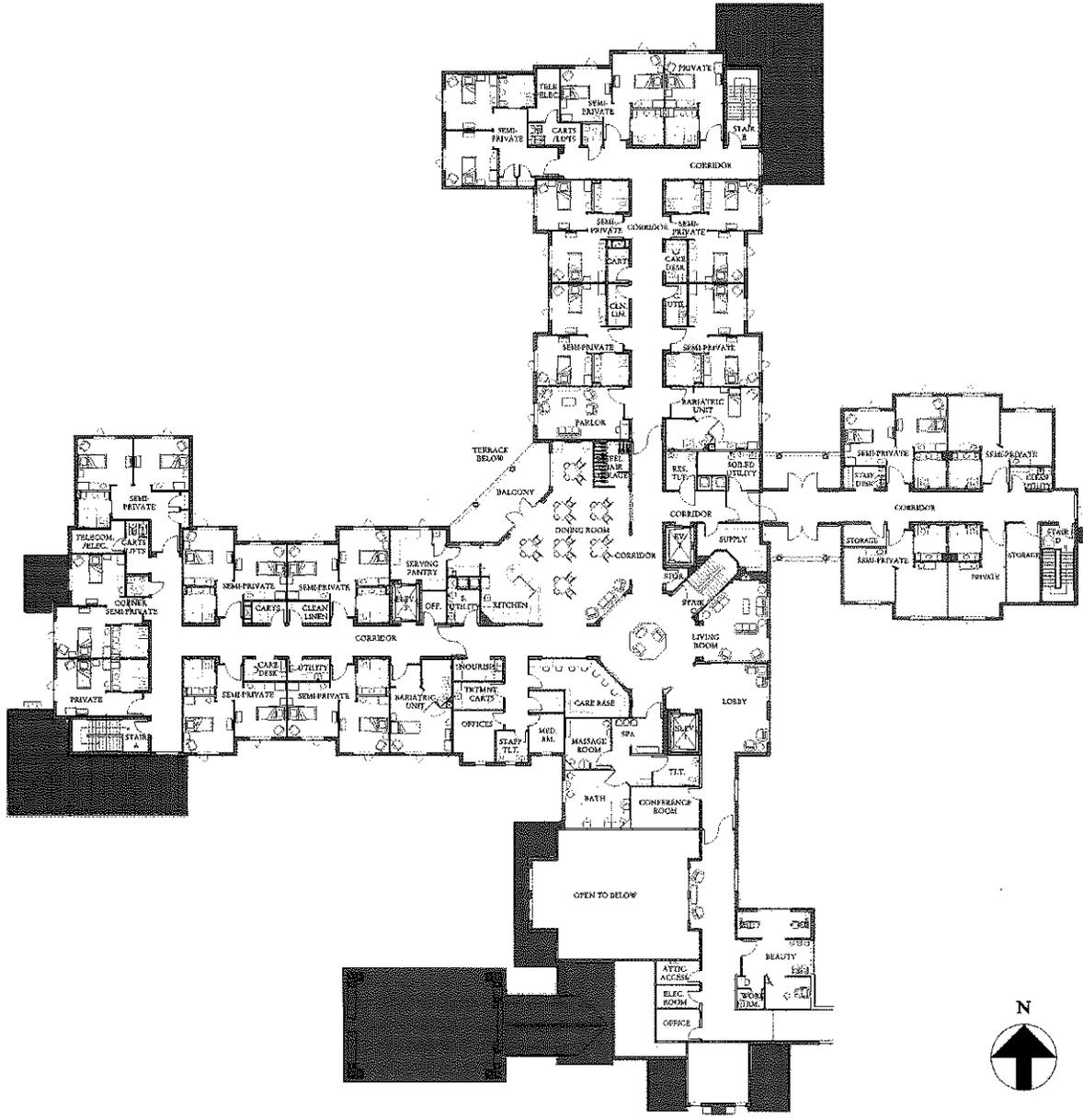
BROOKE GROVE FOUNDATION - SANDY SPRING CAMPUS
Rehabilitation Facility / Lower Level



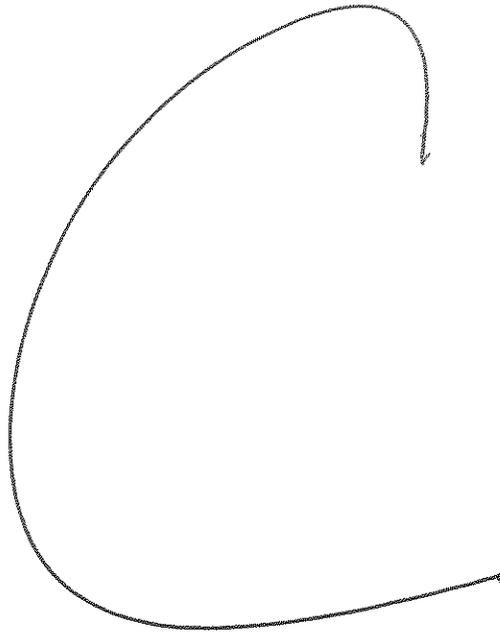


BROOKE GROVE FOUNDATION - SANDY SPRING CAMPUS
Rehabilitation Facility / First Floor





BROOKE GROVE FOUNDATION - SANDY SPRING CAMPUS
Rehabilitation Facility / Second Floor





**MEDICAL CARE POLICY ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201

Parris N. Glendening
Governor

Martin P. Wasserman, M.D., J.D.
Secretary

February 11, 1998

TO: Certificate of Need Applicant – Brooke Grove Foundation, Inc.

FROM: Douglas C. Sommers, Chief 
Division of Long Term Care Services

RE: Memorandum of Understanding

Enclosed, please find the agreement executed by your facility to comply with the Maryland Health Resources Planning Commission's requirement for Certificate of Need.

Enclosure



AGREEMENT

This contract, made and entered into this 11th day of February, 1998, by and between the Maryland Medical Care Programs, hereinafter designated as the Program, and Brooke Grove Foundation, Inc.

hereinafter designated as the Facility,

Witnesseth:

WHEREAS, the Facility is applying for a Certificate of Need for new or replacement Comprehensive Care beds from the Maryland Health Resources Planning Commission (MHRPC) and

WHEREAS, the MHRPC will not approve a Certificate of Need for an applicant which participates and/or proposes to participate in the Medical Assistance Program unless the applicant documents a written Memorandum of Understanding with the Medical Care Programs to maintain "a proportion of Medicaid patients that at a minimum is equal to the proportion of Medicaid patients in all other comprehensive care beds in the jurisdiction or the region, whichever is lower."

NOW THEREFORE, the Facility and the Program enter into this Memorandum of Understanding and agree as follows:

1. The Facility agrees to enroll (or remain enrolled) as a Medicaid provider as specified in COMAR 10.09.11, Intermediate Care Facility Services, within thirty (30) days of issuance of a license to operate the comprehensive care beds requested in the Certificate of Need application entitled Brooke Grove Foundation, Inc.

Docket No. 97-15-1989

-2-

- II. Once the Facility has enrolled as a Medicaid provider, the Facility Agrees;
- A. To serve a proportion of Medicaid patients that at a minimum is equal to the proportion of Medicaid patients in all other comprehensive care beds in the jurisdiction or the region, whichever is lower. This proportion is calculated as the percentage of Medicaid residents to total residents in the facilities located in that jurisdiction or that region based on the most recent nursing home survey data collected by the MHRPC. This Facility will be located in Montgomery County, therefore for the purpose of this agreement, the applicable proportion will be 44.93%. Once the Facility's Medicaid proportion equals the applicable Medicaid proportion in the jurisdiction or region, then the Facility will continue to admit Medicaid patients to maintain the applicable Medicaid proportion.
 - B. To advise any potential purchaser of the Facility of the terms of this Memorandum of Understanding and of the requirement that these terms be binding upon all future operators of the Facility.
 - C. To submit, within fifteen (15) days after notification by the Program that a determination has been made that the requirements of Paragraph II. A. have not been met, a plan for correction that is acceptable to the Program and to the Maryland Health Resources Planning Commission. If the Facility agrees to admit patients on a first-come, first-served basis, without discrimination against any individual seeking care and who is eligible for comprehensive care services available at the Facility, it shall be deemed to have submitted an acceptable plan of correction.
 - D. To abide fully by the requirements of any plan for correction submitted under Paragraph II. C.

-3-

III. Should the Facility fail to meet the requirements of Section II., the Facility agrees to:

- A. Allow the Program to withhold 2% of any amounts due the Facility for each percentage point the Facility's Medicaid occupancy percentages falls below the target percentage specified in Paragraph II. A. until the appropriate Medicaid proportion is met;
- B. Admit only Medicaid patients to the Facility until the target percentage specified in Paragraph II. A. is reached.
- C. Notify the Office of Licensing and Certification Programs, the Gateway II program, hospital discharge planners and the STEPS program in its jurisdiction of each bed vacancy and of the requirement in Paragraph III. B.
- D. Forfeit its claim to any funds withheld for more than 18 months in accordance with Paragraph III. A.
- E. File any appeals, in accordance with IV. C. below, within thirty (30) days of receipt of notice of any administrative decisions made in connection with this Memorandum of Understanding.

IV. The Program Agrees:

- A. To enroll the Facility as a Medicaid Provider under COMAR 10.09.11 Intermediate Care Facility Services if a certificate of need is granted and all conditions for certification are met.
- B. To give the Facility reasonable notice (30 days) whenever a determination is made that a requirement under this Memorandum of Understanding has not been met.
- C. To provide appeal procedures to the Facility in accordance with State Government Article 10-201 et seq., and Health-General Article 2-201 - 2-207, Annotated Code of Maryland, if the Facility wishes to contest any administrative decision made in connection with this Memorandum of Understanding.

V. This Memorandum of Understanding shall terminate upon the mutual agreement of the Program and the Facility, or in the event the State Health Plan is amended to remove the requirement that Certificate of Need applicants seeking comprehensive care beds attain and maintain a specified proportion of Medicaid occupancy.

Brooke Grove Foundation Inc DBA

Brooke Grove Nursing and Rehabilitation Center

BY:

NAME OF FACILITY

Kurt W. Gilt

AUTHORIZED SIGNATURE

President

1-28-98

TITLE

DATE

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Dr. Stephen C. Somman 2/11/98

AUTHORIZED SIGNATURE

BY:

Chief, Division of Long Term Care Services

TITLE

DATE

APPROVED AS TO FORM AND LEGAL SUFFICIENCY

Anna D. Resemblyer

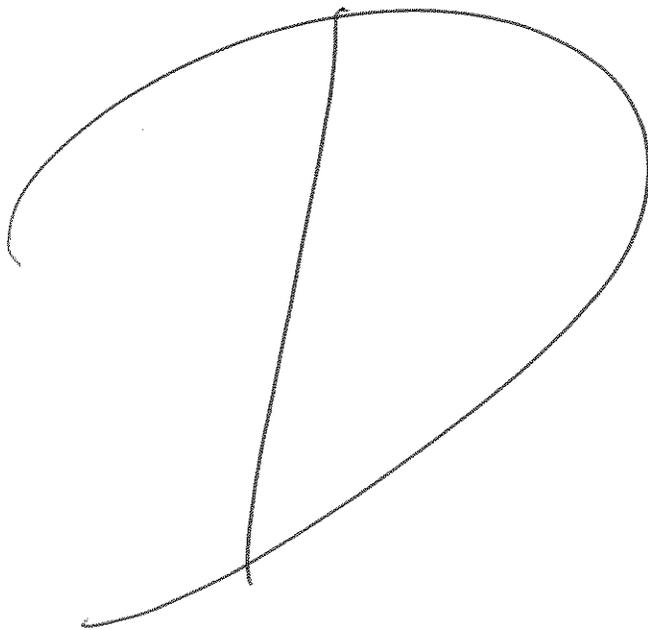
NAME

5/16/98

DATE

Assistant Attorney General

TITLE



BROOKE GROVE REHABILITATION AND NURSING CENTER
MEDICAID PARTIPATION ADMISSIONS POLICY

Policy

The facility will admit residents, with verified payment source, whose medical, nursing, and rehabilitation care needs can be met by the facility. Residents will only be admitted with physician's order.

BGRNC will seek to maintain a proportion once attained of Medicaid patients that at a minimum is equal to the proportion of Medicaid patients in all other comprehensive care beds in the jurisdiction or region, whichever is lower, in accordance with a signed Memorandum of Understanding between Brooke Grove and Maryland Medical Care Programs.

Admissions to the facility are accepted seven days per week. The admission policy applies to all residents admitted to the facility without regard to race, color, creed, national origin, age, (unless specified in state regulations), sex, religion, handicap, ancestry, marital or veteran status, and payment source.

E

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- Selection of home helpers
- Home, hospital and nursing home visits
- Liaison with family
- Coordination of medical services

REFERRALS

- Elder law attorneys
- Geriatric internists / psychiatrists
- Geriatric services / resources

PSYCHOTHERAPY FOR MIDDLE AND OLDER GENERATIONS

- Family relationships
- Loss and grief
- Depression
- Adjustment to change
- Illness and disability

LONG DISTANCE HELP

- ANS national network of 250 geriatric care managers
- Consultation and linkage to care manager in parents' locale

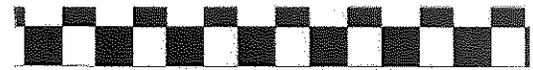
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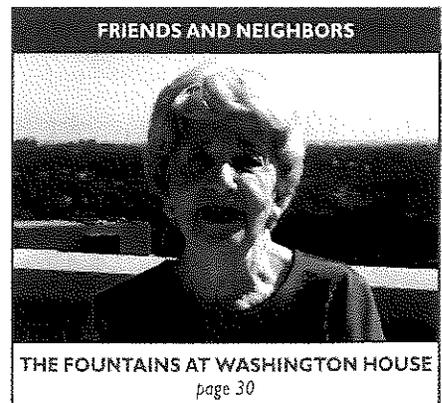
Brains in Training

Dr. Majid Fotuhi and his team of medical experts at the NeurExpand Brain Center apply proven science to help patients retrain their brains.

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FRIENDS AND NEIGHBORS

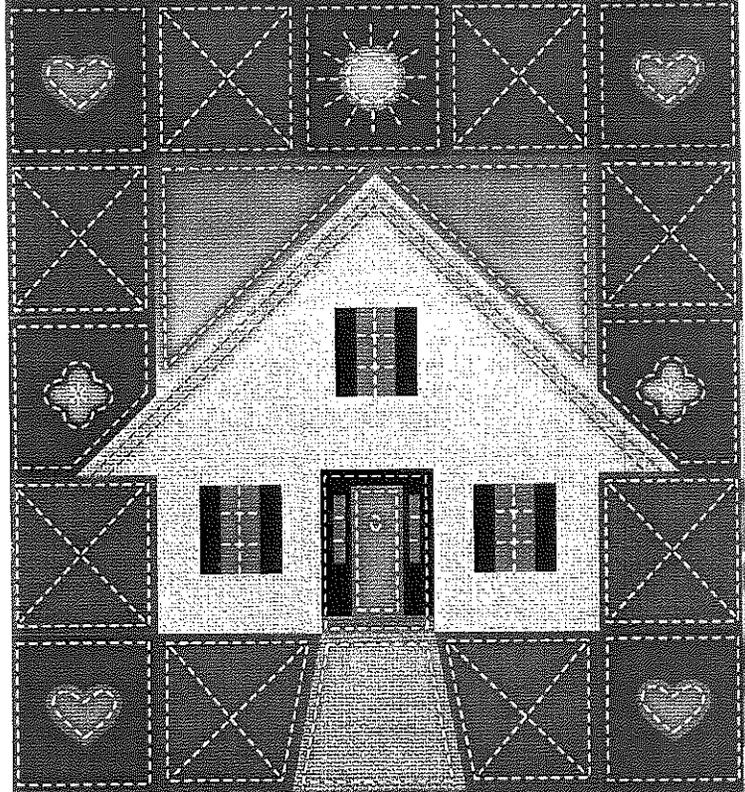
THE FOUNTAINS AT WASHINGTON HOUSE
page 30

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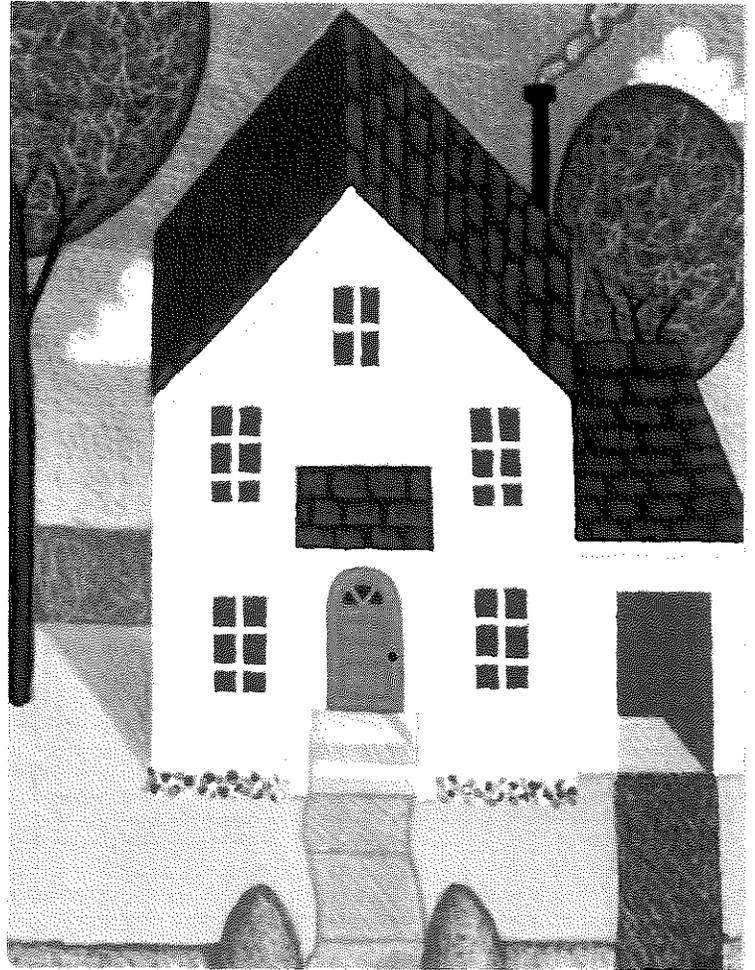
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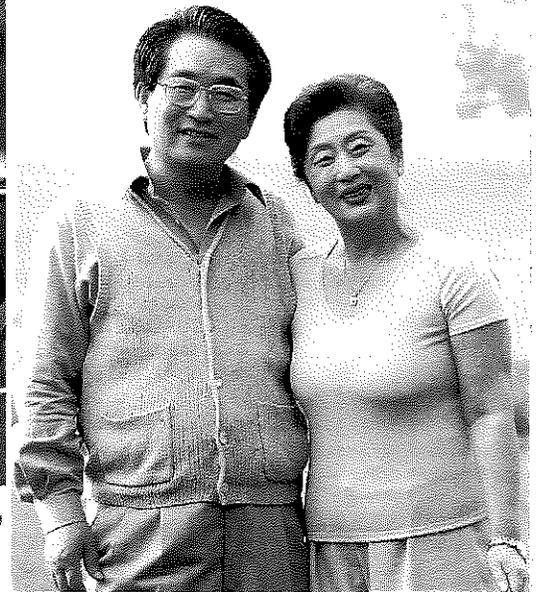


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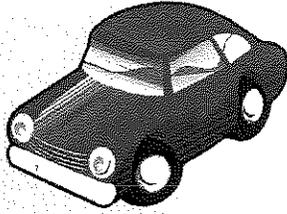
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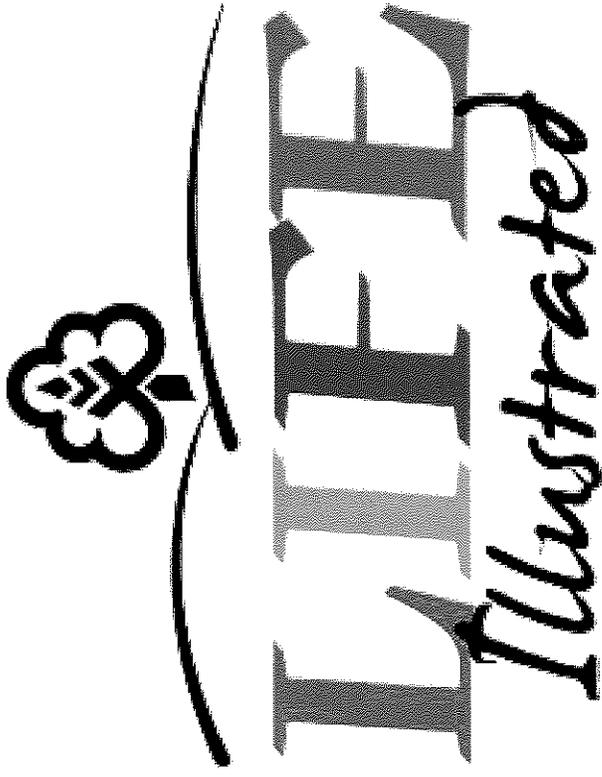
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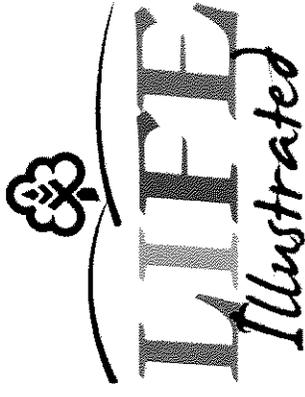


Living Well Together

Individual Discovery

Family Matters

Enriching Experiences

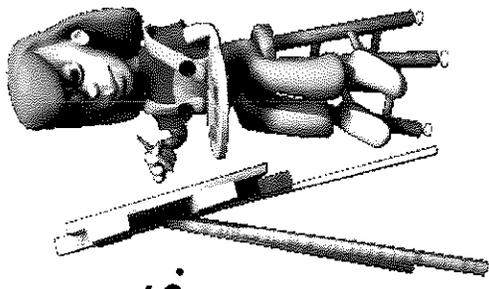


- ◆ LIFE is an acronym that represents our corporate brand of service.
- ◆ Living Well Together, Individual Discovery, Family Matters, Enriching Experiences
- ◆ LIFE's companion word, *Illustrated*, underlines LIFE values with living, breathing action.
- ◆ Brooke Grove Foundation has a company-wide commitment to illustrate the values of the LIFE acronym!



Corporate Brand of Service

- ◆ Our corporate brand of service represents who we are.
- ◆ LIFE Illustrated represents those values that distinguish us from our competition.
- ◆ Everybody plays! There are no spectators. Our brand is genuine if, and only if, EVERY PERSON in the company lives and breathes LIFE Illustrated.
- ◆ **YOU** are a LIFE Illustrator! **YOU** Illustrate LIFE!



Living Well Together



About Living Well Together



- ◆ Living well together is the foundation of our brand.
- ◆ It is all about **valuing people**.
- ◆ People thrive when they are valued as individuals! Our success depends on this.
- ◆ By focusing on valuing others, we take the initial steps necessary to deliver excellent service every time.

Living Well Together

Make eye contact, smile and extend a greeting to staff, residents and visitors.

Reason:

A greeting is a way to say:
"Your presence is important.
I value you as a person."

Thoughts about greeting ...

- ◆ Eye contact with a friendly smile is an essential part of a greeting in Brooke Grove culture.
- ◆ Eye contact says "I am interested in you! I am tuned in to what you may have to say."
- ◆ People **expect** eye contact.
- ◆ Set the tone of every new interaction with an intentional, friendly greeting.



Living Well Together

First listen, then respond.

Reason:

When we listen first — truly listen — we open ourselves to what others have to say. We give space for the speaker to be heard and considered before we respond.

Thoughts about listening...

- ◆ In order to Live Well Together, we must truly listen to each other.
- ◆ Make it a practice to stop what you are doing and face the speaker with interest.
- ◆ Fully focus on what the speaker has to say — without interruption.
- ◆ Listening gives us the vital information we need to respond effectively and provide individualized, excellent customer service.



Living Well Together

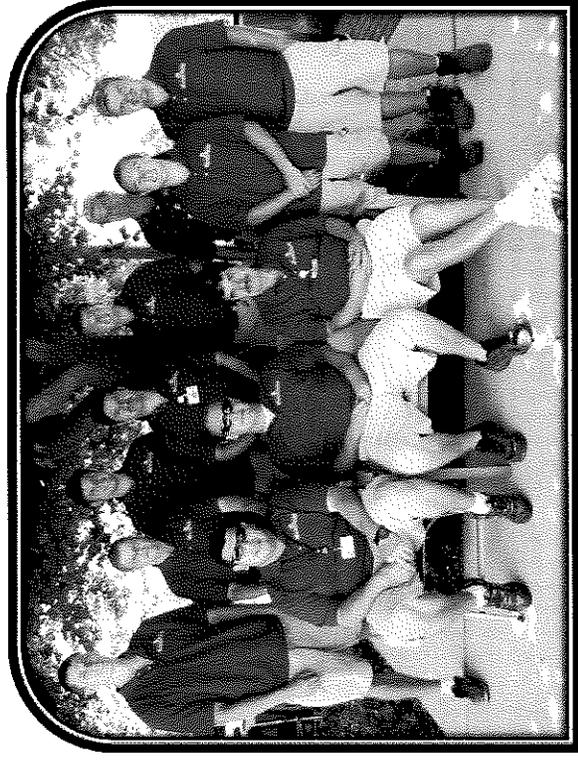
Establish and maintain professional boundaries in your work environment.

Reason:

It is your place of business;
be professional in word and deed.

Thoughts about being professional ...

- ◆ We are all professionals at work!
- ◆ When you arrive at work, step into your role and speak and act in ways that promote and preserve your professional reputation.
- ◆ Professional boundaries keep the focus on providing service to our customers.



REVIEW:

Living Well Together

Make eye contact, smile and extend a greeting to staff, residents and visitors.

First listen, then respond.

Establish and maintain professional boundaries in your work environment.

REVIEW:
Customer Service Standards #1-3

Individual Discovery



About Individual Discovery

- ◆ Individual discovery cultivates meaningful relationships.
- ◆ It is all about **knowing people as individuals**.
- ◆ Everyone is an individual with unique needs — including you, your associates, guests and residents.



Individual Discovery

Know yourself and your value.

Reason:

By understanding ourselves, we are free to value the people around us. Through self awareness, we can play to our strengths, access support where we need it and positively influence our surroundings.

Thoughts about knowing yourself and your value ...

- ◆ Getting to know yourself is a process. We are all on this journey of self-discovery!
- ◆ You are AMAZING!
- ◆ Know it. Live it. Bring it.
- ◆ When we recognize our own distinct value, we confidently and positively influence our surroundings.



Individual Discovery

Discover those around you and speak positively about yourself and others.

Reason:

Getting to know the people around us maximizes our awareness of their unique experiences, interests and needs. When we speak kindly of ourselves and others, we breathe grace into every space.

Thoughts about discovering others ...

- ◆ Discovering ourselves and those around us takes time and intention.
- ◆ What you prefer may be different from what others prefer; what you need may be different from what others need.
- ◆ Providing excellence in customer service means tuning into each individual's unique style and preference — and delivering!



Thoughts about speaking positively ...

- ◆ LIFE Illustrated calls us to think the best of people throughout the discovery process.
- ◆ Thinking the best of people generally invites the best in people.
- ◆ When we speak positively about ourselves, we build confidence.
- ◆ When we speak positively about others, we build trust with the audience — whether or not the “other” is present.



Individual Discovery

*Create empowering opportunities
that promote our mission.*

Reason:

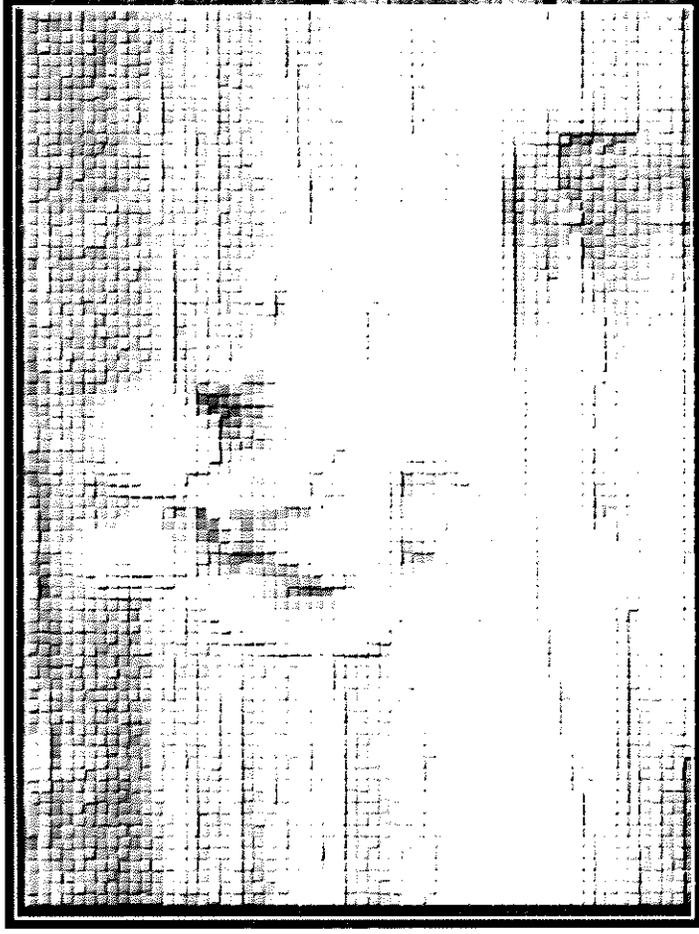
When we empower one another we say,

“You matter! You are heard!

You are valued!”

Thoughts about empowerment ...

- ◆ When we are empowered, we are free to make our own choices.
- ◆ We have the ability to empower ourselves and others.
- ◆ We all have the responsibility to create environments that encourage people to live freely.



REVIEW:
Individual Discovery

Know yourself and your value.

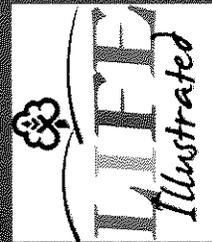
Discover those around you and speak positively about yourself and others.

Create empowering opportunities that promote our mission.



REVIEW:
Customer Service Standards #4-6

Family Matters



About Family Matters ...

- ◆ We are an ever-expanding organization of family members with family matters!
- ◆ The Brooke Grove family includes residents, staff, volunteers, family members and guests.
- ◆ The love of family beats at the heart of our organization.



Family Matters

Embrace the importance of family.

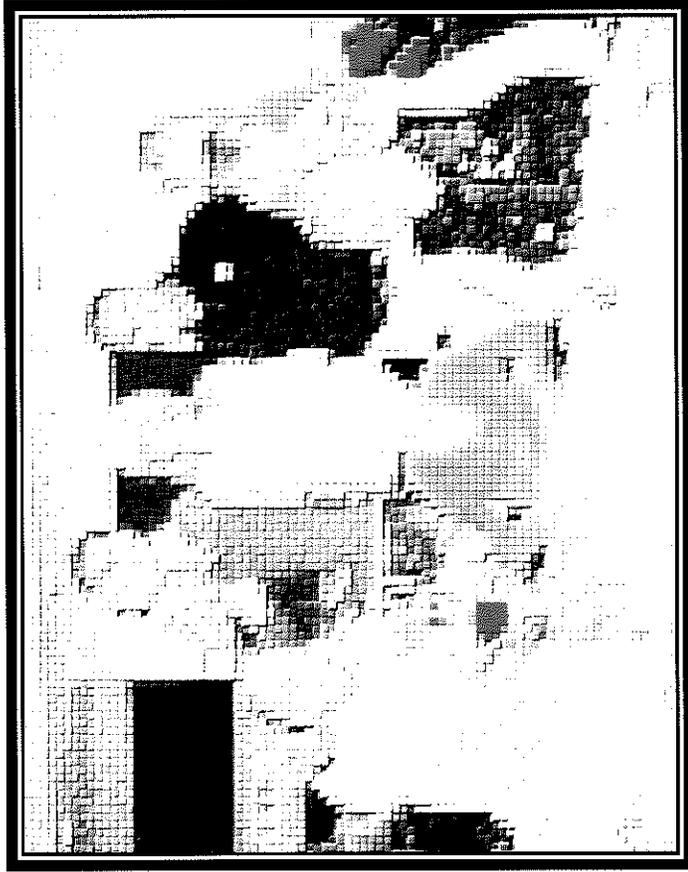
Reason:

By recognizing the essential value of family, we support people professionally and personally.



Thoughts about embracing families ...

- ◆ Brooke Grove is a place where family members feel welcome and included. Family is fostered and valued.
- ◆ Learning and using family members' names is a good first step to welcoming them and acknowledging their importance.



Family Matters

Nurture relationships with family members.

Reason:

When we grow to know a person's family, we deepen connections, foster understanding and build trust.

Thoughts about nurturing relationships ...

- ◆ Nurturing a relationship is like cultivating a garden. It takes time and regular care!
- ◆ Cheerful greetings are like sunshine.
- ◆ Listening is like rain.
- ◆ Encouragement is like fertilizer.
- ◆ Hugs remove the weeds.



Family Matters

Partner with family members.

Reason:

By collaborating, we seek solutions and share in the joy and pain of life's journey.



Customer Service Standard #9

Thoughts about partnering ...

- ◆ To partner means to develop a “win-win” relationship based on mutual trust and teamwork!
- ◆ Trust and teamwork are essential to successful partnerships.
- ◆ When professionals and family members collaborate, they work together to find solutions that honor the individual in every situation.



REVIEW:
Family Matters

Embrace the importance of family.

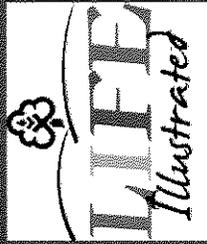
Nurture relationships with family members.

Partner with family members.



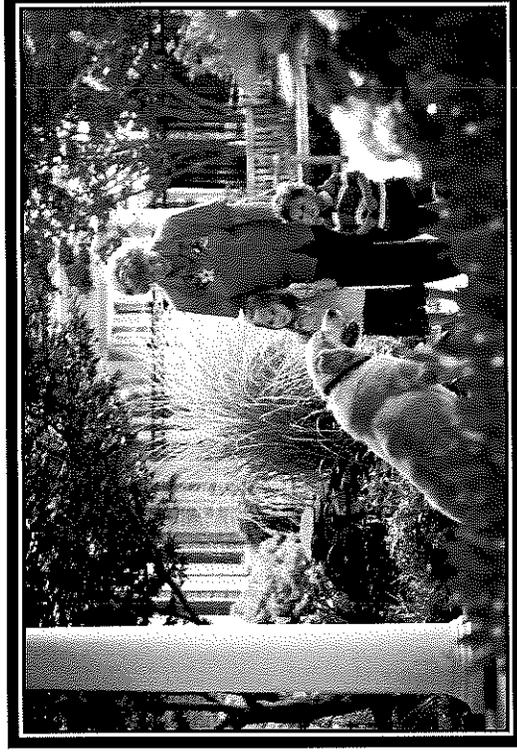
REVIEW:
Customer Service Standards #7-9

Enriching Experiences



About Enriching Experiences ...

- ◆ At Brooke Grove, we celebrate enriching lifestyles.
- ◆ What enriches you? Spread YOUR joy!
- ◆ Discover what enriches your customers and deliver THAT.
- ◆ Enriching experiences may be planned to the finest detail or they may unfold in the moment quite serendipitously.
- ◆ **Learn to pause** and embrace opportunities in your day to foster enriching experiences — one moment, one conversation, one project, one person at a time.

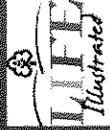


Enriching Experiences

Spread the joy!

Reason:

By finding opportunities to engage in the moment, we make life and work more meaningful and fun.



Thoughts about spreading the joy ...

- ◆ Joy is contagious. It is all around us. Sometimes we forget joy is near — or we temporarily lose it. Yet, we can **CATCH IT** and **SPREAD IT. It's magical!**
- ◆ Laughter truly is the best medicine. Well — and fine dark chocolate!
- ◆ Joy is found on a smiling face, in a listening ear, in a heart that understands.
- ◆ Body language expresses joy. **Smile! Smile!! SMILE!!!**
- ◆ Have fun! Be open to catching and spreading the joy bug.



Enriching Experiences

Hear. See. Taste. Smell. Touch.

Reason:

Enriching experiences stimulate
the five senses.

Thoughts about the five senses ...

- ◆ We are enriched by people, environments and experiences that stimulate our senses — the sounds we love, the beauty of nature, the taste of our favorite foods, the smell of fresh air, a reassuring touch.
- ◆ What do you do in your job that can reach people on a sensory level?
- ◆ Positively engage people's five senses as much as possible!



Enriching Experiences

Everybody plays.

Reason:

Because **YOU** are a LIFE Illustrator!



Customer Service Standard #12

Thoughts about everybody plays ...

- ◆ In **LIFE Illustrated**, there are no spectators!
- ◆ Our brand is genuine if, and only if, **EVERY PERSON** in the company lives and breathes **LIFE Illustrated**.
- ◆ It is up to you to *Illustrate LIFE* every day in your own unique way.



Make LIFE happen!



REVIEW:
Enriching Experiences

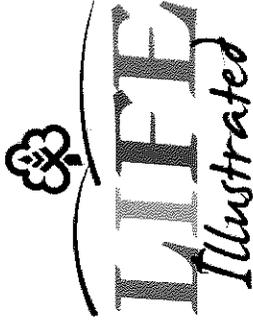
Spread the joy!

Hear. See. Taste. Smell. Touch.

Everybody plays.

REVIEW:
Customer Service Standards #10-12





LIVING WELL TOGETHER

1. Make eye contact, smile and extend a greeting to staff, residents and visitors.
2. First listen, then respond.
3. Establish and maintain professional boundaries in your work environment.

FAMILY MATTERS

7. Embrace the importance of family.
8. Nurture relationships with family members.
9. Partner with family members.

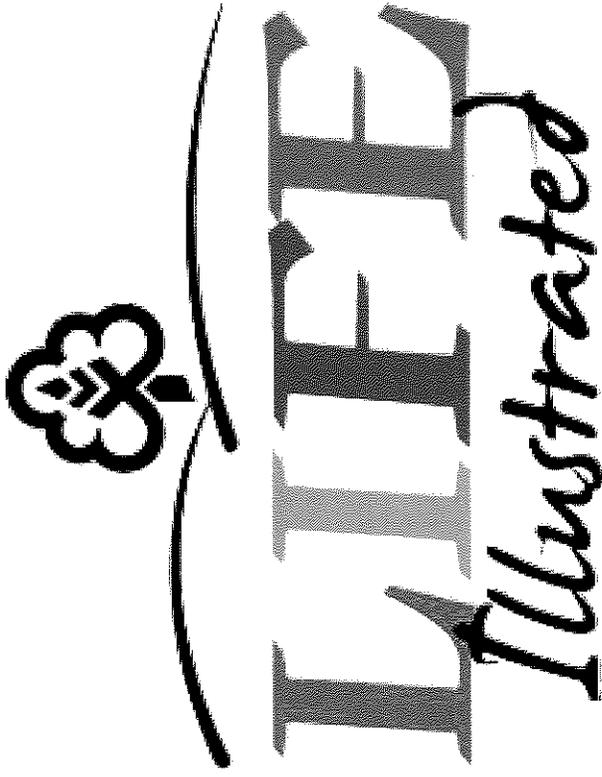
INDIVIDUAL DISCOVERY

4. Know yourself and your value.
5. Discover those around you and speak positively about yourself and others.
6. Create empowering opportunities that promote our mission.

ENRICHING EXPERIENCES

10. Spread the joy!
11. Hear. See. Taste. Smell. Touch.
12. Everybody plays.





Living Well Together

Individual Discovery

Family Matters

Enriching Experiences

G

Brooke Grove Foundation, Inc.
Occupancy Rates for Brooke Grove Rehab & Nursing Center
For the Five Years Ending July 31, 2014

	Census Days			Possible Days	Occupancy Rate		Overall
	Sharon	Remainder of BG	Total Days		Sharon	Remainder of BG	
FY 2010	16,316	39,217	55,533	61,320	93.1%	89.5%	90.6%
FY 2011	14,912	39,201	54,113	61,320	85.1%	89.5%	88.2%
FY 2012	15,054	39,529	54,583	61,488	85.9%	90.0%	88.8%
FY 2013	15,035	41,037	56,072	61,320	85.8%	93.7%	91.4%
FY 2014	14,266	41,298	55,564	61,320	81.4%	94.3%	90.6%

H H

Projected Population Growth of Montgomery County
 Department of Planning
 Maryland State Data Center
 Maryland.gov

		65-69	70-74	75-79	80-84	85+	Total
2010	Total	36,722	25,819	20,450	17,347	19,431	971,777
	Total Male	16,911	11,530	8,728	6,885	6,410	466,402
	Total Female	19,811	14,289	11,722	10,462	13,021	505,375
2015	Total	48,794	33,790	22,826	16,542	21,711	1,036,002
	Total Male	22,516	15,227	9,931	6,790	7,489	497,045
	Total Female	26,278	18,563	12,895	9,752	14,222	538,957
2020	Total	54,511	43,498	29,437	18,341	22,412	1,067,001
	Total Male	24,837	19,487	12,843	7,684	7,936	511,665
	Total Female	29,674	24,011	16,594	10,657	14,476	555,336
2025	Total	60,066	49,511	38,214	23,785	24,104	1,110,004
	Total Male	27,577	21,987	16,619	10,003	8,797	531,825
	Total Female	32,489	27,524	21,595	13,782	15,307	578,179
2030	Total	62,224	55,322	43,759	30,974	28,536	1,153,900
	Total Male	28,131	24,824	18,897	13,003	10,702	552,427
	Total Female	34,093	30,498	24,862	17,971	17,834	601,473
2035	Total	58,723	57,542	48,954	35,516	35,625	1,186,601
	Total Male	26,413	25,435	21,371	14,826	13,587	567,968
	Total Female	32,310	32,107	27,583	20,690	22,038	618,633
2040	Total	56,112	54,220	50,932	39,778	42,900	1,206,802
	Total Male	25,545	23,831	21,889	16,826	16,443	577,827
	Total Female	30,567	30,389	29,043	22,952	26,457	628,975

I

Three Possible Scenarios of Trends in Functional Limitations and the Demand for Long-Term Services and Supports

To assess future needs for LTSS, the Congressional Budget Office prepared projections through 2050 of the prevalence of functional limitations among elderly people living in the community, the demand for caregivers for those people, and spending on LTSS for the elderly. Those projections reflect three different scenarios regarding the future prevalence of functional limitations.

Scenario 1 incorporates the assumption that the prevalence rates of functional impairments among people of different ages and sexes will remain constant over time, reflecting averages calculated from the 2000–2010 waves of the Health and Retirement Study. That scenario is only hypothetical, however, because relationships between impairment, age, and sex observed today might not continue into the future. The prevalence of functional limitations observed over the 2000–2010 period reflects a combination of factors, including the prevalence of certain health conditions and the effectiveness of medical treatments in combatting the loss in functioning associated with those conditions, all of which might change in the future.

To illustrate the range of uncertainty surrounding the future demand for long-term services and supports, CBO constructed two alternative projections of the prevalence of functional limitations. Although many health-related factors affect functioning (for example, obesity, smoking, diabetes, dementia, and heart disease), Scenarios 2 and 3 present hypothetical projections of the prevalence of functional limitations under the assumption of two different trends in the prevalence of obesity (and with all other factors held constant for simplicity). According to CBO's tabulations of data from the Health and Retirement Study, elderly people who are obese have a higher prevalence of functional limitations than elderly people who are not obese. In addition, obesity at younger ages has been shown to increase the probability that a person will have functional limitations at later ages.³⁵ CBO's projections reflect the assumption that the relationship between obesity and functional loss remains constant over the 2010–2050 period.

Scenario 2 incorporates projections of a decline in the prevalence of functional limitations (using the RAND Corporation's Future Elderly Model) under the assumption that, by 2050, the prevalence of

obesity will decline to the level observed in 1978.³⁶ Scenario 3 presents the opposite situation—a rise in the prevalence of functional limitations—under the assumption that the prevalence of obesity increases at the same rate over the next four decades as that observed in the Health and Retirement Study from 2000 to 2010.

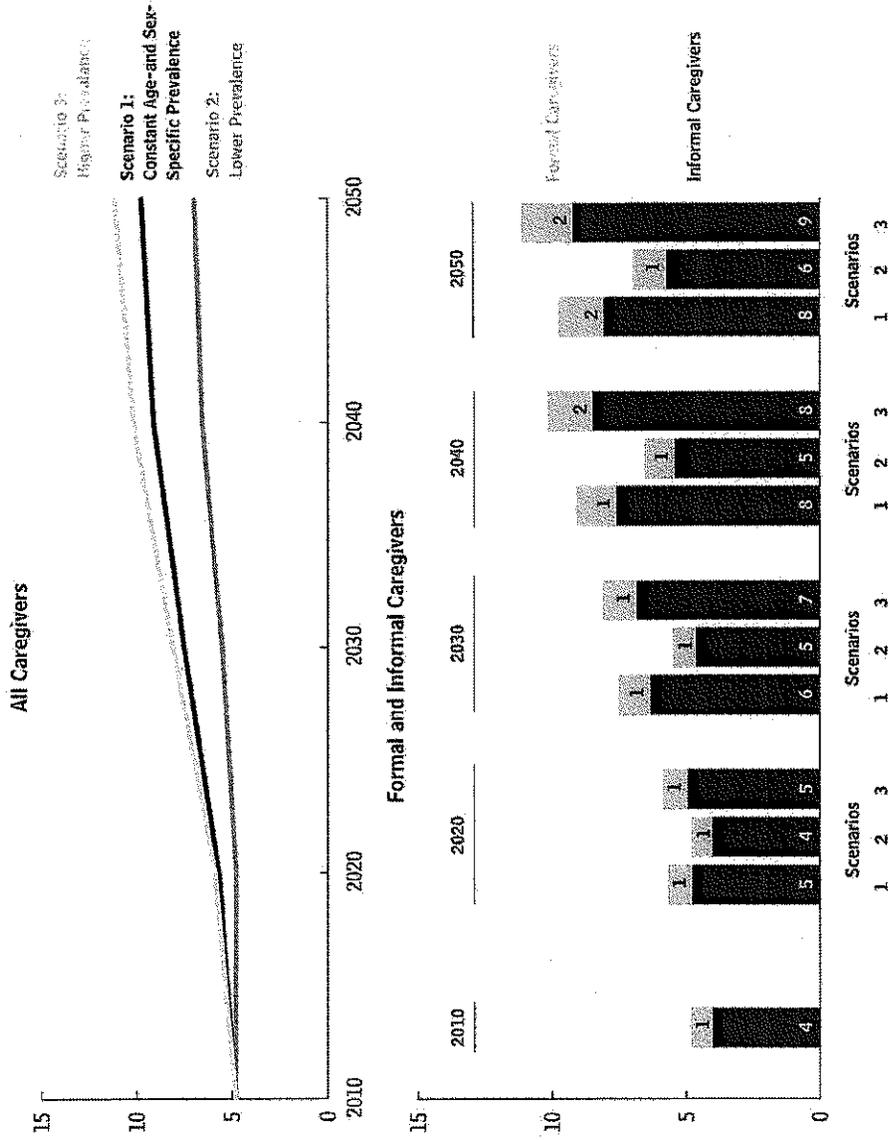
35. Soham Al Snih and others, "The Effect of Obesity on Disability vs. Mortality in Older Americans," *Archives of Internal Medicine*, vol. 167, no. 8 (April 2007), pp. 774–780, <http://tinyurl.com/kbtfp7>; and Honglei Chen and Xuguang Guo, "Obesity and Functional Disability in Elder Americans," *Journal of the American Geriatrics Society*, vol. 56, no. 4 (April 2008), pp. 689–694, <http://tinyurl.com/mk5ge5>.

36. For a description of the model, see RAND Corporation, *Modeling the Health and Medical Care Spending of the Future Elderly*, Research Brief RB-9324 (RAND Corp., 2008), www.rand.org/content/dam/rand/pubs/research_briefs/2008/RAND_RB9324.pdf. Projections of the prevalence of impairment used in Scenario 2 are based on projections in Dana Goldman and others, "The Fiscal Consequences of Trends in Population Health," *National Tax Journal*, vol. 63, no. 2 (June 2010), pp. 307–330, <http://ntj.tax.org/>.

Exhibit 21.

Projected Demand for Caregivers for Elderly People Living in the Community: Three Possible Scenarios, 2010 to 2050

(Percentage of the adult nonelderly population)

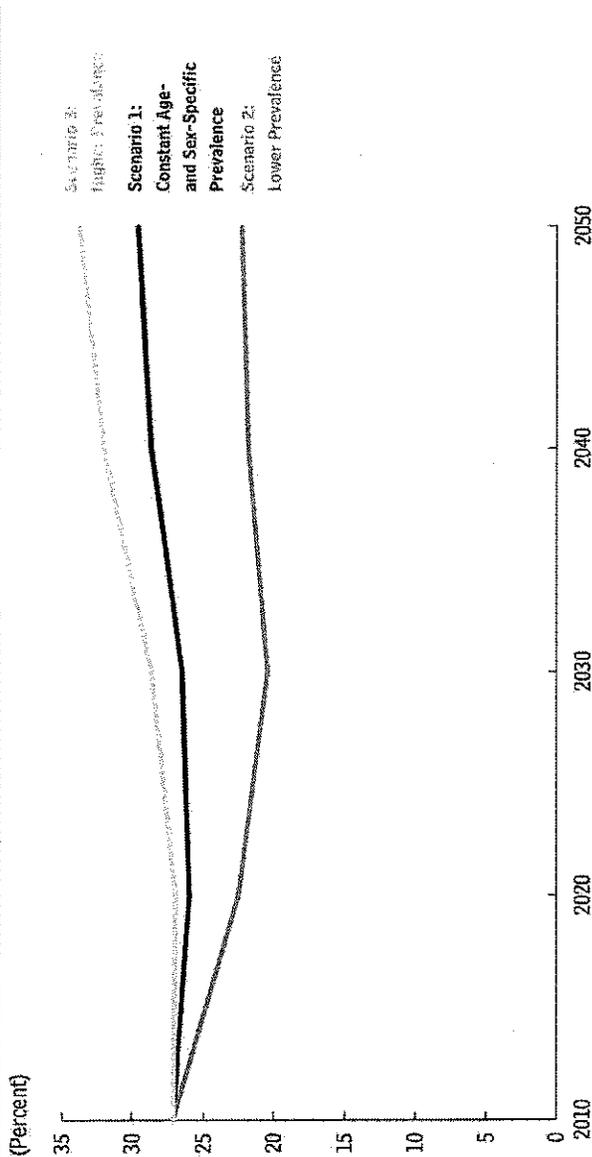


In 2010, 4.0 percent of nonelderly adults provided informal long-term care to elderly people living in the community, and 0.8 percent were employed providing formal care. The increase in the number of people who are elderly (as described in Exhibits 1 and 2) will generate substantial increases in the number of people with functional limitations, and those increases will contribute to a much greater demand for caregivers. The demand for long-term care workers, measured in terms of the share of the nonelderly adult population ages 19 to 64, will increase over the coming decades as the need for services grows. At the same time, the caregiving population will shrink relative to that of the elderly. (In these projections, the Congressional Budget Office assumes that patterns of use of long-term care workers would remain the same under all three scenarios.)

Under Scenario 1, demand for caregivers would more than double, to about 10 percent of the nonelderly adult population by 2050. (The percentages are based on the number of workers, not the number of hours worked.) Under Scenario 2, in which the prevalence of functional limitations declines, demand for workers (as a share of the total workforce) would still increase significantly by 2050, to about 7 percent. Under Scenario 3, in which the prevalence of functional limitations increases, about 11 percent of nonelderly adults would be needed to provide formal and informal care by 2050. ♦

Source: Congressional Budget Office tabulations of data from the Health and Retirement Study. Projections are consistent with projections of the prevalence of functional limitations presented in Exhibit 22.

Notes: The percentages are based on the number of caregivers, regardless of the number of hours they work. For additional notes, see Exhibit 22.

Exhibit 22.**Future Prevalence of Functional Limitations Among Elderly People Living in the Community: Three Possible Scenarios, 2010 to 2050**

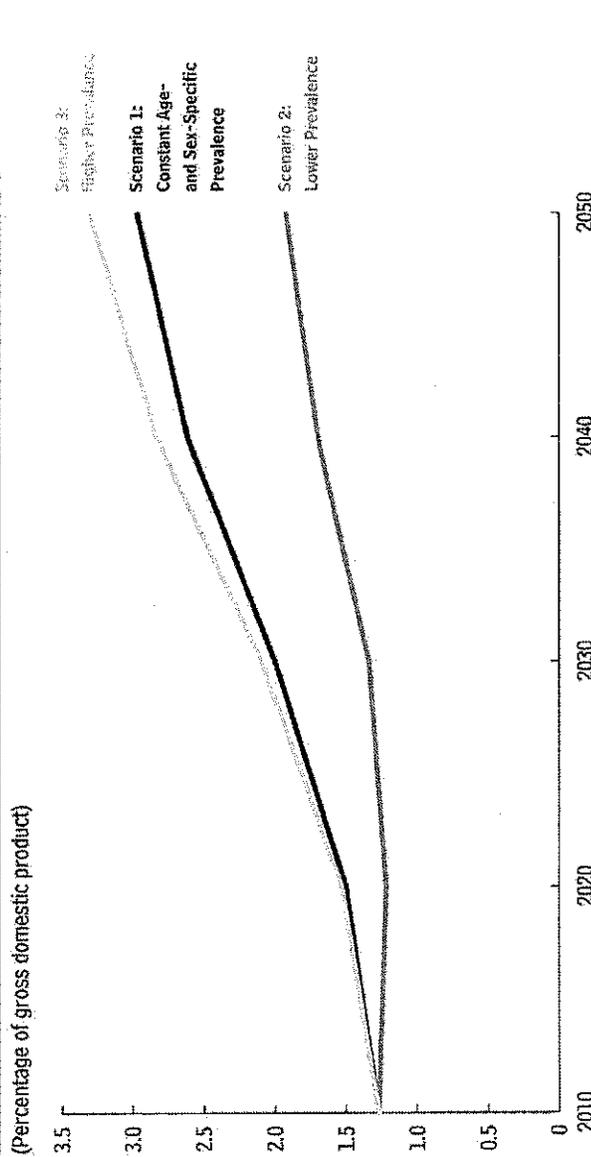
Source: Congressional Budget Office tabulations of data from the Health and Retirement Study (2000–2010 average).

Notes: Scenario 1 incorporates the assumption that the prevalence of functional impairments among people of different ages and sexes remains constant through 2050. Scenario 2 incorporates the assumption that the prevalence of obesity falls back to levels observed in 1978 and that all other factors that could influence trends in functional limitations remain constant. Scenario 3—as opposed to Scenario 2—incorporates the assumption that the prevalence of obesity rises (and holds all other factors constant).

Reported rates of prevalence reflect limitations in one or more activities of daily living or instrumental activities of daily living. For 2010, the prevalence is an average of rates (by age and sex) observed in the 2000–2010 waves of the Health and Retirement Study, weighted by the 2010 population. For more information, see the supplemental material.

The increase in the number of elderly people will have a substantial impact on the need for caregivers under various assumptions about the future prevalence of functional limitations; in fact, future prevalence rates by themselves are unlikely to significantly affect future demand for LTSS or expenditures associated with it.

If the prevalence of functional limitations among people of different ages and sexes remained constant (Scenario 1), the prevalence of functional loss (difficulty performing one or more ADLs or IADLs) among elderly people living in the community would be slightly lower in 2030 (26.5 percent) than it was in 2010 (27.2 percent), because the influx of the baby-boom generation will reduce the average age of the elderly. By 2040 and 2050, however, baby boomers will have reached advanced ages, so the overall prevalence of functional loss among the elderly would be higher—climbing to about 29 percent in 2040 and about 30 percent in 2050. Under Scenario 2, the prevalence of functional loss among elderly people would fall by an average of 0.12 percentage points per year from 2010 to 2050, reaching 22 percent by 2050. (In spite of the projected decline in obesity from 2010 to 2050 under that scenario, the total prevalence of functional limitations would still rise in 2040 and 2050 from the 2030 projection because of the baby-boomer effect, which will boost the number of people age 85 or older.) Under Scenario 3, the prevalence of functional limitations would increase to about 34 percent by 2050. ♦

Exhibit 23.**Future Spending for Long-Term Services and Supports for Elderly People: Three Possible Scenarios, 2010 to 2050**

Sources: Congressional Budget Office based on information from the Centers for Medicare & Medicaid Services, Office of the Actuary. The projections for 2020, 2030, 2040, and 2050 are consistent with the projected increases in impairment reported in Exhibit 21. Projections of GDP are from Congressional Budget Office, *The 2012 Long-Term Budget Outlook* (June 2012), www.cbo.gov/publication/43288. In that report, expenditures for long-term services and supports were included as part of total health care spending, but they were not explicitly identified. For more information, see the supplemental material.

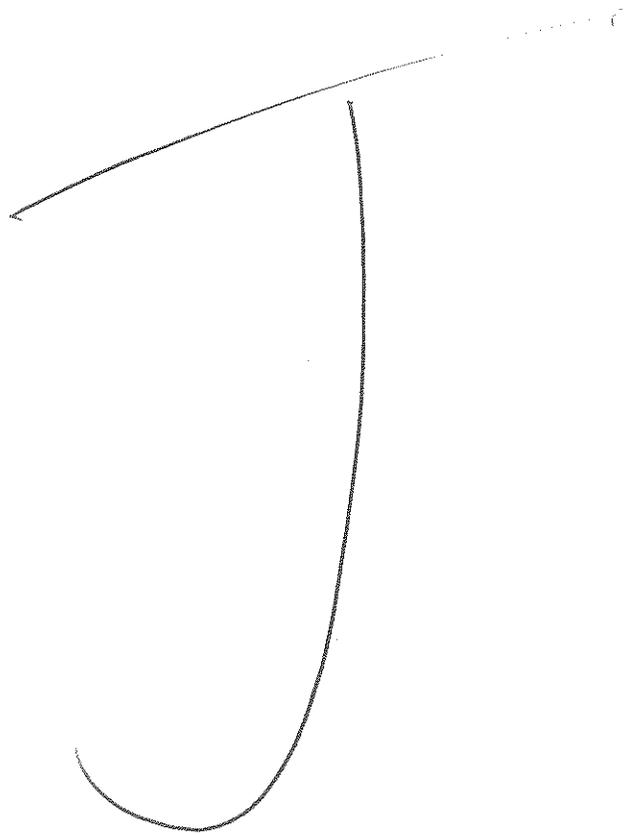
Notes: Scenario 1 incorporates the assumption that the prevalence of functional impairments among people of different ages and sexes remains constant through 2050. Scenario 2 incorporates the assumption that the prevalence of obesity falls back to levels observed in 1978 and that all other factors that could influence trends in functional limitations remain constant. Scenario 3—as opposed to Scenario 2—incorporates the assumption that the prevalence of obesity rises (and holds all other factors constant).

Reported rates of prevalence reflect limitations in one or more activities of daily living or instrumental activities of daily living. For 2010, the prevalence is an average of rates (by age and sex) observed in the 2000–2010 waves of the Health and Retirement Study, weighted by the 2010 population. For more information, see the supplemental material.

By 2050 under all three scenarios, the Congressional Budget Office projects, spending for formal long-term services and supports (not including the economic value of informal care) will rise to a significantly higher share of gross domestic product than it is today, primarily because of the aging of the population. Under the assumption that the prevalence of functional limitations among elderly people of different ages and sexes will remain constant (Scenario 1), spending as a share of GDP will more than double, climbing from 1.3 percent in 2010 to 3.0 percent in 2050. Under Scenario 2's more optimistic projection, spending would still reach 1.9 percent of GDP in 2050. Scenario 3 indicates that if the prevalence of impairment rises rather than falls, even by a relatively modest amount, spending as a percentage of GDP could reach 3.3 percent, two-and-a-half times what it was in 2010, all other things being equal.

The spending estimates vary according to the projections of the prevalence of functional limitations and of the prevalence of institutionalization embodied in the three possible scenarios; all other factors that affect LTSS spending (such as the rate of growth in prices for LTSS, changes in family structure that could affect the provision of informal care, and changes in how services and supports are delivered) are held constant across the scenarios.³⁷ ♦

37. Although not reported in Exhibit 22, projections of the prevalence of institutionalization among elderly people are calculated in the same manner as the prevalence of functional limitations for elderly people living in the community. For more information, see Congressional Budget Office, "Methods for Analysis of the Financing and Use of Long-Term Services and Supports," supplemental material for *Rising Demand for Long-Term Services and Supports for Elderly People* (June 2013).



Admissions to BGRNC, FY2013-2014

	Number	Percent
MedStar Montgomery Med. Ctr.	333	63.2
Holy Cross	61	11.6
Shady Grove Adventist	35	6.6
Suburban	25	4.7
Howard Cnty Gen. Hospital	15	2.8
Washington Hospital Ctr.	13	2.5
Georgetown Univ.	11	2.1
Washington Adventist	6	1.1
National Rehab	2	0.4
Other	26	4.9
	527	100.0

K

Letters of Support

1. Maryland General Assembly
14th Legislative District
Montgomery County
2. MedStar Montgomery Medical Center
Olney, Maryland
3. Johns Hopkins Medicine
Howard County General Hospital
Columbia, Maryland
4. MedStar Health at Leisure World
Silver Spring, Maryland
5. Benjamin Avrunin, MD
Physician, Private Practice
Clinical Professor of Medicine, GW School of Medicine
6. Leisure World of Maryland (3 Letters)
Leisure World Social Services
Silver Spring, Maryland
7. Robert Fields, MD
Physician, Private Practice
8. Arthur Woodward, MD
Physician/Surgeon, Private Practice
9. Philip Henjum, MD
Physician, Private Practice
10. Medical & Wellness Center of Olney (2 Letters)
Olney, Maryland
11. Potomac Valley Orthopaedic Associates (6 Letters)
Olney, Gaithersburg, Silver Spring and Columbia, Maryland



THE MARYLAND GENERAL ASSEMBLY
14TH LEGISLATIVE DISTRICT
MONTGOMERY COUNTY
October 27, 2014

Dr. Craig P. Tanio
Chair, Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Tanio:

We are writing without reservation in support of the Brooke Grove Foundation's project to replace their current 48-bed facility with a 70-bed facility, adding 22 beds to its license.

Brooke Grove Rehabilitation and Nursing Center is recognized as a leading healthcare provider in Montgomery County, providing skilled care, short-stay rehabilitation, and long-term care to area residents for 64 years. Currently, it is ranked #1 in the county based on the State of Maryland's performance rankings.

As the population ages, there will be increased demands on the healthcare system, especially in post-acute, short-stay rehabilitation. Brooke Grove's project will expand its ability to meet this increased need, and we strongly support its efforts.

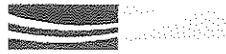
Best wishes,

Karen Montgomery
State Senator

Eric Luedtke
State Delegate

Anne Kaiser
State Delegate

Craig Zucker
State Delegate



MedStar Montgomery Medical Center

18101 Prince Philip Drive
Olney MD 20832
301-774-8771 PHONE
301-774-8866 FAX
medstarontgomery.org

Peter W. Monge, FACHE
President

Administration

October 09, 2014

TO THE MARYLAND HEALTH CARE COMMISSION:

I am writing in support of Brooke Grove Rehabilitation and Nursing Center's certificate of need application for a new rehabilitation wing and additional beds.

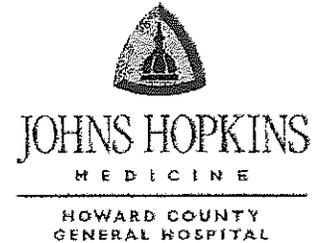
BGRNC is widely recognized as a leading provider of skilled, rehabilitation and comprehensive care in Montgomery County as well as throughout the state of Maryland. Because of this and the fact that our location is adjacent to their campus, **MedStar Montgomery Medical Center** has been a long-time partner of BGRNC, and our referrals to BGRNC have increased significantly over the last few years. We expect that referrals will continue to grow as the boomer population ages and the number of seniors needing rehab increases accordingly. Since BGRNC's rehab beds are often currently full, the construction of a new rehabilitation wing with additional dedicated rehab beds will be both welcome and greatly beneficial to our organization and those we serve.

Thank you for your support of this project.

Sincerely,

Peter W. Monge, FACHE
President, MedStar Montgomery Medical Center
& SVP, MedStar Health

5755 Cedar Lane
Columbia, Maryland 21044
410-740-7890
410-740-7990 (TDD)
www.hcgh.org



October 15, 2014

TO THE MARYLAND HEALTH CARE COMMISSION:

I am writing in support of Brooke Grove Rehabilitation and Nursing Center's certificate of need application for a new rehabilitation wing and additional beds.

BGRNC is widely recognized as a leading provider of skilled, rehabilitation and comprehensive care in Montgomery County as well as throughout the state of Maryland. Because of this, Howard County General Hospital has been a long-time partner of BGRNC, and our referrals to BGRNC have increased significantly over the last few years. We expect that referrals will continue to grow as the boomer population ages and the number of seniors needing rehab increases accordingly. BGRNC is a frequently requested facility by our patients. Since BGRNC's rehab beds are often currently full, the construction of a new rehabilitation wing with additional dedicated rehab beds will be both welcome and greatly beneficial to our organization and those we serve.

Thank you for your support of this project.

Sincerely,

Nancy Larson RN, MSN
Director of Case Management
Howard County General Hospital
5575 Cedar Lane
Columbia, Maryland 21044



MedStar Health

3305 North Leisure World Blvd.
Silver Spring, MD 20906
301-598-1590 PHONE
301-598-1569 FAX
medstarhealth.org/leisureworld

October 15, 2014

TO THE MARYLAND HEALTH CARE COMMISSION:

I am writing in support of Brooke Grove Rehabilitation and Nursing Center's certificate of need application for a new rehabilitation wing and additional beds.

BGRNC is widely recognized as a leading provider of skilled, rehabilitation and comprehensive care in Montgomery County as well as throughout the state of Maryland.

Because of this, MedStar Health at Leisure World has been a long-time partner of BGRNC, and our referrals to BGRNC have increased significantly over the last few years. We expect that referrals will continue to grow as the boomer population ages and the number of seniors needing rehab increases accordingly. Since BGRNC's rehab beds are often currently full, the construction of a new rehabilitation wing with additional dedicated rehab beds will be both welcome and greatly beneficial to our organization and those we serve.

Thank you for your support of this project.

Sincerely,

Crystal R Green

Crystal R. Green
Practice Administrator
MedStar Health at Leisure World Blvd

Knowledge and Compassion
Focused on You

BENJAMIN AVRUNIN, M.D.

October 9, 2014

To the Maryland health care commission:

I am writing in support of the Broke Grove rehabilitation and nursing Center certificate of need application for a new rehabilitation wing and additional beds. I have myself referred to the Center over the years. As my practice ages, I find that I am making more referrals. Often, the beds are currently full, and the construction of a new rehabilitation wing with additional dedicated rehab beds would be very beneficial.

Thank you for your support of this project.

Sincerely yours,



Benjamin Avrunin, M. D.

Clinical professor of medicine, GW school of medicine



LEISURE WORLD SOCIAL SERVICES

3305 N. Leisure World Boulevard • Silver Spring, Maryland 20906

To: Maryland Health Care Commission

I am writing in support of granting Brooke Grove Rehabilitation and Nursing Center a certificate of need to increase their number of rehabilitation beds.

I am the social work supervisor at the Leisure World Community in Silver Spring, MD. This is a community of 8,500 independent living seniors. Many of these residents end up needing in-patient rehab services.

I have worked at Leisure World for 24 years and Brooke Grove has consistently provided quality care to our residents who have turned to them. With the reputation they have gained, there is frequently a demand for their services that surpasses availability. An increase in beds would offer a potential solution.

Thank you for your consideration of this application.

Myrna Cooperstein, LCSW-C
Myrna Cooperstein, LCSW-C

Social Work Supervisor



LEISURE WORLD SOCIAL SERVICES

3305 N. Leisure World Boulevard • Silver Spring, Maryland 20906

October 8, 2014

To: Maryland Health Care Commission

I am writing in support of Brooke Grove Rehabilitation and Nursing Center's certificate of need application for a new rehabilitation wing and additional beds.

The social work department of Leisure World has been a long-term partner of BGRMC and refer residents constantly. We expect referrals will continue to grow as the boomer population ages and the number of seniors needing rehab increases. Since BGRMC's rehab beds are often currently full, the construction of a new rehab wing with additional dedicated rehab beds will be both welcome and greatly beneficial to Leisure World residents. Thank you for your support of the Project! ... in ... Mike Brown LWW-C Leisure World Social Worker



LEISURE WORLD SOCIAL SERVICES

3305 N. Leisure World Boulevard • Silver Spring, Maryland 20906

October 10, 2014

Dear Maryland Health Care Commission,

I am writing in support of Brooke Grove Rehabilitation and Nursing Center's certificate of need application for a new rehabilitation wing and additional beds.

In 1992 I started working for Leisure World as a social worker. Leisure World now has 8,000 residents. Over the years it has become increasingly more difficult to recommend good quality skilled rehabilitation facilities that have a bed available. I feel confident when making referrals to BGRNC that our resident will receive the care and support they need if BGRNC has a bed available. Unfortunately, BGRNC rehab beds are often full. Granting a certificate of need so a new addition could be added to Brooke Grove's Rehabilitation and Nursing Center would be a huge benefit for our community here in Leisure World.

Sincerely,

A handwritten signature in cursive script that reads "Margaret M. Vaughan".

Margaret M. Vaughan LCSW-C

Robert P. Fields, M.D.



October 8, 2014

TO THE MARYLAND HEALTH CARE COMMISSION:

I am writing in support of Brooke Grove Rehabilitation and Nursing Center's certificate of need application for a new rehabilitation wing and additional beds.

BGRNC is widely recognized as a leading provider of skilled, rehabilitation and comprehensive care in Montgomery County as well as throughout the state of Maryland. Because of this, Robert P. Fields, M.D., LLC has been a long-time partner of BGRNC, and my referrals to BGRNC have increased significantly over the last few years. We expect that referrals will continue to grow as the population ages and the number of seniors needing rehab increases accordingly. Since BGRNC's rehab beds are often full, the construction of a new rehabilitation wing with additional dedicated rehab beds will be both welcome and greatly beneficial to my practice.

Thank you for your support of this project.

Sincerely,

Handwritten signature of Robert P. Fields, M.D., FACP

Robert P. Fields, M.D.

Arthur F. Woodward, Jr. M.D.

SUITE 205
3416 OLANDWOOD COURT
OLNEY, MARYLAND 20832
TELEPHONE 301-924-3004
FAX 301-570-0772

October 13, 2014

TO: The Maryland Health Care Commission

I am writing in support of Brooke Grove Rehabilitation and Nursing Center's certificate of need application for a new rehabilitation wing and additional beds.

BGRNC is widely recognized as a leading provider of skilled, rehabilitation and comprehensive care in Montgomery County as well as throughout the state of Maryland. Because of this our office has been a long time partner of BGRNC, and our referrals to BGRNC have increased significantly over the last few years. We expect that referrals will continue to grow as the boomer population ages and the number of seniors needing rehab increases accordingly. Since BGRNC's rehab beds are often currently full, the construction of a new rehabilitation wing with additional dedicated rehab beds will be both welcome and greatly beneficial to our office and to those that we serve.

Thank you for your support of this project.

Sincerely,


Arthur F. Woodward, Jr., M.D.

Philip G. Henjum, M.D.



*Diplomate, American Board of Internal Medicine
Diplomate, American Board of Hospice and Palliative Care*

October 8, 2014

TO THE MARYLAND HEALTH CARE COMMISSION:

I am writing in support of Brooke Grove Rehabilitation and Nursing Center's certificate of need application for a new rehabilitation wing and additional beds.

BGRNC is widely recognized as a leading provider of skilled, rehabilitation and comprehensive care in Montgomery County as well as throughout the state of Maryland. Because of this, Philip G. Henjum, M.D., LLC has been a long-time partner of BGRNC, and my referrals to BGRNC have increased significantly over the last few years. We expect that referrals will continue to grow as the population ages and the number of seniors needing rehab increases accordingly. Since BGRNC's rehab beds are often full, the construction of a new rehabilitation wing with additional dedicated rehab beds will be both welcome and greatly beneficial to my practice.

Thank you for your support of this project.

Sincerely,

Philip G. Henjum, M.D.

Medical & Wellness Center of Olney

Alok N. Mathur, M.D.

4000 Olney- Laytonsville Rd
Olney, MD 20832

Lisa Ng, M.D.

Phone: (301) 774-2506
Fax: (301) 774-3734

October 9, 2014

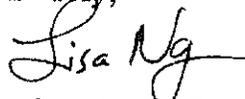
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I am writing in support of Brooke Grove Rehabilitation and Nursing Center's certificate of need application for a new rehabilitation wing and additional beds.

BGRNC is widely recognized as a leading provider of skilled, rehabilitation and comprehensive care in Montgomery County as well as throughout the state of Maryland. Because of this, my practice, Medical and Wellness Center of Olney, has been a long-time partner of BGRNC, and our referrals to BGRNC have increased significantly over the last few years. We expect that referrals will continue to grow as the population ages and the number of seniors needing rehab increases accordingly. It has been important for my patient community to stay within the Olney/Brookeville area as my patients want to continue seeing their doctors in this area, therefore I fully support the construction of a new rehab wing with additional dedicated rehab beds.

Thank you for your attention to this very important project.

Sincerely,



T. Lisa Ng, M.D.

LG/bjs

Medical & Wellness Center of Olney

Alok N. Mathur, M.D.

4000 Olney- Laytonsville Rd
Olney, MD 20832

Lisa Ng, M.D.

Phone: (301) 774-2506
Fax: (301) 774-3734

October 9, 2014

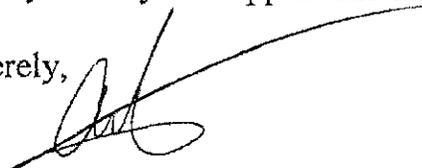
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Thank you for your support and attention to this very important project.

Sincerely,



Alok N. Mathur, M.D.

AM/bjs



POTOMAC VALLEY ORTHOPAEDIC ASSOCIATES

The Centers for Advanced Orthopaedics

BOARD CERTIFIED

Excellence in Orthopaedics

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www.pvoac.com

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Thank you for your support of this project.

Sincerely,

Sheldon Mandel, M.D.



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Thank you for your support of this project.

Sincerely,

Denis O'Brien, M.D.



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Thank you for your support of this project.

Sincerely,

Navin Sethi, M.D.



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Thank you for your support of this project.

Sincerely,

Charles Mess Jr., M.D.



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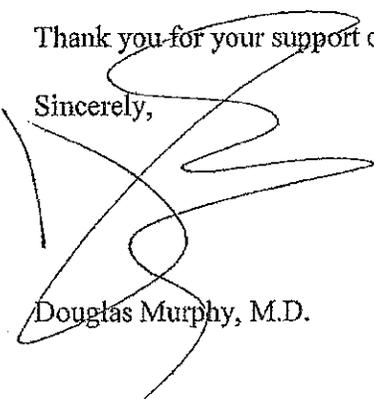
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Thank you for your support of this project.

Sincerely,


Douglas Murphy, M.D.



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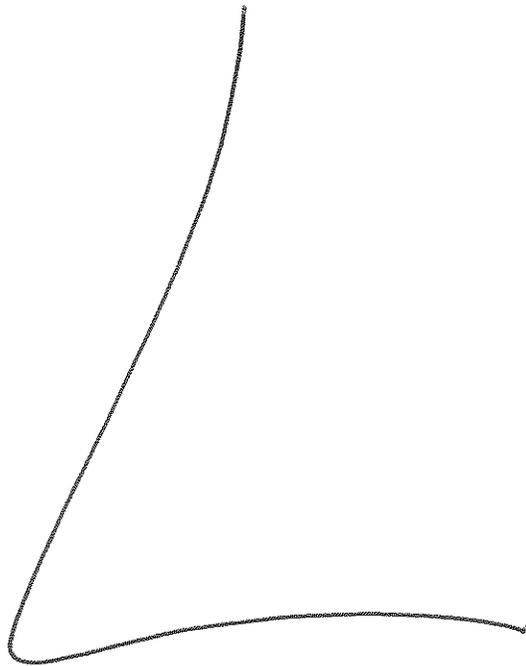
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Thank you for your support of this project.

Sincerely,

Sanjog Mathur, M.D.



BROOKE GROVE REHABILITATION AND NURSING CENTER 2014 QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PLAN

Brooke Grove Rehabilitation and Nursing Center is committed to providing quality care and services to all residents. We do this through implementation of our mission statement, "We Touch People's Lives" and through the adoption of LIFE principles; Living well together, Individual discovery, Family matters and Enrichment through education and an environment that fosters wholeness. We implement our mission by making it our daily reality.

Our goal is to continuously improve the lives of our residents physically, emotionally and spiritually. We will do this through a comprehensive and multi-disciplinary plan that will objectively and systematically monitor, evaluate and identify opportunities to improve care and services in compliance with state and federal standards.

The Quality Assurance Performance Improvement Committee

The committee will meet at least monthly and monitor issues as identified in COMAR. The committee will consist of at least the following department representatives:

- Quality Assurance Coordinator- RN designee of Director of Nursing, Chairperson
- Medical Director- Unexpected deaths
- Administrator
- Director of Nursing- Pressure ulcer monitoring, accidents and injuries, changes in physical or mental status and abuse
- Social Services- Abuse
- Dietician- Dehydration and malnutrition monitoring, Weight gain and loss
- Nursing Assistant

Other departments will be invited to participate. These departments will include at least:

- Environmental Services
- Pharmacy- Medication administration
- Human Resources
- Rehabilitation
- Culinary Services
- Life Enrichment

The Quality Assurance Performance Improvement Committee will meet to:

- Plan a systematic, coordinated and ongoing process to assess overall organizational performance
- Establish priority opportunities for improvement
- Assist in designing monitoring tools to measure performance
- Establish means of determining the root cause of adverse events
- Assist in the development of and approve the yearly organizational and departmental QA activities
- Evaluate progress of ongoing monitoring issues

- Receive department reports
- Establish educational in-services to address opportunities for improved care
- Submit the yearly QA plans and any changes to OHCQ as specified in their guidelines
- Approve the monthly reports to:
 - Ombudsman
 - Family Council
 - Resident Council
- Investigate any allegations of abuse and neglect through the Social Services and Nursing Departments
- Investigate accidents or incidents which result in significant harm to resident, staff or guests
- Review 24 hour reports (concurrent review) and determine if any quality of care issues are identified based on changes in resident condition

Administration supports the use of root cause investigative practices for review of incidents involving pain, bruises, skin tears, facility acquired pressure ulcers, and falls to determine if trends can be identified and actions taken. For systems issues identified, a Continuous Quality Improvement Team may convene.

Data Collection

Sources of data collection may include:

- CMS Quality Indicator Report
- 24 hour reports
- Incident reports
- Resident or family complaints
- Individual department reviews, observations and reports
- Staff concerns
- Medical Rounds
- Government surveys
- Referrals from Medical Director and others
- Infection Control Reports
- Skin Assessment Reports
- "At Risk" meeting reports

Data Analysis

Data submitted to the Quality Assurance Performance Improvement Committee for concurrent review will be based on COMAR regulations. In addition, data related to the Quality Indicator Project will be assessed based upon pre-established targets.

When trends or opportunities for improvement are identified, departments will bring this information to the QAPI Committee for review. A plan of correction, if deemed necessary, will be instituted and ongoing monitoring, evaluation and reassessment will occur.

Corrective Plans

Plans of correction may include, but not be limited to the following:

- In-service Education
- Individual counseling or disciplinary action
- Ad hoc multi-disciplinary Performance Improvement Teams
- Continued monitoring for trends and reevaluation if percentile increases above pre-established thresholds
- Resident or family education
- Policy and procedure changes

Concurrent Review

A policy and procedure for conducting concurrent review of each resident shall be implemented to determine changes in a resident condition (see attached).

Resident Complaints

A policy and procedure for reviewing and investigating resident or responsible party concerns, complaints and grievances shall be implemented and reported to the QA Committee as necessary.

Accidents and Injuries

A policy and procedure for reporting and investigating accidents and injuries shall be implemented and reported to the QA Committee as necessary.

Abuse and Neglect

A policy and procedure for abuse and neglect and a plan for the prevention of abuse shall be implemented and reported to the QA Committee as necessary.

Relocation of Residents

(See attached plan)

Posting of Staff

(See attached plan)

BROOKE GROVE REHABILITATION AND NURSING CENTER

Quality Assurance Committee

Policy Statement

This facility will maintain a Quality Assurance Committee.

Policy Interpretation and Implementation

The primary purpose of the committee is to ensure continuing quality care and safety for residents.

1. The Quality Assurance Coordinator will be designated as the Quality Assurance Committee Chairperson.
2. The Committee will consist of at least the following
 - Medical Director
 - Administrator
 - Director of Nursing
 - Dietician
 - Geriatric Nursing Assistant
 - Social Worker
 - Licensed Nurse
 - Quality Assurance Coordinator
3. The Quality Assurance Committee will meet monthly to review assessment tools, data collection reports, and all activities regarding Quality Assurance as carried out by departments, services or committees which have a direct impact on resident care and safety.
4. The Quality Assurance Committee shall determine the types of Quality Assurance activities to be performed and shall approve all data collection and monitoring tools to determine:
 - A) their appropriateness
 - B) the standards against which they are measured, and
 - C) their effectiveness to meet resident care needs.
5. Individual departments or services will be responsible for monitoring and evaluating all resident care in which they are involved either directly or indirectly at the request/assignment of the Quality Assurance Committee.
6. Reports made by departments or services or committees shall be submitted to the Quality Assurance Committee as directed by the committee.
7. The quality and appropriateness of resident care, including the identification of trends in performance, will be monitored and evaluated in any area that the Quality Assurance Committee deems appropriate.

8. Reports submitted to the committee will be evaluated to identify problems, plan solutions, implement actions and ensure follow-up, as well as consistent monitoring.

9. The Committee will determine the need for ad hoc teams to address specific issues.

10. The Quality Assurance Committee shall report, on a monthly basis, its activities to the

- A) Ombudsman
- B) Resident Council
- C) Family Council

11. The Quality Assurance Committee shall submit to the Office of Health Care Quality all Quality Assurance Plans at time of license renewal and within 30 days of changes to the Quality Assurance Plan. The plan will include:

A) A description of the measurable criteria for ongoing monitoring of all aspects of resident care including:

- 1. Medication Administration
- 2. Prevention of decubitus ulcers, dehydration and malnutrition
- 3. Nutrition status and weight loss or weight gain
- 4. Accidents and injuries
- 5. Unexpected deaths
- 6. Changes in physical or mental status

B) The methodology for data collection

C) The methodology for evaluation and analysis of data to determining trends and patterns.

D) A description of the thresholds and performance parameters that represent acceptable care for the measured criteria

E) Time frames for referral to the QA Committee

F) A description of the plan for follow-up to determine effectiveness of the recommendations

G) A description of how the QA activities will be documented

12. The Quality Assurance Committee shall review and approve the Quality Assurance Program at least annually.

13. The Quality Assurance Committee will make records/documents available to the Office of Health Care Quality.

14. The Quality Assurance Committee will maintain:

- Records of attendance
- Agenda/Schedule for monthly meetings
- Minutes/Notes of QA monthly meetings

Performance Improvement Project *(SEPTEMBER 2014)*

DEPARTMENT:

Nursing Department, Culinary Services, and Dietitians

IDENTIFIED QUALITY ISSUES:

Residents have many items on meal trays and at times these include the supplements added to help meet nutritional needs. The increase in food items is difficult for residents to consume at one setting, during the reasonable meal time. On occasion the commercial supplement such as Boost Plus or Ensure Plus is given during the meal and disrupts the progress the resident is making in consuming the normal meal.

GOALS/PLAN:

1. Identify if supplements provided on the tray were ordered
2. Identify if extra food items are provided due to preferences
3. Identify which items can be removed from the resident's meal plan.
4. Identify reasons (if possible) that items are not consumed: a. no longer likes, b. portion too large c. too salty d. too sweet e. temperature not good f. Other (This may allow team to correct reason for resident not eating or drinking supplement).
5. Identify if increased nutrient goals can be met by substituting or enhancing regular food items, e.g. adding butter and/or sugar/or protein powder to basic menu at point of service.

PLANNED IMPLEMENTATION:

1. Begin on one unit and review left over supplements from meal trays. (Nursing & Dietitians).
2. Monitor quality of supplements, taste, appearance, temperature at point of service.

METHOD TO EVALUATE:

1. Staff to place leftover supplement items on separate tray at end of meal for review by dietitians.
2. Dietitians to track leftover supplements, review tray tickets, review orders.
3. Dietitians to review residents' consumption of meals, nutritional needs, nutrition status, and adjust recommendations.
4. Use pink tracking sheets to identify leftover supplements and resolution.
5. Review when commercial supplements are ordered at meal times, determine consumption and if supplement is beneficial.

PLAN TO REPORT TO QAPI:

Report progress monthly to QAPI. Final report to be given on third month after PIP initiated.

Performance Improvement Project

Dining Experience

DEPARTMENT: Life Enrichment; Environmental Services; Culinary Services; Nursing; Administration

IDENTIFIED QUALITY ISSUES:

1. inability to start resident group activity on time
2. housekeeping was late in cleaning dining areas
3. culinary services staff unable to clean/ bus tables in timely manner
4. trays were passed out late due to many residents needing assistance with meal or care prior to/ during mealtime
5. LE & housekeeping staff were unable to assist with passing trays as they were feeding residents at lunch meal

GOALS/PLAN: provide additional assistance during breakfast & lunch

PLANNED IMPLEMENTATION:

1. enlist the help of 25 staff members from administration and ancillary staff to be "Meal assistants"
2. create a schedule between all dining rooms and request these 26 staff members to choose 2 mealtimes for either breakfast or lunch to help serve in two times per week
3. meal assistants duties included: offering hand wipes to residents, assisting with clothing protectors, turning music on if desired by residents, set-up meals, responding to requests, feeding residents in need of assistance, clearing tables when appropriate

METHOD TO EVALUATE:

- evaluate start times of group activities
- feedback from residents and LE staff

PLAN TO REPORT TO QAPI: LE to randomly audit start times of group activities in various neighborhoods monthly

Performance Improvement Project
Pain Management during Rehab Program

DEPARTMENT: Rehab Department and Nursing Department

IDENTIFIED QUALITY ISSUES:

1. Increased number of residents who complain of pain during rehab sessions
2. Medical regimen

GOALS/PLAN:

1. Implement use of communication tool between nurses and therapists
2. Reduce the number of complaints of pain from residents in skilled rehab

PLANNED IMPLEMENTATION:

1. Educate charge nurses regarding communication tool and procedure
2. Therapists to utilize tool to improve communication regarding concerns/ issues
3. Nursing to utilize daily therapy schedule to determine appropriate administration of medication
4. Nursing to assess pain medication schedule for those residents who complain of pain more than 2 times in a week
5. Refer residents on pain regimen and who continue to complain of pain to attending physician or physiatrist for further management

METHOD TO EVALUATE:

1. Site manager to track all complaints of pain over a 4 week period to establish pattern & gather data
2. Random audit by Nursing & QA to track complaints of pain meds given

PLAN TO REPORT TO QAPI: quarterly and as needed

Performance Improvement Project

Psychotropic Medication Sheets

DEPARTMENT: Nursing

IDENTIFIED QUALITY ISSUES:

1. difficulty in tracking last GDR in resident's psychotropic medications
2. lack of documentation as to effect of drug reduction or increase on resident

GOALS/PLAN: revise current psychotropic med sheets to address identified issues

PLANNED IMPLEMENTATION:

1. revise drug rounds sheet, and develop a new form to enable better tracking of changes in dose of a particular medication
2. implementing a documentation sheet specifically for psychotropic medication changes, and ensuring that the document stays in the active chart for ease of monitoring
3. educate staff on how to record medication changes on new forms

METHOD TO EVALUATE:

- random audit of psychotropic medication sheets every 4 months at drug rounds

PLAN TO REPORT TO QAPI: every 4 months and as needed

Performance Improvement Project

Wheelchair Project

DEPARTMENT: Environmental Services; Nursing; Rehab; Plant Ops; Billing

IDENTIFIED QUALITY ISSUES:

1. inability to track personal wheelchairs brought in by residents
2. inability to determine if resident was renting facility wheelchair
3. inability to track new equipment bought by facility

GOALS/PLAN: develop a tracking system for all wheelchairs being used in facility

PLANNED IMPLEMENTATION:

1. create a document that different departments could access to track wheelchair used by residents
2. have a formal inventory of all chairs (wheelchair, HTR chairs, geri chairs, and leg rests) currently in use by residents
3. develop a system of labeling the chairs for easy tracking

METHOD TO EVALUATE:

- feedback from rehab, nursing, environmental services
- feedback from billing

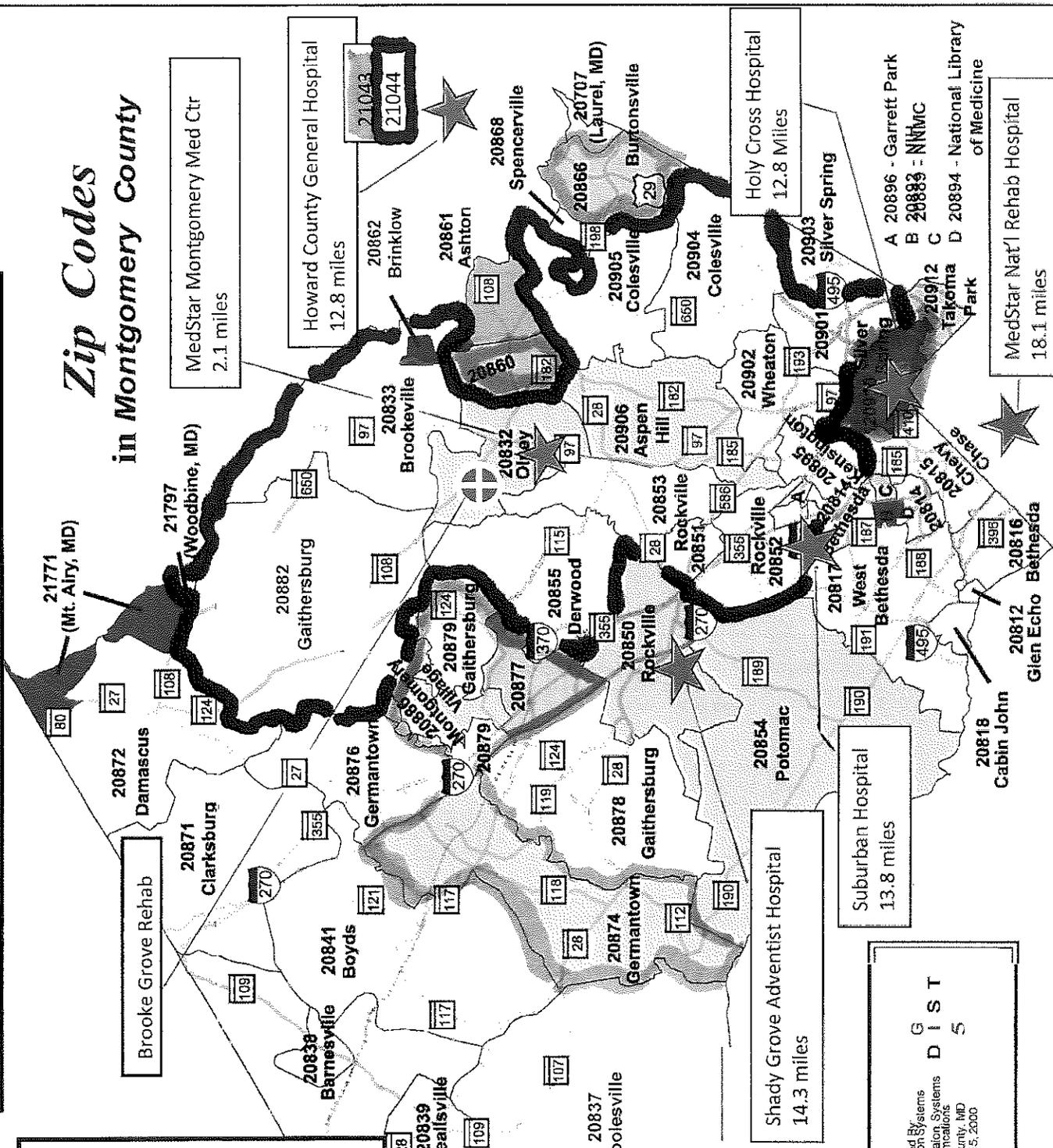
PLAN TO REPORT TO QAPI: quarterly and as needed

M

ZIP CODES COMPRISING PRIMARY AND SECONDARY MARKETS

Zip Codes in Montgomery County

1. Locations of hospitals marked by RED STARS are approximations so as to not block zip codes
2. BLACK OUTLINED AREA = 77% of Admissions
3. PINK OUTLINED AREAS + BLACK AREAS = 85% of Admissions



Map Produced By:
 Geographic Information Systems
 Department of Information Systems
 and Telecommunications
 Montgomery County, MD
 Date: August 15, 2000



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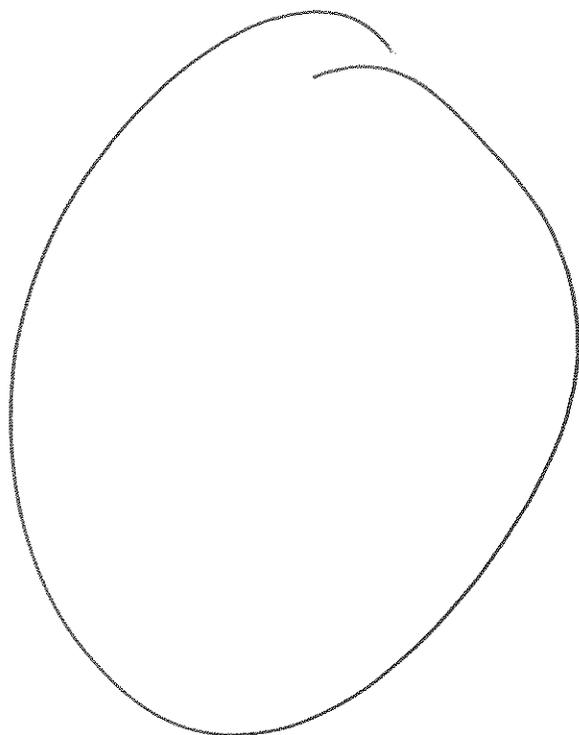


As Reported by the State of Maryland Office of Health Care Quality

Pay for Performance Rankings - Released 2014



NAME	COUNTY	P4P - Overall Rank
ST. JOSEPH'S NURSING HOME	BALTIMORE COUNTY	1
BROOKE GROVE REHAB & NURSING CENTER	MONTGOMERY	2
SACRED HEART HOME	PRINCE GEORGE'S	3
BRINTON WOODS NURSING & REHAB CTR	CARROLL	4
COFFMAN NURSING HOME	WASHINGTON	5
HOMEWOOD AT WILLIAMSPORT MD	WASHINGTON	6
BUCKINGHAM'S CHOICE	FREDERICK	7
DENNETT ROAD MANOR	GARRETT	8
ST. JOSEPH'S MINISTRIES	FREDERICK	9
NATIONAL LUTHERAN HOME FOR THE AGED	MONTGOMERY	10
HILLHAVEN NURSING CENTER	PRINCE GEORGE'S	11
ROCKVILLE NURSING HOME	MONTGOMERY	12
CALVERT MANOR HEALTH CARE CENTER	CECIL	13
OAK CREST VILLAGE CARE CENTER	BALTIMORE COUNTY	14
HEBREW HOME OF GREATER WASHINGTON	MONTGOMERY	15
EGLER NURSING HOME	ALLEGANY	16
RIDERWOOD VILLAGE	MONTGOMERY	17
GOODWILL MENNONITE HOME	GARRETT	18
ST. MARY'S NURSING CENTER	ST. MARY'S	19
FRIENDS NURSING HOME	MONTGOMERY	20
LORIAN MT. AIRY	CARROLL	21
CAROLINE NURSING HOME	CAROLINE	22
ASBURY SOLOMONS ISLAND	CALVERT	23
LITTLE SISTERS OF THE POOR	BALTIMORE COUNTY	24
LORIAN TANEYTOWN	CARROLL	25
COPPER RIDGE	CARROLL	26
HARTLEY HALL NURSING HOME	WORCESTER	27
HERMAN M. WILSON HEALTH CARE CENTER	MONTGOMERY	28
GENESIS THE PINES CENTER	TALBOT	29
LONG VIEW NURSING HOME	CARROLL	30
SNOW HILL NURSING & REHAB CENTER	WORCESTER	31
LIONS CENTER FOR REHABILITATION AND EXTENDED CARE, THE	ALLEGANY	32
CITIZENS NURSING HOME OF HARFORD COUNTY	HARFORD	33
GENESIS CHESAPEAKE WOODS CENTER	DORCHESTER	34
STELLA MARIS	BALTIMORE COUNTY	35
CHARLESTOWN CARE CENTER	BALTIMORE COUNTY	36
JOHNS HOPKINS BAYVIEW CARE CENTER	BALTIMORE CITY	37
CARROLL LUTHERAN VILLAGE	CARROLL	38
POTOMAC VALLEY NURSING AND WELLNESS CENTER	MONTGOMERY	39
GOLDEN LIVING CENTER FREDERICK	FREDERICK	40
FAHRNEY-KEDDY MEMORIAL HOME FOR THE AGED	WASHINGTON	41
CHARLES COUNTY NURSING & REHAB CENTER	CHARLES	42
FUTURE CARE SANDTOWN-WINCHESTER	BALTIMORE CITY	43
GENESIS SPA CREEK CENTER	ANNE ARUNDEL	44
WILLIAMSPORT NURSING HOME	WASHINGTON	45
CROFTON CONVALESCENT CENTER	ANNE ARUNDEL	46
RIDGEWAY MANOR NURSING AND REHAB CENTER	BALTIMORE COUNTY	47
CITIZENS NURSING HOME OF FREDERICK COUNTY	FREDERICK	48
PICKERSGILL	BALTIMORE COUNTY	49
RAVENWOOD LUTHERAN VILLAGE	WASHINGTON	50
LORIAN ENCORE AT TURF VALLEY	HOWARD	51
WICOMICO NURSING HOME	WICOMICO	52
GENESIS CRESCENT CITIES CENTER	PRINCE GEORGE'S	53
GENESIS MULTI-MEDICAL CENTER	BALTIMORE COUNTY	54
GOOD SAMARITAN NURSING CENTER	BALTIMORE CITY	55
VINDOBONA NURSING HOME	FREDERICK	56



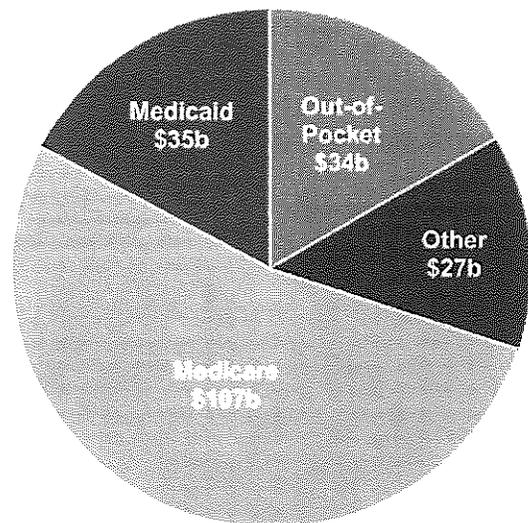
More Americans are dying either from or with Alzheimer's because a growing number of Americans are developing Alzheimer's.

- Today, over 5 million Americans are living with Alzheimer's disease, including an estimated 200,000 under the age of 65. By 2050, up to 16 million will have the disease.
- Of Americans aged 65 and over, 1 in 9 has Alzheimer's, and 1 in 3 people aged 85 and older has the disease.
- Another American develops Alzheimer's disease every 68 seconds. In 2050, an American will develop the disease every 33 seconds.

Alzheimer's takes a devastating toll not just on those with the disease – but also on their caregivers.

- In 2012, 15.4 million family and friends provided 17.5 billion hours of unpaid care to those with Alzheimer's and other dementias – care valued at \$216.4 billion.
- Nearly 15 percent of caregivers are long-distance caregivers, living an hour or more away from their loved ones. Out-of-pocket caregiving costs are nearly twice as high for long-distance caregivers compared with local caregivers.
- More than 60 percent of Alzheimer's and dementia caregivers rate the emotional stress of caregiving as high or very high; more than one-third report symptoms of depression.
- Due to the physical and emotional toll of caregiving, Alzheimer's and dementia caregivers had \$9.1 billion in additional health care costs of their own in 2012.

2013 Costs of Alzheimer's = \$203 Billion



The growing Alzheimer's crisis is helping to bankrupt America.

- In 2013, the direct costs of caring for those with Alzheimer's to American society will total an estimated \$203 billion, including \$142 billion in costs to Medicare and Medicaid.
- Average per-person Medicare costs for those with Alzheimer's and other dementias are three times higher than for those without these conditions.
- Average per-person Medicaid spending for seniors with Alzheimer's and other dementias is 19 times higher than average per-person Medicaid spending for all other seniors.
- Unless something is done, Alzheimer's will cost an estimated \$1.2 trillion (in today's dollars) in 2050. Costs to Medicare and Medicaid will increase over 500 percent.

P

[(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

FY beginning July 1 CY or FY (Circle) FY	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	2013	2014	2015	2016	2017	2018	2019
1. Admissions							
a. ECF							
b. Comprehensive	525	527	541	542	629	728	728
c. Assisted Living							
d. Respite Care*							
e. Adult Day Care							
f. Other (Specify)							
g. TOTAL							
2. Patient Days							
a. ECF							
b. Comprehensive	56,072	55,564	55,495	55,647	57,816	64,193	64,193
c. Assisted Living							
d. Respite Care*							
e. Adult Day Care							
f. Other (Specify)							
g. TOTAL							

Table 1 cont. FY beginning July 1 CY or FY (Circle) FY	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	2013	2014	2015	2016	2017	2018	2019
3. Occupancy Percentage*							
a. ECF							
b. Comprehensive	91.4	90.6	90.5	90.5	90.0	92.6	92.6
c. Assisted Living							
d. Respite Care							
e. Adult Day Care							
f. Other (Specify)							
g. TOTAL							
4. Number of Licensed Beds/Slots							
a. ECF							
b. Comprehensive	168	168	168	168	176	190	190
c. Assisted Living							
d. Respite Care							
e. Adult Day Care							
f. Other (Specify)							
g. TOTAL							

* 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.)

FY beginning July 1	Projected Years (Ending with first full year at full utilization)				
	CY or FY (Circle) FY	2017	2018	2019	20
1. Admissions					
a. ECF					
b. Comprehensive	634	689	689		
c. Assisted Living					
d. Respite Care*					
e. Adult Day Care					
f. Other (Specify)					
g. TOTAL					
2. Patient Days					
a. ECF					
b. Comprehensive	18,396	23,302	23,302		
c. Assisted Living					
d. Respite Care*					
e. Adult Day Care					
f. Other (Specify)					
g. TOTAL					
3. Occupancy Percentage					
a. ECF					
b. Comprehensive	90.0	91.2	91.2		
c. Assisted Living					
d. Respite Care*					
e. Adult Day Care					
f. Other (Specify)					
g. TOTAL					

Table 2 cont. FY beginning July 1 CY or FY (Circle) FY	Projected Years (Ending with first full year at full utilization)			
	2017	2018	2019	20
4. Number of Beds				
a. ECF				
b. Comprehensive	56	70	70	
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.

(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 (including proposed project)

In Thousands (000) FY beginning July 1 CY or FY (Circle) FY	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	2013	2014	2015	2016	2017	2018	2019
1. Revenue							
a. Inpatient Services	22,599	24,226	24,683	25,348	27,729	32,048	32,816
b. Outpatient Services							
c. Gross Patient Services Revenues	22,599	24,226	24,683	25,348	27,729	32,048	32,816
d. Allowance for Bad Debt	120	402	410	421	461	533	546
e. Contractual Allowance	4,963	6,010	6,018	6,180	6,761	7,814	8,001
f. Charity Care	16	13	18	19	20	23	24
g. Net Patient Services Revenue	17,500	17,801	18,237	18,728	20,487	23,678	24,245
h. Other Operating Revenues (Specify)	464	434	446	461	493	564	582
i. Net Operating Revenue	17,964	18,235	18,683	19,189	20,980	24,242	24,827

1h. Beautician fees, rentals, special services (hand feeding, incontinence care).

Table 3 cont. In Thousands (000) FY beginning July 1 CY or FY (Circle) FY	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	2013	2014	2015	2016	2017	2018	2019
2. Expenses							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	9,928	10,400	10,450	10,711	11,547	12,670	12,986
b. Contractual Services	1,986	2,234	2,341	2,405	2,813	3,271	3,353
c. Interest on Current Debt	189	138	170	157	143	128	113
d. Interest on Project Debt					120	720	720
e. Current Depreciation	537	550	563	578	592	607	642
f. Project Depreciation					136	816	816
g. Current Amortization							
h. Project Amortization							
i. Supplies	2,121	2,297	2,376	2,437	2,732	3,095	3,172
j. Other Expenses (Specify)	2,341	2,425	2,486	2,548	2,814	2,966	3,041
k. Total Operating Expenses	17,102	18,044	18,386	18,836	20,897	24,273	24,843
3. Income							
a. Income from Operation	17,964	18,235	18,683	19,189	20,980	24,242	24,827
b. Non-Operating Income	136	82	142	146	150	155	159
c. Subtotal	18,100	18,317	18,825	19,335	21,130	24,397	24,986
d. Income Taxes							
e. Net Income (Loss)	998	273	439	499	233	124	143

2j. Utilities, insurance, real estate tax, marketing, continuing education.

Table 3 cont. Section 4. %'s FY beginning July 1 CY or FY (Circle) FY	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	2013	2014	2015	2016	2017	2018	2019
4. Patient Mix:							
A. Percent of Total Revenue							
1) Medicare	35.3	39.0	39.9	39.7	43.5	44.6	44.4
2) Medicaid	34.1	32.6	32.8	32.6	29.6	27.2	27.1
3) Commercial Insurance							
4) Self-Pay	30.6	28.4	27.3	27.7	26.9	28.2	28.5
5) Other (Specify)							
6) TOTAL	100%	100%	100%	100%	100%	100%	100%
B. Percent of Patient Days\Visits\Procedures (as applicable)							
1) Medicare	22.7	25.5	26.2	26.2	29.7	31.0	31.0
2) Medicaid	48.5	48.4	49.0	48.9	45.8	43.0	43.0
3) Commercial Insurance							
4) Self-Pay	28.8	26.1	24.8	24.9	24.5	26.0	26.0
5) Other							
6) TOTAL	100%	100%	100%	100%	100%	100%	100%

(INSTRUCTION: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS)

RESPONSES TO LETTER FROM MARYLAND HEALTH CARE COMMISSION DATED 9/29/2014

25. Table 1 assumptions, utilization projections for 190 bed CCF

	<u>Admissions</u>	<u>Avg LOS</u>	<u>Beds</u>	<u>% Occupancy</u>	<u>Days</u>	<u>Avg Census</u>
Medicare	686	29.0	60	90.9%	19,900	54.5
Private Pay /Medicaid	42	1,054.6	130	93.3%	44,293	121.4
Total	728	88.2	190	92.6%	64,193	175.9

NOTES

Admissions

1. In 2014 BGRNC denied many admissions because of lack of bed availability, 60 denials alone of MedStar Montgomery Medical Center's referrals, BGRNC's primary referring hospital.
2. Greater capacity will allow more admissions
3. Increased population growth combined with an aging population will result in greater utilization, especially Medicare utilization.
4. Hospitals are financially incentivized to discharge earlier resulting in higher acuity residents which will need short-stay rehab/services.

Length of Stay

Higher Medicare utilization will lower lengths of stay

Occupancy

Demolishing an old wing/building that is very difficult to sell to potential residents and replacing it with a new building will increase admissions and percent occupancy.

29a.

	Actual <u>2013</u>	Actual <u>2014</u>	Projected <u>2015</u>	Projected <u>2016</u>	Projected <u>2017</u>	Projected <u>2018</u>	Projected <u>2019</u>
REVENUE - INPATIENT SERVICES							
Routine Services - Private Pay	\$5,023,278	\$4,754,938	\$4,660,588	\$4,852,540	\$5,153,104	\$6,271,423	\$6,490,923
Routine Services - Medicare	\$6,349,795	\$7,108,839	\$7,450,446	\$7,620,275	\$9,125,166	\$10,804,914	\$11,021,012
Routine Services - Medicaid	\$6,126,478	\$5,936,920	\$6,125,577	\$6,254,974	\$6,208,567	\$6,601,374	\$6,733,401
Special Services	\$464,407	\$434,108	\$446,573	\$461,230	\$493,588	\$564,470	\$581,404
TOTAL REVENUE	\$17,963,958	\$18,234,805	\$18,683,184	\$19,189,019	\$20,980,426	\$24,242,181	\$24,826,740
Days - Private Pay	16,122	14,521	13,752	13,834	14,194	16,690	16,690
Days - Medicare	12,749	14,172	14,562	14,602	17,142	19,900	19,900
Days - Medicaid	27,201	26,871	27,181	27,211	26,480	27,603	27,603
Days - Total	56,072	55,564	55,495	55,647	57,816	64,193	64,193
Rate - Private Pay	\$311.58	\$327.45	\$338.91	\$350.78	\$363.05	\$375.76	\$388.91
Rate - Medicare	\$498.06	\$501.61	\$511.64	\$521.88	\$532.31	\$542.96	\$553.82
Rate - Medicaid	\$225.23	\$220.94	\$225.36	\$229.87	\$234.46	\$239.15	\$243.94
Rate - Special Services	\$8.28	\$7.81	\$8.05	\$8.29	\$8.54	\$8.79	\$9.06