BALTIMORE NURSING AND REHABILITATION, LLC

CERTIFICATE OF NEED APPLICATION

APRIL 10, 2015

Jennifer J. Coyne
Counsel
Direct Dial: 410-823-8247
jcoyne@milesstockbridge.com

April 10, 2015

VIA HAND DELIVERY AND
ELECTRONIC DELIVERY
Ruby Potter
Health Facilities Coordinator
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215
Rruby.potter@maryland.gov

VIA ELECTRONIC DELIVERY ONLY
Kevin McDonald
Chief, Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215
Kevin.mcdonald@maryland.gov

Re: Baltimore Nursing and Rehabilitation, LLC
Docket No.
Certificate of Need Application

Dear Ms. Potter and Mr. McDonald:

Enclosed please find six hard copies of the Certificate of Need ("CON") application, filed on behalf of Baltimore Nursing and Rehabilitation, LLC for the establishment of a new comprehensive care facility in Baltimore City. The enclosed hard copies also include full-size drawings, referenced in the CON.

Also enclosed please find a CD containing searchable PDF files of the CON application and all exhibits and tables.

A copy of the enclosed materials in Microsoft Word also will be sent to you in electronic form via email contemporaneously with this delivery.

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

Sincerely,

Jennifer J. Coyne

Enclosures

cc: Mr. Michael Mahon
Mr. Paul Parker, Director
Suellen Wideman, Esquire, Assistant Attorney General
Dr. Leana S. Wen, Commissioner of Health, Baltimore City

For internal staff use:

MARYLAND HEALTH CARE COMMISSION

_____

MATTER/DOCKET NO.

_____

DATE DOCKETED

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

ALL APPLICATIONS MUST FOLLOW THE FORMATTING REQUIREMENTS DESCRIBED IMMEDIATELY BELOW. NOT FOLLOWING THESE FORMATTING INSTRUCTIONS WILL RESULT IN THE APPLICATION BEING RETURNED.

Required Format:

Table of Contents. The application must include a Table of Contents referencing the location of application materials. Each section in the hard copy submission should be separated with tabbed dividers. Any exhibits, attachments, etc. should be similarly tabbed, and pages within each should be numbered independently and consecutively. **The Table of Contents must include:**

- **Responses to PARTS I, II, III, and IV of the COMPREHENSIVE CARE FACILITY (NURSING HOME) application form**

- **Responses to PART IV must include responses to the standards in the State Health Plan chapter, COMAR 10.24.08*, applicable to the type of nursing home project proposed*.**
    - All Applicants must respond to the general standards, COMAR 10.24.08.05A.
    - Applicants proposing *new construction or expansion* of comprehensive care facility beds, including replacement of an existing facility or existing beds, if new outside walls are proposed must also respond to all the standards in COMAR 10.24.08.05B.
    - Applicants only proposing *renovations within existing facility* walls using beds currently shown in the Commission's inventory as authorized to the facility must respond to all the standards in COMAR 10.24.08.05C in addition to the standards in .05A. Applicants for such renovations should not respond to the standards in .05B.
    - All Applicants must respond to the Review Criteria listed at 10.24.01.08G(3)(b) through 10.24.01.08G(3)(f) as detailed in the application form.

- **Identification of each Attachment, Exhibit, or Supplement**

Application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the completeness review process shall use a consecutive numbering scheme, continuing the sequencing from the original application. (For example, if the last exhibit in the application is Exhibit 5, any exhibits used in subsequent responses should begin with Exhibit 6. However, a replacement exhibit that merely replaces an exhibit to the application should have the same number as the exhibit it is replacing, noted as a replacement.

SUBMISSION FORMATS:

We require submission of application materials and the applicant's responses to completeness questions in three forms: hard copy; searchable PDF; and in Microsoft Word.

- **Hard copy:** Applicants must submit six (6) hard copies of the application to:
  Ruby Potter
  Health Facilities Coordinator
  Maryland Health Care Commission
  4160 Patterson Avenue
  Baltimore, Maryland 21215

- **PDF:** Applicants must also submit *searchable* PDF files of the application, supplements, attachments, and exhibits.[1] All subsequent correspondence should also be submitted both by paper copy and as *searchable PDFs*.

- **Microsoft Word:** Responses to the questions in the application and the applicant's responses to completeness questions should also be electronically submitted in Word. Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

PDFs and spreadsheets should be submitted to ruby.potter@maryland.gov and kevin.mcdonald@maryland.gov.

Note that there are certain actions that may be taken regarding either a health care facility or an entity that does not meet the definition of a health care facility where CON review and approval are not required. Most such instances are found in the Commission's procedural regulations at COMAR 10.24.01.03, .04, and .05. Instances listed in those regulations require the submission of specified information to the Commission and may require approval by the full Commission. Contact CON staff at (410) 764-3276 for more information.

A pre-application conference will be scheduled by Commission Staff to cover this and other topics. Applicants are encouraged to contact Staff with any questions regarding an application.

[1] PDFs may be created by saving the original document directly to PDF on a computer or by using advanced scanning technology

TABLE OF CONTENTS

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: Baltimore Nursing and Rehabilitation Center d/b/a Restore Health – Baltimore

Address:

300-306 W. Fayette St.	Baltimore	21201	Balt. City
Street	City	Zip	County

2. Name of Owner

If Owner is a Corporation, Partnership, or Limited Liability Company, attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the applicant and any related parent entities. Attach a chart that completely delineates this ownership structure.

For Ownership Information Please *See* Exhibit A, attached hereto.

3. APPLICANT. *If the application has a co-applicant, provide the following information in an attachment.*

Legal Name of Project Applicant (Licensee or Proposed Licensee): Baltimore Nursing and Rehabilitation, LLC

Address:

1922 Greenspring Drive, Suite 6	Timonium	21093	MD	Baltimore
Street	City	Zip	State	County

Telephone: 410-308-2300

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

N/A

5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☐	
	(2) For-profit	☐	
	(3) Close	☐	State & date of incorporation ☐
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited liability partnership	☐	
	Limited liability limited partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☒	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☐	

See **Exhibit A** for an Organizational Chart showing the owners of the Applicant.

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: Michael Mahon, Chief Administrative Officer

Company Name Mid-Atlantic Health Care, LLC

Mailing Address:

1922 Greenspring Drive, Suite 6	Timonium	21093	MD	Baltimore
Street	City	Zip	State	County

Maryland

Telephone: 410-308-2300

E-mail Address (required): mmahon@mid-atlanticltc.com

Fax: 410-308-4999

If company name is different than applicant briefly describe the relationship N/A

B. Additional or alternate contact:

Name and Title: Peter Parvis, Esq.

Company Name Miles & Stockbridge P.C.

Mailing Address:

One West Pennsylvania Ave, Suite 900	Towson	21204	MD
Street	City	Zip	State

Telephone: 410-823-8165

E-mail Address (required): pparvis@milesstockbridge.com

Fax: 410-823-8123

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

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

Legal Name of the Owner of the Real Property

Baltimore Nursing and Rehabilitation Realty, LLC

Address:

1922 Greenspring Drive, Suite 6	Timonium	21093	MD	Baltimore
Street	City	Zip	State	County

Telephone: 410-308-2300

If Owner is a Corporation, Partnership, or Limited Liability Company attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the in the real property and any related parent entities. Attach a chart that completely delineates this ownership structure.

For Ownership Information, please *see* **Exhibit A**, attached hereto.

8. NAME OF THE Owner of the Bed Rights (i.e., the person/entity that could sell the beds included in this application to a 3rd party):

Legal Name of the Owner of the Rights to Sell the CCF Beds

Mid-Atlantic Health Care Acquisitions, LLC

If the Legal Entity that has or will have the right to sell the CCF beds is other than the Licensee or the Owner of the Real Property Identified Above Provide the Following Information.

Address:

1922 Greenspring Drive, Suite 6	Timonium	21093	MD	Baltimore
Street	City	Zip	State	County

Telephone: 410-308-2300

9. If a management company or companies is or will be involved in the clinical or financial management of the facility or will provide oversight of any construction or renovations proposed as part of this APPLICATION, identify each company or individual that will provide the services and describe the services that will be provided. Identify any ownership relationship between the management company and the owner of the facility and/or the real property or any related entity.

Name of Management Company: Mid-Atlantic Health Care, LLC

Address:

1922 Greenspring Drive, Suite 6	Timonium	21093	MD	Baltimore
Street	City	Zip	State	County

Telephone: 410-308-2300

For Ownership Information, please see Exhibit A, attached hereto.

10. TYPE OF PROJECT

The following list includes all project categories that require a CON pursuant to COMAR 10.24.01.02(A). Please mark all that apply in the list below.

If approved, this CON would result in (check as many as apply):

(1) A new health care facility built, developed, or established ☒
(2) An existing health care facility moved to another site ☐
(3) A change in the bed capacity of a health care facility ☐
(4) A change in the type or scope of any health care service offered ☐

by a health care facility

(5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf ☐

11. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is, why you need to do it, and what it will cost. A one-page response will suffice. Please include:

(1) Brief Description of the project – what the applicant proposes to do
(2) Rationale for the project – the need and/or business case for the proposed project
(3) Cost – the total cost of implementing the proposed project

(1) and (2) – Description and Rationale of Project:

The Project involves the relocation of 80 temporarily delicensed CCF beds from Johns Hopkins Bayview Medical Center's CCF to a new CCF site to be located on Fayette Street in downtown Baltimore. The new facility will be managed by Mid-Atlantic Health Care, LLC ("Mid-Atlantic" or "MAHC") and trade under the name Restore Health – Baltimore ("Restore Health" or the "Applicant"). Restore Health will be the first state-of-the-art post-acute care facility in Baltimore City built to focus on new reimbursement models created as part of the Affordable Care Act that award providers for minimizing length of stay and hospital readmissions and thereby reduce the overall costs of patients. Restore Health will partner with acute care hospitals to identify at risk populations and patient cohorts that would otherwise require treatment at the hospital and develop clinical programs that will allow them to either be discharged from the hospital sooner or perhaps never get admitted at all. Mid-Atlantic has a strong track record of managing its hospital readmissions as evidenced by its readmit rate of 15% versus the state's average of 25%.

Restore Health will benefit from MAHC's experience managing 18 other facilities comprising almost 3,200 residents per day where our primary goal is to improve the quality of life for each resident. MAHC's accomplishes this through its combination of proprietary in-house clinical programs, (see page 28, 31-34), and proprietary software in concert with electronic health records. MAHC has used this model to become one of the few skilled nursing providers that is currently a bundle payment provider from our five facilities in the Philadelphia market. MAHC looks forward to bringing this focus and experience to Baltimore City.

Restore Health will be distinguished by the scope of clinical services, the staff capabilities, and the acuity levels that it is prepared to serve. This will assure patients and hospital clinicians that the transition to post-acute care will be safe and supportive of special care requirements, and will function to (a) reduce length of stay and cost in the hospital (b) reduce risks of hospital infection by getting patients out of the hospital faster, (c) minimize readmissions to a hospital setting; and (d) reduce the total costs of healthcare in keeping with the goals of

Maryland's new model agreement with the Centers for Medicare and Medicaid Services (CMS). The new facility will also provide the staff training, the clinical rounding, the prevention activities, and the patient education to promote the self-care and family education components that strengthen successful transitions to home.

The building itself is seven stories and comprises 125,000 square feet. The CCF will utilize five of those floors with three floors dedicated to resident care. Two of the floors (5 and 6) are designed for the treatment of short stay patients, served by a 2,500 square foot state-of-the-art rehabilitation gym located on floor 7. The remaining patient care floor will be designed for a more traditional nursing home population, and will provide a broader scope of service capabilities, family education, and connections to community-based care with the goal of having these units, as well, serve a transitional role in post-acute care to the extent possible.

The geographic location of the proposed facility is a critical feature of this project, responding both to access issues and care coordination needs. First, the facility will be a short walk (0.3 miles) away from University of Maryland Medical Center (UMMC) and UM Midtown Campus, two of the City's hospitals with the greatest demand for nursing home placements. This proximity will promote strong clinical relationships between acute care physicians, discharge planners, social workers and nursing home staff; continue to elevate the skill set of nursing home staff; and encourage the most responsive service delivery. An increasing amount of targeted care will be able to be delivered in the post-acute setting and readmissions will be avoided. Second, the proximity will support effective care transition models that rely on nurses, social workers, and discharge planners to maintain effective communications and smooth transitions. Third, the proposed facility will improve access and quality of care: (a) It will be located in West Baltimore where few nursing homes currently exist; (b) it will be readily accessible by public transportation (see **Exhibit B**); (c) it will be convenient to families residing in this area; and (d) it will introduce a high quality rated nursing home provider focused on short stay post-acute services. Fourth, the new facility will respond to the desperate need in this region for dialysis services in the post-acute setting; currently patients at UMMC and UM Midtown often wait weeks in the hospital until a nursing home placement can be arranged with this support.

As the attached letter of support from Dr. Stephen Davis of University Of Maryland Medical Center indicates, MAHC strongly believes there is a need for a facility such as Restore Health. MAHC strongly believes that the dramatic changes in hospital financing and incentives will encourage broader and more effective use of the post-acute setting in Maryland. This state-of-the-art CCF will increasingly function as a valuable transition setting for fragile elderly patients requiring more recuperative time, and as a lower cost setting for restorative care for patients of all ages. Going forward, the Applicant expects to also serve as a short stay setting for patients transferred from the ER (following stabilization) and patients admitted directly from home, thereby avoiding the high cost hospital setting altogether.

If the nursing home is to serve this broader role, new service components must be accommodated and new facility design is required. Baltimore City, in

particular, requires a nursing home setting that can deliver more services and accommodate the more complex patient, given the very high rates of comorbidities and chronic disease in the City's population. The proposed facility will require more space than traditional comprehensive care facilities in order to provide services such as dialysis and more intensive post-acute care, but the benefits of the facility are significant. Maryland continues to be challenged to lower the cost per capita of its Medicare population, and the proposed facility – designed as a high quality, low cost service setting that will reduce readmissions and promote healthy discharge home – will be essential to Maryland's success.

(3) Cost of Project:

The Budget for the total cost of the Project is estimated at $18.4 million. *See* **Table C** for additional information.

B. Comprehensive Project Description: The description should include details regarding:

(1) Construction, renovation, and demolition plans
(2) Changes in square footage of departments and units
(3) Physical plant or location changes
(4) Changes to affected services following completion of the project
(5) Outline the project schedule.

Restore Health will be located at 300 W. Fayette Street. MAHC has signed a purchase agreement subject to the approval of the certificate of need to acquire a former medical office building comprising seven floors and approximately 125,000 square feet. The building is a short walk (0.3 miles) from UMMS with a multi-story public parking deck next door making it easy for employees and visitors to come to the facility. The block includes the Everyman Theater and a recently developed apartment building.

Restore Health plans to renovate the building and use certain areas of the basement and first floor, as well as the entire fourth, fifth, sixth and seventh floors for the nursing facility. The remaining floors will be available for rent as medical offices or other office space. MAHC is already had preliminary discussions with one party interested in leasing the space. Restore Health will have its own entry lobby separate from the other tenants, and have a dedicated elevator for services and resident transport operating separately from the facility's other elevators

Eighty percent (80%) of the rooms (64 of 72 rooms) will be private with the remaining 8 to be semi-private (two beds). Each room will have its own private bathroom and temperature control. The facility will have an upscale, "Ritz-Carlton" look and feel, comparable to the new construction at our recently completed sister Restore Health Facility in Waldorf, Maryland. (Photographs of that facility are included in **Exhibit C** to provide a sense of the look and feel of the proposed facility). The Facility will allow for a resident experience not currently available in Baltimore City.

Given that Mid-Atlantic is acquiring a pre-existing building, the needed construction consists primarily of the demolition and then refinishing of all the interior spaces and also the installation of all new mechanical and electrical

systems. The Facility will include a 2,500 square foot state-of-the-art rehabilitation gym on the 7th floor which will also have a recreation area to allow patients to enjoy the weather. The 6th floor will have two light wells to allow more natural light into the Facility, one of which will stretch down to the fifth floor and stop at the fourth floor to create another outdoor recreation area for residents on that floor.

The renovation project is expected to take 12-16 months to complete. We anticipate breaking ground after receiving CON approval and final zoning approval.

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

TABLE A. BED CAPACITY BY FLOOR AND NURSING UNIT BEFORE AND AFTER PROJECT

INSTRUCTION: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project.
Applicants should add columns and recalculate formulas to address any rooms with 3 and 4 bed capacity. See additional instruction in the column to the right of the table.

Before the Project						After Project Completion					
		Based on Physical Capacity					Based on Physical Capacity			
	Current Licensed Beds	Room Count			Physical Bed Capacity	Service	Room Count			Physical Bed Capacity
Service Location (Floor/Wing)		Private	Semi-Private	Total Rooms		Location (Floor/Wing)	Private	Semi-Private	Total Rooms	
COMPREHENSIVE CARE						**COMPREHENSIVE CARE**				
				0	0	6th Floor	24	0	24	24
				0	0	5th Floor	24	0	24	24
				0	0	4th Floor	16	8	24	32
SUBTOTAL Comprehensive Care						**SUBTOTAL**	**64**	**8**	**72**	**80**
ASSISTED LIVING						**ASSISTED LIVING**				
TOTAL ASSISTED LIVING						**TOTAL ASSISTED LIVING**				
Other *(Specify/add rows as needed)*				0	0	**Other** *(Specify/add rows as needed)*			0	0
TOTAL OTHER						**TOTAL OTHER**				
FACILITY TOTAL	**0**	**0**	**0**	**0**	**0**	**FACILITY TOTAL**	**64**	**8**	**72**	**80**

13. Identify any community based services that are or will be offered at the facility and explain how each one will be affected by the project.

The Facility plans to offer respite services to the citizens in West Baltimore. No other community-based services are contemplated at this time.

14. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: 0.38 acres

B. Have all necessary State and local land use and environmental approvals, including zoning and site plan, for the project as proposed been obtained? YES_____ NO __✓
(If NO, describe below the current status and timetable for receiving each of the

necessary approvals.)

In accordance with the Baltimore City Code, the Project requires the Mayor and City Council to enact an Ordinance approving the conditional use of the Project as a "convalescent, nursing and rest home." All required City permits for the Project will be applied for and prosecuted by Owner at the appropriate times consistent with the Project schedule.

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

(1) Owned by: _____

(2) Options to purchase held by: Agreement of Purchase and Sale held by Baltimore Nursing and Rehabilitation, LLC
Please provide a copy of the purchase option as an attachment.
A copy of the purchase option is attached hereto as **Exhibit D**.

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

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

(5) Other: _____
Explain and provide legal documents as an attachment.

15. PROJECT SCHEDULE

In completing this section, please note applicable performance requirements time frames set forth in Commission regulations, COMAR 10.24.01.12. Ensure that the information presented in the following table reflects information presented in Application Item 11 (Project Description).

Project Schedule Table
Table J

	Proposed Project Timeline	
Obligation of 51% of capital expenditure from approval date	16	Months**
Initiation of Construction within 4 months of the effective date of a binding construction contract	2	Months**
Time to Completion of Construction from date of capital obligation	14	Months**

*** Assumes Grant of CON by January, 2016*

16. PROJECT DRAWINGS

Projects involving new construction and/or renovations should include scalable schematic drawings of the facility at at least a 1/16" scale. Drawings should be completely legible and include dates.

These drawings should include the following before (existing) and after (proposed), as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, number of beds, location of bath rooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as “shell space”.

B. For projects involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. Specify dimensions and square footage of patient rooms.

See **Exhibit E**. A large scale of each drawing will be provided to the Commission.

17. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete the Construction and Renovation Square Footage worksheet in the CON Table Package (Table B)

TABLE B. PROPOSED NEW CONSTRUCTION AND RENOVATION SQUARE FOOTAGE

INSTRUCTION: Account for all existing and proposed square footage by floor. Further breakdown by nursing unit and building wing are at Applicants discretion and should be used by applicants if it adds valuable information to the description of the existing and proposed facilities. Add or delete rows if necessary. See additional instruction in the column to the right of the table.

Gross Square Footage by Floor/Nursing Unit/Wing	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Basement	19,143	0	3,411	15,732	19,143
First Floor	16,425	0	11,590	4,835	16,425
Second Floor*	17,577	0	242	17,335	17,577
Third Floor*	17,577	0	625	16,952	17,577
Fourth Floor	15,677	0	15,677	0	15,677
Fifth Floor	14,973	0	14,973	0	14,973
Sixth Floor	14,973	0	14,973	0	14,973
Seventh Floor	8,001	726	8,001	0	8,727
Total	124,346	726	69,492	54,854	125,072

*The second and third floors are not part of the proposed CCF.

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project and identify the provider of each utility. Specify the steps that will be necessary to obtain utilities.

The site is already served by public utilities for all essential utilities, including water, electricity, sewage and natural gas.

PART II - PROJECT BUDGET

Complete the Project Budget worksheet in the CON Table Package (Table C).

Table C is located on following page.

Note: Applicant should include a list of all assumptions and specify what is included in each budget line, as well the source of cost estimates and the manner in which all cost estimates are derived. Explain how the budgeted amount for contingencies was determined and why the amount budgeted is adequate for the project given the nature of the project and the current stage of design (i.e., schematic, working drawings, etc.)

Budget Assumptions are attached hereto as **Exhibit F**.

TABLE C. PROJECT BUDGET

INSTRUCTION : Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application. If the project involves services other than CCF such as assisted living explain the allocation of costs between the CCF and the NOTE : Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.a as a use of funds and on line B.8 as a source of funds

				CCF Nursing Home	Cost of Other Service Areas	Total
A.	**USE OF FUNDS**					
	1.	**CAPITAL COSTS**				
		a.	**Land Purchased/Donated**	**$3,000,000**		**$3,000,000**
		b.	**New Construction**			
		(1)	Building			$0
		(2)	Fixed Equipment			$0
		(3)	Site and Infrastructure			$0
		(4)	Architect/Engineering Fees			$0
		(5)	Permits (Building, Utilities, Etc.)			$0
			SUBTOTAL New Construction	**$0**	**$0**	**$0**
		c.	**Renovations**			
		(1)	Building	$10,848,668		$10,848,668
		(2)	Fixed Equipment (not included in construction)			$0
		(3)	Architect/Engineering Fees	$740,000		$740,000
		(4)	Permits (Building, Utilities, Etc.)	$150,000		$150,000
			SUBTOTAL Renovations	**$11,738,668**	**$0**	**$11,738,668**
		d.	**Other Capital Costs**			
		(1)	Movable Equipment	$1,584,353		$1,584,353
		(2)	Contingency Allowance	$600,000		$600,000
		(3)	Gross interest during construction period			$0
		(4)	Other *(Specify/add rows if needed)*			$0
			SUBTOTAL Other Capital Costs	***$2,184,353***		**$2,184,353**
			TOTAL CURRENT CAPITAL COSTS	**$16,923,021**	**$0**	**$16,923,021**
		e.	**Inflation Allowance**			$0
			TOTAL CAPITAL COSTS	**$16,923,021**	**$0**	**$16,923,021**
	2.	**Financing Cost and Other Cash Requirements**				
		a.	**Loan Placement Fees**	**$100,000**		$100,000
		b.	**Bond Discount**	**$0**		$0
		c.	**Legal Fees**	**$100,000**		$100,000
		d.	**Non-Legal Consultant Fees**	**$50,000**		$50,000
		e.	**Liquidation of Existing Debt**	**$0**		$0
		f.	**Debt Service Reserve Fund**	**$0**		$0
		g.	**Other *(Specify/add rows if needed)***	**$0**		$0
			SUBTOTAL	***$250,000***		**$250,000**
	3.	**Working Capital Startup Costs**		$1,235,396		$1,235,396
			TOTAL USES OF FUNDS	***$18,408,417***	***$0***	***$18,408,417***
B.	**Sources of Funds**					
	1.	**Cash**		**$4,430,000**		$4,430,000
	2.	**Philanthropy (to date and expected)**		$0		$0
	3.	**Authorized Bonds**		**$0**		$0
	4.	**Interest Income from bond proceeds listed in #3**		**$0**		$0
	5.	**Mortgage**		**$13,978,417**		$13,978,417
	6.	**Working Capital Loans**		**$0**		$0
	7.	**Grants or Appropriations**				
		a.	**Federal**	**$0**		$0
		b.	**State**	**$0**		$0
		c.	**Local**	**$0**		$0
	8.	**Other *(Specify/add rows if needed)***				$0
			TOTAL SOURCES OF FUNDS	***$18,408,417***		**$18,408,417**
Annual Lease Costs (if applicable)						
	1.	**Land**				$0
	2.	**Building**				$0
	3.	**Major Movable Equipment**				$0
	4.	**Minor Movable Equipment**				$0
	5.	**Other *(Specify/add rows if needed)***				$0

Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.

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

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

   For ownership information, please *see* **Exhibit A**, attached hereto**.**

2. Are the applicant, owners, or the responsible persons listed in response to Part 1, questions 2, 3, 4, 7, and 9 above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

   Yes. MAHC owns and operates a total of 18 skilled nursing facilities comprising almost 3,200 beds in Maryland, Pennsylvania and Delaware. Please *see* **Exhibit G**, attached hereto.

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

   Villa Rosa Nursing and Rehabilitation, LLC - On 11/06/2014, based upon a Life and Safety Code Survey revisit, conducted by the Office of Health Care Quality, it was found that this facility was not in compliance with the requirements of participation and received an imposition of denial of payments for new admissions. (Please *see* **Exhibit H**.)

   Mid-Atlantic of Delmar, LLC - On May 10, 2013, an abbreviated survey was conducted by the Delaware Department of Health and Social Services and determined that the facility was not in substantial compliance with the participation agreement requirements. (Please *see* **Exhibit I**.)

   The bans were lifted and both facilities are now in full compliance.

4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) received inquiries in last from 10 years from any federal or state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with any state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

Mid-Atlantic of Delmar, LLC - On June 7, 2014, Mid-Atlantic of Delmar, LLC (herein "Delmar") made a submission pursuant to OIG's Self Disclosure Protocol. The OIG accepted Delmar into the Protocol on July 23, 2014. This case involved an employee who was hired as a nurse for the provision of nursing services for which payment was made under a Federal health care program from October 18, 2013 through May 30, 2014. Unbeknownst to Delmar, at the time of hiring, the employee had been listed on the OIG List of Excluded Individuals and Entities at the time of hiring. Upon discovery of the employees excluded status, the employee was immediately terminated. Delmar followed the law and self-reported the incident to the OIG. Delmar agreed to pay to OIG $92,344.60 dollars. In consideration of the obligations of Delmar, the OIG released Delmar from any claims or causes of action it had against Delmar under 42 U.S.C. §§ 1320a-7a and 1320a-7(b) (7). It should be noted, that the OIG recognized that Mid-Atlantic Health Care, LLC and it facilities had the integrity to self-report recognized reportable events. As a result, Delmar received the lowest penalty multiplier under the Civil Monetary Penalty formula. (Please see **Exhibit J**.)

5. Have the applicant, owners or responsible individuals listed in response to Part 1, questions 2, 3, 4, 7, and 9, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

   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.

April 9, 2015
Date

Signature of Owner or Board-designated Official
Chief Financial Officer
Position/Title
Scott Potter
Printed Name

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

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

10.24.01.08G(3)(a). <u>The State Health Plan</u>.

Every Comprehensive Care Facility ("CCF" -- more commonly known as a nursing home) applicant must address each applicable standard from **COMAR 10.24.08: State Health Plan for Facilities and Services -- Nursing Home and Home Health Services.**[2] Those standards follow immediately under ***10.24.08.05 Nursing Home Standards*.**

Please provide a direct, concise response explaining the project's consistency with each standard. <u>In cases where demonstrating compliance with a standard requires the provision of specific documentation, please include the documentation as a part of the application.</u>

10.24.08.05 Nursing Home Standards.

A. General Standards. The Commission will use the following standards for review of all nursing home projects.

(1) Bed Need. The bed need in effect when the Commission receives a letter of intent for the application will be the need projection applicable to the review.

<u>RESPONSE:</u>

Mid-Atlantic proposes to build an 80-bed facility TO RELOCATE 80 comprehensive care beds that are in the Maryland Health Care Commission's existing bed inventory. Therefore, Mid-Atlantic is not seeking additional beds under the need methodology. The 80 beds to be used are beds that were temporarily delicensed by the Johns Hopkins Bayview Medical Center (JHBMC) on November 15, 2013, with an extension issued by the Commission. Mid-Atlantic signed a Purchase and Sale Agreement with JHBMC on September 19, 2014 to acquire these 80 beds, with the purchase contingent upon the issuance of a certificate of need to relocate the beds. (See **Exhibit D**.)

Under current regulations (COMAR 10.24.01.03C(1), a nursing home may temporarily delicense beds for up to one year by filing timely notice, and notifying the Commission at least 30 days

[2] [1] Copies of all applicable State Health Plan chapters are available from the Commission and are available on the Commission's web site here:http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp

before the end of the time period that it will take one of the actions permitted under COMAR 10.24.01.03C(5), which includes executing a binding contract to transfer ownership of the previously licensed bed capacity, contingent on the filing within thirty (30) days of a letter of intent to apply for CON approval (or other applicable level of Commission action pursuant to COMAR 10.24.01.03 and 10.24.01.04 if required) to relocate the bed capacity.[3] To meet this timing, JHBMC requested, and was granted, a time extension to take one of the permitted actions, and within that extended time limit entered into the sales agreement with Mid-Atlantic Health Care Acquisitions, LLC, which assigned the agreement to Baltimore Nursing and Rehabilitation, LLC, which filed a letter of intent dated December 15, 2014, and again on February 6, 2015, with the Commission to construct a new CCF using the 80 beds to be purchased and relocated from JHBMC to a new site on 300-306 W. Fayette St, in Baltimore City.

As a result, the Applicant is not proposing an increase to the number of licensed and certified beds in Baltimore as a result of this application. The Applicant will address the need for these beds in its response to COMAR 10.24.08.05.B(1), Bed need, on pages 26-30, *infra*.

Consistent with this allowance, Mid-Atlantic is not required to demonstrate need for these beds under current bed need methodology or utilization targets.

(2) Medical Assistance Participation.

(a) Except for short-stay, hospital-based skilled nursing facilities required to meet .06B of this Chapter, the Commission may approve a Certificate of Need for a nursing home only for an applicant that participates, or proposes to participate, in the Medical Assistance Program, and only if the applicant submits documentation or agrees to submit documentation of a written Memorandum of Understanding with Medicaid to maintain the proportion of Medicaid patient days required by .05A 2(b) of this Chapter.

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

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[3] COMAR 10.24.01.03C(5)(e). The other available options include the following:

(a) Apply to relicense the temporarily de-licensed bed capacity;

(b) Submit and receive the Executive Director's approval of a specific plan for the re-licensure of the bed capacity or facility, that: (i) imposes stated time frames by which steps toward the re-licensure of the bed capacity or facility will be accomplished, or the bed capacity or facility will be deemed abandoned, and (ii) may be revised upon a proposal by the owner or operator, with the approval of the Executive Director;

(c) File a letter of intent, followed within sixty (60) days by a Certificate of Need application (or request the applicable level of Commission action pursuant to COMAR 10.24.01.03 and 10.24.01.04) for the relocation of the bed capacity or facility, or for a capital expenditure deemed necessary to relicense the temporarily de-licensed beds;

(d) Execute a binding contract to transfer ownership of the health care facility, if the requirements of COMAR 10.24.01.03.A are met; or

(f) Relinquish the bed capacity, or seek the appropriate Commission approval to delicense and permanently close the health care facility.

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

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

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

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

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

RESPONSE:
Restore Health agrees to serve the Medicaid patient population as required, and shall execute the required MOU with the Medical Assistance Program of the Department of Health and Mental Hygiene prior to licensure.

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

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

(b) Initiating discharge planning on admission; and

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

RESPONSE:
Consistent with its other facilities, Restore Health will provide information to all prospective residents about the existence of alternative community-based services, including but not limited to Medicaid home and community-based waiver programs, home care, medical day care, assisted living and other initiatives to promote care in the most appropriate settings. Please see **Exhibit K** for examples of such material distributed to prospective residents at other Mid-Atlantic facilities.

Restore Health will initiate discharge planning on admission as part of its development of a care plan. Mid-Atlantic's has a strong track record of getting residents out of the facility and back into the community safely as demonstrated by its hospital readmission rate of 15% across its facilities. Upon admission, an interdisciplinary group that includes the Director of Nursing, the medical directors, and department directors, reviews all patients demonstrating a change in status, abnormal lab values, unstable status or patient/family concerns. In fact, Mid-Atlantic continues to

follow residents after they leave the facility to insure they are getting the community based services they require to remain healthy and independent.

Restore Health will permit access to all residents for the Olmstead efforts approved by the Department of Health and Mental Hygiene to provide education and outreach for residents and their families.

(4) Nonelderly Residents. An applicant shall address the needs of its nonelderly (<65 year old) residents by:

(a) Training in the psychosocial problems facing nonelderly disabled residents; and

(b) Initiating discharge planning immediately following admission with the goal of limiting each nonelderly resident's stay to 90 days or less, whenever feasible, and voluntary transfer to a more appropriate setting.

RESPONSE:

Short Stay Patients - The top two floors of Restore Health will be designed to serve short stay patients of all adult ages. Non-elderly patients are expected to include the following patient cohorts:

- Rehabilitation patients – The proposed facility will serve patients discharged from acute care hospitals after injury, trauma, elective surgery, and similar reasons for hospitalization who require active rehabilitation programs but do not need the resources of an acute care hospital. As managed care plans, commercial insurers and ACOs are not constrained by the 3 day hospital rule, the proposed facility may admit non-elderly patients after 1-2 day stays in the hospital, and directly following outpatient surgery.

- Young adults with chronic neurologic conditions –There is a population of adults who have been treated at Mount Washington Pediatric Hospital, and who continue to need periodic treatments or "tune ups," but who have "outgrown" this pediatric facility. The proposed facility - - with its working relationship with University of Maryland faculty, and its specialty capabilities - - will be well positioned to serve this patient population that is now of adult age.

Restore Health will locate non-elderly patient in rooms approximate to one another as possible and consistent with its sister facilities will provide staff with appropriate training. Consistent with all residents, Restore Health will focus on developing discharge plans immediately upon admission to help manage stays to less than 90 days.

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

(a) In a **new construction** project:

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

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

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

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

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

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

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

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

RESPONSE:
Restore Health will have 64 private rooms and 8 semi-private rooms (i.e., two beds). Each room will have individual temperature controls and have its own private bathroom assuring that only two residents will share a toilet.

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

RESPONSE:
The location of the facility is within Baltimore City limits and is served by public water and sewer systems.

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

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

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

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

RESPONSE:
Restore Health's design is oriented toward treating a combination of (a) shorter stay patients that otherwise might be served in a hospital and (b) more typical comprehensive care residents. This facility will have a strong emphasis on rehabilitation and creating a restorative environment unlike any other in Baltimore City; its design will create a hotel-like look and feel as opposed to a typical, more institutional, nursing home environment. A working example of this type of facility is MAHC's newly constructed Restore Health Facility (opened in March 2015) in Charles County. This application includes pictures of that facility to provide a sense of the "look and feel" we are seeking in this facility as well (*see* Ex. C).

The first floor of the Facility will include a dedicated entrance and lobby for the nursing facility. This floor will also include the admissions office and administrative offices. There are three sets

of elevators in the building including a service elevator so food delivery can be made from that elevator as opposed to the more public elevators. We are installing a new stairwell to accommodate the design and ensure safety.

In looking at the design plans, one will notice that floors 5 and 6 are comprised entirely of private rooms. Floor 4 will have 16 private rooms as well bringing the total to 64 private rooms and 8 semi-private rooms. These private rooms vary in size, but are all larger than 320 square feet providing ample space for the residents. Each room contains its own bathroom and shower meaning no more than two residents will share a bathroom with shower. The 7th floor will contain a 2,500 square foot state-of-the-art rehabilitation gym. This floor has large floor to ceiling windows providing views of downtown Baltimore and will also have an outside patio on the roof to allow residents to enjoy outside activities as well. We also have created an outside recreation area on the fourth floor to allow residents on that floor to enjoy outside activities as well. The design calls for a large skylight to be installed above the common area on floor 6 and for a large window well to be created for floors four, five, and six to create a more cheerful, light and airy environment for the residents.

Restore Health will be equipped with a WanderGuard monitoring system so that residents who wander will not be able to leave the building without setting off an alarm. In addition, we are also designing rooms to accommodate bariatric patients with oversized doors and specialized equipment including specialized bariatric beds and mattresses and lift equipment to handle these types of residents safely in a respectful manner. Mid-Atlantic is prepared to equip the facility with the specialized equipment for dialysis (potentially at the bedside) and also a vent unit. We will make the final determination based on discussions with our hospital partners, but each has currently expressed a need for these services.

The Facility is analyzing utilizing “green” features and energy efficient mechanical systems.

Consistent with MAHC’s other facilities, specific attention has been made to resident safety. The facility has been designed to provide a safe environment for the residents, including the following:

- **Proximity of Staff to residents**
  The nursing stations (one per floor) are located central to all the rooms in the facility so that nurses and other staff can see all the resident rooms from each station. The activity and dining areas are also located opposite to the nursing stations so that nurses can observe residents while there as well.

- **Standardization**
  While the rooms may be slightly different in shape each room will have common equipment.

- **Automation and Technology**
  MAHC is dedicated to using technology to make our nurses and other care staff more proactive and productive. Restore Health will include a wireless infrastructure to enable the use of an electronic medical record system allowing nurses to get information efficiently at the point of care. Furthermore, the EMR will interface with Real Time Medical Systems (see page 35 for additional discussion), which is a data mining tool used in conjunction with the EMR to identify at risk patents and alerts our nurses when they should intervene **before** a resident may have an adverse event. These technologies allow for greater accuracy, efficiency and care for our residents.

- **Noise Reduction**
  The materials in the facility will be designed to reduce noise as much as possible to create a safer, more restful and enjoyable resident experience.

- **Resident Involvement in Care**
  Consistent with our philosophy, the proposed Facility will promote Resident and family involvement in care whenever possible. The Facility is readily accessible using public transportation and is located directly next door to a large public parking garage with an exit just a few steps away from the entrance to allow resident families to visit their loved one easily and safely. The Facility will hold routine care planning meetings with resident and/or family participation. It will also create a resident council to solicit feedback from the residents.

- **Precarious Events**
  The entire facility will have sprinklers and the staff will be trained how to react quickly and safely to all potential precarious events.

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

RESPONSE:
None.

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

RESPONSE:
Mid-Atlantic has begun to establish collaborative relationships with local providers. As illustrated by the letter from Dr. Stephen Davis, Dr. Scott Rifkin, CEO of Mid-Atlantic is in active discussions with the Department of Medicine in the School of Medicine at University of Maryland Medical System, (*see* Ex. P), about integrating clinical pathways to advance the care of the patients and promote new research opportunities to determine optimal care plans. In addition, once the facility is open, the Facility expects to collaborate with the Local Area Office on Aging and other community based providers, as follows:

Assisted Living

ABC Assisted Living 1
All About Love II
All together Network, INC
Almost Like Home
Ambrozean Assisted Living Care Center
Angel's Cove Assisted Living
Betty's and Debbie's Family Place I
Caritas House Assisted Living
Chelsea Manor
Dorchester House
Esther's Place at Montebello
Esther's Place at Pinewood
Esther's Place at Strathmore
Esther's Place at the Park
Evergreen Valley Assisted Living
Harry & Jeanette Weinberg Park
Hawkin's Christian Care Home
Heavenly Grace Assisted Living #2
JL Care Enterprises, Inc.
Keswick Memory Care
Lamplight Inn of Baltimore
Peregrine's Landing At Tudor Heights
Roland Park Place
Rosemarie Manor II, LLC
Rosemarie Manor, LLC - Ashburton
Rosies Assisted Living

Scotland Manor
Serenity Garden Manor
Serenity Manor
Specialized Home Care
Springwell Senior Living
St. John's Community
Sterling Hospitality
Symphony Manor Premier Assisted Living and Memory
Victorian Inn, Inc.

Adult Day Care

A Caring Hand Medical MADC
Adult Medical Day Care of Overlea
Caring Hands ADC of Dundalk
Extended Family Adult Day Care
Golden Doves Senior Medical Day Ctr.
Golden Pond Adult Day Program, Inc.
Happy Days Health Care Center
Keswick Multi-Care Center
Levels Medical Adult Day Care
Levindale Adult Day Services
LIFE Adult Medical Day Care Services
Maryland Avenue Medical Day Care Center
Paradise Adult Medical Day Care Center
Phoenix Adult Medical Center
Providence Medical Adult Day Care, Inc.
Rainbow of Milbrook, LLC
Ravens Medical Adult Day Care
St. Ann Adult Day Services
The League for People with Disabilities
Today's Care and Family
Today's' Care & Family - Harford

Home Health

Amedisys Home Health of Baltimore
Amedisys Home Health of Maryland
Amedisys Home Health of Westminster
Amedisys Home Health, Greater Chesapeake
Bayada Nurses
Community Home Health of Maryland
Comprehensive Home Health Services
Gentiva Health Services
Home Health Connection, Inc.
HomeCall - Baltimore City
HomeCare Maryland, LLC
Johns Hopkins Home Health Services
Johns Hopkins Pediatrics at Home
MedStar Health VNA - Baltimore
MedStar Health VNA - Calverton
P-B Health Home Care Agency, Inc.
Personal Touch Home Care Baltimore
PHR of Baltimore
Stella Maris, Inc.
Visiting Nurse Association of Maryland, LLC

Hospice

Amedisys Hospice of Greater Chesapeake
Community Hospice of MD
Gilchrist Hospice
Heartland Hospice-Baltimore
Joseph Richey Hospice
Professional Healthcare Resources of Baltimore Hospice (PHR Hospice)
Seasons Hospice
Stella Maris Inc.

B. **New Construction or Expansion of Beds or Services.** The Commission will review proposals involving new construction or expansion of comprehensive care facility beds, including replacement of an existing facility or existing beds, if new outside walls are proposed, using the following standards in addition to .05A(1)-(9):

(1) **Bed Need.**

(a) An applicant for a facility involving **new construction** or expansion of beds or services, using beds currently in the Commission's inventory, must address in detail the need for the beds to be developed in the proposed project by submitting data including, but not limited to: demographic changes in the target population; utilization trends for the past five years and expected changes in the next five years;

and demonstrated unmet needs of the target population.

RESPONSE:

While Mid-Atlantic is not seeking additional beds, the project entails new construction. The need for new construction is supported by the following data:

Nursing home volume for Baltimore City residents has increased considerably – Between 2009-2013, the number of nursing home discharges for Baltimore City residents has continued to increase as documented below:

TABLE K
Nursing Home Utilization, Baltimore City Residents
2009-2013

	2009	2010	2011	2012	2013
# Discharges, Age 0-65	2,579	2,720	2,781	3,049	3,042
# Discharges, Age 65+	6,045	6,061	6,377	6,751	6,795
# Discharges, All Ages	**8,624**	**8,781**	**9,158**	**9,800**	**9,837**
% Annual	-	1.8%	4.3%	7.0%	0.4%
% Change, 2009-2013					14.1 %

Source: Long Term Care Minimum Data Set

Volumes at Baltimore City nursing homes are beginning to level – While the total number of patient days at Baltimore City nursing homes declined between Years 2009-2013, this four year decline has begun to moderate, and expectations are that post-acute days will increase, (*see* factors described below).

TABLE L
Utilization of Nursing Homes in Baltimore City
2009-2013

Baltimore City	2009	2010	2011	2012	2013
Number of Patient Days	1,352,973	1,344,660	1,292,957	1,248,305	1,212,988
Average Daily Census	3,707	3,684	3,542	3,411	3,323
% Annual	-	-0.614%	-3.845%	-3.453%	-2.829%
% Change, 2009-2013					-10.3 %

Source: Medicaid Cost Reports

The elderly population in Baltimore City is growing – While the total population in Baltimore City is projected to remain relatively flat, the elderly population is projected to grow, resulting in an 8% increase in the elderly population between the years 2013-2020, and a 17% increase by the Year 2025.

TABLE M
Baltimore City Population
Historical and Projected, 2009-2025

	Actual					Projected	
Baltimore City	**2009**	**2010**	**2011**	**2012**	**2013**	**2020**	**2025**
0-64 Years	547,853	548,394	548,401	548,709	546,682	552,808	555,416
65-74 Years	38,442	38,590	38,781	40,442	42,155	49,379	53,257
75-84 Years	24,206	23,821	23,330	22,679	22,571	22,194	25,963
85+ Years	10,008	10,405	10,475	10,587	10,696	9,711	9,362
TOTAL	620,509	621,210	620,987	622,417	622,104	634,092	643,998
65+ Years	72,656	72,816	72,586	73,708	75,422	81,284	88,582
Annual % Change	**2009**	**2010**	**2011**	**2012**	**2013**	**2020**	**2025**
0-64 Years	-	0.10%	0.00%	0.06%	-0.37%	0.16%	0.09%
65-74 Years	-	0.38%	0.49%	4.28%	4.24%	2.29%	1.52%
75-84 Years	-	-1.59%	-2.06%	-2.79%	-0.48%	-0.24%	3.19%
85+ Years	-	3.97%	0.67%	1.07%	1.03%	-1.37%	-0.73%
TOTAL	-	0.11%	-0.04%	0.23%	-0.05%	0.27%	0.31%
65+ Years, Annual Change	-	0.22%	-0.32%	1.55%	2.33%	1.08%	1.73%
65+ Years, Change 2013-2020						**7.8%**	
65+ Years, Change 2013-2025							**17.4%**

Source: Maryland Department of Planning

The proposed facility will provide services, staff capabilities, and facility design that are not generally offered by area nursing homes but are reported to be needed by area hospitals– While some capacity may exist at area nursing homes, this capacity does not meet the demand for distinct services, accommodations, and acuity levels reported to be needed by area hospitals. **This patient volume represents demand for nursing home care that is not being met currently, and is therefore not reflected in utilization trends and occupancy statistics for long term care**. In other words, there is bed need that is not reflected in current occupancy statistics.

The proposed facility will be designed to meet much of this demand by accommodating the patient populations who require the following:

- Dialysis
    - Only a limited number of facilities in Baltimore City accept patients who require dialysis, and oftentimes these facilities are operating at capacity and cannot accept additional dialysis patients. The result is that dialysis patients ready for discharge remain in the acute care setting awaiting placement. Therefore, the documented number of nursing home days understates the demand for CCF

beds. Case managers at UMMC and UM Midtown indicate there can be 2-3 dialysis patients in the acute care hospital at one time who are awaiting placement in a nursing home.
    - Case managers at UMMC note that capacity is even more limited for patients on ventilators who also require dialysis. Restore Health will be equipped to accept these patients.
- Medical monitoring after acute cardiac episode
    - Reportedly, clinicians are often uneasy about discharging cardiac patients from the acute care setting due to concerns about the level of attention and monitoring that is provided at area nursing homes. The result is that length of stay in the acute care hospital is extended for these patients when, in fact, a lower acuity/lower cost setting could meet the patient's needs. These patient days are not reflected in nursing home days reported for Baltimore City facilities.
- Patients with Left Ventricular Assisted Device (LVAD)
    - Rehabilitation care for these patients is generally not provided in most nursing homes because of the special equipment and skill set required to monitor these patients. While this cohort represents a relatively small number of patients, this volume is expected to grow with an accompanying increase in CCF patient days. Currently, this demand for CCF beds is not fully reflected in the CCF bed days documented.
- Accommodations for bariatric patients
    - Only a limited number of nursing homes provide the equipment to accommodate this patient population, and several nursing homes reportedly "cap" the number of bariatric patients that can be served at any one time. As a result, bariatric patients who require nursing home placement may wait in the hospital for days/weeks until placement can be arranged. This demand is not fully reflected in CCF beds days currently reported.

Restore Health will be constructed with the staffing, the physical space, and the design features to accommodate these patient populations. This will translate into a reduction in acute care days and an increase in nursing home utilization, as Restore Health meets a need that is not currently served by area nursing homes.

The working partnerships between Mid-Atlantic and the University of Maryland Medical System is expected to result in an increase in referral volume to the post-acute setting – In CY2014, more than **400 nursing home placements per month** were arranged from the University of Maryland Medical Center and approximately 50 nursing home placements per month arranged from the UM Midtown Campus. With the working partnership in place, the number of referrals to this new state-of-the-art facility is expected to grow as a function of the following:

- Opportunity for clinicians to maintain their role as primary physician in this local facility
- Opportunity for faculty to extend teaching and research activity to this setting
- Opportunity to leverage this new facility for post-acute care in order to reduce acute care length of stay, assure effective restoration/rehabilitation, and lower the total costs of care (see below)

Use rates for nursing home care are expected to grow considerably under new payment models - Under GBR contracts in place for all Maryland acute care hospitals, under bundled payment contracts, and under other risk-based payment models, the demand for lower cost service settings is expected to grow considerably. Already, many Maryland hospitals have begun to

build closer working relationships with local nursing homes to reduce readmissions, and many more hospitals are expected to work toward leveraging the resources of nursing homes to maximize effective utilization of the post-acute setting. Indeed, several hospitals have invested heavily in care transition specialists, nurse practitioners based in nursing homes, additional physician support to nursing homes, and structured communications/reporting systems, all of which forecast increased utilization of nursing home capacity.

Waiver of the 3 day hospital stay rule is expected to result in further growth in referral volume from area hospitals and direct admissions from the community – Already, CMS has waived the 3 day rule for the Medicare Pioneer ACO programs as well as for CMS-sponsored bundled payment contracts. CMS is expected to extend this waiver to other demonstration models, including Maryland's Demonstration Model. This would provide increased flexibility to utilize the nursing home setting in place of hospital care for patients currently treated in an observation setting, and would result in increased demand for nursing home beds to provide the following care:

- Transfer of patients after 1-2 days stabilization in acute care
- Transfer of patients stabilized in the Emergency Room or Observation Unit

Case workers from UMMC suggest that waiver of the 3 day hospital stay would be expected to result in **at least 20-25 additional referrals per month from the acute care service and emergency room**. This represents only one of several referring hospitals to the proposed facility, and represents the impact on only one nursing home facility; the projected increase in demand would affect virtually all nursing homes in the state. Therefore, the demand for beds would be expected to increase and occupancy rates would be expected to rise considerably across the state.

Demand for direct admission of patients from the community for symptom management, pain control, and palliative care is expected to increase – The proposed facility will be equipped to provide this valuable service in a high quality, low cost service setting. This service will be provided in the upper floors of the new facility.

Statement of need: Summary

#1 Baltimore City requires additional nursing home capacity to serve dialysis patients.

Reports indicate that hospital patients requiring dialysis currently experience long delays until placement can be arranged; there is limited capacity at area nursing homes.

#2: The State of Maryland requires post-acute providers who operate settings that work closely with acute care hospitals and are effective at reducing Maryland's readmission rate. Clinicians at hospitals in the West Baltimore area – striving toward more effective care management – should be supported with a progressive, state of the art nursing home in close proximity to the hospital.

Reducing readmission rates will be critical to Maryland's successful performance under the new model agreement with CMS. Mid-Atlantic invests heavily in prevention and early intervention, and has a successful track record of low readmission rates at its nursing homes. Mid-Atlantic also operates with effective protocols and communications systems with managing physicians to minimize the need for transfers to the acute hospital.

Finally, Mid-Atlantic encourages local physicians to continue managing the care of patients in the nursing home. This model promotes smooth care transitions and strengthens continuity of care for patients.

#3: Baltimore City requires a nursing home setting that can serve patients with more complex medical needs and that can provide the ability for "step up" care when necessary. This will permit earlier discharge from the hospital and minimize the need to transfer patients to the acute care hospital.

The UMMC and UM Midtown together account for more than 5,000 nursing home and rehabilitation placements per year, but many more patients could be discharged from the acute care setting earlier if the post-acute setting could provide staff with cardiac care training and the capacity for "step up care". These capabilities will also minimize the need to transfer patients from nursing homes to the acute care hospital. This will improve the quality of care to patients, reduce the disruption and disorientation that results from hospitalizations, reduce readmission rates, and improve Maryland's performance on the new model agreement with CMS.

#4: Baltimore City requires a nursing home that is positioned to meet the future demand for direct admissions and admissions of patients after a one to two day acute care stay.

This requires the facility design, equipment planning, and staffing models, to provide more treatment protocols and provide palliative care/symptom management. In this context, the successful nursing home provider must also demonstrate collaborative relationships with hospital clinicians and a track record of low readmission rates.

#5: Residents of West Baltimore should be provided with more alternatives for post-acute care in their local community, and clinicians at hospitals in the West Baltimore area – striving toward more effective care management – should be supported with a progressive, state of the art nursing home in close proximity to the hospital, that will encourage continuity of care.

- The majority of nursing homes in the West Baltimore area are operating at above 90% occupancy. Residents of this community should be provided with more choices for high quality post-acute care and more alternatives that are in close proximity to where families reside.

- Mid-Atlantic has always encouraged continuity of care by allowing hospital-based physicians and clinicians from the community to maintain the care management role in the nursing home.

#6: The State of Maryland should support a new facility that can serve as a teaching and research site for progressive, state-of-the-art care for Geriatric Medicine.

Geriatric Medicine will be an increasingly critical area of study, and a strong local training program can elevate the quality of care and influence newly-trained physicians to remain in Maryland for practice.

(b) For a **relocation** of existing comprehensive care facility beds, an applicant must demonstrate need for the beds at the new site, including, but not limited to: demonstrated unmet needs; utilization trends for the past five years and expected changes in the next five years; and how access to, and/or quality of, needed services

will be improved.

RESPONSE:

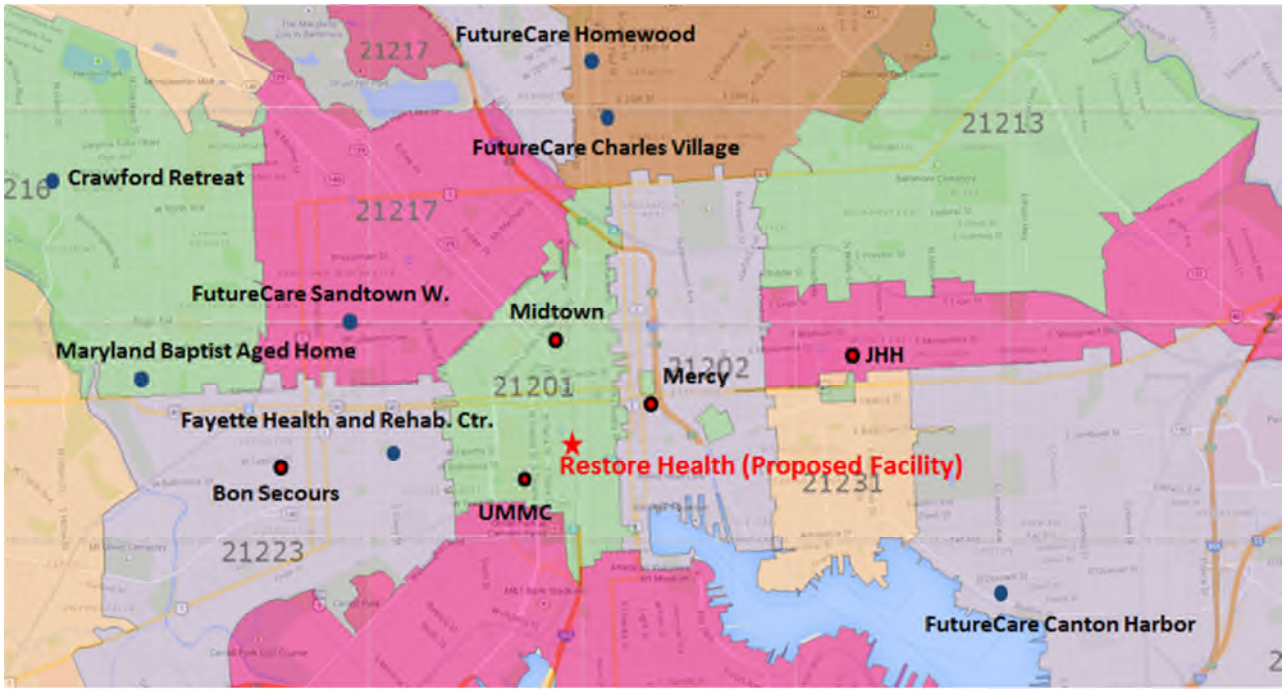
Mid-Atlantic intends to relocate the 80 beds it acquired to a location that will be:

- More responsive to the unmet needs in West Baltimore
- Directly supportive of new care management models at the two local UMMS hospitals in the West Baltimore community, and
- Positioned to maximize the resources at the University of Maryland Medical System, with whom Mid-Atlantic expects to work closely

The rationale and evidence for relocating these beds to the proposed site, in addition to the discussion in response to sub-section (a) above, is provided below:

- *The proposed location will support more effective use of currently licensed bed capacity* – Historical data documents an occupancy rate for these 80 beds, when located at the Johns Hopkins Bayview site, of 62% for an average daily census of 50. Mid-Atlantic expects to operate these beds at 90-95% occupancy (based on the factors described below) thereby supporting the relocation plan.
- *The proposed location will provide proximity to three hospitals that demonstrate some of the highest demand for post-acute placements of complex patients* – The proposed site will operate within 0.3 miles of the University of Maryland Medical Center, within 1 mile of the University of Maryland Midtown Campus, and within 2 miles of Bon Secours Hospital. In CY2014, these three hospitals together accounted for more than 5,000 placements to post-acute facilities. In addition, the patient populations at these hospitals are noted for very high rates of chronic disease and high rates of comorbidities; these patients are ones who could benefit considerably from extended stays in a post-acute setting to support self-care/family management before transitioning home.

EXHIBIT L - MAP



Source: http://www.usnaviguide.com/zip.htm

- *The proposed location provides the opportunity to elevate the level of care and treatment capabilities in the West Baltimore region through working relationships with University of Maryland Medical System* - Geographic proximity to the University campus will support a program partnership for medical management, teaching, and research.

- *The proposed location will respond to access needs in the West Baltimore community* – Several area nursing homes are operating at 90%+ occupancy, and many patients must be transferred to nursing homes outside their community, reflecting the limited choices available for West Baltimore residents. The proposed facility will provide West Baltimore residents with greater access to a local service site and more alternatives for post-acute care.

- *The proposed facility will expand options for post-acute care in Baltimore City and build capacity for integrated delivery systems* - The proposed facility will provide Baltimore residents with a new alternative for post-acute care, offered by a post-acute provider with an established track record of success and a readiness to participate in new payment models and quality-based performance

How will quality be improved?

Mid-Atlantic currently owns and operates 18 nursing homes and serves almost 3,200 residents across Maryland, Pennsylvania, and Delaware, and will bring to this new facility its experience and its care redesign initiatives, experience that promises quality improvement and increased patient satisfaction. Examples of care redesign and quality improvement initiatives include the following:

- Care transitions – The "Nurse Liaison" program is designed to assure that referrals to Mid-Atlantic's nursing homes are appropriate and to assure that complete information exchange occurs at the point of transfer. With this in place, the nursing home is more immediately equipped to respond to patient needs, complication rates are reduced, and adverse events are minimized. This program also aims to conduct close discussion with patients and family members at the point of transition. Advanced directives are properly prepared and patient and family preferences/wishes around palliative care/end-of-life care are better communicated.

- Patient assessment – An RN conducts an assessment of every new patient within 24 hours of admission. This promotes safety, reassures patients, and minimizes complications associated with patient transfer.

- Increased surveillance/prevention with a Nurse Practitioner model – Nurse practitioners routinely round on high risk patients, and provide interim patient assessments between scheduled physician visits.

- Care redesign in the nursing home– Mid-Atlantic has introduced the "Stop and Watch" program which assigns CNAs increased responsibility for early detection and reporting of problems. In this model, CNAs are assigned to watch for subtle changes such as dehydration and nutrition problems, to document observations on a formal reporting form, and to submit this report to an RN or LPN for attention and direct response. This care redesign model assigns responsibility for observation/patient monitoring with the care provider who spends the most time with the patient and equips the CNA with tools to sharpen his/her diagnostic skills, and empowers the CNA to call for immediate attention to a concern.

- Treatment and restoration: (1) All of Mid-Atlantic's facilities provide rehabilitation services seven days per week, a notable distinction among nursing homes. Mid-Atlantic invests heavily in rehabilitation equipment: Its facilities typically include a modality suite to provide adjunct therapies to the traditional modes of therapy and speed up healing. (2) Each of Mid-Atlantic's facilities typically develops a "specialty niche rehab program," in response to the needs of the local community. These programs include specialty fall programs, specialty dialysis programs, specialty neurologic programs, and specialty cardiac programs. The proposed facility will feature similar programs. By way of illustration:

    - Specialty dialysis program – This program is designed to customize the rehabilitation program schedule in response to the patient's treatment schedule and energy levels. Oftentimes, patients are so fatigued by dialysis that they must miss therapy sessions. Mid-Atlantic schedules special rehabilitation session to stagger treatments and even provide evening therapy sessions to respond to patient need.
    - Cardiac program (expected to operate at Restore Health) – Restore Health will provide a team of nurses with advanced cardiac care training to care for patients discharged with more complex CHF-related diagnoses, and to respond to episodic needs of the general CHF patient population. Clinical capabilities and dedicated space will allow consolidation of CHF patients, and protocols will be designed to extend the protocols begun in the hospital; this will ensure that post-acute protocols are consistent with the hospital treatment plan, and that criteria for

transfer to the acute care facility are jointly defined to ensure that post-acute protocols are consistent with the hospital treatment plan and that criteria for transfer to the acute care facility are jointly defined. In addition, this nursing team is expected to meet some of the urgent care needs of patients who are currently transferred to the ER.

- LVAD (Left Ventricular Assist Device) - Patients with this device are typically very weak and very deconditioned. Care for these patients requires specialized training and monitoring equipment. Mid-Atlantic is prepared to set up just such a "sub unit" (as it has in other facilities) as volume materializes.
- Vent unit – Mid-Atlantic serves patients on ventilators at a number of its facilities including the facility in Berlin, Maryland, and expects to expand this unit. The unit in Berlin serves a number of short term patients on weaning protocols, and outcomes are excellent. This facility is in the process of developing the capacity for bedside dialysis for patients on ventilators.

- Improving information exchange and decision-making – As nurses identify concerns, they use a checklist to compile all relevant clinical information before calling the physician to discuss the need for possible hospital transfer. This avoids the unnecessary hospitalizations that may be due to incomplete profiles/lack of information, rather than clinical necessity. This protocol represents one of several protocols in place that has helped reduce readmissions.

- Prevention and monitoring: Early respiratory therapy treatment – Mid-Atlantic provides in-house respiratory therapists (7 days/week) to conduct daily rounds on all patients with respiratory problems, provide regular staff training focused on assessment of pulmonary function / early detection of problems, and promote early management of problems detected (e.g. COPD-related flare up). Early detection of problems helps minimize the number of serious complications. Nurse training and skills upgrading to manage episodic needs are expected to reduce the number of ER visits and hospitalizations

- Structured approach to readmission reduction – Each day, an interdisciplinary group that includes the Director of Nursing, the medical directors, and department directors, reviews all patients demonstrating a change in status, abnormal lab values, unstable status or patient/family concerns. In addition, this group reviews every unplanned transfer to a hospital to consider what factors led to transfer, how the case was managed, and what opportunities there may have been for alternative management; every unplanned transfer to a hospital is review by this group to provide steady focus and ongoing progress to reduce unnecessary admissions. A retrospective analysis also occurs: The Senior Director of Transitional Care compiles a Quality Assurance tool for this effort, producing routine reports on readmission patterns, by unit, by shift, by physician, by diagnosis. These retrospective analyses identify specific opportunities for improvement and provide the hard data with which to design targeted initiative for care improvement.

- Training and education – "Assessment training" operates at Mid-Atlantic's facilities to establish exactly what skills nurses have mastered and to structure scenarios and clinical variables to which nurses must respond. Increasing emphasis has been placed on early detection, and nursing personnel now utilize checklists for patient assessments to sharpen diagnostic assessments and assure thorough evaluation.

- Step Up™ Unit – Step Up™ Units are specific units within a Mid-Atlantic facility where patients are temporarily placed to receive higher level observation and assessment by a more advanced and trained team including nurse practitioners, registered nurses and practitioners. These residents are typically experiencing an acute onset of a change in condition that may otherwise require then to be readmitted to the hospital. Once they are stabilized, they can return to a more standard level of care.

- Focus on progress and transition to home – As early as Week 1, therapists meet with the patient and family members to assess any issues that must be addressed for a successful transition to home. Therapists focus on what training, accommodations and service supports are required for patients to be safe and for caregivers to be well-trained.

- Real Time Medical Systems ("RTMS") – This sophisticated electronic records system generates relevant and real-time data to support successful care management. This electronic system receives hourly data feed from the electronic medical record of nursing home patients, summarizes and analyzes this data, and provides daily reports about abnormal test results, exceptions, and patient variability to clinical staff who can then respond directly. In this way, clinical staff can prevent minor problems from escalating and minimize the number of ER/hospitalizations. RTMS represents a dramatic advance in care management for the long term care arena, and produces consolidated reports on a daily basis to alert nursing staff of possible concerns/gaps/exceptions. Patients can be identified in distinct clinical cohorts (e.g. orthopedics), by physician, by specific contracting initiatives, or by specific interventions to allow comparative evaluations to be made across clinical cohorts and/or across intervention types.

A set of initiatives focused on the transition from nursing home to home will also be implemented to improve quality:

- Patient education and self-management – Patient education and self-management skills are explicitly incorporated into the careplan during the nursing home stay. This includes review of the medication regimen, coaching for ongoing therapy, and discussion about early detection.
- Almost Home Program- In preparation for discharge from the facility, a team member will: (1) Review medication, therapy, and diet in context of the patient's normal daily routine, and restructure the daily schedule, as appropriate (2) Conduct a home visit and evaluate the patient's home setting to recommend adaptations (3) Conduct a "teach back" with the patient around medication, diet, and treatment instructions; include patient "mimicking" of normal home activities to demonstrate readiness for discharge
- Post-discharge communications – A nurse calls the patient within 24 hours of patient's return home, with calls again on Day 3, Day 7, and Day 30 post-discharge to assess compliance and ongoing needs. The patient is also assured of on-call telephone availability of a nurse.

Expectations are that the combined effect of these initiatives will be to reduce complications associated with poor compliance, reduce ER visits/rehospitalizations, and heighten patient and family satisfaction.

(2) *Facility Occupancy*.

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

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

RESPONSE:
N/A

(3) *Jurisdictional Occupancy.*

(a) The Commission may approve a CON application for a new nursing home only if the average jurisdictional occupancy for all nursing homes in that jurisdiction equals or exceeds a 90 percent occupancy level for at least the most recent 12 month period, as shown in the Medicaid Cost Reports for the latest fiscal year, or the latest Maryland Long Term Care Survey, if no Medicaid Cost Report is filed. Each December, the Commission will issue a report on nursing home occupancy.
(b) An applicant may show evidence why this rule should not apply.

RESPONSE:
(a) CY2013 occupancy statistics at nursing homes in Baltimore City are presented in Table M below.

Table N
Baltimore City Nursing Homes Occupancy Statistics
Calendar Year 2013

Facility Name	Total Days	Number of Beds [2]	Occupancy %
Keswick Multi-Care Center_ Inc.	83,123	242	94.1%
Frankford Nursing and Rehabilitation Center	71,822	225	87.5%
Levindale Hebrew Geriatric Center & Hospital_ Inc.	72,693	210	94.8%
FutureCare Irvington_ LLC	67,754	200	92.8%
FutureCare – Lochearn	69,320	200	95.0%
St. Elizabeth Rehabilitation and Nursing Center	55,811	162	94.4%
FutureCare - Canton Harbor	55,639	160	95.3%
Overlea Health and Rehabilitation Center	43,580	150	79.6%
FutureCare - Sandtown Winchester	48,759	148	92.1%
FutureCare – Homewood	47,994	148	88.8%
Good Samaritan Nursing Center	44,191	146	82.9%
Fayette Health and Rehabilitation Center	46,628	145	88.1%
Caton Manor	45,908	140	89.8%
FutureCare - Cold Spring	40,501	137	86.8%
Long Green Center	41,620	135	84.5%
Blue Point Nursing and Rehabilitation Center	43,334	135	87.9%
Manor Care - Roland Park MD_ LLC	41,026	120	93.7%
Rock Glen Nursing and Rehabilitation Center	37,693	120	86.1%
Homewood Center	32,394	112	79.2%
Perring Parkway Center	33,424	110	83.2%
Futurecare - Charles Village_ LLC	34,428	109	87.2%
Alice Manor	35,026	105	91.4%
BridgePark Healthcare Center	27,399	94	79.0%
Northwest Nursing and Rehabilitation Center	30,046	91	90.5%
Arlington West Nursing and Rehabilitation Center	25,236	82	84.3%
The Green House Residences at Stadium Place	12,880	49	72.0%
The Villa	9,007	30	82.3%
Maryland Baptist Aged Home	8,897	29	84.1%
Crawford Retreat_ Inc.	6,855	20	93.9%
Total	1,212,988	3,754	88.8%

Source: Medicaid Cost Reports

(b) In context of the proposed project, it is critical to note that while the overall occupancy rate for all Baltimore City facilities in CY 2013 was 89%, the occupancy rates at facilities in the vicinity of the proposed facility is notably higher. Three of the seven facilities currently operating in the immediate area have been consistently operating at above 90% occupancy, and six of the seven facilities operated at above 87% occupancy in each of the last

5 years.

(c) Finally, the provision related to jurisdictional occupancy appears to be aimed at new facilities proposing a bed increase, which is not the case here, and the applicant believes this standard is not applicable to this Project.

Table O
Occupancy Trend of Nursing Homes Near Proposed Location
2009 - 2013

	Occupancy %				
Facility Name	**2009**	**2010**	**2011**	**2012**	**2013**
FutureCare - Canton Harbor	90.9%	93.2%	94.8%	94.5%	95.3%
Crawford Retreat_ Inc.	94.4%	94.6%	98.5%	97.9%	93.9%
FutureCare - Sandtown Winchester	94.4%	92.7%	90.9%	91.6%	92.1%
FutureCare – Homewood	92.0%	91.5%	91.4%	89.4%	88.8%
Fayette Health and Rehabilitation Center	82.1%	87.3%	89.7%	84.9%	88.1%
Futurecare - Charles Village_ LLC	92.2%	90.8%	89.6%	89.6%	87.2%
Maryland Baptist Aged Home	89.0%	88.3%	75.4%	87.0%	84.1%
Ravenwood Nursing & Rehab Center	80.6%	74.6%	63.9%	-	-
Total	87.9%	88.4%	86.5%	90.2%	90.4%

Source: Medicaid Cost Reports

(4) Medical Assistance Program Participation.

(a) An applicant for a new nursing home must agree in writing to serve a proportion of Medicaid residents consistent with .05A 2(b) of this Chapter.

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

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

(d) An applicant for nursing home expansion or replacement of an existing facility must modify its MOU upon expansion or replacement of its facility to encompass all of the nursing home beds in the expanded facility, and to include a Medicaid percentage that reflects the most recent Medicaid participation rate.

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

RESPONSE:
The Applicant has responded that it will comply with these requirements.

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

RESPONSE:
N/A. The Project involved new construction to house beds to be relocated from JHBMC.

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

RESPONSE:
See the response to 10.24.08.05C(1)(a) and (b) *supra*.

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

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

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

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

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

(a) Shall participate in the Medicaid Program;

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

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

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

.

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

RESPONSE:
The Applicant has responded in its response to New Construction on pages 26-34.

10.24.01.08G(3)(b). Need.

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

INSTRUCTIONS: Fully address the way in which the proposed project is consistent with any specific applicable need standard or need projection methodology in the State Health Plan.
If the current bed need projection published by the MHCC based on the need formula in the State Health Plan does not project a need for all of the beds proposed, the applicant should identify the need that will be addressed by the proposed project by quantifying the need for all facility and service capacity proposed for development, relocation or renovation in the project.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population of the nursing home. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified and identify all the assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), and the relevant population considered in the analysis with information that supports the validity of these assumptions. The existing and/or intended service area population of the applicant should be clearly defined.

Complete the Statistical Projection (Tables D and E, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Table D must be completed if the applicant is an existing facility. Table E must be completed if the application is for a new facility or service or if it is requested by MHCC staff.

RESPONSE:
Statement of Need and Supporting Evidence

#1 Baltimore City requires a nursing home with capacity to serve dialysis patients and capacity to serve bariatric patients.

Reports indicate that hospital patients requiring dialysis currently experience long delays until placement can be arranged; there is limited capacity at area nursing homes. Similarly, only a limited number of nursing homes are equipped to accept bariatric patients; these patients also may wait days or weeks in the acute care hospital until placement can be arranged.

Caseworkers at the UMMC and UM Midtown Campus report that on many days, there are hospital patients ready for discharge, but await transfer to a nursing home that can provide dialysis; post-acute capacity for this care is extremely limited.

- The proposed facility will provide dialysis, and will also provide care to patients on ventilators who require dialysis. This responds directly to the severe need described by

UMMC/UM Midtown case managers who indicate that nursing home capacity for these patients is severely limited.

#2: Baltimore City requires a nursing home setting that can serve patients with more complex medical needs and that can provide the ability for "step up" care when necessary to permit earlier discharge from the hospital and minimize the need to transfer patients to the acute care hospital.

The UMMC and UM Midtown together account for more than 5,000 nursing home and rehabilitation placements per year, but many patients could be discharged from the acute care setting earlier if the post-acute setting could provide staff with cardiac care training and the capacity for "step up care" (described more fully at page 34). Case managers estimate that more than 100 patients per year might be discharged earlier if higher level capabilities and distinct service components were provided by the nursing home setting.

These capabilities will be provided at Restore Health, consistent with the level of care provided at its other nursing homes. Clinicians at area hospitals will be familiarized with the step up unit expected to operate at Restore Health, and Mid-Atlantic will establish the communications systems and protocols to respond to the requests of clinicians at the acute care hospital. The staff capabilities, the step-up unit, and the collaborative relationships will assure patients and their families of high quality care, and will minimize the need to transfer patients back to the acute care hospital; this will improve the quality of care to patients, reduce the disruption and disorientation that results from hospitalizations, reduce readmission rates, and improve Maryland's performance on the waiver.

#3: The State of Maryland requires post-acute providers who will help reduce Maryland's readmission rate. Clinicians at hospitals in the West Baltimore area - - striving toward more effective care management - -should be supported with a progressive, state of the art nursing home in close proximity to the hospital.

This will be critical to Maryland's successful performance under the waiver. Mid-Atlantic invests heavily in clinical staff and reporting mechanisms to closely monitor patient conditions and quickly mobilize resources to respond to concerns while patients ar in the nursing home. Experience at Mid-Atlantic's facilities in Maryland, Pennsylvania, and Delaware demonstrates relatively low readmission rates, reflecting strong medical management, steady rounding and monitoring by nurse practitioners, and structured assessments by nursing assistants, and response teams when a concern is identified.

Evidence from Mid-Atlantic's nursing homes documents the following readmission rates:

Overall readmission rates CY2014

- Maryland nursing homes (9 facilities) = 15%
- Pennsylvania nursing homes (8 facilities) = 15%
- Delaware nursing homes (1 facility) = 14%

Worth noting is the steady decline in readmission rates that Mid-Atlantic has achieved after taking ownership of facilities.

Overall readmission rates CY2012-2014
Maryland nursing homes, 2012 = 17%
Maryland nursing homes, 2014 = 15%

Pennsylvania nursing homes, 2012 = 22%
Pennsylvania nursing homes, 2014 = 15%

Delaware nursing homes, 2012 = 20%
Delaware nursing homes, 2014 = 14%

Although Maryland does not currently publish readmission rates from Maryland CCFs, **Exhibit M** contains a study prepared by the Office of Inspector General, which cites a 25% national admission rate for nursing home patients, and a Maryland-specific rate of 25.3%. Mid-Atlantic's admission rate of 15% or lower compares very favorably and represents a very substantial potential for reduction in avoidable hospital utilization.

Mid-Atlantic participates in bundled payment innovation projects with several of its nursing homes in Pennsylvania, and this has provided further experience with managing clinical conditions in the nursing home setting and reducing readmission rates. Mid-Atlantic awaits the opportunity to participate in bundled payment projects in Maryland once these projects are permitted by CMS.

#4: Baltimore City requires a nursing home that is positioned to meet the future demand for direct admissions and admissions of patients after a 1-2 day acute care stay.

This requires the facility design, equipment planning, and staffing models to respond to more treatment requirements, transport issues, and palliative care/symptom management.
In this context, the successful nursing home provider must also demonstrate collaborative relationships with hospital clinicians and a track record of low readmission rates.

The value-added of a nursing home equipped to serve this function includes the following:

- Patient care will be delivered in a lower cost setting
- Patient transfers will be avoided
- Duplication of diagnostics/assessments will be avoided
- Hardship imposed on fragile elderly and/or disoriented elderly patients will be minimized; hospitalization and changes of setting often result in complications and disorientation.

Caseworkers at UMMC estimate that if the 3 day rule were waived, there might be as many as 20-25 additional referrals per month for nursing home placement.

#5: Residents of West Baltimore should be provided with more alternatives for post-acute care in their local community, and the opportunity to maintain relationships with their physicians.

- Residents of this community should be provided with more alternatives for post-acute care that are in close proximity to where families reside.
- The majority of nursing homes in the West Baltimore area are operating at above 90% occupancy. The proposed facility will provide residents with a new alternative for post-acute care, offered by a provider with a track record of high quality service in Maryland, Delaware, and Pennsylvania.
- A local nursing home will provide the opportunity for continuity of care with physicians, as Mid-Atlantic encourages local physicians to maintain the role of primary care physician. Patients are more likely to maintain steady relationships with physicians who

have been caring for them.

- Hospital-based physicians can provide ongoing support to post-acute patients and professional staff
- Community-based physicians are encouraged to follow patients in the post-acute setting
- Residents are also permitted to care for nursing home patients at Mid-Atlantic's facilities

#6: The State of Maryland should support a new facility that can serve as a teaching and research site for progressive, state-of-the-art care for Geriatric Medicine.

Geriatric Medicine will be an increasingly critical area of study, and a strong local training program can elevate the quality of care and influence newly-trained physicians to remain in Maryland for practice.

TABLE D. UTILIZATION PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Account for all inpatient and outpatient volume that produce or will produce revenue. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 3 & 4, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY										
1. ADMISSIONS										
a. Comprehensive Care (public)										
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL ADMISSIONS										
2. PATIENT DAYS										
a. Comprehensive Care (public)										
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS										
3. NUMBER OF BEDS										
a. Comprehensive Care (public)										
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care Beds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL BEDS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
4. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:*** *Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. Comprehensive Care (public)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. Comprehensive Care (CCRC Restricted)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Comprehensive Care Beds	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Assisted Living	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
5. OUTPATIENT (specify units used for charging and recording revenues)										
a. Adult Day Care										
b. Other (Specify/add rows of needed)										
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***

TABLE E. UTILIZATION PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Account for all inpatient and outpatient volume that produce or will produce revenue. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 3 & 4, the number of beds and occupancy percentage should be reported on the basis of proposed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must

	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.				
Indicate CY or FY	**CY 2017**	**CY 2018**	**CY 2019**	**CY 2020**	**CY 2021**
1. ADMISSIONS					
a. Comprehensive Care (public)	169	715	750	750	750
b. Comprehensive Care (CCRC Restricted)					
Total Comprehensive Care	**169**	**715**	**750**	**750**	**750**
c. Assisted Living	0	0	0		
d. Other (Specify/add rows of needed)	0	0	0		
TOTAL ADMISSIONS					
2. PATIENT DAYS					
a. Comprehensive Care (public)	5,113	26,432	27,740	27,740	27,740
b. Comprehensive Care (CCRC Restricted)					
Total Comprehensive Care	**5,113**	**26,432**	**27,740**	**27,740**	**27,740**
c. Assisted Living	0	0	0	0	0
TOTAL PATIENT DAYS	***5,113***	***26,432***	***27,740***	***27,740***	***27,740***
3. NUMBER OF BEDS					
a. Comprehensive Care (public)	80	80	80	80	80
b. Comprehensive Care (CCRC Restricted)					
Total Comprehensive Care Beds	**80**	**80**	**80**	**80**	**80**
c. Assisted Living	0	0	0		
TOTAL BEDS	***80***	***80***	***80***	***80***	***80***
4. OCCUPANCY PERCENTAGE ****IMPORTANT NOTE:*** *Leap year formulas should be changed by applicant to*					
a. Comprehensive Care (public)	17.5%	90.5%	95.0%	95.0%	95.0%
b. Comprehensive Care (CCRC Restricted)	NA	NA	NA	NA	NA
Total Comprehensive Care Beds	**17.5%**	**90.5%**	**95.0%**	**95.0%**	**95.0%**
c. Assisted Living	NA	NA	NA	NA	NA
d. Other (Specify/add rows of needed)	NA	NA	NA	NA	NA
TOTAL OCCUPANCY %	**17.5%**	**90.5%**	**95.0%**	**95.0%**	**95.0%**
5. OUTPATIENT (specify units used for charging and recording revenues)					
a. Adult Day Care					
b. Other (Specify/add rows of needed)					
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***

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

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

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the project. It should also identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including the alternative of the services being provided by existing facilities.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development cost to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective goal and objective achievement or the most effective solution to the identified problem(s) for the level of cost required to implement the project, when compared to the effectiveness and cost of alternatives including the alternative of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

RESPONSE:

The alternative settings to the proposed facility include:

(a) Hospital setting – A large percentage of the patients to be served by this facility are patients who now remain in the acute care hospital for lack of a post-acute setting that can meet their service needs. Evidence indicates that existing nursing home capacity in Baltimore City simply does not meet the demand for care. Nursing home capacity in Baltimore City is not available to meet the demand for dialysis care or the medical monitoring requirements for some of the higher acuity patients, **even as the lower cost post-acute setting might be suitable.**

The alternative setting, then, for many of the target patient population is the acute care hospital. In high level terms, the cost of care comparison is stark: The average revenue per day in a Medicine Unit at the University of Maryland Medical Center is approximately $1,158 per day; in contrast, the Medicare revenue per day at Restore Health is projected to be $550 per day.

(b) Existing nursing homes –The balance of patients at the proposed facility are expected to shift from existing nursing homes in Maryland to this new facility. Restore Health represents a cost-effective alternative along several dimensions:

1. Lower readmission rates – Mid-Atlantic has a documented track record of low readmission rates averaging 15% as compared to the state average of 25%.
2. Reduced delays – As noted above, Restore Health will be equipped to accept patients earlier than other nursing homes are prepared to accept; this will reduce acute care days
3. Employment of local Baltimore City Citizens – Restore Health will create

approximately 89 new positions upon its opening and of these jobs likely to go to Baltimore City residents.

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

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

Complete applicable Revenue & Expense Tables and the Workforce and Bedside Care Staffing worksheets in the CON Table Package, as required (Tables H and I for all applicants and Table F for existing facilities and/or Table G, for new facilities, new services, and when requested by MHCC staff). Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item. Instructions are provided in the cover sheet of the CON package and on each worksheet. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable. If the projections are based on Medicare percentages above the median for the jurisdiction in which the nursing home exists or is proposed, explain why the projected Medicare percentages are reasonable.

RESPONSE:
Please see **Exhibit E** for rationale for financial projections.

TABLE F. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION : Complete this table for the entire facility, including the proposed project. The table should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the utilization projections in Table D reflecting changes in volume and with the costs of the Workforce identified in Table H. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projected revenue and expenses specifying all assumptions used. Applicants must explain why the assumptions are reasonable. Revenue should be projected based on actual charges with calculations detailed in the attachment and Contractual Allowance should not be

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY										
1. REVENUE										
a. Inpatient Services										
b. Outpatient Services										
Gross Patient Service Revenues	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
c. Allowance For Bad Debt										
d. Contractual Allowance										
e. Charity Care										
Net Patient Services Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
f. Other Operating Revenues (Specify/add rows if needed)										
NET OPERATING REVENUE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. EXPENSES										
a. Salaries & Wages (including 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/add rows if needed)										
TOTAL OPERATING EXPENSES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3. INCOME										
a. Income From Operation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
b. Non-Operating Income										
SUBTOTAL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
c. Income Taxes										
NET INCOME (LOSS)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare										
2) Medicaid										
3) Blue Cross										
4) Commercial Insurance										
5) Self-pay										
6) Other										
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Inpatient Days										
1) Medicare										
2) Medicaid										
3) Blue Cross										
4) Commercial Insurance										
5) Self-pay										
6) Other										
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE G. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). This table should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the utilization projections in Table E and with the Workforce costs identified in Table H. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Revenue should be projected based on actual charges with detailed calculation by payer in the attachment. The contractual allowance should not be reported if it is a positive adjustment to gross revenue. Specify the sources of non-operating income. See additional

	Projected Years (ending five years after completion) Add columns of needed.				
Indicate CY or FY	**CY 2017**	**CY 2018**	**CY 2019**	**CY 2020**	**CY 2021**
1. REVENUE					
a. Inpatient Services	$ 2,150,501	$ 10,614,471	$ 11,140,848	$ 11,140,848	$ 11,140,848
b. Outpatient Services					
Gross Patient Service Revenues	***$ 2,150,501***	***$ 10,614,471***	***$ 11,140,848***	***$ 11,140,848***	***$ 11,140,848***
c. Allowance For Bad Debt	$ 42,015	$ 222,594	$ 231,891	$ 232,708	$ 233,295
d. Contractual Allowance					
e. Charity Care					
Net Patient Services Revenue	***$ 2,108,486***	***$ 10,391,877***	***$ 10,908,957***	***$ 10,908,140***	***$ 10,907,554***
f. Other Operating Revenues (Specify)	$ (9,745)	$ 515,243	$ 453,691	$ 494,554	$ 523,880
NET OPERATING REVENUE	***$ 2,098,740***	***$ 10,907,120***	***$ 11,362,648***	***$ 11,402,694***	***$ 11,431,433***
2. EXPENSES					
a. Salaries & Wages (including benefits)	$ 1,708,293	$ 4,622,928	$ 4,642,049	$ 4,642,049	$ 4,642,049
b. Contractual Services	$ 347,241	$ 1,521,751	$ 1,595,071	$ 1,595,071	$ 1,595,071
c. Interest on Current Debt					
d. Interest on Project Debt	$ 316,352	$ 638,698	$ 567,686	$ 567,686	$ 567,686
e. Current Depreciation					
f. Project Depreciation	$ 252,253	$ 509,701	$ 511,562	$ 511,562	$ 511,562
g. Current Amortization					
h. Project Amortization					
i. Supplies					
j. Other Expenses (Specify)	$ 706,552	$ 2,837,318	$ 2,971,107	$ 2,970,289	$ 2,969,703
TOTAL OPERATING EXPENSES	**$ 3,330,692**	**$ 10,130,396**	**$ 10,287,474**	**$ 10,286,657**	**$ 10,286,071**
3. INCOME					
a. Income From Operation	**$ (1,231,951.44)**	**$ 776,724.44**	**$ 1,075,174.01**	**$1,116,036.78**	**$ 1,145,362.77**
b. Non-Operating Income					
SUBTOTAL	***$ (1,231,951.44)***	***$ 776,724.44***	***$ 1,075,174.01***	***$ 1,116,036.78***	***$ 1,145,362.77***
c. Income Taxes	$ -	$ 142,206.57	$ 416,599.72	$ 416,599.72	$ 416,599.72
NET INCOME (LOSS)	***$ (1,231,951.44)***	***$ 634,517.86***	***$ 658,574.29***	***$ 699,437.06***	***$ 728,763.05***
4. PATIENT MIX					
a. Percent of Total Revenue					
1) Medicare	66.4%	56.4%	56.8%	56.6%	56.5%
2) Medicaid	26.5%	31.0%	31.3%	31.2%	31.1%
3) Blue Cross					
4) Commercial Insurance	4.6%	5.4%	5.4%	5.4%	5.4%
5) Self-pay	3.0%	3.5%	3.5%	3.5%	3.5%
6) Other	-0.5%	3.7%	3.0%	3.3%	3.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Inpatient Days					
1) Medicare	50.0%	42.0%	42.0%	42.0%	42.0%
2) Medicaid	40.5%	47.0%	47.0%	47.0%	47.0%
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%
4) Commercial Insurance	5.2%	6.0%	6.0%	6.0%	6.0%
5) Self-pay	4.3%	5.0%	5.0%	5.0%	5.0%
6) Other	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE H. WORKFORCE INFORMATION

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G. See additional instruction in the column to the right of the table.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table H, if submitted)*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Administrator			$0	1.0	$120,000	$120,000			$0	1.0	$120,000
Receptionist			$0	2.0	$25,000	$50,000			$0	2.0	$50,000
Billing			$0	1.0	$50,000	$50,000			$0	1.0	$50,000
Human Resources				1.0	$50,000	$50,000				1.0	$50,000
Admissions				1.0	$50,000	$50,000				1.0	$50,000
Medical Records			$0	1.0	$31,200	$31,200			$0	1.0	$31,200
Total Administration			$0	7.0		$351,200			$0	7.0	$351,200
Direct Care Staff *(List general categories, add rows if needed)*											
Director Of Nursing			$0	1.0	$100,000	$100,000			$0	1.0	$100,000
Assistant Director Of Nursing			$0	1.0	$80,000	$80,000			$0	1.0	$80,000
Evening Nurse Spuervisor			$0	1.0	$78,000	$78,000				1.0	$78,000
MDS Coordinator			$0	1.0	$70,000	$70,000				1.0	$70,000
Quality Assurance			$0	1.0	$78,000	$78,000				1.0	$78,000
RNs			$0	12.6	$66,500	$837,900				12.6	$837,900
LPNs			$0	9.8	$52,000	$509,600				9.8	$509,600
CNAs			$0	32.2	$27,040	$870,688			$0	32.2	$870,688
Floor Secretary			$0	2.0	$26,000	$52,000			$0	2.0	$52,000
Total Direct Care			$0	61.6		$2,676,188			$0	61.6	$2,676,188
Support Staff *(List general categories, add rows if needed)*											
Central Supply			$0	1.0	$35,000	$35,000			$0	1.0	$35,000
Social Service			$0	1.0	$50,000	$50,000			$0	1.0	$50,000
Activities			$0	1.0	$35,000	$35,000			$0	1.0	$35,000
Asst. Activities			$0	1.4	$22,880	$32,032			$0	1.4	$32,032
Nurse Liason			$0	1.0	$65,000	$65,000				1.0	$65,000
Food Service Mgr			$0	1.0	$50,000	$50,000				1.0	$50,000
Cooks			$0	3.5	$31,200	$109,200				3.5	$109,200
Cooks Helpers			$0	4.2	$20,800	$87,360				4.2	$87,360
Laundry			$0	2.0	$41,600	$83,200				2.0	$83,200
Housekeeping Supervisor			$0	1.0	$35,000	$35,000			$0	1.0	$35,000
Housekeeping Staff			$0	3.0	$20,800	$62,400			$0	3.0	$62,400
Maintenance			$0	1.0	$55,000	$55,000				1.0	$55,000
Total Support			$0	21.1		$699,192			$0	21.1	$699,192
REGULAR EMPLOYEES TOTAL			$0	***89.7***		$3,726,580			$0	89.7	$3,726,580
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0	0.0		$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
Medical Director			$0	1.0	$30,000	$30,000			$0	1.0	$30,000
Psychiatrist			$0	1.0	$10,000	$10,000			$0	1.0	$10,000
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0	2.0		$40,000			$0	2.0	$40,000
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0			$40,000			$0	0.0	$40,000
Benefits *(State method of calculating benefits below)*:						**915,469.0**					**915,469.0**
Calculated based on average among other MAHC faciliti											
TOTAL COST	***0.0***		***$0***	***89.7***		***$4,682,049***	***0.0***		***$0***		***$4,682,049***

TABLE I –SCHEDULED STAFF FOR TYPICAL WORK WEEK
INSTRUCTION: Quantify the staff that will provide bedside care that would be counted toward the current minimum staffing as required by COMAR 10.07.02.12

	Weekday Hours Per Day					Weekend Hours Per Day			
Staff Category	**Day**	**Evening**	**Night**	**Total**		**Day**	**Evening**	**Night**	**Total**
Registered Nurses	24	24	24	72		24	24	24	72
L. P. N. s	24	16	16	56		24	16	16	56
Aides									
C. N. A.s	64	64	56	184		64	64	56	184
Medicine Aides									
Total	112	104	96	312		112	104	96	312
Licensed Beds at Project Completion				80		**Licensed Beds at Project Completion**			**80**
Hours of Bedside Care per Licensed Bed Per Day				3.90		**Hours of Bedside Care per Licensed Bed Per Day**			3.90
Ward Clerks (bedside care time calculated at 50%	8	0	0	8		0	0	0	0
Total Including 50% of Ward Clerks Time	116	104	96	316		112	104	96	312
Total Hours of Bedside Care per Licensed Bed Per Day				3.95		**Total Hours of Bedside Care per Licensed Bed Per Day**			3.90

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an independent Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.

- If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.

- Describe and document relevant community support for the proposed project.

- Identify the performance requirements applicable to the proposed project (see Part I question 15) and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).

RESPONSE:

MAHC plans to finance the construction and operations of Restore Health through a combination of equity from its owners and debt financing from a financial institution. A letter from the independent certified public accountant firm that is the auditor for many of the other Mid-Atlantic Health Care entities is attached attesting to the ability of the applicant to provide the equity and debt financing needed for the Project. *See* **Exhibit N.** There is also a letter from a local lending institution with whom MAHC has financed other construction projects attesting to their interest in exploring the financing. *See* **Exhibit O.** A letter of Community Support is attached as **Exhibit P**. Please see pages 7-10, and comments throughout, concerning compliance with performance requirements.

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

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

***INSTRUCTIONS**: List all of the Maryland Certificates of Need that have been issued to the project applicant, its parent, or its affiliates or subsidiaries over the prior 15 years, including their terms and conditions, and any changes to approved Certificates that needed to be obtained. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.*

RESPONSE:
Mid-Atlantic Health Care has been issued one Certificate of Need to build a 67-bed facility in Waldorf, Maryland in Charles County. The initial CON (Docket No. 11-08-2325) was issued September 10, 2010, but was modified in 2012 to change the location due to issues with the seller completing certain storm water improvements for the location. Mid-Atlantic has since completed the construction of the Facility in 2015 and opened in March 2015. The project was completed on time and within the budgeted cost.

10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System.

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

INSTRUCTIONS*: Please provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:*

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;
b) On Payer Mix;
c) On access to health care services for the service area population; and
d) On costs to the health care delivery system.

RESPONSE:
a) The proposed facility expects to serve one cohort of patients whom nursing homes traditionally serve ***("COHORT 1"),*** and several distinct cohorts *not traditionally served by area nursing homes* ***("COHORTS 2-3").***

COHORT 1 Patients whom nursing homes traditionally serve, but for whom demand is growing and/or supply is constrained.

This includes traditional, long stay nursing home patients – for whom demand will grow with population growth – as well as those types of patients who routinely experience delays until placement can be arranged:

- Patients requiring dialysis
- Patients requiring ventilation care and dialysis
- Low acuity patients such as wound care and cancer patients requiring light levels of care.
    - Reportedly, nursing homes are slow to accept these patients "because they are poorly reimbursed" (this represents an assessment by a hospital caseworker)

COHORT 2 Higher acuity patients or patients who require nursing staff with special skills set.

COHORT 2(a) Patients who might be discharged to the post-acute setting earlier if skills of nursing home staff were upgraded, protocols and specialty supports were strengthened, and facility were to provide a step up unit.

- By way of illustration, UMMC provided an estimate of potential demand for this care. Caseworkers estimate that at least 10 patients/month = 120 patients per year might be discharged earlier (this includes short stay and long stay patients in the nursing home).
- These cases are represented in the total number of nursing home patients who are now admitted to nursing homes, but many of these patients could have been transferred earlier, i.e. nursing home days would be far higher if genuine "need" were represented.

COHORT 2(b) Patients whose length of stay in the hospital is extended for lack of suitable post-acute setting, and are then discharged home; these are patients who currently remain in the hospital and are never even referred to the nursing home.

- By way of illustration, UMMC provided an estimate of the demand for this care. Caseworkers estimate that at least 10 patients/month (120 patients per year) might be discharged to a nursing home if a suitable setting were provided.
- This cohort might include LVAD patients (with left ventricular implants) who require specialized equipment and nurse training to provide recuperative care. Mid-Atlantic cares for these patients in its other facilities.

COHORT 3 If the 3 day rule were waived, additional Medicare populations might be served (new volume not currently served by nursing homes)

COHORT 3(a) Medicare patients who only require 1-2 days in acute care, and who could then be discharged to a nursing home for short stays or long stays.

- Currently, these patients are kept for the extra day or two in the hospital to meet the three day requirement.
- This cohort would include patients with low acuity medical need, patients admitted for pain management and palliative care, and patients who were admitted to acute care in a deconditioned state and would benefit from a rehabilitation stay.
- Caseworkers at UMMC estimate that approximately 20 patients per month (including Medicare patients), or 240 patients per year might be referred for placement. This would translate into a reduction in acute care days and incremental patients/incremental days to nursing home utilization.

COHORT 3(b) Patients admitted directly from the Emergency Room or the Observation Unit.

- This would represent new volume to the nursing home, and would translate into a reduction in Observation Days at the hospital. This plan of care would be expected to reduce the infection risks associated with hospital stays, reduce the costs per day, and reduce the high copayments now borne by patients in the Observation Unit.

- Caseworkers at UMMC estimate that approximately 10-12 patients per month of this profile might be served in the post-acute setting, or 120-144 patients per year of new demand. This category would likely include patients who suffer falls – for whom neurologic and cardiac issues have been ruled out, but who are deconditioned and could benefit from additional time for restorative care and rehabilitation.

b) With regard to payer mix, the Project is not expected to have any impact on payer mix at other area nursing homes since a significant portion of the anticipated patients represent individuals who currently are not being served.

c) With regard to access to health care services for the service area population, the proposed project will improve access to nursing home services for Baltimore City residents who currently face very limited access to nursing homes that can provide dialysis services, accommodations for bariatric patients, and clinical capabilities to serve higher acuity needs. The proposed project will also improve access for residents of the West Baltimore community where local area nursing homes currently operate at 90+% occupancy rates and who often must be admitted to nursing homes farther from home and family supports.

With regard to the costs to the health care delivery system, Restore Health will be distinguished in its ability to care for the more complex medical patients and patients with distinct service needs who are generally not able to be accommodated in other area nursing homes. This will permit earlier discharges from the acute care hospital, thereby reducing overall acute care days and health care costs for Maryland. The positive impact will be produced on multiple levels:

- Increased patient satisfaction as a result of shorter hospital stays
  - Patients will not have to remain in the hospital for lack of an appropriate sub-acute setting
- Lower costs to payers and patients
  - The per diem at Restore Health is expected to be more than $600 -$1,000 lower relative to the per diem at the University of Maryland Medical Center. This will result in savings to both payers as well as to patients, who are bearing increasing copayment burdens.
- Improved performance under the Medicare waiver test
  - Leveraging the lower cost setting will translate into a reduction in the "total Medicare spend;" this will support Maryland's performance under the waiver test which requires Maryland to generate $330 million in Medicare savings over the 5 year Demonstration period.
- Improved performance under the readmission waiver test
  - The state of Maryland continues to struggle with lowering its overall readmission rate in line with the national average, and this is a critical component of the waiver test. In Calendar Year 2014, Maryland's reported rate was 16.94%, close to 8% higher than the national average. But this target rate is a moving target, and while the state is improving, it will be challenged to keep reducing its readmission rate performance.
  - Restore Health is expected to reduce readmission rates from the nursing home to the hospital as a function of its in-house capabilities and as a function of the close working relationship it will maintain with hospital clinicians. Mid-Atlantic has a successful track record in reducing readmissions. At its existing nursing homes, it has made significant investments in clinical staff and reporting mechanisms to

closely monitor patient conditions and quickly mobilize resources to respond to concerns while patients are in the nursing homes. Readmission rates at Mid-Atlantic's nursing homes are lower than the industry average. See discussion on Page 37, supra. Given Mid-Atlantic's track record of hospital readmission rates well below the state average (15% vs. 25%), Restore Health can be a valuable partner in helping individual hospitals and the state of Maryland achieve its readmission target.

If the applicant is an existing nursing home, provide a summary description of the impact of the proposed project on costs and charges of the applicant nursing home, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

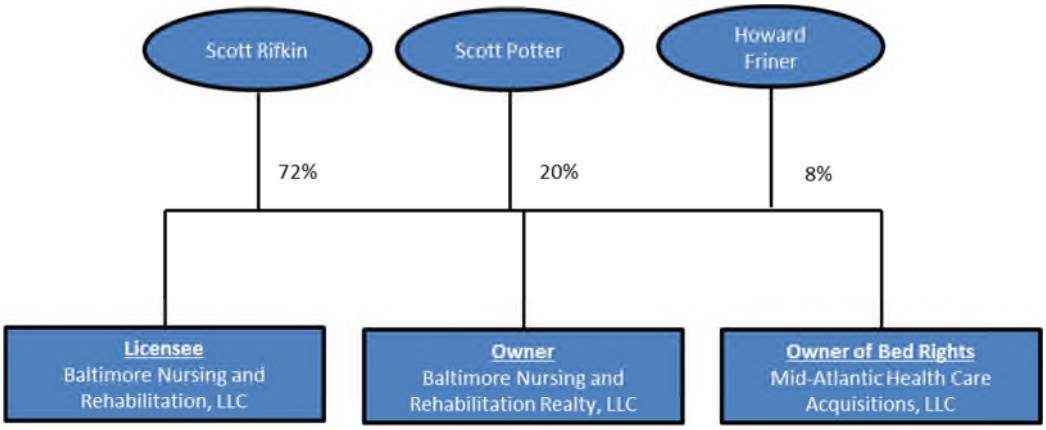
RESPONSE: N/A.

TABLE OF TABLES

TABLE OF EXHIBITS

EXHIBIT A

Ownership:



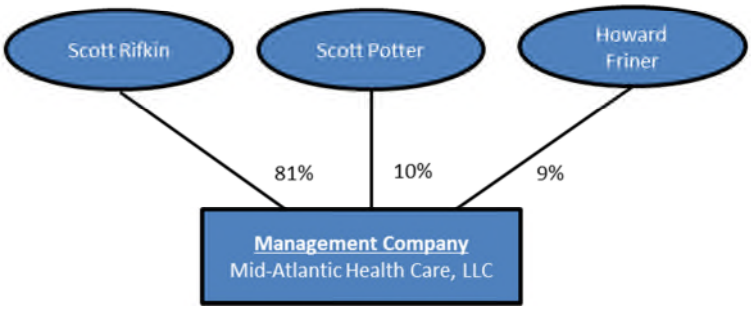


EXHIBIT B

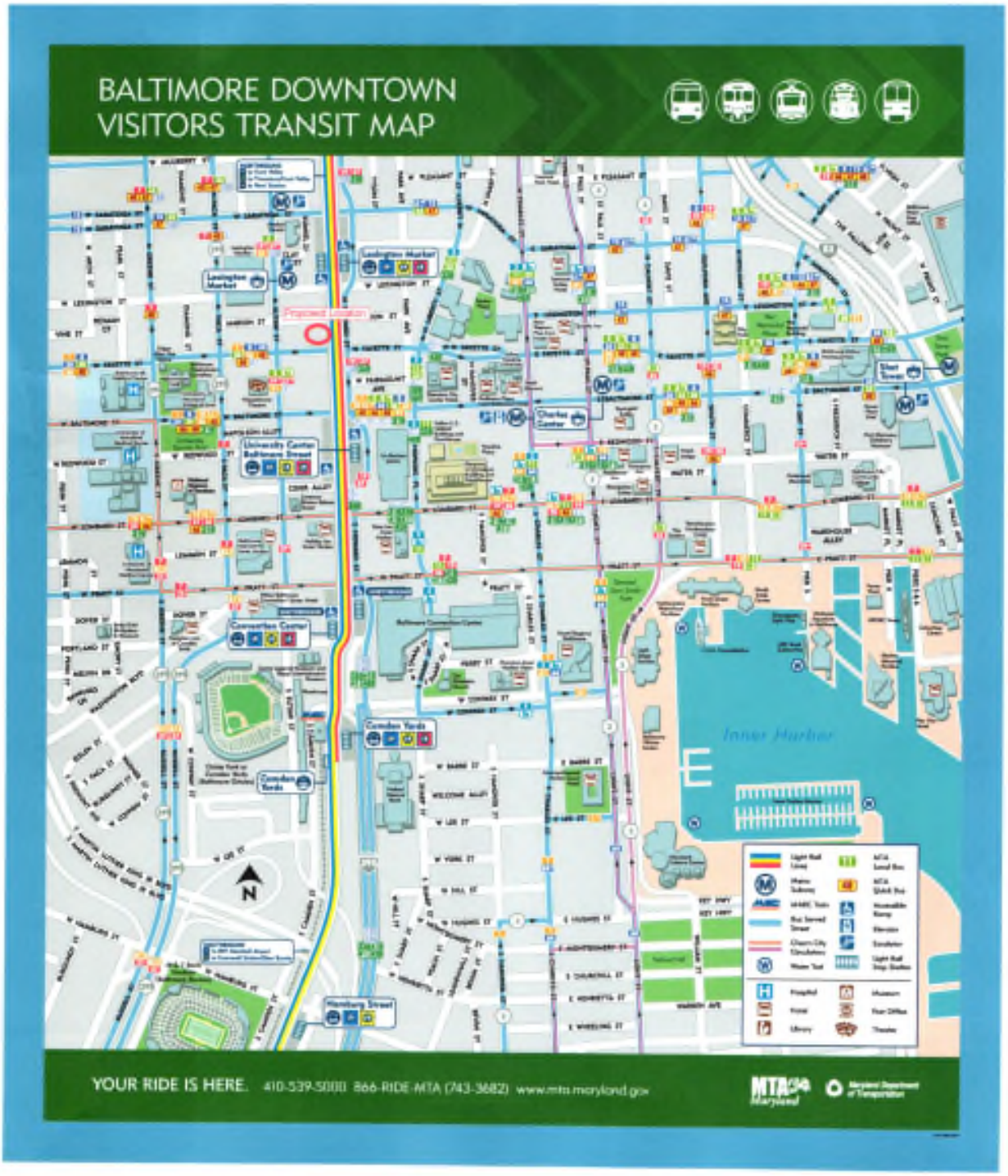

BALTIMORE DOWNTOWN
VISITORS TRANSIT MAP
Project Location
Lexington Market
University Center Baltimore Street
Convention Center
Camden Yards
Hamburg Street
Charles Center
Inner Harbor
N
YOUR RIDE IS HERE. 410-539-5000 866-RIDE-MTA (743-3682) www.mta.maryland.gov
MTA Maryland

Exhibit C: Samples of Planned Interior Look from Restore Health - Waldorf

Entrance Lobby

Dining Room

Typical Hallway

Nurse's Station

EXHIBIT C

Rehab Gym

Salon

EXHIBIT C

Resident Room

Resident Bathroom

EXHIBIT D

PURCHASE AND SALE AGREEMENT

This PURCHASE AND SALE AGREEMENT (this "Agreement") is made this 19th day of September, 2014 by and between Johns Hopkins Bayview Medical Center, Inc., a Maryland non-profit corporation (the "Seller"), and Mid-Atlantic Health Care Acquisitions, LLC, a Maryland limited liability company (the "Purchaser"), as follows:

RECITALS:

WHEREAS, Seller has certain rights, title and interest in and to eighty (80) licensed long-term care facility beds known in Maryland as comprehensive care facility ("CCF") beds (the "Bed Rights"), formerly operated as part of Johns Hopkins Bayview Care Center located at 5505 Hopkins Bayview Circle, Baltimore, Maryland 21224 (the "Prior Facility"); and

WHEREAS, Seller has received authorization from the Maryland Health Care Commission ("MHCC") with an effective date of November 15, 2013 to temporarily delicense the Facility and for the Bed Rights to be retained in the MHCC's nursing home bed inventory for a period of one (1) year from the effective date of the authorization (the "Delicensure Authorization"); and

WHEREAS, Seller desires to sell and Purchaser desires to purchase the Bed Rights so the Purchaser can operate those beds in Baltimore City, Maryland.

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

ARTICLE I

DEFINITIONS

1.1. **Definitions**. The following terms not otherwise defined in the body of this Agreement shall have the meaning set forth below:

(a) CCF: A duly licensed comprehensive care facility or nursing home as defined by applicable OHCQ regulations.

(b) MHCC: The Maryland Health Care Commission.

(c) OHCQ: The Office of Health Care Quality of the Maryland Department of Health and Mental Hygiene.

(d) Closing Date: The date mutually agreed upon by the parties to occur within fifteen (15) days after Purchaser's receipt of a final, non-appealable MHCC decision as expressed in a written Certificate of Need ("CON") approving Purchaser's Application for CON and authorizing Purchaser to purchase the Bed Rights and their

transfer for use in a CCF operated by Purchaser in Baltimore City, Maryland. References in this Agreement to matters to be effective on or before closing shall refer to the completion of this transaction on the Closing Date. A CON shall be considered non-appealable upon its receipt if there are no other parties with standing to file an appeal or, if there are such parties with standing to file an appeal, upon the expiration of thirty (30) days after the effective date of the CON if no appeal has been filed as of such date.

ARTICLE II

PURCHASE AND SALE

2.1. **Purchase and Sale**. Subject to the terms and conditions set forth in this Agreement, Seller agrees to sell to Purchaser, and Purchaser agrees to purchase from the Seller, all of the Seller's rights, title or interest in and to the Bed Rights, free and clear of any and all liens, claims, charges, actions, security interests, or other encumbrances of any kind, provided that Purchaser agrees to purchase the Bed Rights subject to any customary and reasonable conditions imposed by the MHCC as part of its approval of Purchaser's CON application, which conditions are approved by Purchaser in its reasonable discretion.

2.2. **Conveyance**.

(a) Seller will sell, convey, transfer, and deliver to Purchaser the Bed Rights in accordance with the terms of this Agreement upon the Closing Date.

(b) To accomplish the transfer of the Bed Rights, and provided that the Purchase Price (defined below) has been paid in full and all of the other conditions precedent to closing have been satisfied fully, Seller will execute and deliver to Purchaser on the Closing Date those documents set forth in Section 6.2.

2.3. **Purchase Price**. In consideration of the transfer of the Bed Rights, Purchaser shall pay to the Seller the sum of Five Hundred and Fifty Thousand Dollars ($550,000.00) (the "Purchase Price"). The Purchase Price shall be payable by Purchaser to Seller in one lump sum payment of immediately available funds on the Closing Date by wire transfer to an account designated by Seller, provided that Purchaser shall receive credit against the Purchase Price paid at closing for payment of the deposits referenced in Section 2.4.

2.4. **Deposits**. Within five (5) business days of the execution of this Agreement, Purchaser shall deposit $25,000.00 (the "Initial Deposit") in escrow (the "Escrow Account") with Bank of America, National Association, as escrow agent, pursuant to an escrow agreement executed by the parties substantially in the form attached hereto as Exhibit B. The Initial Deposit shall be refundable to Purchaser within three (3) business days if either party notifies the other in writing within three (3) business days following the expiration of the Due Diligence Period (defined hereinafter in Section 2.7 below) that it is dissatisfied with results of its due diligence and therefore is terminating the Agreement. If neither party issues a termination notice within three (3) business days following the

expiration of the Due Diligence Period, then (a) the Initial Deposit shall become non-refundable (except as set forth below) and the parties shall direct the escrow agent to release the Initial Deposit to Seller immediately, and (b) Purchaser shall make an additional refundable deposit of $25,000.00 (the "Second Deposit") into the Escrow Account. Both the Initial and Second Deposits shall be applied to the Purchase Price on the Closing Date. In the event of a termination of this Agreement for any reason pursuant to Section 7.1 below, the Second Deposit shall be immediately returned to Purchaser within three (3) business days of the effective date of termination, but the Initial Deposit shall remain non-refundable except in the case of a termination of this Agreement pursuant to 7.1(a), in which case the Initial Deposit shall be refundable to Purchaser. Purchaser and Seller shall each be responsible for half of the costs and expenses of the escrow agent under the escrow agreement, and each shall timely pay the escrow agent its portion of such costs and expenses.

2.5. **No Assumption of Obligations**. Purchaser has not agreed to pay, shall not be required to assume, and shall have no liability or obligation with respect to, any liability or obligation, direct or indirect, absolute or contingent, of any type, nature or kind of Seller, any affiliate of Seller, or any other person, including, without limiting the foregoing, any liability or obligation with respect to (a) Seller's employees, (b) any outstanding financial obligation of Seller, (c) taxes owed by Seller (d) Seller's costs of delicensing of the Bed Rights for Seller's use, (e) Seller prior billing and reimbursement practices or (f) the care of any patients treated or seen by or on behalf of Seller.

2.6. **Broker Fees**. Seller and Purchaser represent to each other that neither has engaged the services of any broker, agent, finder or commission sales agent in connection with the transactions described in this Agreement, except that Seller has engaged Healthcare Transactions Group, Inc. ("HTG"). Seller shall be solely responsible to pay, in accordance with the terms of a separate agreement between Seller and HTG, the fee due and payable by Seller to HTG thereunder upon consummation of the transactions contemplated hereby. Each party agrees to defend, indemnify and hold the other harmless from and against any and all claims, actions and demands for any fees or commissions due, or claimed to be due, by a broker, agent, finder or commission sales agent engaged by such party.

2.7 **Due Diligence**. For a period of thirty (30) days from the date of execution of this Agreement (the "Due Diligence Period"), Purchaser shall have the right to conduct due diligence and obtain information concerning the regulatory status of the Bed Rights and its ability to obtain all regulatory approvals required for the consummation of the transaction hereunder. During the Due Diligence Period, Seller shall have the right to conduct due diligence and obtain information concerning the ability of Purchaser to consummate the transaction hereunder, including, without limitation, due diligence regarding Purchaser's financial condition and regulatory status. If a party determines for any reason that the results of its due diligence inspections are not satisfactory in its sole discretion, such party shall have the right to terminate this Agreement without cause or penalty within three (3) business days following the expiration of the Due Diligence Period upon written notice to the other party of the exercise of said option. In such case, this Agreement shall terminate immediately and the Initial Deposit shall be returned to

Purchaser in accordance with the terms of Section 2.4 above. Notwithstanding anything to the contrary, the Due Diligence Period shall not delay Purchaser's submission of the LOI and efforts to submit and obtain approval for the Application under Section 4.2(a).

ARTICLE III

REPRESENTATIONS AND WARRANTIES

3.1. **Representations and Warranties of Seller**. Seller represents and warrants as follows, each of which constitutes a material inducement to Purchaser's execution of this Agreement and the purchase of the Bed Rights:

(a) Organization and Standing; Power. Seller is a non-profit corporation duly organized, validly existing, and in good standing under the laws of the State of Maryland. Except as otherwise set forth herein, Seller has all requisite power and authority to own and operate its properties and enter into, execute, and, subject to obtaining all necessary approvals, carry out this Agreement and the transactions herein contemplated. Seller holds all applicable rights, title and interests in and to the Bed Rights.

(b) Binding Obligation. This Agreement is a valid and binding obligation of Seller, enforceable against Seller in accordance with its terms, subject to applicable bankruptcy, insolvency, reorganization and moratorium laws, and other laws of general application affecting enforcement of creditors' rights generally.

(c) Authority. The execution, delivery, and performance of this Agreement by Seller and the transactions herein contemplated will not: (i) conflict with, result in any breach or violation of, or constitute a default (or give rise to any right of termination, cancellations or acceleration) under the Articles of Incorporation or Bylaws of Seller, as amended as of the date hereof, or any note, bond, mortgage, indenture, lease, permit, agreement, or other instrument or other obligation to which Seller is a party or by which Seller is bound; or (ii) violate any law, order, license, permit, rule or regulation applicable to Seller or the Bed Rights. No consent or approval by any private third party or, to the best of Seller's knowledge, any governmental authority, except the MHCC, is required in connection with the execution, delivery, and performance of this Agreement by the Seller or the consummation of the transaction contemplated by this Agreement.

(d) Compliance. With respect to this Section 3.1(d), Seller states the following to the best of its knowledge without any further diligence on its part, but subject to Purchaser's due diligence under Section 2.7 above:

(i) Except as otherwise stated herein, Seller is not in violation of any applicable federal, state or municipal laws, ordinances, notices, orders, rules, regulations, decrees, awards, writs, injunctions, judgments, or requirements pertaining to the Bed Rights such that there is a material impairment of Seller's ability to consummate the transaction contemplated by this Agreement; and

(ii) Seller is not subject to or bound by any order of any court, regulatory commission, board or administrative body entered in any proceeding to which it is a party or of which it has knowledge with respect to the Bed Rights or the operation of the Prior Facility which would materially impair Seller's ability to consummate the transaction contemplated by this Agreement.

(e) Licenses and Approvals. Seller holds in good standing all licenses, permits, approvals, and other authorizations necessary to own the Bed Rights (the "Licenses"), subject to the Delicensure Authorization. Seller is not a party to and has no knowledge of any proceedings, pending or to the Seller's knowledge threatened, to revoke or limit the scope of any Licenses, and is not in violation of any of the Licenses. Seller has obtained approval from the MHCC, and given notice to the OHCQ, to temporarily delicense the Prior Facility and the Bed Rights, and pursuant thereto has ceased operation of the Bed Rights. None of the Bed Rights are currently in operation, and there are no patients currently occupying the beds that are the subject to the Bed Rights. Seller shall also timely file all required Seller notices, if any, with the MHCC and or the OHCQ to advise them of the transaction contemplated by this Agreement and to preserve the Licenses in good standing (subject to Delicensure Authorization) following execution of this Agreement. As of the Closing Date, Seller shall have taken all necessary steps, including the timely filing of further Seller notices to the MHCC and the OHCQ, to transfer to Purchaser the Bed Rights and its right to operate the Bed Rights, and shall have reasonably cooperated with Purchaser to enable Purchaser to purchase the Bed Rights, it being agreed that, after the Closing, Purchaser is solely responsible for complying with the terms of the Certificate of Need approval and developing and operating its CCF.

(f) Interest in the Bed Rights. Except as otherwise set forth herein, Seller holds a transferable interest in the Bed Rights, and on the Closing Date, Seller shall transfer the Bed Rights free and clear of any liens, restrictions or encumbrances other than the requirement that Purchaser obtain the requisite approvals from the MHCC before being able to operate the Bed Rights.

(g) No Impediments. To the best of Seller's knowledge, there are no matters that could delay, impede, or otherwise prevent Seller or Purchaser from consummating the transactions contemplated by this Agreement.

(h) General. All representations and warranties by Seller herein are true, complete and accurate in all material respects as of the date of this Agreement and will be true, complete and accurate in all material respects as of the Closing and do not contain and will not contain an untrue statement of any material fact, or omit to state a material fact necessary in order to make all of such representations and warranties not materially misleading as of this date and as of the Closing Date.

3.2. **Representations and Warranties of Purchaser**. Purchaser represents and warrants as follows, each of which constitutes a material inducement to Seller's execution of this Agreement and the sale of the Bed Rights:

(a) Organization and Standing; Power. Purchaser is a Maryland limited liability company duly organized, validly existing, and in good standing under the laws of the State of Maryland. Purchaser has all requisite power and authority to own and operate its properties and enter into, execute, and carry out this Agreement and the transactions being contemplated.

(b) No Impediments. To the best of Purchaser's knowledge, there are no matters that could delay, impede, or otherwise prevent Seller or Purchaser from consummating the transactions contemplated by this Agreement.

(c) Binding Obligation. This Agreement is a valid and binding obligation of Purchaser, enforceable against Purchaser in accordance with its terms, subject to applicable bankruptcy, insolvency, reorganization and moratorium laws, and other laws of general application affecting enforcement of creditors' rights generally.

(d) General. All representations and warranties by Purchaser herein are true, complete and accurate in all material respects as of the date of this Agreement and will be true, complete and accurate in all material respects as of the Closing and do not contain and will not contain an untrue statement of any material fact, or omit to state a material fact necessary in order to make all of such representations and warranties not materially misleading as of this date and as of the Closing Date.

3.3 **Knowledge**. For purposes of this Agreement, the term "knowledge" as applicable to a party shall mean that no trustee or officer of the party has received any actual knowledge as to the subject matter of the representation in question.

ARTICLE IV

COVENANTS

4.1. **Covenants of Seller**. Seller covenants to Purchaser that, except as otherwise consented to in writing by Purchaser after the date of this Agreement:

(a) Regulatory Approvals. Seller agrees to participate in meetings with MHCC and the OHCQ upon reasonable request of Seller and to provide Seller with all information and documentation concerning the Bed Rights as Purchaser may reasonably request to support its CON application, all at no cost or expense to the Seller. Prior to November 15, 2014, Seller agrees to submit to the MHCC a binding contract to transfer ownership of the Bed Rights to Purchaser pursuant to MHCC Regulations, along with all associated documentation as required by MHCC (the "Bed Transfer Contract").

(b) No Inconsistent Action. Seller will not take any action that is inconsistent with or impairs the consummation of the transaction contemplated by this Agreement, including, without limitation, attempting to re-license, activate or otherwise operationalize the Bed Rights for its own use or the use of any third party other than Purchaser. During the term of this Agreement, Seller will (i) deal exclusively with Purchaser with respect to the purchase and sale of the Bed Rights, (ii) not, directly or

indirectly, solicit, initiate or encourage any inquiry proposal, offer or contract from any other person or entity for the purchase and sale of the Bed Rights, and (iii) not participate in any discussions or negotiations with any other person or entity with respect to the purchase and sale of the Bed Rights. Seller will notify Purchaser promptly of any matters that could delay, impede or otherwise prevent Seller from consummating this transaction.

(c) Disclosure. Seller will inform Purchaser promptly of anything that would make Seller's representations, warranties, and disclosures made herein materially untrue or materially misleading or which constitutes a material breach of any covenant contained herein.

4.2. **Covenants of Purchaser**.

(a) Regulatory Approval for Transfer of the Bed Rights. Purchaser, at its own expense, shall use commercially reasonable efforts to obtain the MHCC's approval of an Application for Certificate of Need authorizing the transfer of Seller's rights to the Bed Rights to Purchaser for use in its CCF in Baltimore City, Maryland as soon as reasonably practicable. Following the execution of this Agreement, Purchaser shall file a Letter of Intent to file a Certificate of Need Application with the MHCC on or before December 15, 2014 (the "LOI") and shall file an Application for Certificate of Need with the MHCC on or before April 10, 2015 (the "Application"), all in accordance with the review schedule published by the MHCC, unless the MHCC publishes a revised review schedule, in which case Purchaser shall use commercially reasonable efforts to comply with that schedule. Purchaser shall comply fully with all requests for information, plans, or other materials sought by the MHCC in a timely fashion, and shall use commercially reasonable efforts to secure the CON contemplated by this Agreement as soon as reasonably practicable, including without limitation, obtaining a site on which the Bed Rights will be located.

(b) No Inconsistent Action. Purchaser will not take any action that is inconsistent with, materially delays or impairs the consummation of the transaction contemplated by this Agreement. Purchaser will notify Seller promptly of any matters that could delay, impede or otherwise prevent Purchaser from consummating this transaction.

(c) Disclosure. Purchaser will inform Seller promptly of anything that would make Purchaser's representations, warranties, and disclosures made herein materially untrue or materially misleading or which constitutes a material breach of any covenant contained herein.

ARTICLE V

CONDITIONS

5.1 **Conditions to Purchaser's Obligations**. Unless waived by Purchaser in writing at its sole discretion, all obligations of Seller under this Agreement are subject to the fulfillment of each of the following conditions at or prior to the closing:

(a) Representations and Warranties. The representations and warranties of Seller contained in this Agreement shall continue to be true and correct as of the Closing Date in all material respects.

(b) Covenants. Seller shall have performed all obligations and complied with all covenants required by this Agreement to be performed or complied with by it on or prior to the Closing Date, as applicable.

(c) MHCC Approval. A final, non-appealable MHCC decision approving an Application for Certificate of Need authorizing Purchaser to purchase and relocate the Bed Rights to and for use in its CCF operated by Purchaser in Baltimore City, Maryland shall have been received by Purchaser, which final decision may be subject to ordinary limited conditions typically imposed by the MHCC under similar circumstances. In the event that, notwithstanding Purchaser's best efforts, such MHCC approval is not obtained and the MHCC denies the Application for Certificate of Need, subject to Sections 7.2 and 7.3, this Agreement shall be null and void, provided, however, that if the Purchaser in its sole discretion determines to undertake a judicial appeal of the MHCC's denial, this Agreement shall continue in full force and effect during the pendency of any appeals.

(d) Execution of Closing Documents. Seller at closing shall have executed, acknowledged, and delivered to Purchaser each of the documents described in Section 6.2 hereof.

5.2. **Conditions to Seller's Obligations**. Unless waived by Seller in writing at its sole discretion, all obligations of Purchaser under this Agreement are subject to the fulfillment of each of the following conditions at or prior to the Closing Date:

(a) Representations and Warranties. The representations and warranties of Purchaser contained in this Agreement shall continue to be true and correct as of the Closing Date in all material respects.

(b) Covenants. Purchaser shall have performed all obligations and complied with all covenants required by this Agreement to be performed or complied with by it on or prior to the Closing Date, as applicable.

(c) MHCC Approval. A final, non-appealable MHCC decision approving an Application for Certificate of Need authorizing Purchaser to purchase and relocate the Bed Rights to and for use in its CCF operated by Purchaser in Baltimore City, Maryland shall have been received by Purchaser, which final decision may be subject to ordinary

limited conditions typically imposed by the MHCC under similar circumstances. In the event that, notwithstanding Purchaser's best efforts, such MHCC approval is not obtained and the MHCC denies the Application for Certificate of Need, subject to Sections 7.2 and 7.3, this Agreement shall be null and void, provided, however, that if the Purchaser in its sole discretion determines to undertake a judicial appeal of the MHCC's denial, this Agreement shall continue in full force and effect during the pendency of any appeals.

(d) Payment of the Purchase Price. Purchaser shall have paid the Purchase Price on the Closing Date in accordance with Section 2.3 above.

(e) Execution of Closing Documents. Purchaser at closing shall have executed, acknowledged, and delivered to Seller each of the documents described in Section 6.2 hereof.

ARTICLE VI

CLOSING

6.1 **Closing Date**. In accordance with the terms of this Agreement, the closing shall take place on the Closing Date in the offices of Seller's attorney, or at such other place mutually agreed upon by the parties.

6.2 **Closing Obligations**. At Closing, the parties shall execute and deliver the following documents:

(a) The Seller shall execute and deliver an Assignment of Intangibles conveying all of Seller's right, title, and interest in and to the Bed Rights in the form of the Assignment attached as Exhibit A; and

(b) The parties shall execute and deliver such other documents and instruments as either party may reasonably require to consummate the transactions contemplated by this Agreement.

ARTICLE VII

DEFAULT; TERMINATION

7.1 **Right to Terminate**.

(a) Purchaser shall have the right to terminate this Agreement by written notice sent to Seller, at any time prior to the Closing Date if Seller is in material breach of any of the terms hereof, which breach or violation materially impairs Purchaser's ability to consummate this transaction; provided, however, Seller is provided at least thirty (30) days advance written notice and is afforded an opportunity to cure the breach.

(b) Seller shall have the right to terminate this Agreement by written notice sent to Purchaser, at any time prior to the Closing Date if Purchaser is in material

breach of any of the terms hereof, which breach or violation materially impairs Seller's ability to consummate this transaction; provided, however, Purchaser is provided at least thirty (30) days advance written notice and is afforded an opportunity to cure the breach.

(c) Either party may terminate this Agreement by providing written notice to the other party if the Closing Date has not occurred for any reason within twenty-four (24) months of the date of this Agreement, provided that Purchaser may request, and Seller may provide written approval in writing for, an extension of the foregoing twenty-four (24) month period, which consent Seller shall not unreasonably withhold.

(d) A party may terminate this Agreement in accordance with the terms of Section 2.7 above.

(e) A party may terminate this Agreement prior to the Closing Date by providing at least sixty (60) days' prior written notice to the other party in the event that the terminating party reasonably concludes that the Closing Date will not occur within the twenty-four (24) month period described in Section 7.1(c) above (subject to any extensions granted by Seller) or the transaction contemplated by this Agreement is otherwise incapable of being consummated, provided that a party may not terminate under this paragraph if (1) the terminating party is in material breach at the time of termination and (2) if the delay in closing is caused by the breach.

7.2 **Procedure Upon Termination**. In the event of termination by a party pursuant to Section 7.1, written notice thereof shall be given as provided herein and the transaction contemplated by this Agreement shall be terminated without further action or notice by either party. If the transaction contemplated by this Agreement is terminated as provided herein:

(a) Seller and Purchaser shall return all documents, work papers, and other material of any other party relating to the transaction contemplated hereby (or copies thereof), whether obtained before or after the execution hereof, to the party furnishing the same.

(b) All confidential information received by Seller or Purchaser with respect to the business of any other party or its affiliates shall be treated in accordance with Section 9.2 hereof.

7.3 **LIMITATION OF LIABILITY**. TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW, IN NO EVENT SHALL EITHER PARTY BE LIABLE FOR ANY INDIRECT, SPECIAL, PUNITIVE, EXEMPLARY OR CONSEQUENTIAL DAMAGES UNDER THIS AGREEMENT OR ARISING FROM ANY ACTIVITIES CONDUCTED PURSUANT TO THIS AGREEMENT, EVEN IF A PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. SELLER'S TOTAL LIABILITY UNDER THIS AGREEMENT AND PURCHASER'S RIGHT TO RECOVER ANY DAMAGES (INCLUDING REASONABLE ATTORNEY'S FEES OR ANY OTHER COSTS OR EXPENSES), SHALL BE ABSOLUTELY LIMITED TO THE AMOUNT OF THE

PURCHASE PRICE PAID BY PURCHASER TO SELLER HEREUNDER. THE LIMITATIONS OF LIABILITY IN THIS PARAGRAPH SHALL NOT APPLY TO A PARTY'S BREACH OF SECTION 9.2.

7.4. **Time is of the Essence**. The parties acknowledge and agree that time is of the essence with respect to the each parties' obligations under this Agreement.

7.5. **Remedies**. The parties agree that irreparable damage may occur in the event of a breach by a party hereunder. It is accordingly agreed that a non-breaching party may seek appropriate equitable relief in the event of party's breach, without prejudice to any other rights and remedies that the non-breaching party may have at law or in equity.

ARTICLE VIII

SURVIVAL

8.1. **Survival**. The representations, warranties, and agreements made by the parties in this Agreement and in any certificates and documents delivered in connection herewith, shall survive the Closing Date for a period of six (6) months regardless of any investigation made by the party making claim hereunder, and thereafter automatically shall terminate, provided that, if a party makes a claim with respect to any representation, warranty or agreement herein within such six (6) month period, then such representation, warranty or agreement shall survive only as it concerns the pending claim until the final determination of the matter.

ARTICLE IX

MISCELLANEOUS

9.1. **Third Parties**. Nothing herein expressed or implied is intended or shall be construed to confer upon or give to any person other than the parties hereto and their successors and assigns any rights or remedies under or by reason of this Agreement.

9.2. **Confidentiality**. Prior to the Closing Date, Purchaser and Seller shall hold, and shall cause their employees, representatives, agents, and affiliated persons to hold, in strict confidence and not use in any way except in connection with the transactions contemplated hereby, any confidential or proprietary information obtained from the other party in connection with the transactions contemplated by this Agreement, except such information may be disclosed: (i) to regulatory authorities or governmental agencies and to any other person to the extent necessary to obtain the consents or approvals contemplated by this Agreement; (ii) if required by court order or decree or applicable law; (iii) if it is publicly available through no act or failure to act of the disclosing party; (iv) during the course of or in connection with any litigation, governmental investigation, arbitration, or other proceedings based upon or in connection with the subject matter of this Agreement; (v) upon the prior written consent of the other party; or (vi) if it is otherwise expressly provided for herein. In the event that a disclosure is required under Section 9.2(ii) or 9.2(iv), the disclosing party shall provide reasonable prior written notice of the disclosure and will reasonably cooperate with the other party as requested

to protect the information to be disclosed.

9.3 **Notices**.

(a) All notices, requests, demands, and other communications required or permitted to be given hereunder shall be deemed to have been duly given if in writing and delivered personally, by overnight courier, or mailed first-class, postage prepaid, registered or certified mail, as follows:

If to Seller:

Johns Hopkins Bayview Medical Center, Inc.
5300 Alpha Commons Drive
Alpha Commons Building, Executive Offices
Baltimore, MD 21224-2780

With a copy to:

G. Daniel Shealer, Esq.
Vice President & General Counsel
The Johns Hopkins Health System Corporation
600 N. Wolfe Street
Baltimore, MD 21287-1900

If to the Purchaser:

Mid-Atlantic Health Care Acquisitions, LLC
1922 Greenspring Drive, Suite #3
Timonium, Maryland 21093
Attn: Chief Executive Officer

With a copy to:

Miles & Stockbridge, P.C.
100 Light Street
Baltimore, Maryland 21202
Attn: Joseph P. Ward, Esq.

(b) The parties may change the address to which such communications are to be directed by giving written notice to the other in the manner provided in this Section.

(c) Any such notice, request, consent, or other communication shall be deemed received at such time as it is personally delivered or on the third business day after it is so mailed, as the case may be.

9.4. **No Waiver; Cumulative Remedies**. No failure by a party to exercise and no delay in exercising any right, power, privilege, or discretion under this Agreement shall operate as a waiver thereof; nor shall any single or partial exercise of any right, power,

privilege, or discretion hereunder preclude any other exercise thereof; nor shall any waiver thereof be effective unless in writing and signed by the party waiving the same.

9.5. **Applicable Law**. This Agreement is made, executed and delivered in the State of Maryland, and Maryland law shall govern its interpretation, performance, and enforcement, exclusive of conflict of law rules.

9.6 **Forum**. The Parties consent to submit to the exclusive jurisdiction of the courts of the State of Maryland located in Howard County for any proceeding arising in connection with this Agreement, and each Party agrees not to commence any such proceeding except in such courts. The Parties waive any objection to the laying of venue of any such proceeding in the courts of the State of Maryland located in Howard County.

9.7. **Entire Agreement**. This Agreement, including the recitals set forth above which are intended to be an integral part hereof, sets forth the entire agreement and understanding of the parties with respect to the transactions contemplated hereby and supersedes all prior agreements, arrangements, and understandings relating to the subject matter hereof.

9.8. **Severability**. In case one or more of the provisions contained in this Agreement shall for any reason be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provision hereof, and this Agreement shall be construed as if such invalid, illegal, or unenforceable provision had never been contained herein.

9.9. **General**. The Section headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement. All references made in the neuter, masculine, or feminine gender shall be deemed to have been made in all such genders; and in the singular or plural number shall be deemed to have been made respectively, in the plural or singular number as well.

9.10 **Assignment**. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors and permitted assigns. Purchaser may not assign or delegate its rights or obligations hereunder without the prior written consent of Seller, provided that Purchaser shall be permitted to assign all of its rights and obligations under this Agreement without the consent of Seller to any entity (whether currently existing or hereafter created) that is owned solely by all of the same members of Purchaser . Any such assignment or delegation, however, shall not relieve Purchaser of any obligations under the terms of this Agreement, and Purchaser agrees to unconditionally guarantee the full and complete performance hereunder by its assignee.

9.11. **Expenses**. Purchaser and Seller shall each pay all of its own expenses relating to the transaction contemplated by this Agreement, including but not limited to the fees and disbursements of their respective counsel, accountants, consultants, and financial

advisors, whether or not the transactions contemplated hereunder are consummated.

9.12. **Counterparts**. This Agreement may be executed in any number of counterparts, each of which shall be an original with the same effect as if the signatures thereto and hereto were upon the same instrument. Any signature duly affixed to this Agreement and delivered by facsimile transmission or in PDF format shall be deemed to have the same legal effect as the actual signature of the person signing this Agreement. Any Party receiving delivery of a facsimile or PDF copy of the signed Agreement may rely on such as having actually been signed.

9.13 **Public Announcements**. Unless required to do so by applicable law or regulation, Purchaser and Seller each agree that it shall not release, publish or otherwise make available to the public in any manner whatsoever any information or announcement regarding this Agreement or the transactions contemplated hereby without the prior written consent of the other Party except for purposes of obtaining the Regulatory Approvals.

[This space is intentionally left blank. Signature page to follow.]

IN WITNESS WHEREOF, the parties hereto have executed and sealed this Purchase and Sale Agreement as of the day and year first written above.

SELLER:

JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.

By: _____
Richard G. Bennett, M.D.
President

PURCHASER:

MID-ATLANTIC HEALTH CARE ACQUISITIONS, LLC

By: _____
Name:
Title:

IN WITNESS WHEREOF, the parties hereto have executed and sealed this Purchase and Sale Agreement as of the day and year first written above.

SELLER:

JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.

By: _____
Richard G. Bennett, M.D.
President

PURCHASER:

MID-ATLANTIC HEALTH CARE ACQUISITIONS, LLC

By: _____
Name: SCOTT RIFKIN
Title: MANAGING MEMBER

EXHIBIT A

ASSIGNMENT OF INTANGIBLES

KNOW ALL MEN BY THESE PRESENTS, that the undersigned, Johns Hopkins Bayview Medical Center, Inc., a Maryland non-profit corporation ("Seller"), for good and valuable consideration to it paid by [Mid-Atlantic Health Care Acquisitions], LLC, a Maryland limited liability company ("Purchaser"), the receipt of which is hereby acknowledged, does hereby grant, bargain, sell and transfer to Purchaser, its successors and assigns, all its right, title, and interest in and to eighty (80) Comprehensive Care Facility Beds identified as the Bed Rights in the Purchase and Sale Agreement (the "Agreement") dated September 19, 2014 by and between Seller and Purchaser.

AND TO HAVE AND TO HOLD all and singular the aforesaid property to Purchaser, its successors and assigns forever.

Seller warrants and represents that it has and is conveying to Purchaser good title to the aforesaid Bed Rights, free and clear of all mortgages, liens, claims and encumbrances, and Seller covenants and agrees to warrant and defend title to said property unto Purchaser, its successors and assigns.

IN WITNESS WHEREOF, Seller has caused this instrument to be executed this ___ day of _____, 2014.

SELLER:

JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.

By: _____
Richard G. Bennett, M.D.
President

EXHIBIT B

ESCROW AGREEMENT

ESCROW AGREEMENT

THIS ESCROW AGREEMENT (the "*Agreement*") is made and entered into as of September __, 2014, by and among Johns Hopkins Bayview Medical Center, Inc., a not-for-profit corporation organized under the laws of the State of Maryland ("JHBMC"), Mid-Atlantic Health Care Acquisitions, LLC, a limited liability company organized under the laws of the State of Maryland ("Mid-Atlantic"), and Bank of America, National Association, a national banking association duly organized and existing under the laws of the United States of America, having an office in Chicago, Illinois (the "*Escrow Agent*"). JHBMC and Mid-Atlantic are individually referenced herein as a "Party" and collectively as the "Parties".

WHEREAS, JHBMC and Mid-Atlantic have entered into that certain Purchase and Sale Agreement dated as of September 19, 2014 (the "Purchase Agreement") under which Mid-Atlantic seeks to purchase, and JHBMC seeks to sell to Mid-Atlantic, certain rights, title and interests of JHBMC in and to eighty (80) licensed long-term care facility beds known in Maryland as comprehensive care facility ("CCF") beds (the "Bed Rights"), formerly operated as part of Johns Hopkins Bayview Care Center located at 5505 Hopkins Bayview Circle, Baltimore, Maryland 21224; and

WHEREAS, pursuant to Section 2.4 of the Purchase Agreement, Mid-Atlantic is required to pay two deposits which together total fifty thousand dollars ($50,000.00) in escrow to be applied toward the purchase price for the Bed Rights.

NOW, THEREFORE, in consideration of the mutual promises contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

ARTICLE I
ESTABLISHMENT OF ESCROW

(a) Within five (5) business days of the Parties' execution of the Purchase Agreement, Mid-Atlantic will deposit twenty-five thousand dollars ($25,000.00) (the "*Initial Deposit*") with the Escrow Agent. It is acknowledged that additional deposits may be made following the Initial Deposit in accordance with the terms of the Purchase Agreement. The Initial Deposit as well as any additional deposits, shall hereinafter collectively be referred to as the "*Escrow Fund.*"

(b) The parties hereto hereby appoint the Escrow Agent, and the Escrow Agent hereby agrees to serve, as the escrow agent and depositary subject to the terms and conditions set forth herein. The Escrow Agent shall receive the Initial Deposit and any additional deposits and agrees to hold the Escrow Fund in a separate and distinct account (the "*Escrow Account*") which is hereby established and which will be held and disbursed by the Escrow Agent only in accordance with the express terms and conditions of this Agreement. The Escrow Agent may accept an item for deposit into the Escrow Account from either Party. Escrow Agent is not required to question the authority of the person

making the deposit on behalf of a Party.

ARTICLE II
INVESTMENT OF ESCROW FUND

The Escrow Fund shall remain uninvested. The parties hereto hereby acknowledge and agree that they will not have any claim or cause of action against the Escrow Agent for its failure to invest the Escrow Fund in an interest bearing or otherwise accreting account, and each Party shall indemnify and hold the Escrow Agent harmless from any such claim (and any expenses incurred defending such claim) asserted, as applicable, by any of its respective shareholders, creditors, trustee(s) in bankruptcy or other persons not a party to this Agreement.

ARTICLE III
DISBURSEMENTS FROM THE ESCROW ACCOUNT

The Escrow Agent shall only disburse amounts held in the Escrow Account upon receipt of a written notice ("*Disbursement Request*") from JHBMC and Mid-Atlantic two (2) Business Days prior to the requested disbursement date specifying (i) the amount to be disbursed, (ii) the date of disbursement, (iii) the recipient of the disbursement, and (iv) the manner of disbursement and delivery instructions. A form of Disbursement Request is attached hereto as Annex I. For the avoidance of doubt, if any Disbursement Request authorizes the disbursement of all of the then-remaining Escrow Funds, such Disbursement Request shall constitute a Termination Notice (as defined below) and shall be treated as such in accordance with the provisions of Article VII. Further, the Escrow Agent is authorized to obtain confirmation of such Disbursement Request by telephone call-back to the person or persons designated for verifying such requests on Exhibit B (such person verifying the request shall be different than the person initiating the request).

ARTICLE IV
COMPENSATION; EXPENSES

As compensation for its services to be rendered under this Agreement, for each year or any portion thereof, the Escrow Agent shall receive a fee in the amount specified in Exhibit A to this Agreement and shall be reimbursed upon request for all expenses, disbursements and advances, including reasonable fees of outside counsel, if any, incurred or made by it in connection with the carrying out of its duties under this Agreement. Mid-Atlantic and JHBMC shall each be responsible for paying half of such fees and expenses. The Escrow Agent is hereby authorized and directed to withdraw from the Escrow Funds any fees or expenses that have been invoiced but that have remained unpaid for sixty (60) days or more. Further, and in addition to the right given to it in the preceding sentence, the Escrow Agent is hereby authorized to withhold any disbursement it would otherwise make from the Escrow Account if at the time of such disbursement any invoiced fees or expenses remain unpaid. In the event of a withdrawal by Escrow Agent from the Escrow Funds to pay fees or expenses of the Escrow Agent, JHBMC and Mid-Atlantic each agree to immediately make an additional deposit (equal to half of the amount of such unpaid fees or expenses) into the escrow account in order to

bring the balance back to its intended balance as contemplated by the Purchase Agreement. Amounts due for fees and expenses at the time this Agreement is executed shall be deemed to have been invoiced at such time and for purposes of this Article IV shall be deemed an invoice. It is understood that the foregoing provisions may affect the disbursement of funds to parties not responsible for the payment of fees and expenses.

ARTICLE V
REPRESENTATIONS AND WARRANTIES

The Parties each hereto hereby represents and warrants as of the date hereof and each date prior to the termination of this Agreement as follows:

(a) such party is duly organized, validly existing and in good standing under the laws of the State of its organization;

(b) such Party has all requisite corporate or other power, authority and capacity, and such other consents and approvals as are required to enter into this Agreement and to perform the obligations required of it hereunder and thereunder. The execution and delivery of this Agreement, and the consummation of the transactions contemplated herein, have been duly and validly authorized by all necessary action. This Agreement constitutes a valid and legally binding agreement of such Party enforceable in accordance with its terms, and no offset, counterclaim or defense exists to the full performance by such Party of this Agreement, except as the same may be limited by bankruptcy, insolvency, reorganization and similar laws affecting the enforcement of creditors' rights generally and by general equity principles;

(c) such Party is in full compliance with all applicable anti-money laundering and anti-terrorist financing laws and regulations;

(d) the Escrow Account will be used by such Party for business use only and not primarily for personal, family or household use;

(e) such Party will not use the Escrow Account for illegal transactions, including, without limitation, those prohibited by the Unlawful Internet Gambling Enforcement Act, 31 U.S.C. Section 5361 et. seq.

ARTICLE VI
EXCULPATION AND INDEMNIFICATION

6.1(a) The obligations and duties of the Escrow Agent are confined to those specifically set forth in this Agreement which obligations and duties shall be deemed purely ministerial in nature. No additional obligations and duties of the Escrow Agent shall be inferred or implied from the terms of any other documents or agreements, notwithstanding references herein to other documents or agreements. In the event that any of the terms and provisions of any other agreement between any of the parties hereto

conflict or are inconsistent with any of the terms and provisions of this Agreement, the terms and provisions of this Agreement shall govern and control the duties of the Escrow Agent in all respects. The Escrow Agent shall not be subject to, or be under any obligation to ascertain or construe the terms and conditions of any other instrument, or to interpret this Agreement in light of any other agreement whether or not now or hereafter deposited with or delivered to the Escrow Agent or referred to in this Agreement. The Escrow Agent shall not be obligated to inquire as to the form, execution, sufficiency, or validity of any such instrument nor to inquire as to the identity, authority, or rights of the person or persons executing or delivering same. The Escrow Agent shall have no duty to know or inquire as to the performance or nonperformance of any provision of any other agreement, instrument, or document. The parties hereto shall provide the Escrow Agent with a list of authorized representatives, initially authorized hereunder as set forth on Exhibit B; as such Exhibit B may be amended or supplemented from time to time by delivery of a revised and re-executed Exhibit B to the Escrow Agent. The Escrow Agent may, but is not required to, investigate payment instructions, make further inquiries, and, where required, block or reject services due to domestic or global economic or trade-based sanctions. Notwithstanding the foregoing sentence, the Escrow Agent is authorized to comply with and rely upon any notices, instructions or other communications believed by it to have been sent or given by a person or persons authorized by the parties. The Escrow Agent specifically allows for receiving direction by written or electronic transmission from an authorized representative with the following caveat, the Parties agree to indemnify and hold harmless the Escrow Agent against any and all claims, losses, damages, liabilities, judgments, costs and expenses (including reasonable attorneys' fees) (collectively, "Losses") incurred or sustained by the Escrow Agent as a result of or in connection with the Escrow Agent's reliance upon and compliance with instructions or directions given by written or electronic transmission, provided, however, that such Losses have not arisen from the gross negligence or willful misconduct of the Escrow Agent.

(b) In the event funds transfer instructions are given to the Escrow Agent pursuant to the terms of this Agreement (other than with respect to fund transfers to be made contemporaneously with the execution of this agreement), regardless of the method used to transmit such instructions, such instructions must be given by an individual designated on Exhibit B. Further, the Escrow Agent is authorized to obtain and rely upon confirmation of such instructions by telephone call-back to the person or persons designated for verifying such instructions on Exhibit B (such person verifying the instruction shall be different than the person initiating the instruction). The parties hereto aside from the Escrow Agent agree that the Escrow Agent may delay the initiation of any fund transfer until all security measures it deems to be necessary and appropriate have been completed and shall incur no liability for such delay.

6.2 The Escrow Account shall be maintained in accordance with applicable laws, rules and regulations and policies and procedures of general applicability to accounts established by the Escrow Agent. The Escrow Agent shall not be liable for any act that it may do or omit to do hereunder in good faith and in the exercise of its own best judgment or for any damages not directly resulting from its gross negligence or willful misconduct. Without limiting the generality of the foregoing sentence, it is hereby agreed that in no event will the Escrow Agent be liable for any lost profits or other indirect, special,

incidental or consequential damages which the parties may incur or experience by reason of having entered into or relied on this Agreement or arising out of or in connection with the Escrow Agent's duties hereunder, notwithstanding that the Escrow Agent was advised or otherwise made aware of the possibility of such damages. The Escrow Agent shall not be liable for acts of God, acts of war, breakdowns or malfunctions of machines or computers, interruptions or malfunctions of communications or power supplies, labor difficulties, actions of public authorities, or any other similar cause or catastrophe beyond the Escrow Agent's reasonable control. Any act done or omitted to be done by the Escrow Agent pursuant to the advice of its attorneys shall be conclusively presumed to have been performed or omitted in good faith by the Escrow Agent.

6.3 In the event the Escrow Agent is notified of any dispute, disagreement or legal action relating to or arising in connection with the escrow, the Escrow Fund, or the performance of the Escrow Agent's duties under this Agreement, the Escrow Agent will not be required to determine the controversy or to take any action regarding it. The Escrow Agent may hold all documents and funds and may wait for settlement of any such controversy by final appropriate legal proceedings, arbitration, or other means as, in the Escrow Agent's discretion, it may require. Furthermore, if confronted with conflicting demands such that it determines in good faith that it risks incurring expense or liability regardless of any action it may take or refrain from taking, the Escrow Agent may, at its option, file an action of interpleader requiring the parties to answer and litigate any claims and rights among themselves. The Escrow Agent is authorized, at its option, to deposit with the court in which such action is filed, all documents and funds held in escrow, except all costs, expenses, charges, and reasonable attorneys' fees incurred by the Escrow Agent due to the interpleader action and which JHBMC and Mid-Atlantic agree on a joint and several basis to pay. Upon initiating such action, the Escrow Agent shall be fully released and discharged of and from all subsequent obligations and liability otherwise imposed by the terms of this Agreement.

6.4 The Parties hereby agree, on a joint and several basis, to indemnify and hold the Escrow Agent, and its directors, officers, employees, and agents, harmless from and against all costs, damages, judgments, attorneys' fees (whether such attorneys shall be regularly retained or specifically employed), expenses, obligations and liabilities of every kind and nature which the Escrow Agent, and its directors, officers, employees, and agents, may incur, sustain, or be required to pay in connection with or arising out of this Agreement, unless the aforementioned results from the Escrow Agent's gross negligence or willful misconduct, and to pay the Escrow Agent on demand the amount of all such costs, damages, judgments, attorneys' fees, expenses, obligations, and liabilities. Without limitation, the foregoing indemnities shall extend to any breach of the representations, warranties or covenants in Section 10.3 of this Agreement. The costs and expenses of enforcing this right of indemnification also shall be paid by the Parties. The foregoing indemnities in this paragraph shall survive the resignation or substitution of the Escrow Agent and the termination of this Agreement.

ARTICLE VII
TERMINATION OF AGREEMENT

This Agreement shall terminate:

(a) On the termination date set forth in a properly executed and delivered Termination Notice (as defined below). The Parties may, at any time, terminate this Agreement by delivering to the Escrow Agent written notice (the "*Termination Notice*") signed by the Parties setting forth (i) the requested termination date and (ii) instructions for the return or delivery of the parties' then-escrowed property. The Termination Notice shall be received by the Escrow Agent not fewer than two (2) Business Days prior to the requested termination date. A form of Termination Notice is attached hereto as Exhibit C.

(b) Should the Parties terminate the Agreement pursuant to this Article VII, it is understood and agreed by each of them that the Escrow Agent shall be entitled (i) to keep any monies paid to it in respect of fees or expenses previously due and owing and (ii) to offset from the amount of Escrow Funds on deposit as of the date of the Termination Notice, any amounts due for fees and expenses that, as of such date, have been previously invoiced and remain unpaid or which are then due and payable on a *pro rata* basis. Notwithstanding any other provision hereof, this Agreement shall not terminate before all amounts in the Escrow Account shall have been distributed by the Escrow Agent in accordance with the terms of this Agreement.

ARTICLE VIII
RESIGNATION OF ESCROW AGENT

The Escrow Agent may resign at any time upon giving at least thirty (30) days prior written notice to JHBMC and Mid-Atlantic; provided that no such resignation shall become effective until the appointment of a successor escrow agent which shall be accomplished as follows: JHBMC and Mid-Atlantic shall use their best efforts to select a successor escrow agent within thirty (30) days after receiving such notice. If JHBMC and Mid-Atlantic fail to appoint a successor escrow agent within such time, the Escrow Agent shall have the right at the joint expense of JHBMC and Mid-Atlantic to petition any court of general jurisdiction sitting in Cook County, Illinois for the appointment of a successor escrow agent. The successor escrow agent shall execute and deliver an instrument accepting such appointment and it shall, without further acts, be vested with all the estates, properties, rights, powers, and duties of the predecessor escrow agent as if originally named as escrow agent. Upon delivery of such instrument, the Escrow Agent shall be discharged from any further duties and liability under this Agreement. The Escrow Agent shall be paid any outstanding fees and expenses prior to transferring assets to a successor escrow agent.

ARTICLE IX
NOTICES

All notices required by this Agreement shall be in writing and shall be deemed to have been received (a) immediately if sent by hand delivery (with signed return receipt), (b) the next Business Day if sent by nationally recognized overnight courier or (c) the second following Business Day if sent by registered or certified mail, in any case to the respective addresses as follows:

If to JHBMC:

Johns Hopkins Bayview Medical Center, Inc.
5300 Alpha Commons Drive
Alpha Commons Building, Executive Offices
Baltimore, MD 21224-2780
Attn: President

With a copy to:

G. Daniel Shealer, Esq.
Vice President & General Counsel
The Johns Hopkins Health System Corporation
600 N. Wolfe Street, Admin. 400
Baltimore, MD 21287-1900

If to Mid-Atlantic:

Mid-Atlantic Health Care Acquisitions, LLC
922 Greenspring Drive, Suite #3
Timonium, Maryland 21093
Attn: Chief Executive Officer

If to the Escrow Agent:

Bank of America, National Association
Global Custody and Agency Services
135 S. LaSalle Street
IL4-135-05-07
Chicago, Illinois 60603
Attention: Arlene Kaminski

ARTICLE X
TAX REPORTING

10.1 The Parties understand and agree that they are required to provide the Escrow Agent with a properly completed and signed Tax Certification (as defined below) and that the Escrow Agent may not perform its duties hereunder without having been provided with such Tax Certification. Accordingly, the Parties understand and agree that unless and until all Parties have provided Tax Certifications to the Escrow Agent, the Escrow Account shall not be invested as otherwise provided herein nor shall disbursements be made from the Escrow Account as otherwise provided at Article III. In the case of a person that is a "United States person" within the meaning of Section 7701(a)(30) of the Internal Revenue Code of 1986, as amended (the "*Code*"), an original IRS Form W-9 (or applicable successor form) will be provided. In the case of a person that is not a "United States person" within the meaning of Section 7701(a)(30) of the Code (hereinafter a "*foreign person*"), an original applicable IRS Form W-8ECI, W-

8IMY, W-8EXP or W-8BEN (or applicable successor form), along with any required attachments, will be provided to the Escrow Agent. As used herein "*Tax Certification*" shall mean an IRS form W-9 or W-8 as described above. Under current law, the applicable IRS Form W-8ECI, W-8IMY, W-8EXP or W-8BEN generally will expire every three (3) years and must be replaced with another properly completed and signed original sent to the Escrow Agent. A new original IRS Form W-8, indicating the relevant Escrow Account number, (or such other information or forms as required by law) must be delivered by each foreign person to, and received by, the Escrow Agent either prior to December 31st of the calendar year inclusive of the third (3rd) anniversary date of the date listed on the previously submitted form or as otherwise required by law.

10.2 The Escrow Agent will comply with any U.S. tax withholding or backup withholding and reporting requirements that are required by law.

10.3 Each Party hereby (i) represents and warrants each for itself that, as of the date this Agreement is made and entered into, the Escrow Account is not a Qualified Settlement Fund, Designated Settlement Fund, or Disputed Ownership Fund within the meaning of section 468B of the Code (and the regulations thereunder) and (ii) covenants that they shall not respectively take, fail to take or permit to occur any action or inaction, on or after the date this Agreement is made and entered into, that causes the Escrow Account to become such a Qualified Settlement Fund, Designated Settlement Fund, or Disputed Ownership Fund at any time.

10.4 The Parties agree that they are not relieved of their respective obligations, if any, to prepare and file information reports under Code Section 6041, and the Treasury regulations thereunder, with respect to amounts of imputed interest income, as determined pursuant to Code Sections 483 or 1272. The Escrow Agent shall not be responsible for determining or reporting such imputed interest.

ARTICLE XI
MISCELLANEOUS PROVISIONS

11.1 Each party hereto represents and warrants that such party has all necessary power and authority to execute and deliver this Agreement and to perform all of such party's obligations hereunder. This Agreement constitutes the legal, valid, and binding obligation of each party hereto, enforceable against such party in accordance with its respective terms, except as such enforceability may be limited by bankruptcy, insolvency, reorganization or other similar laws affecting the enforcement of creditors' rights generally and by general principles of equity, regardless of whether such enforceability shall be considered in a proceeding in equity or at law.

11.2 This Agreement shall be governed by and construed in accordance with the laws of the State of Illinois and the parties hereto consent to jurisdiction in the State of Illinois and venue in any state or Federal court located in the City of Chicago.

11.3 Any bank or corporation into which the Escrow Agent may be merged or with which it may be consolidated, or any bank or corporation to whom the Escrow Agent may transfer a substantial amount of its escrow business, shall be the successor to the

Escrow Agent without the execution or filing of any paper or any further act on the part of any of the parties, anything herein to the contrary notwithstanding.

11.4 This Agreement may be amended, modified, and/or supplemented only by an instrument in writing executed by all parties hereto.

11.5 This Agreement may be executed by the parties hereto individually or in one or more counterparts, each of which shall be an original and all of which shall together constitute one and the same agreement. This Agreement, signed and transmitted by facsimile machine or pdf file, is to be treated as an original document and the signature of any party hereon, if so transmitted, is to be considered as an original signature, and the document so transmitted is to be considered to have the same binding effect as a manually executed original.

11.6 The headings used in this Agreement are for convenience only and shall not constitute a part of this Agreement. Any references in this Agreement to any other agreement, instrument, or document are for the convenience of the parties and shall not constitute a part of this Agreement.

11.7 As used in this Agreement, "*Business Day*" means a day other than a Saturday, Sunday, or other day when banking institutions in Chicago, Illinois are authorized or required by law or executive order to be closed.

11.8 This Agreement constitutes a contract solely among the parties by which it has been executed and is enforceable solely by the parties by which it has been executed and no other persons. It is the intention of the parties hereto that this Agreement may not be enforced on a third party beneficiary or any similar basis.

11.9 The parties agree that if any provision of this Agreement shall under any circumstances be deemed invalid or inoperative this Agreement shall be construed with the invalid or inoperative provisions deleted and the rights and obligations of the parties shall be construed and enforced accordingly.

11.10 No party hereto shall assign its rights hereunder until its assignee has submitted to the Escrow Agent (i) Patriot Act disclosure materials and the Escrow Agent has determined that on the basis of such materials it may accept such assignee as a customer and (ii) assignee has delivered an IRS Form W-8 or W-9, as appropriate, to the Escrow Agent which the Escrow Agent has determined to have been properly signed and completed. In addition, the foregoing rights to assign shall be subject, in the case of any party having an obligation to indemnify the Escrow Agent, to the Escrow Agent's approval based upon the financial ability of assignee to indemnify it being reasonably comparable to the financial ability of assignor, which approval shall not be unreasonably withheld.

11.11 Any claim against the Escrow Agent arising out of or relating to this Agreement shall be settled by arbitration in accordance with commercial rules of the American Arbitration Association. Arbitration proceedings conducted pursuant to this Section 11.11 shall be held in Chicago, Illinois.

11.12 Escrow Agent will treat information related to this Agreement as confidential but, unless prohibited by law, the Parties authorize the transfer or disclosure of any information relating to the Agreement to and between the subsidiaries, officers, affiliates and other representatives and advisors of Escrow Agent and third parties selected by any of them, wherever situated, for confidential use in the ordinary course of business, and further acknowledge that Escrow Agent and any such subsidiary, officer, Affiliate or third party may transfer or disclose any such information as required by any law, court, regulator or legal process.

The Parties will treat the terms of this Agreement, including any Fee Schedule, as confidential except on a "need to know" basis to persons within or outside such Party's organization (including affiliates of such Party), such as attorneys, accountants, bankers, financial advisors, auditors and other consultants of such party and its affiliates, except as required by any law, court, regulator or legal process and except pursuant to the express prior written consent of the other parties, which consent shall not be unreasonably withheld;

[SIGNATURES APPEAR ON THE FOLLOWING PAGE]

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Agreement as of the day and year first above written.

JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.

By: 

Name: Richard Bennett, M.D.
Title: President

MID-ATLANTIC HEALTH CARE ACQUISITIONS, LLC

By: _____

Name:
Title:

Escrow Agent:

BANK OF AMERICA, NATIONAL ASSOCIATION

By: _____

Name:
Title:

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Agreement as of the day and year first above written.

JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.

By: _____
Name: Richard Bennett, M.D.
Title: President

MID-ATLANTIC HEALTH CARE ACQUISITIONS, LLC

By: _____
Name: Scott Ripkin
Title: Managing Member

Escrow Agent:

BANK OF AMERICA, NATIONAL ASSOCIATION

By: _____
Name:
Title:

EXHIBIT A

ESCROW AGENT FEE SCHEDULE

Set-Up Fee:	**$500.00**
Tax Reporting Set-up Fee:	$0.00
Annual Administration Fee:	**$3,500.00**
Wire or Check Disbursement Fee:	**$20.00 per wire/check**

THE SET-UP FEES AND FIRST YEAR'S ANNUAL ADMINISTRATION FEES ARE DUE UPON EXECUTION OF THE ESCROW AGREEMENT.*

Escrow Agent reserves the right to bill at cost for all out-of-pocket expenses, including out-of-pocket expenses in connection with the closing. Out-of-pocket expenses include, but are not limited to, professional services (e.g. legal or accounting), travel expenses, telephone and facsimile transmission costs, postage (including express mail and overnight delivery charges), and copying charges.

(The Annual Administration Fee will be invoiced yearly in advance, without pro-ration for partial years. Wire and check disbursement fees will be invoiced on a quarterly basis.)

[AN "EXHIBIT B" MUST BE COMPLETED AND EXECUTED FOR EACH PARTY TO THE AGREEMENT]

EXHIBIT B

Escrow Agreement Dated as of September ___, 2014 by and among Johns Hopkins Bayview Medical Center, Inc., Mid-Atlantic Health Care Acquisitions, LLC, and Bank of America, National Association

Certificate of Authorized Representatives – Johns Hopkins Bayview Medical Center, Inc.

Name: Richard Bennett, M.D.	**Name:** Carl Francioli
Title: President	**Title:** VP, Finance
Phone: (410) 550-0781	**Phone:** (410) 550-0909
Facsimile:	**Facsimile:**
E-mail: rbennett@jhmi.edu	**E-mail:** cfranc@jhmi.edu
Signature:	**Signature:**
Fund Transfer / Disbursement Authority Level:	Fund Transfer / Disbursement Authority Level:
☒ Initiate	☒ Initiate
☒ Verify transactions initiated by others	☒ Verify transactions initiated by others
Name:	**Name:**
Title:	**Title:**
Phone:	**Phone:**
Facsimile:	**Facsimile:**
E-mail:	**E-mail:**
Signature:	**Signature:**
Fund Transfer / Disbursement Authority Level:	Fund Transfer / Disbursement Authority Level:
☐ Initiate	☐ Initiate
☐ Verify transactions initiated by others	☐ Verify transactions initiated by others

The Escrow Agent is authorized to comply with and rely upon any notices, instructions or other communications believed by it to have been sent or given by the person or persons identified above including without limitation, to initiate and verify funds transfers as indicated.

Johns Hopkins Bayview Medical Center, Inc.:

By: _____
Richard Bennett, M.D.
President
Date: September 18, 2014

[AN "EXHIBIT B" MUST BE COMPLETED AND EXECUTED FOR EACH PARTY TO THE AGREEMENT]

EXHIBIT B

Escrow Agreement Dated as of September ___, 2014 by and among Johns Hopkins Bayview Medical Center, Inc., Mid-Atlantic Health Care Acquisitions, LLC, and Bank of America, National Association

Certificate of Authorized Representatives – Mid-Atlantic Health Care Acquisitions, LLC

Name: Scott M. Rifkin	**Name:** Scott Potter
Title: Chief Executive Officer	**Title:** Chief Financial Officer
Phone: (410) 960-7975	**Phone:** (410) 308-2300, ext. 200
Facsimile: (410) 308-4999	**Facsimile:** (410) 308-4999
E-mail: scottrifkin@gmail.com	**E-mail:** spotter@mid-atlantic.com
Signature: Scott R	**Signature:**
Fund Transfer / Disbursement Authority Level:	Fund Transfer / Disbursement Authority Level:
☒ Initiate ☒ Verify transactions initiated by others	☒ Initiate ☒ Verify transactions initiated by others
Name:	**Name:**
Title:	**Title:**
Phone:	**Phone:**
Facsimile:	**Facsimile:**
E-mail:	**E-mail:**
Signature:	**Signature:**
Fund Transfer / Disbursement Authority Level:	Fund Transfer / Disbursement Authority Level:
✓ Initiate ✓ Verify transactions initiated by others	☐ Initiate ☐ Verify transactions initiated by others

The Escrow Agent is authorized to comply with and rely upon any notices, instructions or other communications believed by it to have been sent or given by the person or persons identified above including without limitation, to initiate and verify funds transfers as indicated.

Mid-Atlantic Health Care Acquisitions, LLC:

By: Scott R

Name: Scott Rifkin

Title: Managing Member

Date:

EXHIBIT C
FORM OF TERMINATION NOTICE
[*Date*]

Bank of America, National Association
Global Custody and Agency Services
135 S. LaSalle Street
IL4-135-05-07
Chicago, Illinois 60603
Attention: Arlene Kaminski

NOTICE OF TERMINATION

Ladies and Gentlemen:

We refer you to that certain Escrow Agreement (the "*Agreement*"), dated as of September __, 2014, among Johns Hopkins Bayview Medical Center, Inc., Mid-Atlantic Health Care Acquisitions, LLC, and Bank of America, National Association, a photocopy of which is attached hereto. Capitalized terms used but not defined in this letter shall have the meanings given them in the Agreement.

We hereby notify you, in accordance with the terms and provisions of Article VII(a) of the Agreement, that we are terminating the Agreement. Accordingly, we request that you terminate the Agreement as of [•][1]. Those undertakings that, under the provisions of the Agreement, shall survive termination of the Agreement shall continue as provided therein. All Escrow Funds or items of property thereafter on deposit or held in the Escrow Account or by the Escrow Agent pursuant to the Agreement shall, concurrently with the termination of the Agreement, be delivered by, as applicable, federal wire transfer or nationally recognized overnight courier service as follows:

[*Describe escrowed property or funds amount to be delivered*]:

To [*Designate Party*], at: [*insert fed wire instructions or physical address for overnight courier delivery*].

Very truly yours,

JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.

By: _____
Name:
Title:

MID-ATLANTIC HEALTH CARE ACQUISITIONS, LLC

By: _____
Name:
Title:

[1] Date should be not fewer than 2 Business Days after the date of this Notice.

ANNEX I
FORM OF DISBURSEMENT REQUEST

[*Date*]

Bank of America, National Association
Global Custody and Agency Services
135 S. LaSalle Street
IL4-135-05-07
Chicago, Illinois 60603
Attention: Arlene Kaminski

DISBURSEMENT REQUEST

Ladies and Gentlemen:

We refer you to that certain Escrow Agreement (the "*Agreement*"), dated as of September ___, 2014, among Johns Hopkins Bayview Medical Center, Inc., Mid-Atlantic Health Care Acquisitions, LLC, and Bank of America, National Association, as Escrow Agent. Capitalized terms used but not defined in this letter shall have the meanings given them in the Agreement.

Pursuant to the provisions of the Agreement, you are hereby directed to disburse funds held in the Escrow Account as follows:

(i) [the amount to be disbursed],

(ii) [the date of disbursement],

(iii) [the recipient of the disbursement, and]

(iv) [the manner of disbursement and delivery instructions (including wiring instructions if applicable.]

Very truly yours,

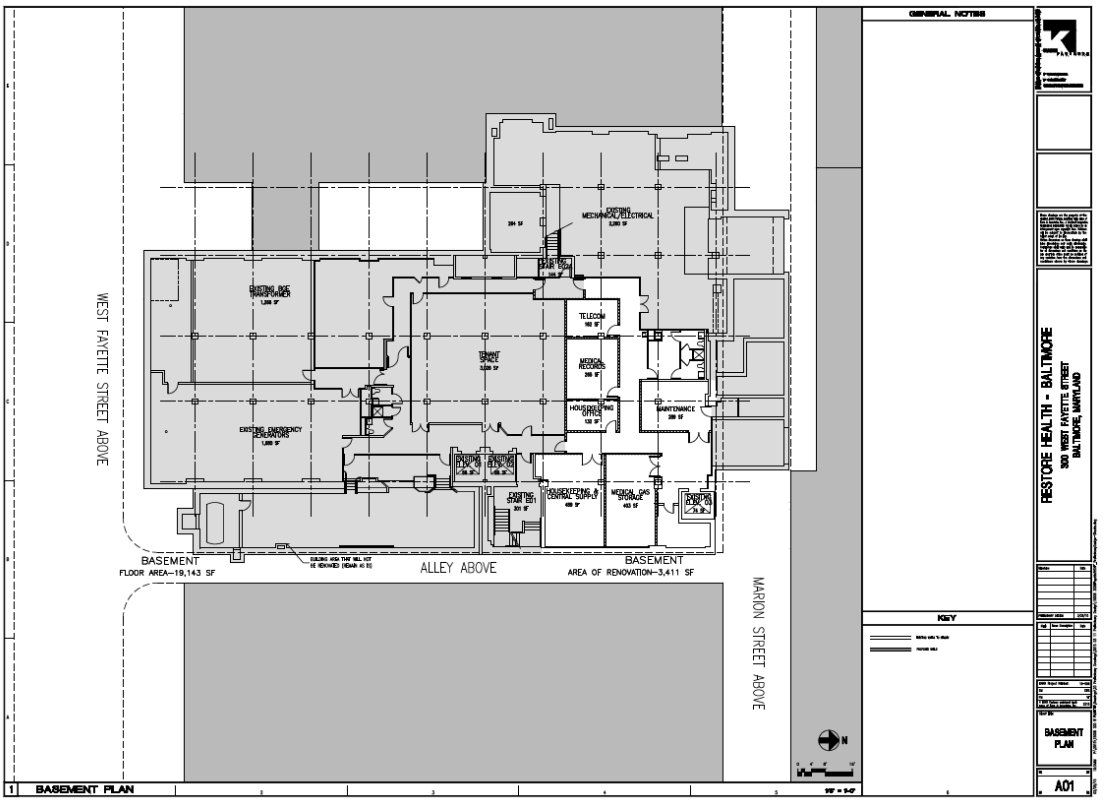
JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.

By: _____
Name:
Title:

MID-ATLANTIC HEALTH CARE ACQUISITIONS, LLC

By: _____
Name:
Title:

EXHIBIT E


WEST FAYETTE STREET ABOVE
BASEMENT
FLOOR AREA–19,143 SF
ALLEY ABOVE
BASEMENT
AREA OF RENOVATION–3,411 SF
MARION STREET ABOVE
GENERAL NOTES
KEY
RESTORE HEALTH - BALTIMORE
300 WEST FAYETTE STREET
BALTIMORE, MARYLAND
BASEMENT PLAN
A01
1 BASEMENT PLAN

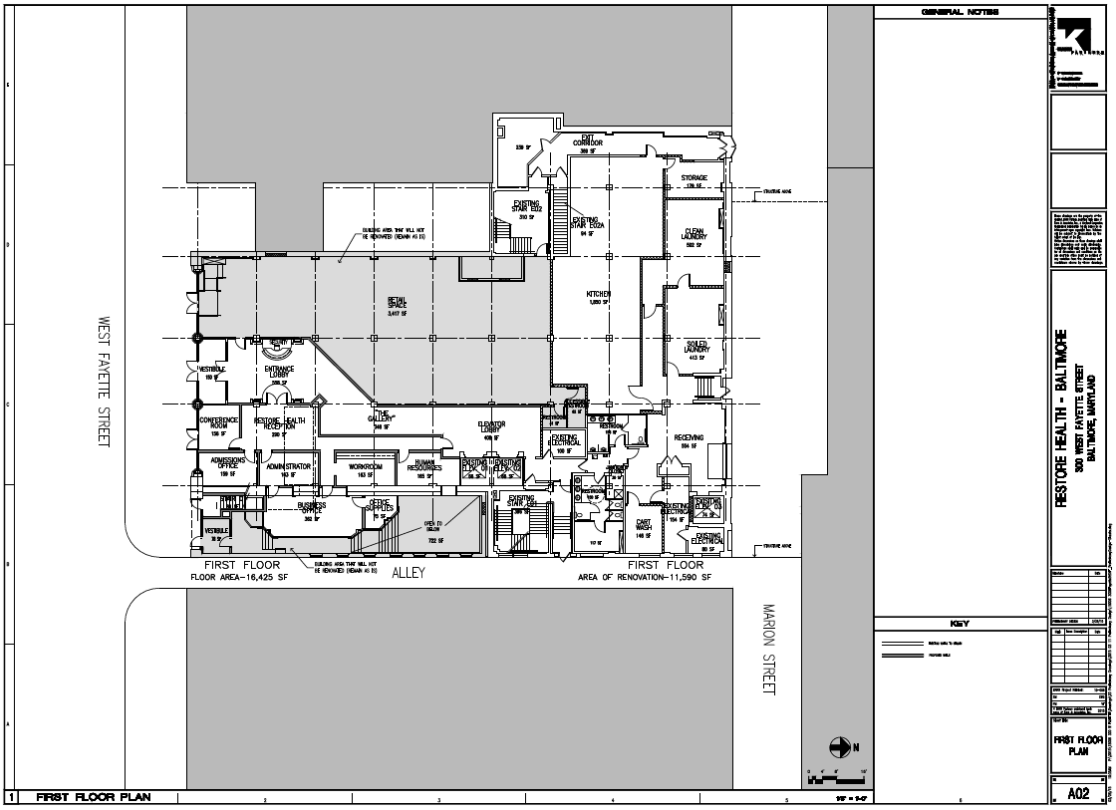
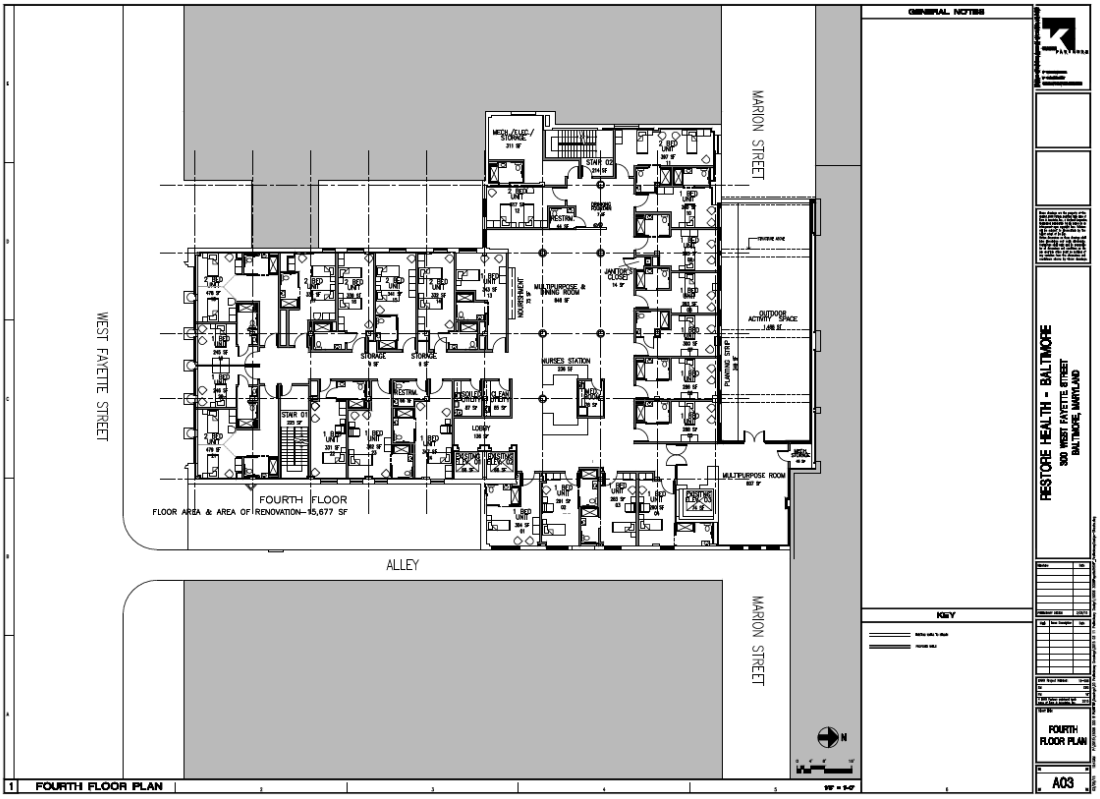

WEST FAYETTE STREET
FIRST FLOOR
FLOOR AREA–16,425 SF
ALLEY
FIRST FLOOR
AREA OF RENOVATION–11,590 SF
MARION STREET
GENERAL NOTES
KEY
RESTORE HEALTH - BALTIMORE
300 WEST FAYETTE STREET
BALTIMORE, MARYLAND
FIRST FLOOR PLAN
A02
1 FIRST FLOOR PLAN

EXHIBIT E


WEST FAYETTE STREET
MARION STREET
ALLEY
FOURTH FLOOR
FLOOR AREA & AREA OF RENOVATION- 15,677 SF
MULTIPURPOSE ROOM
OUTDOOR ACTIVITY SPACE
NURSES STATION
GENERAL NOTES
KEY
RESTORE HEALTH - BALTIMORE
300 WEST FAYETTE STREET
BALTIMORE, MARYLAND
FOURTH FLOOR PLAN
A03
1 FOURTH FLOOR PLAN

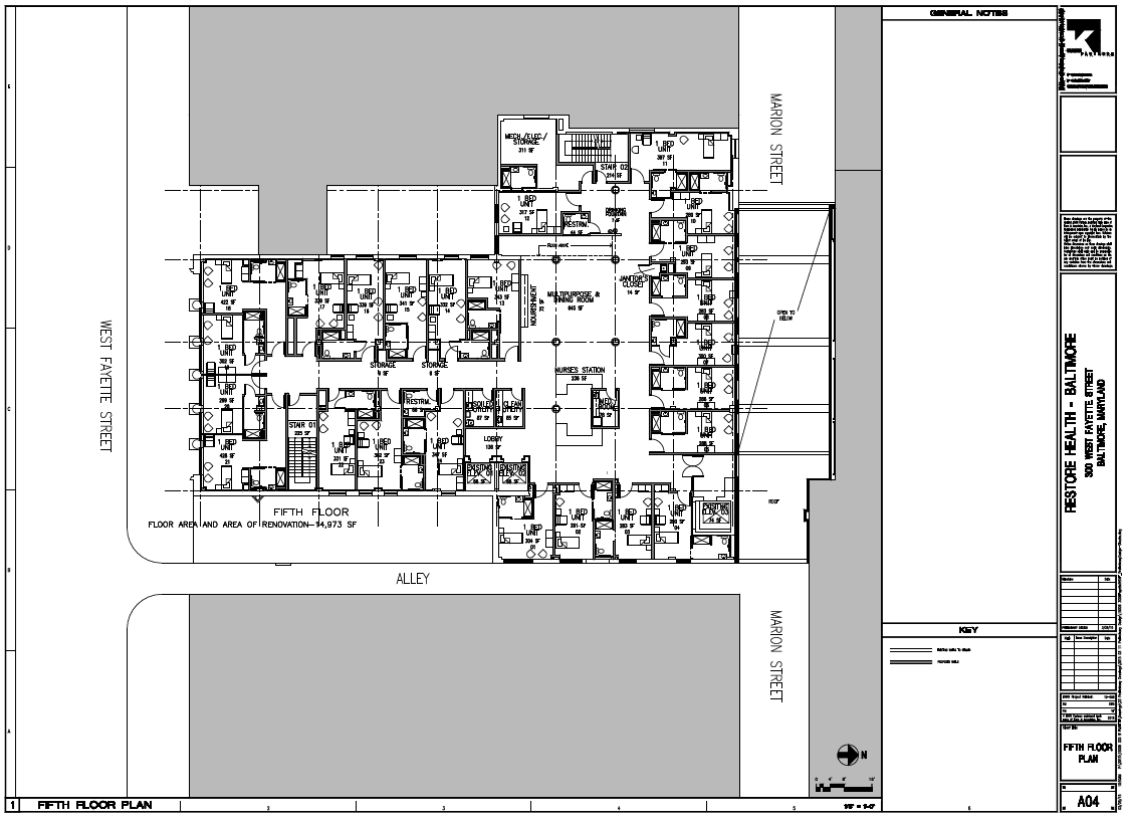
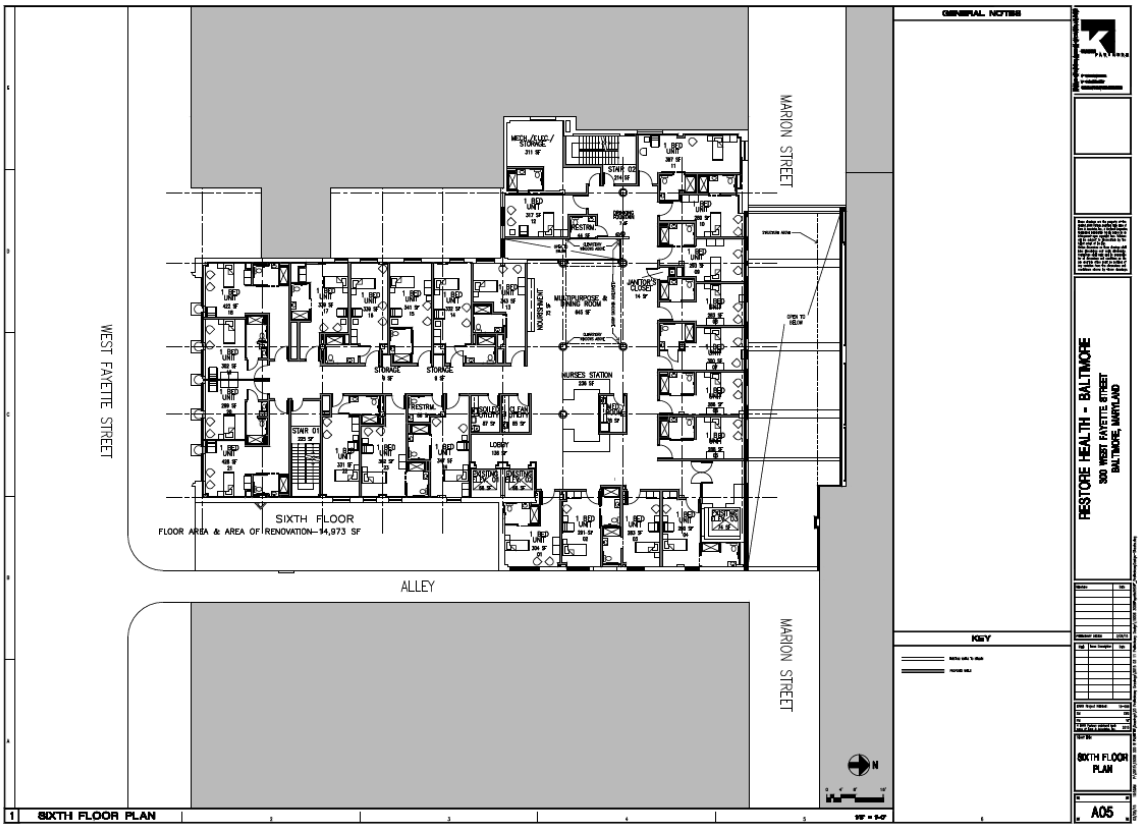

WEST FAYETTE STREET
MARION STREET
ALLEY
FIFTH FLOOR
FLOOR AREA AND AREA OF RENOVATION- 14,973 SF
NURSES STATION
GENERAL NOTES
KEY
RESTORE HEALTH - BALTIMORE
300 WEST FAYETTE STREET
BALTIMORE, MARYLAND
FIFTH FLOOR PLAN
A04
1 FIFTH FLOOR PLAN

EXHIBIT E


WEST FAYETTE STREET
MARION STREET
ALLEY
SIXTH FLOOR
FLOOR AREA & AREA OF RENOVATION–14,973 SF
GENERAL NOTES
KEY
RESTORE HEALTH - BALTIMORE
300 WEST FAYETTE STREET
BALTIMORE, MARYLAND
SIXTH FLOOR PLAN
A05
1 SIXTH FLOOR PLAN

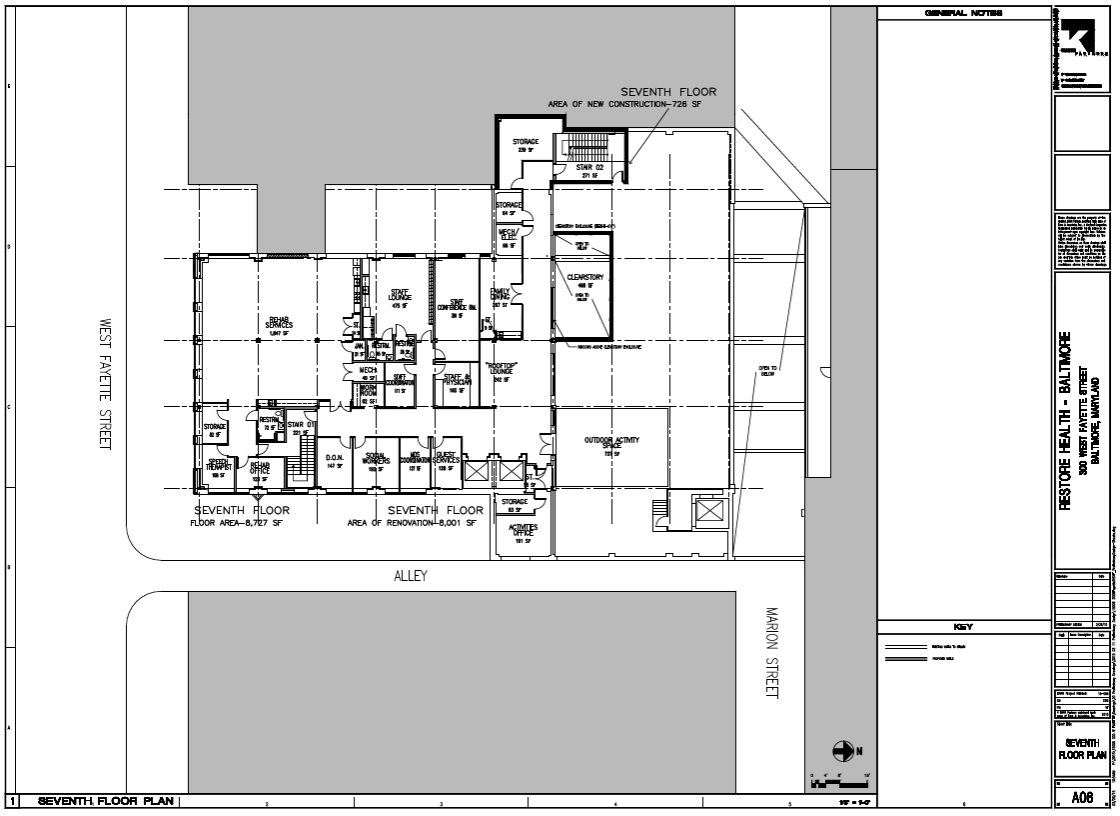

WEST FAYETTE STREET
MARION STREET
ALLEY
SEVENTH FLOOR
AREA OF NEW CONSTRUCTION–726 SF
SEVENTH FLOOR
FLOOR AREA–8,727 SF
SEVENTH FLOOR
AREA OF RENOVATION–8,001 SF
GENERAL NOTES
KEY
RESTORE HEALTH - BALTIMORE
300 WEST FAYETTE STREET
BALTIMORE, MARYLAND
SEVENTH FLOOR PLAN
A06
1 SEVENTH FLOOR PLAN

Exhibit F: Assumptions behind Financial Projections

MAHC has used its experience operating 18 skilled nursing facilities to develop its financial projections with a particular focus of one its facilities in Maryland that has a payor mix and clinical focus comparable to the proposed facility.

Assumed Opening & Pre-Opening Expenses

The projections begin in March 2017, to cover any pre-opening labor expenses as construction is being completed and the facility prepares to admit patients and finalize licensing. This period is expected to last 4 months with the facility opening and admitting residents starting July 1, 2017. The pre-opening expenses include costs associated for the following positions:

March 2017	April 2017	May 2017	June 2017
• Administrator	• Human Resources • Maintenance Manager	• Director of Nursing • Food Service Manager • Housekeeping Supervisor • Housekeeping Staff • Admissions	• Assistant Director Of Nursing • Nurse Liaison • MDS Coordinator • Central Supply • Social Service Director • Activities Director • Cooks & Cooks Helpers • Laundry • Billing

Census / Volume Growth

The projections assume the first residents are admitted to the facility July 1, 2017. To drive our census assumptions we have split admissions between short stay and long stay residents.

Short Stay Residents:

- Aggressive return to home rehab
- LVAD
- Vent units
- Cardiac patients
- Short term observation stays
- Palliative Care

Long Stay Residents:

- Dialysis
- Bariatric
- Other typical comprehensive care patients
- Longer term rehabilitation

Another key assumption is the payor mix at the facility. We have modeled our payor mix to be comparable to Fairfield, one of our Maryland-based facilities that has a similar resident mix and is a similar size (96 beds). As mentioned elsewhere in the application, we have projected a 47.01% census for Medicaid which is the average of all the nursing homes in the jurisdiction within which the Facility operates. Beyond that, given the focus on aggressive return to home rehabilitation residents and other more acute conditions, we estimate a high percentage of patients (42%) to be Medicare patients. This is a similar percentage to the payor mix operating at Mid-Atlantic's Fairfield facility. The remaining split of 11% is split between private pay (5%) and commercial insurance (6%).

Projected Reimbursement Rates

The Applicant has assumed rates based on expected case mix and by application of rates at another of its MD-based facility with a similar patient mix. Mid-Atlantic has projected the expected Medicaid reimbursement rate based on a projected case mix index and application of the Maryland pricing methodology. Based on Mid-Atlantic's experience and this specific facility's focus on higher acuity patients, the Applicant used a CMI of 1.09 in Year 1 and 1.20 in Year 2. These are comparable to the state average of 1.07 and a Mid-Atlantic average of 1.22 at its other facilities. Based on these assumptions, the Applicant estimates its per diem Medicaid reimbursement to be $275.12 during the first 12 months and then $275.31 for the remainder of the projection period

We have used rates similar to our other facilities for projected reimbursement rates from other payors:

Medicare Part A	$550.05 per patient day
Private	$290.00 per patient day
Managed Care	$375.00 per patient day
Medicare Part B	$10.00 per patient day

Other Revenue

Rental Income

The CCF will comprise a majority of the basement and 1st floor and all of floors 4 – 7. That leaves approximately 43,233 square feet for other tenants. The building currently has a tenant in the first floor for a period of 5 years starting February 2014. For purposes of the projections, we have assumed that MAHC will lease the basement and floors 2 & 3 as well as continue to lease out retail space on floor 1. We have applied rental rates as provided to us by commercial real estate brokers, (see **Exhibit Q**), who

estimate the space could rent for $18-20 per square foot. We have used $12 per square foot for the basement and $18 per square foot for the 2nd and 3rd floors starting July 1, 2018 to allow for time to lease it up. This yields the following rental income stream recorded as non-operating income since it is separate from the facility.

	2017	2018	2019	2020	2021
Rent Income	$39,996	$407,775	$769,988	$792,058	$803,764

Miscellaneous Income

We have assumed approximately $20,000 per year in revenue from family meals and other non-patient charges. We have also assumed a bed tax as a contra-revenue based on MAHC estimates.

Expense Assumptions

Expense assumptions have been built on a detailed line item basis based on per diem rates and totals from other Mid-Atlantic facilities. We have broken out our expense items into more detail as follows:

Salaries & Wages					
Nursing Services	$ 825,786	$ 2,711,188	$ 2,711,188	$ 2,711,188	$ 2,711,188
Nursing Services Benefits	174,362	643,041	656,335	656,335	656,335
Other Patient Care	84,753	182,032	182,032	182,032	182,032
Other Patient Care Benefits	18,017	43,174	44,067	44,067	44,067
Routine Services	257,557	482,160	482,160	482,160	482,160
Routine Services Benefits	54,484	114,359	116,723	116,723	116,723
Administrative	240,600	351,200	351,200	351,200	351,200
Administrative Benefits	52,735	95,773	98,343	98,343	98,343
Total Salaries, Wages & Benefits	$ 1,708,293	$ 4,622,928	$ 4,642,049	$ 4,642,049	$ 4,642,049
Contractual Services					
Therapy					
Medical Director	327,241	1,481,751	1,555,071	1,555,071	1,555,071
Psychiatrist	15,000	30,000	30,000	30,000	30,000
Total	5,000	10,000	10,000	10,000	10,000
	347,241	1,521,751	1,595,071	1,595,071	1,595,071
Other expenses					
Nursing Services	$ 34,347	$ 161,236	$ 169,214	$ 169,214	$ 169,214
Other Patient Care	143,956	629,065	659,648	659,648	659,648
Routine Services	215,715	716,198	745,699	745,699	745,699
Administrative	122,695	344,950	362,252	361,435	360,848
Management Fee	105,038	515,037	540,162	540,162	540,162
Capital/Property	84,514	469,335	492,559	492,559	492,559
Capital Rental	288	1,498	1,572	1,572	1,572
Total Other Expenses	$ 706,552	$ 2,837,318	$ 2,971,107	$ 2,970,289	$ 2,969,703

Exhibit G: Facilities Managed By Mid-Atlantic Health Care, LLC

Facility Name	City	Date Acq'd	Beds	Address	Zip
Pennsylvania					
Care Pavilion Nursing and Rehabilitation Center	Philidelphia	Jul-11	396	6212 Walnut Street	19139
York Nursing Home	Oak Lane	Jul-11	240	7101 Old York Road	19126
Cliveden Nursing and Rehabilitation Center	Philidelphia	Jul-11	180	6400 Greene Street	19119
Maplewood Nursing and Rehab Center	Philidelphia	Jul-11	180	125 W Schoolhouse Lane	19144
Tucker House Nursing and Rehabilitation Center	Philidelphia	Jul-11	180	1001-11 Wallace Street	19123
Milton Nursing and Rehabilitation Center	Milton	May-13	138	743 Mahoning Street	17847
Watsontown Nursing and Rehabilitation Center (1)	Watsontown	May-13	125	245 East Eight Street	17777
Falling Spring Nursing and Rehab	Chambersburg	Jan-14	186	201 Franklin Farm Lane	17201
Parkhouse Nursing and Rehabilitation Center	Royersford	Mar-14	467	1600 Black Rock Road	19468
Subtotal Pennsylvania			**2,092**		
Maryland					
Berlin Nursing and Rehabilitation Center (1)	Berlin	May-03	192	9715 Healthway Drive, PO Box 799	21811
Oakland Nursing & Rehabilitation Center	Oakland	Jul-05	112	706 East Alder Street	21550
Fairfield Nursing & Rehabilitation Center (1)	Crownsville	Dec-06	96	1454 Fairfield Loop Road	21032
Mid-Atlantic Of Chapel Hill, LLC	Randallstown	Jul-08	63	4511 Robosson Road	21133
Allegany Health Nursing and Rehab (1)	Cumberland	Jul-09	153	730 Furnace Street	21502
Villa Rosa Nursing and Rehabilitation	Mitchellville	Mar-13	101	3800 Lottsford Vista Road	20721
Forest Haven Nursing	Catonsville	Feb-15	167	701 Edmondson Ave	21228
Restore Health Rehabilitation Center (Startup)	White Plains	Feb-15	67	4615 Einstein Place	20695
Subtotal Maryland			**951**		
Delaware					
Delmar Nursing and Rehabilitation	Delmar		109	101 East Delaware Avenue	19940
Total All Facilities			**3,152**		

(1) Represents operational beds -- ability to increase to licensed amount (Berlin - 165, Oakland - 153, Fairfield - 96, Watsontown - 125)

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

November 12, 2014

Mr. Steven Wynn, Administrator
Villa Rosa Nursing And Rehabilitation, LLC
3800 Lottsford Vista Road
Mitchellville, MD 20721

RE: 215350
Notice of Deficiencies as a Result of Revisit, Imposition of Denial of Payments for New Admissions under Federal Regulations

Dear Mr. Wynn:

On November 6, 2014, a revisit Life Safety Code survey was conducted at your facility by the Office of Health Care Quality, to verify that your facility had achieved and maintained compliance for those deficiencies cited during the survey completed on August 21, 2014.

We had presumed, that based on your allegation of compliance that your facility was in substantial compliance as of 10/31/2014. However, based on our revisit we found that your facility is not in substantial compliance with the requirements for participation.

All references to regulatory requirement(s) contained in this letter are found in Title 42, Code of Federal Regulations.

I. IMPOSITION OF REMEDIES

As a result of our finding that your facility is not in substantial compliance, the following remedy (ies) will be imposed:

Imposition of denial of payment for new admissions, effective November 21, 2014.

If substantial compliance is not achieved by February 21, 2015, the CMS Regional Office and/or the State Medicaid Agency may terminate your provider agreement on that date.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should CMS determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

II. AUTOMATIC CONSEQUENCES AS A RESULT OF IMPOSITION OF DENIAL OF PAYMENT FOR NEW ADMI$$IONS

If you disagree with this determination, you or your legal representative may request a hearing before an Administrative Law Judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR 498.40, et seq. A written request for a hearing must be filed no later that 60 days from the date of receipt of this letter. Such a request may be made to:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver A. Potts, Chief
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

Should you choose to exercise your right to appeal, please forward a copy that appeal to:

Mr. James C. Newman, Chief Counsel
Office of the General Counsel
Public Ledger Building, Suite 418
150 South Independence Mall West
Philadelphia, PA 19106

III. PLAN OF CORRECTION (POC)

A Poc for the deficiencies identified in the attached CMS 2567 must be submitted within 10 days of your receipt of this notice. Failure to submit an acceptable PoC by this date may result in the imposition of remedies.

Your PoC must contain the following:

- What corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Specific date when the corrective action will be completed.
- **References to a resident(s) by Resident # only** as noted in the previously supplied Resident Roster. This applies to the PoC as well as any attachments to the PoC. It is unacceptable to include a resident(s) name in these documents since the documents are released to the public.

The enclosed CMS-2567 form, Statement of Deficiencies and Plan of Correction, shall be returned to the attention of the Health Facilities Survey Coordinator at the following address:

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY
55 Wade Avenue Bland Bryant Building
Catonsville, Maryland 21228
410.402.8249
Fax: 410.402.8234

IV. ALLEGATION OF COMPLIANCE

If you believe that the deficiencies identified in the form CMS 2567 have been corrected, you may contact your Survey Coordinator, Ranada Cooper, at the Office of Health Care Quality, Spring Grove Hospital Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, Maryland 21228 with your written credible allegation of compliance (*i.e. **attached lists of attendance at provided training and/or revised statements of policies/procedures and/or staffing patterns with revisions or additions***). If you choose, and so indicate, the PoC may constitute your allegation of compliance.

If upon a subsequent revisit or by other means, we verify that the facility is in substantial compliance, we will recommend to CMS that the remedy (ies) be terminated. However, if the seriousness of noncompliance changes from the survey findings, the remedies selected may change. If this occurs, you will be advised of any change.

V. INFORMAL DISPUTE RESOLUTION

In accordance with §488.331, you have one opportunity to question cited deficiencies through

an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiency being disputed, and an explanation of why you are disputing the deficiency, to me, Patricia Tomsko Nay, M.D., Executive Director, Office of Health Care Quality, Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, Maryland 21228. This request must be sent within 10 days of your receipt of the CMS 2567.

An informal dispute resolution for the cited deficiencies will not delay the imposition of any enforcement action

VI. LICENSURE ACTION

In the event a revisit determines that substantial compliance has not been achieved, appropriate administrative action may be taken against your State license.

If you have any questions concerning the instructions contained in this letter, please contact me at (410) 402-8201 or by fax at (410) 402-8234.

Sincerely,

Patricia Tomsko Nay, M.D.
Executive Director
Office of Health Care Quality

NG/lm

Enclosures: CMS 2567

cc: Health Facilities Survey Coordinator
Jane Sacco
Ruby Potter
Patricia A. Hannigan
File II

EXHIBIT H

PRINTED: 11/13/2014
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. BUILDING A1 B. WING _____	R 11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ROSA NURSING AND REHABILITATION, LLC	3000 LOTTSFORD VISTA ROAD MITCHELLVILLE, MD 20721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(K 000)	INITIAL COMMENTS The following deficiencies are the result of a revisit Life Safety Code Survey conducted on November 6, 2014 to determine the status of the facility's compliance with the plan of correction submitted for deficiencies cited during the Life Safety Code survey that concluded on August 21, 2014. As a result of the revisit survey, Villa Rosa Nursing Home was not found to be in substantial compliance with the requirements for participation in Medicare and Medicaid. Survey activities included observation of the physical environment, review of records, review of evacuation policies, observation of staff practices, and interviews with the staff members. This is a two story building built on a concrete slab with a partial basement. It has a brick siding exterior. The roof system consists of a flat roof on steel with a membrane and built up covering. The interior walls are drywall supported by steel studs, and masonry painted walls. The facility is partially sprinklered, with a new fire pump, and an updated partial sprinkler system. The upgrading of the facility to full sprinkler coverage has not been achieved as of this date.	(K 000)		
(K 056) SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the	(K 056)		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

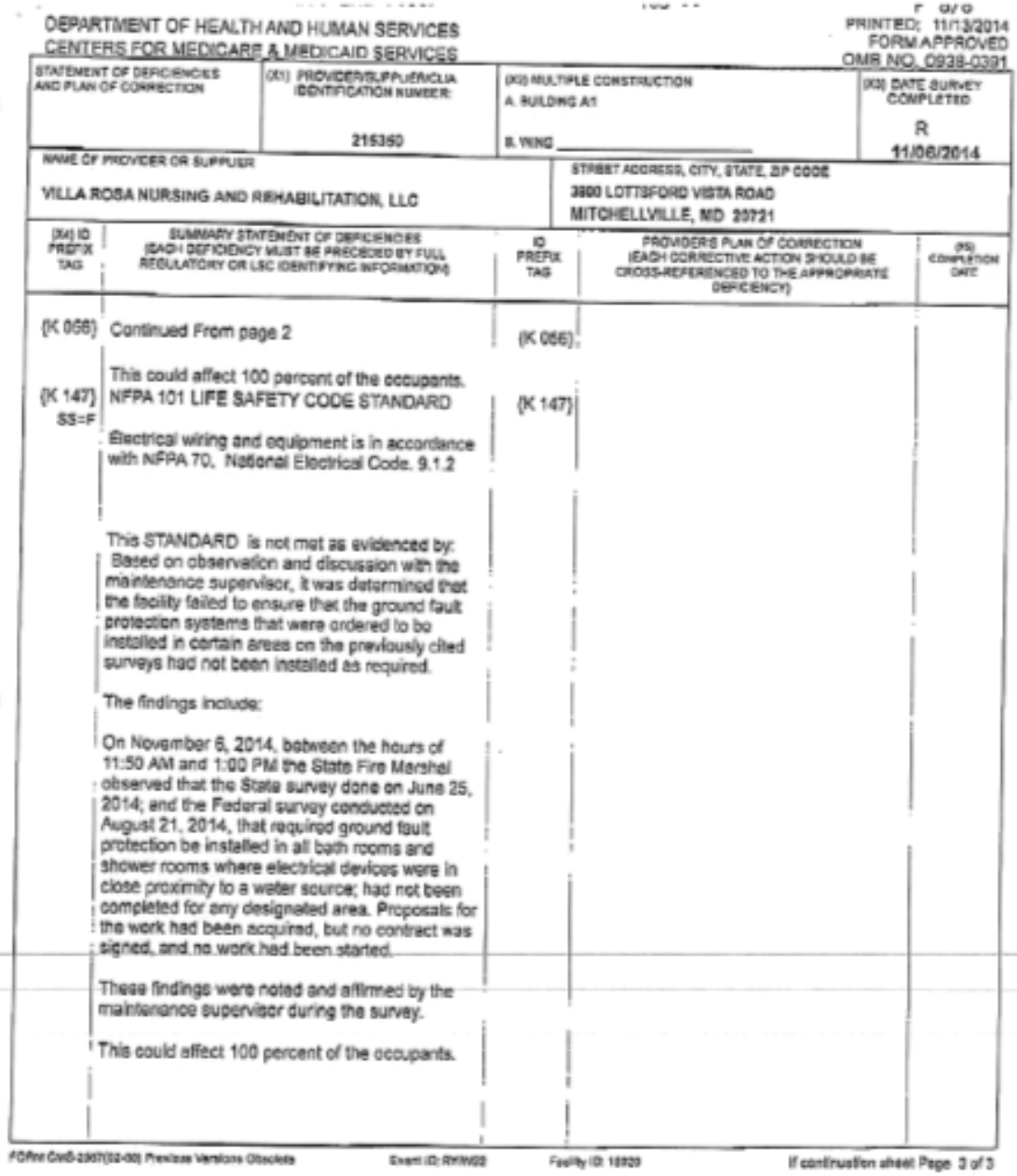
PRINTED: 11/13/2014
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. BUILDING A1 _____ B. WING _____	R 11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ROSA NURSING AND REHABILITATION, LLC	2000 LOTTSFORD VISTA ROAD MITCHELLVILLE, MD 20721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(K 056)	Continued From page 1 Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and discussion with the maintenance supervisor, it was determined that the facility failed to ensure that the sprinkler system had been upgraded to full coverage of all areas of the facility as required. The findings include: On November 6, 2014, between the hours of 11:00 AM and 1:00 PM the State Fire Marshal observed that the deficiencies noted during the State survey done on June 25, 2014 and the Federal survey done on August 21, 2014 had not been completed. All bathrooms are now sprinklered but the renovations have not passed local jurisdiction acceptance inspections. It is uncertain when the sprinkler system will be passed for acceptance. In addition several bathrooms are missing large sections of the ceiling where it was removed to facilitate the sprinkler installation of the bathroom. This is a health and safety hazard that must be corrected as soon as possible. These findings were noted and affirmed by the maintenance supervisor during the survey.	(K 056)		



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. BUILDING A1 B. WING	R 11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ROSA NURSING AND REHABILITATION, LLC	3800 LOTTSFORD VISTA ROAD MITCHELLVILLE, MD 20721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(K 066)	Continued From page 2	(K 066)		
	This could affect 100 percent of the occupants.			
(K 147) SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2	(K 147)		
	This STANDARD is not met as evidenced by: Based on observation and discussion with the maintenance supervisor, it was determined that the facility failed to ensure that the ground fault protection systems that were ordered to be installed in certain areas on the previously cited surveys had not been installed as required. The findings include: On November 6, 2014, between the hours of 11:50 AM and 1:00 PM the State Fire Marshal observed that the State survey done on June 25, 2014; and the Federal survey conducted on August 21, 2014, that required ground fault protection be installed in all bath rooms and shower rooms where electrical devices were in close proximity to a water source; had not been completed for any designated area. Proposals for the work had been acquired, but no contract was signed, and no work had been started. These findings were noted and affirmed by the maintenance supervisor during the survey. This could affect 100 percent of the occupants.			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RHW02 Facility ID: 18929 If continuation sheet Page 3 of 3

EXHIBIT H

2014-12-05 10:58 LTC 2nd floor 103 >> P 1/7

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Hospital Center • Bland Bryant Building
55 Wade Avenue • Baltimore, Maryland 21228-4663
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor –Joshua M. Sharfstein, M.D., Secretary

LONG TERM CARE UNIT

FACSIMILE TRANSMITTAL SHEET

To:	Vila Rosa Nursing and Rehab	**From:**	OHCQ/Long Term Care Unit
	Attn: Steven Wynn		Ranada Cooper
Fax:	301-429-2731	**Pages:**	7
Phone:	301-459-4700	**Date:**	12/05/2014
Re:	2567 for 12/1/14 revisit survey	**CC:**	

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

● Mr. Wynn:

Attached please find the CMS-2567 for the second revisit LSC survey completed by OHCQ at your facility on 12/1/14. A hard copy has also been sent to your facility via standard mail. Please feel free to contact me if you have any questions.

Thank you,

Ranada Cooper
Health Facilities Survey Coordinator
410-402-8017
410-402-8234-fax

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

December 4, 2014

Mr. Steven Wynn, Administrator
Villa Rosa Nursing and Rehabilitation, LLC
3800 Lottsford Vista Road
Mitchellville, MD 20721

RE: 215350
Notice of Deficiencies as a Result of Second Revisit, Imposition of Denial of Payments for New Admissions under Federal Regulations

Dear Mr. Wynn:

On December 1, 2014, a second revisit Life Safety Code survey was conducted at your facility by the Office of Health Care Quality, to verify that your facility had achieved and maintained compliance for those deficiencies cited during the survey completed on August 21, 2014.

We had presumed, that based on your allegation of compliance that your facility was in substantial compliance as of November 18, 2014.

However, based on our revisit we found that your facility is not in substantial compliance with the requirements for participation.

All references to regulatory requirement(s) contained in this letter are found in Title 42, Code of Federal Regulations.

I. IMPOSITION OF REMEDIES

As a result of our finding that your facility is not in substantial compliance, the following remedy(ies) will remain in effect:

Imposition of denial of payment for new admissions, effective November 21, 2014.

If substantial compliance is not achieved by February 21, 2014, the CMS Regional Office and/or the State Medicaid Agency may terminate your provider agreement on that date.

Please note that this notice does not constitute formal notice of imposition of alternative

remedies or termination of your provider agreement. Should CMS determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

II. AUTOMATIC CONSEQUENCES AS A RESULT OF IMPOSITION OF DENIAL OF PAYMENT FOR NEW ADMISSIONS

If you disagree with this determination, you or your legal representative may request a hearing before an Administrative Law Judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR 498.40, et seq. A written request for a hearing must be filed no later that 60 days from the date of receipt of this letter. Such a request may be made to:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver A. Potts, Chief
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

Should you choose to exercise your right to appeal, please forward a copy that appeal to:

Mr. James C. Newman, Chief Counsel
Office of the General Counsel
Public Ledger Building, Suite 418
150 South Independence Mall West
Philadelphia, PA 19106

III. PLAN OF CORRECTION (POC)

A Poc for the deficiencies identified in the attached CMS 2567 must be submitted within 10 days of your receipt of this notice. Failure to submit an acceptable PoC by this date may result in the imposition of remedies.

Your PoC must contain the following:

- What corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Specific date when the corrective action will be completed.
- **References to a resident(s) by Resident # only** as noted in the previously provided Resident Roster. This applies to the PoC as well as any attachments to the PoC. It is unacceptable to include a resident(s) name in these documents since the documents are released to the public.

The enclosed CMS-2567 form, Statement of Deficiencies and Plan of Correction, shall be returned to the attention of the Health Facilities Survey Coordinator at the following address:

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY
55 Wade Avenue Bland Bryant Building
Catonsville, Maryland 21228
410.402.8249
Fax: 410.402.8234

IV. ALLEGATION OF COMPLIANCE

If you believe that the deficiencies identified in the form CMS 2567 have been corrected, you may contact your Survey Coordinator, Ranada Cooper, at the Office of Health Care Quality, Spring Grove Hospital Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, Maryland 21228 with your written credible allegation of compliance (***i.e. attached lists of attendance at provided training and/or revised statements of policies/ procedures and/or staffing patterns with revisions or additions***). If you choose, and so indicate, the PoC may constitute your allegation of compliance.

If upon a subsequent revisit or by other means, we verify that the facility is in substantial compliance, we will recommend to CMS that the remedy (ies) be terminated. However, if the seriousness of noncompliance changes from the survey findings, the remedies selected may change. If this occurs, you will be advised of any change.

V. INFORMAL DISPUTE RESOLUTION

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiency being disputed, and an explanation of why you are disputing the deficiency, to me, Dr. Patricia Tomsko Nay, M.D., Executive Director, Office of Health Care Quality, Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, Maryland 21228. This request must be sent within 10 days of your receipt of the CMS 2567.

An informal dispute resolution for the cited deficiencies will not delay the imposition of any enforcement action.

VI. LICENSURE ACTION

In the event a revisit determines that substantial compliance has not been achieved, appropriate administrative action may be taken against your State license.

If you have any questions concerning the instructions contained in this letter, please contact me at (410) 402-8201 or by fax at (410) 402-8234.

Sincerely,

Patricia Tomsko Nay, MD

Patricia Tomsko Nay, M.D.
Executive Director
Office of Health Care Quality

NG/lm

Enclosures: CMS 2567

cc: Health Facilities Survey Coordinator
Jane Sacco
Ruby Potter
Patricia A. Hannigan
File II

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. BUILDING A1 B. WING	R 12/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ROSA NURSING AND REHABILITATION, LLC	3600 LOTTSFORD VISTA ROAD MITCHELLVILLE, MD 20721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(K 000)	INITIAL COMMENTS The following deficiencies are the result of a second revisit Life Safety Code Survey that was conducted on December 1, 2014 to determine the status of the facility's compliance with the plan of correction submitted for deficiencies cited during the first revisit Life Safey Code survey that concluded on November 6, 2014. This is a two story building built on a concrete slab with a partial basement. It has a brick siding exterior. The roof system consists of a flat roof on steel with a membrane and built up covering. The interior walls are drywall supported by steel studs, and masonry painted walls. The facility is now fully sprinklered, with a new fire pump.	(K 000)		
(K 147) SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and discussion with the maintenance supervisor, it was determined that the facility failed to ensure that the electrical system for the shower rooms was compliant with NFPA 70; the Electrical Code. The findings include: On December 1, 2014, between the hours of 11:40 AM and 12:25 PM the State Fire Marshal observed that the ground fault receptacles in rooms 102 and 229 did not function properly when tested by the surveyor and the maintenance supervisor. These receptacles could cause a fatal	(K 147)		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RYW23 Facility ID: 18023 If continuation sheet Page 1 of 2

PRINTED: 12/04/2014
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215359	A. BUILDING A1 B. WING _____	R 12/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ROSA NURSING AND REHABILITATION, LLC	2000 LOTTSFORD VISTA ROAD MITCHELLVILLE, MD 20721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(K 147)	Continued From page 1 electrical shock to a resident or a staff person. The receptacle in room 229 was being used by an electrical scale for weighing residents in the shower room. These findings were noted and affirmed by the maintenance supervisor during the survey. This could affect 100 percent of the occupants.	(K 147)		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215360	A. BUILDING A1 B. WING	R 12/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ROSA NURSING AND REHABILITATION, LLC	3900 LOTTSFORD VISTA ROAD MITCHELLVILLE, MD 20721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS The following deficiencies are the result of a second revisit Life Safety Code Survey that was conducted on December 1, 2014 to determine the status of the facility's compliance with the plan of correction submitted for deficiencies cited during the first revisit Life Safety Code survey that concluded on November 6, 2014. This is a two story building built on a concrete slab with a partial basement. It has a brick siding exterior. The roof system consists of a flat roof on steel with a membrane and built up covering. The interior walls are drywall supported by steel studs, and masonry painted walls. The facility is now fully sprinklered, with a new fire pump.	{K 000}		
{K 147} SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and discussion with the maintenance supervisor, it was determined that the facility failed to ensure that the electrical system for the shower rooms was compliant with NFPA 70; the Electrical Code. The findings include: On December 1, 2014, between the hours of 11:40 AM and 12:25 PM the State Fire Marshal observed that the ground fault receptacles in rooms 102 and 229 did not function properly when tested by the surveyor and the maintenance supervisor. These receptacles could cause a fatal	{K 147}	The ground fault circuit interrupters were repaired and/or replaced. An audit was completed of the building to ensure ground fault circuit interrupters are functioning properly and that they are located in appropriate locations through out the building. This audit was conducted by an independent third party auditor, a licensed electrician. (See Enclosed). The ground fault circuit interrupters will be tested on a regular basis by the director of maintenance or designee. This random audit will be done weekly for the first four weeks and if 100% compliance is still be done on a monthly basis moving forward. Findings will be reported to the facility's safety and quality assurance committee. The committee will take appropriate action if needed. Corrective actions will be completed by December 5, 2014.	

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 8 DEC 14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RYN03 Facility ID: 19020 If continuation sheet Page 1 of 2

EXHIBIT I

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Philadelphia Regional Office
Suite 216, The Public Ledger Building
150 S. Independence Mall, West
Philadelphia, PA 19106-3413

Northeast Division of Survey & Certification

July 22, 2013

Mr. Robert Lanzo, Administrator
Delmar Nursing & Rehabilitation Center
101 E. Delaware Avenue
Delmar, DE 19940

CMS Certification Number: 085041

DENIAL OF PAYMENT - PLEASE READ CAREFULLY

Dear Mr. Lanzo:

After a careful review of the facts, the Department of Health & Human Services, Centers for Medicare & Medicaid Services (CMS), has determined that Delmar Nursing & Rehabilitation Center no longer meets the requirements for participation as a provider of services in the Health Insurance Program for the Aged and Disabled (Medicare) established under Title XVIII of the Social Security Act (the Act), and Medicaid, Title XIX of the Act.

To participate in the Medicare program as a provider of skilled nursing facility services, a facility must meet all of the provisions of Section 1819 (b), (c), and (d) of the Act. In addition, a skilled nursing facility must be in compliance with the Requirements for Long Term Care Facilities established by the Secretary of Health and Human Services, and be free of hazards to the health and safety of residents. If that facility participates in the Medicaid program, it must also meet all of the provisions of Sections 1919 (b), (c), and (d) of the Act.

On May 10, 2013, an abbreviated survey was completed at your facility by the Delaware Department of Health and Social Services (State survey agency) to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. That survey found that your facility was not in substantial compliance with the participation requirements.

Although a revisit has not been completed at your facility we are denying Medicare and Medicaid payment for all new admissions to your facility effective August 10, 2013. This action is required by sections 1819 (h)(2)(B)(i), 1819 (h)(2)(D), 1919 (h)(3)(B)(ii), and 1919 (h)(3)(C)(i) of the Social Security Act. **If a revisit is completed which finds that your facility regained compliance prior to August 10, 2013 this action will be withdrawn.** In addition, you are advised that, should you remain out of compliance, your provider agreement will be terminated on November 10, 2013. **Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in Medicare managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payments for new admissions.**

If you disagree with this determination, you or your legal representative may request a hearing before an Administrative Law Judge of the Department of Health & Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR 498.40, et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen Robinson, Division Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

Should you choose to exercise your right to appeal, please forward a copy of that appeal to:

Mr. James C. Newman, Chief Counsel
Office of the General Counsel
Public Ledger Building, Suite 418
150 South Independence Mall West
Philadelphia, PA 19106

Should we take action to terminate your participation in the Medicare program, we will advise you of your appeal rights as a result of that action. Please note that those appeal rights are separate and distinct from the appeal rights cited above.

You will be notified separately by the Delaware State Medicaid agency regarding their application of the remedies in this letter.

If you have any questions, please contact Pat McNeal of my staff at (215) 861-4662.

Sincerely,

Timothy J. Hock, Manager
Certification and Enforcement Branch

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE
OFFICE OF THE DIRECTOR

July 23, 2013

Mr. Robert Lanzo, Administrator
Delmar Nursing & Rehabilitation Center
101 E. Delaware Avenue
Delmar, DE 19940

CMS Certification Number: 085041

DENIAL OF PAYMENT - PLEASE READ CAREFULLY

Dear Mr. Lanzo:

Based on the July 22, 2013 letter sent to you by Mr. Timothy J. Hock, Certification and Enforcement Branch of CMS, the Delaware Division Medicaid & Medical Assistance hereby notifies you that the following two actions will ensue.

- Delaware Medicaid will deny payments for all new Medicaid admissions effective August 10, 2013. This means that Medicaid vendor payments for Delaware Medicaid patients admitted to your facility from August 10, 2013 forward will not be honored.

- Your Delaware Medicaid contract will be terminated no later than November 10, 2013.

These actions are mandated by the Code of Federal Regulations 42, Part 30 to End - Part 442, Subpart B - Provider Agreement, 442.12 which states "... **a Medicaid agency may not execute a provider agreement with a facility for nursing facility services nor make Medicaid payment to a facility for those services unless the Secretary or the State Survey agency has certified the facility under this part to provide those services.**"

This notice results from the findings of the Division of Long Term Care Residents Protection that your facility is not in substantial compliance with Federal participation requirements and State regulations. Evidence upon which this decision was based was enclosed in the letter that Mr. Hock sent to you. If an acceptable Plan of Correction is submitted to Mr. Hock within the time frame mandated by him, and if he finds that substantial compliance has been achieved, this action will be stayed.

P.O. BOX 906 • NEW CASTLE • DELAWARE • 19720 • TELEPHONE: (302) 255-9500

If this action is not stayed, Delaware Medicaid will either-

- work with your facility to find alternate placements for our Medicaid patients in the case of termination, and/or –
- work with CMS, and/or the Division of Long Term Care Residents Protection in the imposition and implementation of remedies specified by them.

Mr. Hock's letter to you specified the remedy/ies that will be imposed if substantial compliance is not achieved. Note that the enforcement action(s) may be revised if there is a change in the seriousness of noncompliance.

In accordance with 42 CFR 498.40, your facility may request a hearing before an Administrative Law Judge. This request should be made per the procedures outlined in Mr. Hock's letter to you.

If you have any questions, please feel free to call me.

Sincerely,

Stephen Groff
Director
Division of Medicaid & Medical Assistance

pc: Robert Smith

SG: gr

EXHIBIT J

SETTLEMENT AGREEMENT

I. Recitals

1. Parties. The Parties to this Settlement Agreement (Agreement) are the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) and Mid-Atlantic of Delmar, LLC (Respondent).

2. Factual Background and Covered Conduct. The OIG contends that from October 18, 2013 through May 30, 2014, Respondent employed Douglas Entenman (DE) for the provision of items or services for which payment may be made under a Federal health care program. On June 7, 2014, Respondent made a submission pursuant to OIG's Self Disclosure Protocol (Protocol), and OIG accepted Respondent into the Protocol on July 23, 2014. The OIG contends that Respondent knew or should have known that DE was excluded from participation in all Federal health care programs and that no Federal health care program payments could be made for items or services furnished by DE. The OIG contends that the conduct described in this Paragraph (hereinafter referred to as the "Covered Conduct") subjects Respondent to civil monetary penalties, assessments, and exclusion under 42 U.S.C. §§ 1320a-7a and 1320a-7(b)(7).

3. No Admission or Concession. This Agreement is neither an admission of liability by Respondent nor a concession by the OIG that its claims are not well-founded.

4. Intention of Parties to Effect Settlement. In order to avoid the uncertainty and expense of litigation, the Parties agree to resolve this matter according to the Terms and Conditions of this Agreement.

II. Terms and Conditions

5. Payment. Respondent agrees to pay to OIG $92,344.60 (Settlement Amount). This payment shall be made via wire transfer to the United States Department of Health and Human Services according to written instructions provided by OIG. Respondent shall make full payment no later than three business days after the Effective Date.

6. Release by the OIG. In consideration of the obligations of Respondent under this Agreement and conditioned upon Respondent's full payment of the Settlement Amount, the OIG releases Respondent from any claims or causes of action it may have against Respondent under 42 U.S.C. §§ 1320a-7a and 1320a-7(b)(7) for the Covered Conduct. The OIG and HHS do not agree to waive any rights, obligations, or causes of action other than those specifically referred to in this Paragraph. This release is applicable only to Respondent and is not applicable in any manner to any other individual, partnership, corporation, or entity.

7. Agreement by Respondent. Respondent shall not contest the Settlement Amount under this Agreement or any other remedy agreed to under this Agreement. Respondent waives all procedural rights granted under the exclusion statute (42 U.S.C. § 1320a-7), the CMPL (42 U.S.C. § 1320a-7a) and related regulations (42 C.F.R. Part 1003), and HHS claims collection regulations (45 C.F.R. Part 30), including, but not limited to, notice, hearing, and appeal with respect to the Settlement Amount.

8. Reservation of Claims. Notwithstanding any term of this Agreement, specifically reserved and excluded from the scope and terms of this Agreement as to any entity or person (including Respondent) are the following:

a. Any criminal, civil, or administrative claims arising under Title 26 U.S. Code (Internal Revenue Code);

b. Any criminal liability;

c. Except as explicitly stated in this Agreement, any other administrative liability, including mandatory exclusion from Federal health care programs; and

d. Any liability to the United States (or its agencies) for any conduct other than the Covered Conduct.

9. Binding on Successors. This Agreement is binding on Respondent and its successors, transferees, and assigns.

10. Costs. Each Party to this Agreement shall bear its own legal and other costs incurred in connection with this matter, including the preparation and performance of this Agreement.

11. No Additional Releases. This Agreement is intended for the benefit of the Parties only, and by this instrument the Parties do not release any claims against any other person or entity except as provided in paragraph 12.

12. Claims Against Beneficiaries. Respondent waives and shall not seek payment, including co-pay and deductible amounts, for any of the health care billings covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals, or third party payers based upon the claims defined as Covered Conduct.

13. Effect of Agreement. This Agreement constitutes the complete agreement between the Parties. All material representations, understandings, and promises of the

Parties are contained in this Agreement. Any modifications to this Agreement shall be set forth in writing and signed by all Parties. Respondent represents that this Agreement is entered into with advice of counsel and knowledge of the events described herein. Respondent further represents that this Agreement is voluntarily entered into in order to avoid further administrative proceedings and litigation, without any degree of duress or compulsion.

14. Disclosure. Respondent consents to the OIG's disclosure of this Agreement, and information about this Agreement, to the public.

15. Effective Date. The Effective Date of this Agreement shall be the date of signing by the last signatory.

16. Execution in Counterparts. This Agreement may be executed in counterparts, each of which constitutes an original, and all of which shall constitute one and the same agreement.

17. Authorizations. The individuals signing this Agreement on behalf of the Respondent represent and warrant that they are authorized by Respondent to execute this Agreement. The individuals signing this Agreement on behalf of the OIG represent that they are signing this Agreement in their official capacities and that they are authorized to execute this Agreement.

RESPONDENT

Donna L. Rooney, JD, BSN, CHC, CPC
Vice President of Corporate Compliance
Mid-Atlantic of Delmar, LLC

10/30/2014
Date

FOR THE OFFICE OF INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROBERT K. DECONTI
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services

10/31/14
DATE

ADRIENNE SHELFER
Program Analyst
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services

10/31/2014
DATE

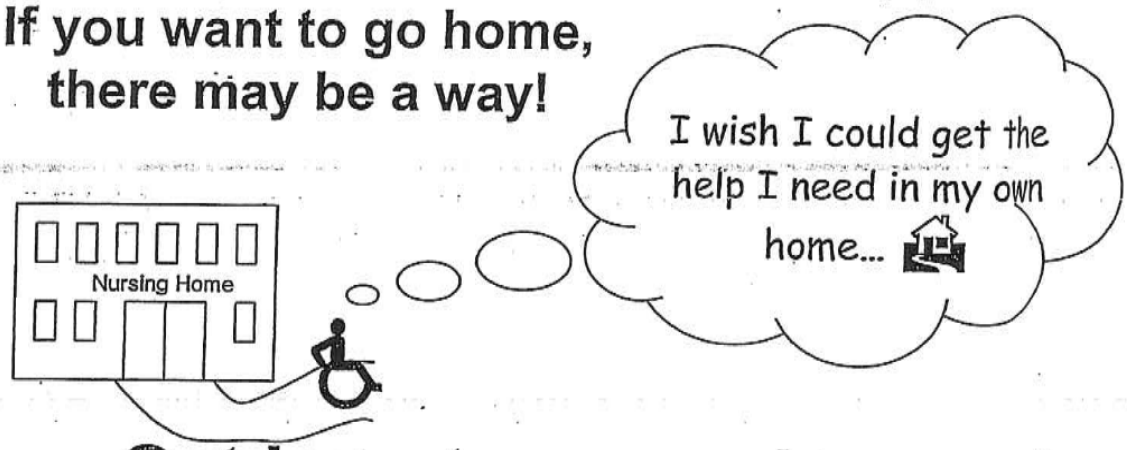
Wire Transfer Instructions for CMS

Subtype/Type Code:	10 00
Amount:	$92,344.60
Sending Bank Routing Number:	*Insert information*
ABA Number of Receiving Institution:	[redacted]
Receiver Name:	Treasury NYC
Receiving Institution Name:	[redacted]
Receiving Institution Address:	[redacted]
Beneficiary Account Number:	[redacted]
Beneficiary Name:	Centers for Medicare & Medicaid Services (CMS)
Beneficiary Physical Address:	7500 Security Blvd., Baltimore, MD 21244
CMS Tax ID Number:	[redacted]
Federal Reserve Assistance Number:	(202) 874-6894
Re:	Mid-Atlantic of Delmar OIG CMP Settlement Payment for the Employment of an Excluded Individual

Please email confirmation that the wire transfer has been made to Adrienne Shelfer at adrienne.shelfer@oig.hhs.gov

Exhibit K

If you want to go home, there may be a way!



Get long term services and supports in the community!

If Medical Assistance pays for any part of your nursing home care, you may be able to get care and services in your own community home instead of in a nursing home.

In the last few years, hundreds of people have moved out of nursing homes to receive services in the community. There are several programs that provide services in the community. We can help you decide which one may be right for you and help you apply. **Just let us know.**

If you would like to learn more about services that may help you move back to the community, ask a social worker at your nursing home, or contact one of the places listed on the back of this page.

State Government	
Maryland Department of Disabilities	800-637-4113
Maryland Department of Health and Mental Hygiene Community First Choice/Community Options Waiver MFP Nursing Facility Transition Program	 877-463-3464 or 410-767-1739 410-767-7242 (MFP)
Maryland Department on Aging	1-800-AGE-DIAL (1-800-243-3425)
Maryland Access Point	1-844 MAP-LINK (844-627-5465) www.marylandaccesspoint.info
Adult Evaluation and Review Services (AERS)	877-463-3464 or 410-767-7479
Developmental Disabilities Administration	Central MD 410-234-8200 Western MD 301-791-4670 Southern MD 301-362-5100 Eastern Shore 410-572-5920

Advocacy	
Independence Now (PG & Montgomery Counties)	301-277-2839
Southern MD CIL (Calvert, Charles, St. Mary's Counties)	301-884-4498
The Freedom Center (Frederick & Carroll Counties)	301-846-7811
Resources for Independence (Western Maryland)	800-371-1986
Bay Area CIL (BACIL) (Cecil Co. and the Eastern Shore)	443-260-0822 or 877-511-0744
The IMAGE Center (Baltimore City/Co. & Harford)	410-982-6311
Accessible Resources for Independence (Howard & Anne Arundel Counties)	410-636-2274
Brain Injury Association of Maryland	410-448-2924 or 800-221-6443
Maryland Statewide Independent Living Council	240-638-0074
Mental Health Association of Maryland	443-901-1550

Legal Resources	
Legal Aid Bureau LTC Assistance Program & MD Senior Legal Hotline1-866-635-2948 www.mdlab.org The Assisted Living/Nursing Home Program provides legal assistance to financially eligible nursing home residents anywhere in Maryland.	Maryland Disability Law Center (MDLC) 1-800-233-7201, TDD number: 410-727-6387 www.mdlclaw.org MDLC is a non-profit legal services established by federal and state law to advocate for the rights of persons with disabilities in Maryland.

This document is produced by the Maryland Department of Health and Mental Hygiene. By law, nursing homes must ...

Long Term Care Services in the Community

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

Signature _____ Date _____

Print Name _____

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

EXHIBIT L - MAP

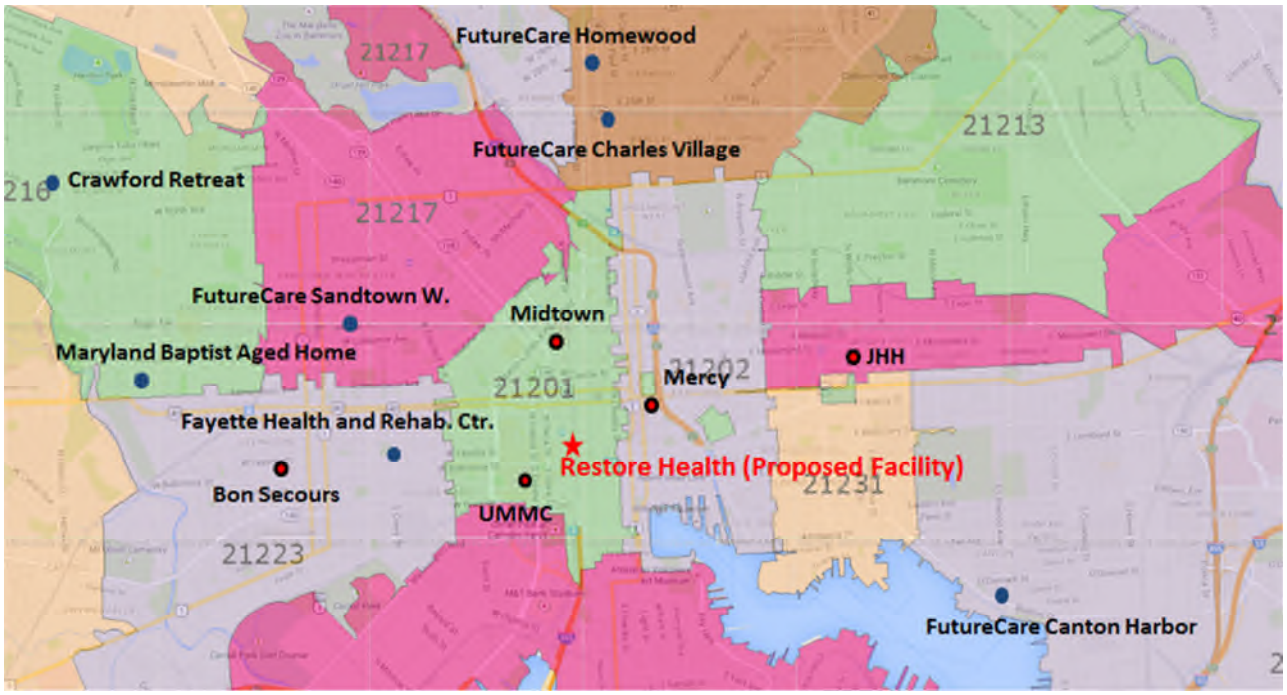


Exhibit M

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

MEDICARE NURSING HOME RESIDENT HOSPITALIZATION RATES MERIT ADDITIONAL MONITORING

Daniel R. Levinson
Inspector General

November 2013
OEI-06-11-00040

EXECUTIVE SUMMARY: MEDICARE NURSING HOME RESIDENT HOSPITALIZATION RATES MERIT ADDITIONAL MONITORING
OEI-06-11-00040

WHY WE DID THIS STUDY

Nursing homes hospitalize residents when physicians and nursing staff determine that residents require acute-level care. Such transfers to hospitals provide residents with access to needed acute-care services. However, hospitalizations are costly to Medicare, and research indicates that transfers between settings increase the risk of residents' experiencing harm and other negative care outcomes. High rates of hospitalizations by individual nursing homes could signal quality problems within those homes.

HOW WE DID THIS STUDY

We used administrative and billing data both for nursing homes and hospitals to identify all Medicare residents in Medicare- or Medicaid-certified nursing homes who experienced hospitalizations—i.e., transfers to hospitals for inpatient stays—in fiscal year (FY) 2011. We included all Medicare nursing home residents—those in Medicare-paid skilled nursing and rehabilitative (referred to as "SNF") stays and those in nursing home stays not paid for by Medicare, which include long-term care (LTC) stays)—in our analysis. We calculated the percentage of Medicare nursing home residents that each nursing home hospitalized. We identified the diagnoses associated with these hospitalizations, calculated Medicare reimbursements for the hospital stays, and calculated the rates and costs of hospitalizations of nursing home residents. We also examined the extent to which annual rates of resident hospitalizations varied among individual nursing homes.

WHAT WE FOUND

In FY 2011, nursing homes transferred one quarter of their Medicare residents to hospitals for inpatient admissions, and Medicare spent $14.3 billion on these hospitalizations. Nursing home residents went to hospitals for a wide range of conditions, with septicemia the most common. Annual rates of Medicare resident hospitalizations varied widely across nursing homes. Nursing homes with the following characteristics had the highest annual rates of resident hospitalizations: homes located in Arkansas, Louisiana, Mississippi, or Oklahoma and homes with one, two, or three stars in the Centers for Medicare & Medicaid Services' (CMS) Five-Star Quality Rating System.

WHAT WE RECOMMEND

In its comments on the draft report, CMS concurred with both of our recommendations to: (1) develop a quality measure that describes nursing home resident hospitalization rates and (2) instruct State survey agencies to review the proposed quality measure as part of the survey and certification process.

TABLE OF CONTENTS

OBJECTIVES

1. To determine the percentage of Medicare nursing home residents hospitalized in fiscal year (FY) 2011 and the associated costs to Medicare.
2. To identify the medical conditions most commonly associated with these hospitalizations.
3. To determine the extent to which these hospitalization rates varied across nursing homes.
4. To determine the extent to which these hospitalization rates varied according to select nursing home characteristics.

BACKGROUND

Nursing homes send residents to hospitals when physicians or nursing staff determine that residents require acute-level care. These transfers to hospitals provide residents with access to needed acute-care services.[1]

However, research indicates that transfers between health care facilities increase the risk of residents' experiencing harm and other negative care outcomes and that these hospitalizations are costly to Medicare.[2] The harm that residents experience during hospitalizations can include disruption of their care plans, disorientation, stress, and iatrogenic illness (e.g., adverse events).[3, 4, 5] The Centers for Medicare & Medicaid Services (CMS), in its *2012 Nursing Home Action Plan*, suggests that negative outcomes associated with hospitalizations are further complicated because health care providers often do not communicate critical information when transferring the residents.[6] Financial costs associated with hospitalizations of nursing home residents include, but are not limited to, Medicare

[1] D. Saliba, "Appropriateness of the Decision to Transfer Nursing Facility Residents to the Hospital," *Journal of the American Geriatrics Society*, 48, 2, 2000, p. 155.

[2] Assistant Secretary for Planning and Evaluation (ASPE), *Hospitalizations of Nursing Home Residents: Background and Options*, June 2011, p. 1.

[3] D. Saliba, op. cit., pp. 154–155.

[4] J.G. Ouslander, "Reducing Potentially Avoidable Hospitalizations of Nursing Home Residents: Results of a Pilot Quality Improvement Project," *Journal of the American Medical Directors Association*, 2009, p. 645.

[5] E. Hutt, "Precipitants of Emergency Room Visits and Acute Hospitalization in Short-Stay Medicare Nursing Home Residents," *Journal of the American Geriatrics Society*, 50, 2, 2002, pp. 223–224.

[6] CMS, *2012 Nursing Home Action Plan*, 2012. Accessed at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/2012-Nursing-Home-Action-Plan.pdf on February 5, 2013.

reimbursements for hospital stays, physician services during these stays, and applicable copayments.

Although nursing homes may hospitalize residents primarily for clinical reasons, research indicates that several nonclinical factors can also influence homes' decisions to hospitalize residents. These factors include the availability and training of nursing staff in the home, resident and family member preferences, and physician availability and preferences.[7] Additionally, research suggests that aspects of Medicare payment policies and other economic factors can influence hospitalization rates.[8, 9]

Payment for Hospitalizations. Medicare pays for hospitalizations of nursing home residents primarily by reimbursing acute-care hospitals according to the Inpatient Prospective Payment System (IPPS).[10] Under IPPS, hospitals may submit Medicare claims with codes from the Internal Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM codes) representing resident conditions and procedures for each hospital stay.[11] Payment for most Medicare resident hospitalizations is determined largely by grouping the diagnosis and procedure codes into Diagnosis-Related Groups based on the average cost of care for residents with similar conditions.

Nursing Homes

There are two primary types of care for Medicare beneficiaries in nursing homes: skilled nursing and rehabilitative care (referred to as "SNF")[12] and long-term care (LTC). Over 90 percent of nursing homes can admit residents into either type of care, depending on their clinical needs.[13]

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[7] ASPE, *Hospitalizations of Nursing Home Residents: Background and Options*, June 2011, pp. 6–7.

[8] Ibid., pp. 8–14.

[9] Congressional Research Service (CRS), *Medicare Hospital Readmissions: Issues, Policy Options and PPACA [the Patient Protection and Affordable Care Act]*, September 21, 2010, pp. 11–17.

[10] CMS does not pay all hospitals for resident stays through the IPPS. CMS pays several types of hospitals (e.g., critical access hospitals, inpatient psychiatric hospitals) and most hospitals in Maryland through alternate payment methodologies. CMS, *Pub. No. 100-04 Medicare Claims Processing,* April 2004. Accessed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R156CP.pdf on March 18, 2013.

[11] The ICD-9-CM system assigns diagnoses and procedure codes associated with hospital stays and is maintained jointly by CMS and the National Center for Health Statistics. CMS, *Acute Inpatient PPS Overview*, last modified February 22, 2010. Accessed at http://www.cms.gov/AcuteInpatientPPS/01_overview.asp on March 18, 2013.

[12] In this report, we use the commonly used acronym for skilled nursing facility ("SNF") to describe residents in skilled nursing and rehabilitative stays covered under Medicare Part A (i.e., "SNF residents").

[13] Medicare Payment Advisory Committee (MedPAC), *Report to the Congress: Medicare Payment Policy, Skilled Nursing Facility Services*, March 2013, p. 161.

Federal law requires all nursing homes to provide residents with care that enables them to attain or maintain the highest practicable physical, mental, and psychosocial well-being.[14] (In this report, we refer to all Medicare beneficiaries in nursing homes as "residents" or "nursing home residents.")

SNF Care in Nursing Homes. In 2011, about 20 percent of all hospitalized Medicare beneficiaries went to 1 of the 15,207 nursing homes for SNF care following their hospital stays.[15] Examples of nursing home residents in SNF stays include those recovering from surgical procedures performed in hospitals (e.g., hip or knee replacements) or recovering from acute medical conditions (e.g., septicemia, urinary tract infection, heart failure).[16] In 2009, the Medicare Standard Analytical Files (SAF) categorized over 50 percent of residents in Medicare Part A SNF care as having illnesses of major or extreme severity.[17]

Medicare beneficiaries have access to SNF care benefits through Medicare Part A. Medicare coverage of SNF care is typically limited to 100 days per benefit period.[18] Examples of services provided to SNF residents include the development, management, and evaluation of resident care plans; physical therapy; administration of intravenous feedings; insertion of suprapubic catheters; medication management; and wound care. CMS pays for SNF care when residents have preceding hospital stays of at least 3 days and a medical professional verifies the need for nursing and rehabilitative care related to the hospitalizations.[19] In 2011, Medicare Part A paid $32 billion for SNF stays for Medicare beneficiaries.[20]

LTC in Nursing Homes. Nursing home residents in LTC stays typically need assistance accomplishing two or more activities of daily living (e.g., eating, bathing, dressing, walking). This group includes, but is not limited to, Medicare beneficiaries who are also enrolled in a State Medicaid program (known as dual eligibles).

State Medicaid requirements specify that nursing home residents in LTC stays must have access to several services including basic nursing care,

[14] Social Security Act § 1819 (b)(2) and §1919 (b)(2).
[15] MedPAC, *Report to the Congress: Medicare Payment Policy, Skilled Nursing Facility Services*, March 2013, p. 161.
[16] Ibid.
[17] Avalere Publishing, *Medicare SAF Data Book*, 2009, p. 27.
[18] CMS, *Medicare Benefit Policy Manual: Duration of Covered Inpatient Services, Chapter 3,* October 1, 2003.
[19] CMS, *Medicare Benefit Policy Manual: Coverage of Extended Care (SNF) Services Under Hospital Insurance*, Chapter 8, April 4, 2012.
[20] MedPAC, *Report to the Congress: Medicare Payment Policy, Skilled Nursing Facility Services*, March 2012, p. 171.

medical-related social services, pharmaceutical services, specialized rehabilitative services, individualized dietary services, emergency dental services, and other quality-of-life services.[21] Medicare Part A does not pay for LTC stays in nursing homes, but Medicare Part B may pay for certain LTC services (e.g., enteral nutrition) for these nursing home residents.[22, 23] Payment for Medicare beneficiaries' nursing home LTC comes from sources other than Medicaid, including personal resources, LTC insurance, or (if beneficiaries are dual eligibles) Medicaid.

Medicare Oversight of Nursing Homes

CMS verifies that Medicare- and Medicaid-certified nursing homes comply with Federal requirements.[24] It enters into agreements with State survey agencies to conduct onsite reviews of each nursing home to certify compliance with Federal requirements.[25] When surveyors identify noncompliance, CMS requires nursing homes to submit plans of correction and to correct the problems. If nursing homes do not correct the problems, CMS may take enforcement actions. These actions include imposing civil monetary penalties, denying payment for new admissions of Medicare residents, or terminating the nursing home from participation in Medicare and Medicaid.[26]

Nursing Home Quality Measures. Nursing homes routinely collect resident assessment data at specific intervals during a nursing home stay, and CMS stores the assessment results in the Minimum Data Set (MDS).[27] CMS converts MDS data into 18 Quality Measures (QM).[28, 29] The QMs

[21] CMS, *Nursing Facilities*. Accessed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Nursing-Facilities-NF.html on January 22, 2013.

[22] CMS. *What is Long-Term Care?,* August 3, 2012. Accessed at http://www.medicare.gov/longtermcare/static/home.asp on May 15, 2013

[23] Office of Inspector General (OIG), *Medicare Part B Services During Non-Part A Nursing Home Stays: Enteral Nutrient Pricing*, January 2010, pp. 2-4.

[24] Nursing Home Reform Act as part of the Omnibus Budget Reconciliation Act of 1987; 42 CFR Part 483.

[25] 42 CFR §§ 488.308(a), 488.330(a)(1)(i), and CMS, *Survey and Certification: General Information*, April, 11, 2013. Accessed at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/index.html?redirect=/surveycertificationgeninfo/ on May 15, 2013.

[26] 42 CFR §§ 488.402(d), 488.408, and 488.456.

[27] CMS, *MDS 3.0 for Nursing Homes and Swing Bed Providers.* Accessed at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30.html on March 4, 2013.

[28] CMS, *Nursing Home Quality Initiative: Quality Measures.* Accessed at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html on April 16, 2013.

[29] See Appendix A for a complete listing of the 18 QMs.

indicate how well a nursing home provides care to its residents. Examples of QMs include the percentage of residents who report moderate to severe pain, the percentage of residents who were appropriately given the seasonal influenza vaccine, and the percentage of residents who have lost significant amounts of weight.[30] CMS provides QMs to nursing homes for them to use in quality improvement efforts. Currently, the QMs do not include a measure of how often nursing homes hospitalize residents.

Public Reporting of QMs and Other Data Through the Five-Star Quality Rating System. CMS publicly reports nursing home QMs through the Five-Star Quality Rating System. CMS gives each Medicare- and Medicaid-certified nursing home an overall rating between one and five stars. A rating of one star indicates that a nursing home is "much below average" in terms of quality, and a rating of five stars indicates that a nursing home is "much above average."[31]

CMS bases the overall five-star rating on the nursing homes' ratings in three areas: performance on inspection surveys (survey metric), QMs (quality metric), and staffing (staffing metric). CMS calculates these three metrics as follows:

- The survey metric is based on points assigned to the results of nursing home surveys, complaint surveys, and survey revisits conducted within the last 3 years.
- The quality metric is based on nursing homes' performance on 10 QMs. Seven of the QMs relate to LTC residents (e.g., mobility decline, use of physical restraints), and the three remaining QMs relate to SNF residents (e.g., delirium, level of pain).
- The staffing metric is based on registered nurse (RN) hours per resident day and total staffing hours (hours by RNs, licensed practical nurses, and nurse aides).

Efforts To Monitor and Reduce Rates of Hospitalization and Other Types of Transfers

Rates of hospitalizations and other types of resident transfers have received increased attention from government agencies and key stakeholders because of the resident risk and high associated cost.

[30] RTI [Research Triangle Institute] International, *MDS 3.0 Quality Measures User's Manual*. Accessed at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-Users-Manual-V60.pdf on February 19, 2013.

[31] CMS, *Consumer Fact Sheet*, December 2008. Accessed at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/consumerfactsheet.pdf on October 4, 2013.

Congress, through the Affordable Care Act, established several initiatives designed to reduce hospital resident readmissions.[32, 33] CMS publicly reports hospital readmission rates, has requested that Quality Improvement Organizations examine resident transfers, and is developing nursing home surveyor guidance related to the evaluation of hospitalizations of nursing home residents.[34, 35, 36] The National Quality Forum (NQF) adopted measures of hospital performance based on hospital resident readmission rates.[37] MedPAC made recommendations to CMS to limit payment policies that incentivize unnecessary hospitalizations of nursing home residents.[38] Researchers have suggested changes to Medicare payment policies that can reduce hospitalization rates for the benefit of both the program and beneficiaries.[39, 40] The provider community has also focused attention on developing best practices to reduce hospitalizations of nursing home residents.[41]

METHODOLOGY

To determine the percentage of Medicare residents transferred to hospitals for acute inpatient stays in FY 2011, we collected nursing home resident assessment data from the MDS, beneficiary information from the Enrollment Database (EDB), and hospital claims data from the National Claims History (NCH). We combined these data sources to identify all transfers of Medicare nursing home residents to hospitals for inpatient stays. For this report, we defined a Medicare nursing home resident as any Medicare beneficiary who stayed in a Medicare- or Medicaid-certified

[32] Patient Protection and Affordable Care Act of 2010, P.L. 111-148 § 3025.

[33] CMS, *Community-Based Care Transitions Program Fact Sheet*. Accessed at http://innovations.cms.gov/Files/fact-sheet/Community-based-Care-Transitions-Program-Fact-Sheet-.pdf on February 5, 2013.

[34] CMS, *Hospital Quality Initiatives: Outcome Measures*. Accessed at https://www.cms.gov/HospitalQualityInits/20_OutcomeMeasures.asp on January 12, 2012.

[35] CMS, *Medicare Quality Improvement Organization 9th Scope of Work*, p. 69. Accessed at http://www.cms.gov/QualityImprovementOrgs/Downloads/9thSOWBaseContract_C_08-01-2008_2_.pdf on September 13, 2011.

[36] CMS, *2012 Nursing Home Action Plan*, 2012, pp. 25–26 and 37–39.

[37] NQF, *Candidate Hospital Care Additional Priorities: 2007 Performance Measure*. Washington, DC, 2007.

[38] MedPAC, *Report to the Congress: Reforming the Delivery System*, June 2008, p. 87.

[39] ASPE, *Hospitalizations of Nursing Home Residents: Background and Options*, June 2011, pp. 15–23.

[40] CRS, *Medicare Hospital Readmissions: Issues, Policy Options and PPACA*, September 21, 2010, pp. 18–36.

[41] National Transitions of Care Coalition, 2011. Accessed at http://www.ntocc.org/ on September 13, 2011.

nursing home for at least 1 day in FY 2011. We defined a hospitalization as an instance when a Medicare nursing home resident went to a hospital for a Medicare-reimbursed inpatient stay within 1 day of discharge from a nursing home.

Identifying Hospitalizations of Medicare Nursing Home Residents

We identified hospitalizations of Medicare nursing home residents using data from the MDS, the EDB, and the NCH. To identify all Medicare beneficiaries who were nursing home residents in FY 2011, we used the MDS and the EDB. The MDS contains resident Social Security Numbers (SSN), admission and discharge dates, and the related nursing home identification numbers. We matched SSNs in the MDS to those in the EDB to identify Medicare beneficiaries and their associated Medicare Health Insurance Claim Numbers. We excluded from this analysis the small number of beneficiaries in the MDS who had SSNs that did not match their SSNs as listed in the EDB. We used the Medicare Part A claims data in the NCH to determine whether nursing home residents entered hospitals following their nursing home stays and to determine whether the nursing home stays were reimbursed through Medicare Part A.[42]

The resulting data set enabled us to determine when beneficiaries were admitted to nursing homes, whether they were discharged from nursing homes, and whether they were hospitalized following discharge from nursing homes.

Analysis

Using the data set described above, we determined the percentage of Medicare nursing home residents hospitalized in FY 2011, the Medicare costs associated with hospitalizations of nursing home residents, the medical conditions associated with the hospitalizations, each nursing home's rate of resident hospitalization (which we refer to as the "annual hospitalization rate"), and the extent to which annual hospitalization rates varied according to select characteristics. For analysis, we combined all Medicare nursing home residents—those in Medicare-paid SNF stays and

[42] We excluded nursing home stays that occurred in "swing bed" units within hospitals from our analysis. (A swing-bed unit is a hospital unit in which residents receive skilled nursing services.) We excluded these stays because the associated facilities differ substantially from the freestanding nursing homes that are the focus of this report. Excluding these stays removed 111,298 stays and 1,149 hospital swing-bed facilities from our analysis. CMS, *Swing Bed Services,* January 2013. Accessed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SwingBedFactsheet.pdf on March 18, 2013.

those in nursing home stays not paid by Medicare—and refer to them as "Medicare nursing home residents" or "nursing home residents."

Calculating the Percentage of Hospitalized Nursing Home Residents. To calculate the percentage of nursing home residents hospitalized, we divided the total number of Medicare nursing home residents hospitalized at least once in FY 2011 by the total number of residents who had nursing home stays of at least 1 day in FY 2011.

Calculating the Medicare Costs Associated With Resident Hospitalizations. We calculated the amount Medicare spent on hospitalizations of nursing home residents by summing the Medicare reimbursements for each hospital stay that we identified as a hospitalization of a Medicare nursing home resident. These costs represent only the amounts that Medicare paid hospitals for the residents' acute-care hospital stays. Our analysis included payments made to IPPS and non-IPPS hospitals. When hospitalized residents were transferred from their initial hospitals to other hospitals, we combined the reimbursements paid by Medicare to each hospital.[43]

We calculated the amount Medicare spent on all hospitalizations of Medicare beneficiaries by summing Part A reimbursements for all hospital stays with admission dates in FY 2011.

Identification of Medical Conditions Associated With Hospitalization. To identify the medical conditions associated with hospitalizations of nursing home residents, we reviewed the primary ICD-9-CM diagnosis codes on the Medicare claims submitted for the hospital stays. To categorize the diagnosis codes, we used the clinical classification system (CCS) of the Agency for Healthcare Research and Quality's (AHRQ) Healthcare Cost and Utilization Project (HCUP). The CCS enables researchers to collapse ICD-9-CM codes into clinically meaningful categories for analysis and comparison between studies.[44]

Calculating Annual Hospitalization Rates for Nursing Homes. To calculate the annual hospitalization rate for each nursing home in FY 2011, we divided the number of nursing home stays that ended in hospitalization in a given home by the total number of nursing home stays

[43] Under CMS's transfer policy, CMS reduces reimbursements for hospitalizations under several scenarios, including instances when residents are transferred to other hospitals covered by the IPPS. CMS, *Acute Care Hospital Inpatient Prospective Payment System,* February 2012. Accessed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AcutePaymtSysfctsht.pdf on March 18, 2013.

[44] See Appendix B for a detailed description of the methodology we used to describe the ICD-9-CM codes on the hospital claims using the HCUP CCS.

of at least 1 day in the home. We calculated annual hospitalization rates only for homes that provided care to 30 or more Medicare residents in FY 2011.

Analysis of Characteristics Associated With Variation in Annual Hospitalization Rates. To determine whether annual hospitalization rates varied according to select nursing characteristics, we divided homes into subgroups based on characteristics and then calculated average annual hospitalization rates for the subgroups. To determine how much annual hospitalization rates varied by geographic location, we divided homes into groups by the State code in their billing addresses and then calculated the average annual hospitalization rate for nursing homes in each State and the District of Columbia. To determine how much annual hospitalization rates varied by scores on the four CMS Five-Star Quality Rating System metrics, we divided nursing homes into two groups—one group consisting of those with one, two, or three stars and the other consisting of those with four or five stars—for each metric and calculated the rates for each group. To determine how much annual hospitalization rates varied by nursing home size, we divided nursing homes into three categories based on the number of beds within each home and then calculated the rate for each group. To determine how much annual hospitalization rates varied by ownership type, we divided nursing homes into three groups based on ownership type and then calculated the rate for each group.

We collected information on nursing homes' locations, bed counts, and ownership categories from CMS's Certification and Survey Provider Enhanced Reports (CASPER) database. CMS provided five-star ratings data applicable to our observation period.

Limitations. The annual hospitalization rates are not adjusted to account for "case mix"—in this instance, the physical and mental health of residents in a given nursing home—or other factors. Additionally, the cost figures associated with the hospitalizations of nursing home residents do not include copayments for the hospital stays, physician reimbursements for the hospital stays, or payments made by the Medicare program or other payers for post-hospitalization services (e.g., followup physician office visits). Therefore, we likely underestimate the costs associated with hospitalizations of nursing home residents to the Medicare program and beneficiaries.

Standards

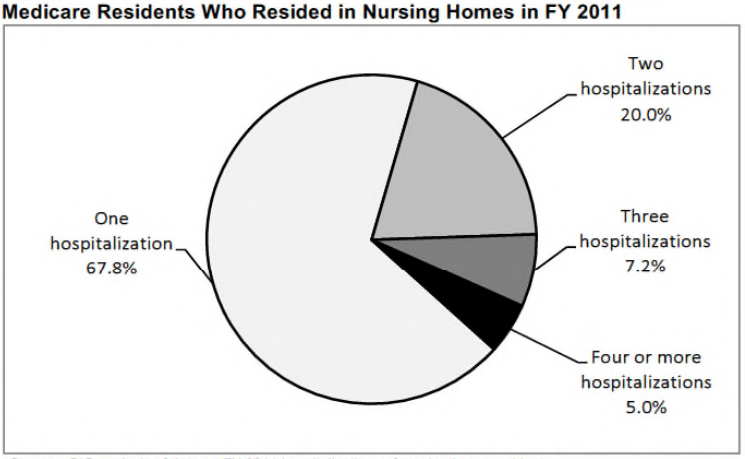
This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

One-quarter of Medicare nursing home residents experienced hospitalizations in FY 2011, and Medicare spent $14.3 billion on these hospitalizations

Of the 3.3 million Medicare residents who stayed in nursing homes for at least 1 day in FY 2011, 825,765 (24.8 percent) experienced hospitalizations. The majority of hospitalized residents (67.8 percent) transferred from nursing homes to hospitals only once. Twenty percent transferred two times, 7.2 percent transferred three times, and the remaining 5 percent transferred four or more times (see Figure 1).

Figure 1: Number of Hospitalizations Experienced by Hospitalized Medicare Residents Who Resided in Nursing Homes in FY 2011



Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

Medicare spent $14.3 billion in FY 2011 on hospital stays for nursing home residents, spending 33 percent more per stay than for the average Medicare hospitalization

Medicare spent $14.3 billion on 1.3 million hospital stays associated with hospitalizations of nursing home residents. These costs represent 11.4 percent of Medicare Part A spending on all hospital admissions ($126 billion) in the same year.[45] Medicare spent an average of $11,255 on each hospitalization of a nursing home resident, which was 33.2 percent above the average cost ($8,447) of hospitalizations for all Medicare residents.

[45] Cost estimates presented in this report are based only on reimbursements paid by Medicare Part A for the initial hospitalizations. They do not include any other costs paid by Medicare or by other payers for further medical care—such as physician office visits or additional nursing home stays—needed as a result of the hospitalizations.

Nursing home residents went to hospitals most commonly for septicemia, pneumonia, and congestive heart failure

Medicare nursing home residents went to hospitals for a wide range of conditions—236 of the possible 285 primary diagnosis categories described in the HCUP CCS. The primary diagnosis describes the most significant medical condition found during an inpatient admission.[46] The 15 most frequent CCS diagnosis categories accounted for 60.9 percent of all resident hospitalizations (see Table 1).

Table 1: Primary Diagnoses on Claims of All Hospitalized Medicare Nursing Home Residents in FY 2011

CCS Primary Diagnosis Category	Percentage of Hospitalizations
Fifteen Most Frequent CCS Categories	**60.9%**
Septicemia	13.4%
Pneumonia	7.0%
Congestive heart failure, nonhypertensive	5.8%
Urinary tract infections	5.3%
Aspiration pneumonitis, food/vomitus	4.0%
Acute renal failure	3.9%
Complication of device, implant, or graft	3.3%
Respiratory failure, insufficiency, or arrest	2.7%
Gastrointestinal hemorrhage	2.4%
Complications of surgical procedures or medical care	2.4%
Chronic obstructive pulmonary disease (COPD) and bronchiectasis	2.4%
Delirium, dementia, and amnestic and other cognitive disorders	2.2%
Acute cerebrovascular disease	2.1%
Fluid and electrolyte disorders	2.0%
Fracture of neck of femur (hip)	2.0%
Remaining 221 CCS Categories on Nursing Home Claims	**39.1%**
All CCS Diagnosis Categories on Nursing Home Claims	**100%**

Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

Hospitalizations for septicemia accounted for 21 percent of Medicare spending on nursing home resident hospitalizations

Septicemia led to the most hospitalizations among all CCS categories (13.4 percent). Septicemia and sepsis (a related condition) are serious bloodstream infections that can rapidly become life threatening.[47]

[46] CMS, *Medicare Claims Processing Manual*, Chapter 23, "Fee Schedule Administration and Coding Requirements."

[47] Centers for Disease Control and Prevention (CDC), *Inpatient Care of Septicemia or Sepsis: A Challenge for Patients and Hospitals*, National Center for Health Statistics Data Brief, 2011. In the data brief, CDC found that the rate of nursing home resident hospitalizations for septicemia more than doubled from 2000 to 2008 and that hospitalizations for septicemia ended in death much more often than hospitalizations for all other conditions.

Medicare spent almost $3 billion on nursing home resident hospitalizations associated with septicemia, more than the next three most expensive conditions combined. The high total reimbursement amount for septicemia is the result of both its frequency as a primary diagnosis on hospital claims and its above-average reimbursement rate. Table 2 shows the costs associated with the 15 most costly CCS diagnosis categories.

Table 2: Medicare Costs Associated With Medicare Nursing Home Resident Hospitalizations in FY 2011 by Sum of Reimbursement

CCS Primary Diagnosis Category	Sum of All Hospital Reimbursements	Percentage of All Hospital Reimbursements	Average Reimbursement
Fifteen Most Costly CCS Categories	**$9,268,066,011**	**65.2%**	**$11,554**
Septicemia	$2,963,329,522	20.8%	$17,430
Pneumonia	$844,817,051	5.9%	$9,464
Congestive heart failure, nonhypertensive	$643,386,174	4.5%	$8,731
Respiratory failure, insufficiency, or arrest	$637,201,272	4.5%	$18,438
Complication of device, implant, or graft	$619,241,745	4.3%	$14,629
Aspiration pneumonitis, food/vomitus	$618,310,799	4.3%	$12,223
Complications of surgical procedures or medical care	$449,236,625	3.2%	$14,731
Acute renal failure	$425,965,874	3.0%	$8,679
Urinary tract infections	$422,251,024	3.0%	$6,296
Delirium, dementia, and amnestic and other cognitive disorders	$321,003,626	2.3%	$11,515
Fracture of neck of femur (hip)	$311,417,099	2.2%	$12,578
Acute cerebrovascular disease	$285,667,898	2.0%	$10,847
Gastrointestinal hemorrhage	$264,867,028	1.9%	$8,544
COPD and bronchiectasis	$238,845,320	1.7%	$7,727
Acute myocardial infarction	$222,524,954	1.6%	$11,475
Remaining 221 CCS Categories	**$4,991,830,494**	**34.4%**	**$11,188**
All CCS Diagnosis Categories on Nursing Home Claims	**$14,259,896,509**	**100%**	**$11,211**

Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

Nursing homes' annual rate of resident hospitalization varied according to select characteristics, including geographic location and rating on CMS's Five-Star Quality Rating System

Nursing homes' individual annual hospitalization rates varied widely, ranging from less than 1 percent to 69.7 percent. The annual hospitalization rate averaged 25 percent. Additionally, 1,059 nursing homes (7 percent) had annual hospitalization rates greater than 40 percent. Table 5 shows the distribution of annual hospitalization rates among Medicare- and Medicaid-certified nursing homes.

Table 5: Percentages of Nursing Homes by Annual Hospitalization Rate in FY 2011

Annual Hospitalization Rate	Percentage of Homes
Above 50 percent	0.6%
40 percent to 49.9 percent	6.2%
30 percent to 39.9 percent	22.1%
20 percent to 29.9 percent	39.9%
10 percent to 19.9 percent	26.9%
Less than 9.9 percent	4.3%
All Homes	**100.0%**

Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

Nursing homes' annual hospitalization rates varied by the four characteristics that we examined: the nursing home's geographic location, its size, its rating on CMS' Five-Star Quality Rating System, and the category of its ownership.[48]

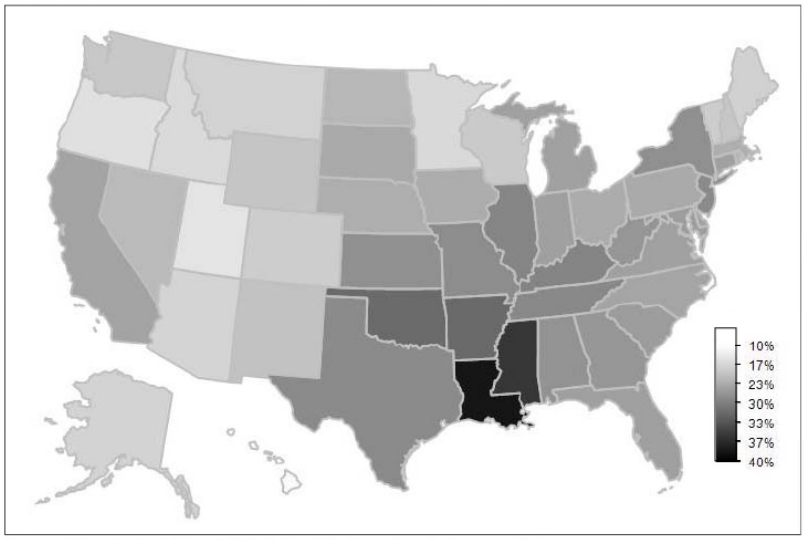
Homes with high annual hospitalization rates were not evenly distributed across the country

Nursing homes in Arkansas, Louisiana, Mississippi, and Oklahoma had the highest annual hospitalization rates when averaged at the State level. The average hospitalization rate for nursing homes in Louisiana (38.3 percent) was 14 percentage points higher than the national average (24.3 percent). Generally, nursing homes in States in the upper Pacific West, Mountain West, upper North Central Midwest, and New England

[48] The extent of identified variations suggests that average annual rates of hospitalization differed by the reviewed characteristics, but we do not try to explain these variations. Other factors—such as State bed hold policies—have been shown to influence hospitalization rates. D.C. Grabowski, "Medicaid bed-hold policy and Medicare skilled nursing facility rehospitalizations," *Health Services Research*, 45, 6, 2010, pp. 1963–1980.

regions had the lowest average annual hospitalization rates (see Figure 2).[49]

Figure 2: Geographic Distribution of Average Annual Hospitalization Rate in FY 2011



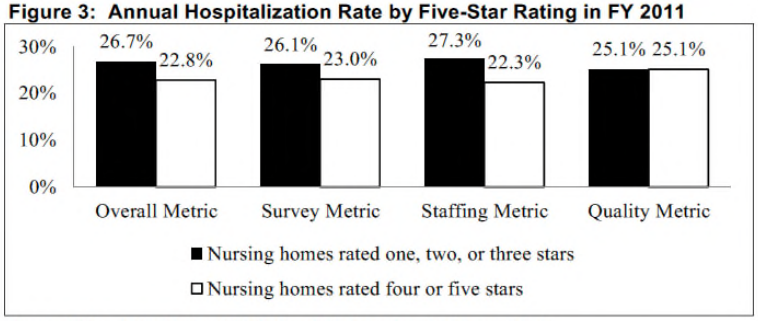
Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

In general, nursing homes rated one, two, or three stars on the Nursing Home Compare Five-Star Quality Rating System had higher annual hospitalization rates than those rated as four or five stars

Nursing homes rated one, two, or three stars (the lowest five-star ratings) on three of the four metrics (the overall, survey, and staffing metrics) had higher annual hospitalization rates than those rated four or five stars (the highest five-star ratings). The biggest difference between annual hospitalization rates appears in the staffing metric, where nursing homes rated one, two, or three stars had hospitalization rates that were 5 percentage points higher than that of those rated four or five stars. The exception is the quality metric, where nursing homes rated one, two, or three stars had the same hospitalization rate as those rated four or five stars (see Figure 3).

[49] Appendix C lists the average annual hospitalization rates for nursing homes in all States. Regions are defined by the Census Bureau.

Figure 3: Annual Hospitalization Rate by Five-Star Rating in FY 2011



Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

Large and medium-sized nursing homes had higher annual hospitalization rates than small nursing homes

Small nursing homes had annual hospitalization rates 2.4 percentage points lower than the national average. Large and medium-sized nursing homes had annual hospitalization rates 1.6 and 0.9 percentage points higher than the national average, respectively (see Table 6).

Table 6: Annual Hospitalization Rate by Nursing Home Size in FY 2011

Size of Home	Number of Homes	Average Annual Hospitalization Rate	Percentage Point Difference From National Rate
Nationwide	15,497*	25.0%	n/a
• Large nursing homes (more than 120 beds)	4,749	26.6%	**1.6%**
• Medium-sized nursing homes (80–120 beds)	5,539	25.9%	**0.9%**
• Small nursing homes (fewer than 80 beds)	5,209	22.6%	**-2.4%**

Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.
*CASPER did not contain bed count information for one home.

As a group, for-profit nursing homes had the highest annual hospitalization rate compared to the rate for government-owned and nonprofit nursing homes

As shown in Table 7, for-profit homes had an annual hospitalization rate 1.5 percentage points higher than the national average. Government-owned and nonprofit homes had annual hospitalization rates about 1.5 and 3.8 percentage points lower than the national average, respectively.

Table 7: Average Annual Hospitalization Rate by Ownership Category in FY 2011

Ownership Category	Number of Homes	Percentage of Medicare Population Served Annually	Average Annual Hospitalization Rate	Percentage Point Difference From National Rate
Nationwide	15,497*	109.0%**	25.0%	n/a
• For-profit nursing homes	10,761	76.4%	26.5%	**1.5%**
• Government-owned public nursing homes	850	4.8%	23.5%	**-1.5%**
• Nonprofit nursing homes	3,886	27.8%	21.2%	**-3.8%**

Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.
*CASPER did not contain ownership information for one home.
**Percentage exceeds 100 percent because some residents received care in multiple nursing homes.

CONCLUSION AND RECOMMENDATIONS

We found that nursing homes hospitalized one-quarter of nursing home residents in FY 2011, that these hospitalizations cost Medicare $14.3 billion, and that a small number of medical conditions (e.g., septicemia) accounted for the majority of hospitalizations and costs. We also identified wide variation in rates of hospitalization among individual nursing homes. Among 1,059 nursing homes, more than 40 percent of stays ended in hospitalization. Nursing homes in certain States (Arkansas, Louisiana, Mississippi, and Oklahoma) and nursing homes rated as one, two, or three stars on CMS's Five-Star Quality Rating System had the highest average annual hospitalization rates.

Hospitalizations of nursing home residents are necessary when physicians and nursing staff determine that residents require acute-level care. However, the higher-than-average resident hospitalization rates of some nursing homes in FY 2011 suggest that some hospitalizations could have been avoided through better nursing home care.

We recommend that CMS:

Develop a QM That Describes Nursing Home Rates of Resident Hospitalization

CMS should develop a QM of nursing home rates of resident hospitalization and consider publicly reporting this measure on the Nursing Home Compare Web site. One possible QM could be a measure of each home's overall hospitalization rate. Alternatively, CMS could develop more discrete measures that would identify nursing homes that hospitalize residents more frequently than other homes for certain conditions. Adding a measure of hospitalization rates to the existing QMs not only would enable nursing homes and the public to compare these rates across nursing homes, but also would provide greater incentive for nursing homes to reduce avoidable hospitalizations.

Instruct State Agency Surveyors To Review Nursing Home Rates of Resident Hospitalization as Part of the Survey and Certification Process

After developing the QM recommended above, CMS should instruct State survey agencies to use the QM in preparing to survey homes and provide the agencies with guidance for interpreting and using the QM. Examining these data could help surveyors identify areas of concern—such as infection control practices in homes with high rates of hospitalizations for septicemia—within individual nursing homes.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on the draft report, CMS concurred with both of our recommendations.

CMS concurred with the recommendation to develop a QM that describes nursing home rates of resident hospitalization. CMS stated that it is taking steps to develop and implement a nursing home hospitalization QM in accordance with the rulemaking process. Further, CMS indicated that it is developing a skilled nursing facility readmission measure, which it intends to submit to the National Quality Forum for endorsement in late 2013.

CMS also concurred with the recommendation to instruct State survey agency surveyors to review rates of hospitalization for nursing home residents as part of the survey and certification process. CMS indicated that surveyors should consider measures of hospitalization during their nursing home reviews. CMS stated that reducing hospitalizations is a major public health goal and that hospitalization measures can be used to assess the quality of care that nursing home residents receive.

For the full text of the CMS's comments, see Appendix D. We made minor changes to the report based on technical comments.

APPENDIX A

Nursing Home Quality Measures

Nursing homes routinely collect resident assessment data at specific intervals during a nursing home stay, and CMS stores the assessment results in the MDS. CMS converts MDS data into the 18 QMs described in Table A-1. [50]

Table A-1: Nursing Home Quality Measures

Short Stay Quality Measures
1. Percent of Residents Who Self-Report Moderate to Severe Pain
2. Percent of Residents With Pressure Ulcers That Are New or Worsened
3. Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine
4. Percent of Residents Who Were Assessed and Appropriately Given the Pneumococcal Vaccine
5. Percent of Short-Stay Residents Who Newly Received Antipsychotic Medications
Long-Stay Quality Measures
6. Percent of Residents Experiencing One or More Falls With Major Injury
7. Percent of Residents Who Self-Report Moderate to Severe Pain
8. Percent of High-Risk Residents With Pressure Ulcers
9. Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine
10. Percent of Residents Who Were Assessed and Appropriately Given the Pneumococcal Vaccine
11. Percent of Residents With Urinary Tract Infections
12. Percent of Low-Risk Residents Who Lose Control of Their Bowels or Bladder
13. Percent of Residents Who Have/Had Catheters Inserted and Left in Their Bladders
14. Percent of Residents Who Were Physically Restrained
15. Percent of Residents Whose Need for Help With Activities of Daily Living Has Increased
16. Percent of Residents Who Lose Too Much Weight
17. Percent of Residents Who Have Depressive Symptoms
18. Percent of Long-Stay Residents Who Received Antipsychotic Medications

Source: CMS, *MDS 3.0 QM User's Manual V8.0.*

[50] CMS, *Nursing Home Quality Initiative: Quality Measures.* Accessed at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html on April 16, 2013.

APPENDIX B

Detailed Methodology for Categorizing the Primary Diagnosis Codes on Hospital Claims

To describe the ICD-9-CM codes on the hospitalized residents' inpatient claims, we used the CCS established by AHRQ's HCUP.[51] The HCUP CCS enables researchers to identify patterns of diagnosis and procedure codes. Researchers use the CCS to collapse the ICD-9-CM system's 14,000 diagnosis codes and 3,900 procedure codes into a smaller number of clinically meaningful categories for presentation and analysis. AHRQ used the CCS in its 2012 review of data on hospitalizations of nursing home residents.[52]

For this review, we used the CCS "single-level" categorization. The single-level categorization system is designed for ranking diagnoses and procedures. We matched the primary diagnosis codes on the hospital claims associated with the hospitalizations to the appropriate CCS single-level category. See Table B-1 for an example of how the CCS collapses individual ICD-9-CM codes into clinically meaningful groups.

Table B-1: Examples of Single-Level CCS Matching

General Description of Condition	ICD-9-CM Diagnosis Codes Used	CCS Category
Septicemia	0031 0202 0223 0362 0380 0381 03810 03811 03812 03819 0382 0383 03840 03841 03842 03843 03844 03849 0388 0389 0545 449 77181 7907	2
Pneumonia	00322 0203 0204 0205 0212 0221 0310 0391 0521 0551 0730 0830 1124 1140 1144 1145 11505 11515 11595 1304 1363 4800 4801 4802 4803 4808 4809 481 4820 4821 4822 4823 48230 48231 48232 48239 4824 48240 48241 48242 48249 4828 48281 48282 48283 48284 48289 4829 483 4830 4831 4838 4841 4843 4845 4846 4847 4848 485 486 5130 5171	122
Congestive heart failure, nonhypertensive	39891 4280 4281 42820 42821 42822 42823 42830 42831 42832 42833 42840 42841 42842 42843 4289	108

Source: HCUP, *Clinical Classifications Software (CCS) 2013 User Guide.*

[51] A. Elixhauser, C. Steiner, and L. Palmer, *Clinical Classifications Software (CCS)*, AHRQ, 2013. Accessed at http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp on February 5, 2013.

[52] AHRQ, *Transitions between Nursing Homes and Hospitals in the Elderly Population, 2009*, September 2012. Accessed at http://www.hcup-us.ahrq.gov/reports/statbriefs/sb141.pdf on February 5, 2013.

APPENDIX C

Average Annual Rate of Hospitalization of Nursing Home Residents by State

Table C-1 reports the average annual rates of resident hospitalization in FY 2011 for nursing homes in all States. We did not include in this analysis homes with fewer than 30 admissions in FY 2011 or facilities designated as "swing bed" providers.

Table C-1: Average Annual Hospitalization Rates by State in FY 2011

State	Rate	State	Rate	State	Rate
Louisiana	38.3%	Maryland	25.3%	Nevada	20.9%
Mississippi	35.7%	Indiana	24.9%	New Mexico	19.5%
Arkansas	31.7%	Florida	24.9%	Wyoming	19.1%
Oklahoma	31.6%	Michigan	24.8%	New Hampshire	19.0%
Kentucky	29.2%	Virginia	24.8%	Washington	18.6%
Illinois	29.0%	Connecticut	24.7%	Wisconsin	18.3%
Tennessee	28.4%	California	24.2%	Vermont	17.9%
New Jersey	28.2%	North Carolina	24.2%	Colorado	17.8%
Texas	28.2%	Delaware	24.2%	Maine	17.2%
Missouri	27.9%	Pennsylvania	23.4%	Montana	17.0%
Kansas	27.5%	South Dakota	23.4%	Alaska	16.9%
New York	27.4%	Ohio	23.0%	Arizona	16.7%
Alabama	26.9%	Iowa	22.9%	Minnesota	16.0%
West Virginia	26.5%	Nebraska	22.7%	Idaho	15.9%
District Of Columbia	26.5%	Massachusetts	22.5%	Oregon	14.9%
Georgia	26.3%	Rhode Island	21.6%	Utah	14.2%
South Carolina	25.3%	North Dakota	21.4%	Hawaii	10.6%

Source: Office of Inspector General analysis of data on FY 2011 hospitalizations of nursing home residents.

APPENDIX D

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 19 2013

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring (OEI-06-11-00040)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above subject OIG draft report. Nursing home quality measurement and oversight is of critical importance to us, including addressing unnecessary hospital admissions and readmissions. One example, focusing on dual eligible beneficiaries, is the CMS Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents. In this initiative, which was launched in 2012, CMS selected organizations to partner with nursing facilities and deploy interventions aimed at reducing avoidable hospitalizations, improving transitions and outcomes, and reducing costs among Medicare-Medicaid enrollees. Lessons learned from this initiative will help inform future policy decisions.[1]

In addition, the Fiscal Year (FY) 2014 President's Budget includes a proposal addressing high rates of hospital readmissions in skilled nursing facilities (SNFs). Currently, there is a Hospital Readmission Reduction program that reduces payments for hospitals with high rates of readmission, many of which could have been avoided with better care. To promote similar high-quality care in SNFs, the President's Budget proposal would reduce payments by up to three percent for SNFs with high rates of care-sensitive, preventable hospital readmissions.

The purpose of this OIG study was to (1) Determine the proportion of Medicare nursing home residents hospitalized in FY 2011 and the associated costs to Medicare; (2) Identify the medical conditions most commonly associated with these hospitalizations; (3) Describe the extent to which these hospitalization rates varied across nursing homes; and (4) Describe the extent to which these hospitalization rates varied according to select nursing home characteristics.

The OIG recommendations and CMS's responses to those recommendations are discussed below.

OIG Recommendation

The OIG recommends that CMS develop a quality measure that describes hospitalization rates for residents of nursing homes.

[1] Additional information on this initiative is available at http://innovation.cms.gov/initiatives/rahnfr

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CMS Response

The CMS concurs. The rate of nursing home resident hospitalization measure concept was included in CMS's Measures under Consideration (MUC) list that we made public on December 1, 2012, in accordance with the pre-rulemaking process established by section 1890A(a)(2) of the Affordable Care Act. This MUC list was posted for CMS on the website of the National Quality Forum (NQF), and NQF's stakeholder group, the Measure Applications Partnership supported this measure concept for future development. Making this list public is one step in CMS's obligation to establish a pre-rulemaking process prior to adopting certain categories of measures. CMS must include potential measures on the MUC list if it is considering adopting them through rulemaking at any time in the future. Development of this proposed hospitalization outcome measure is commencing later this year and is intended to measure the percent of long-stay residents who are hospitalized during a specific reporting period.

In addition, CMS is developing a Skilled Nursing Facility 30-Day All-Cause Readmission Measure and intends to submit this measure to the NQF for endorsement in late 2013. The specifications for this measure will be designed to harmonize, to the extent possible, with CMS's hospital-wide all-cause unplanned readmission measure endorsed by the NQF for the Hospital Readmission Reduction Program.

OIG Recommendation

The OIG recommends that CMS instruct state agency surveyors to review rates of hospitalization for nursing home residents as part of the survey and certification process.

CMS Response

The CMS concurs. Reducing re-hospitalizations is a major public health goal of CMS and the Department of Health and Human Services, as well as a goal that has been widely embraced by health care providers. As noted above, CMS is actively developing a hospitalization measure for all nursing home residents and a re-hospitalization measure for Medicare SNF residents. We concur that evidence suggests these types of measures are important to assess the quality of care that residents receive. We concur that adding measures of hospitalization and/or re-hospitalization to the list of quality measures that nursing home surveyors review is a logical and useful outcome of CMS's quality measure development efforts.

The CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

ACKNOWLEDGMENTS

This report was prepared under the direction of Kevin K. Golladay, Regional Inspector General for Evaluation and Inspections in the Dallas regional office; Blaine Collins, Deputy Regional Inspector General; and Ruth Ann Dorrill, Deputy Regional Inspector General.

Jeremy Moore served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Dallas regional office who contributed to the report include Maria Balderas, Nathan Dong, and Chetra Yean. Central office staff who provided support include Kevin Farber, Heather Barton, Sandy Khoury, Starr Kidda, and Christine Moritz.

Office of Inspector General

http://oig.hhs.gov

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HERTZBACH
certified public accountants · consultants

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

April 3, 2015

Re: Baltimore Nursing and Rehabilitation, LLC Certificate of Need in Baltimore City

To whom it may concern:

We are the accountants and auditors for Mid-Atlantic Health Care, LLC and its subsidiaries, including Mid-Atlantic Health Care Acquisitions, LLC and Baltimore Nursing and Rehabilitation, LLC and Baltimore Nursing and Rehabilitation Realty, LLC. We have been the accountants and auditors for the consolidated entity for over 10 years. Mid-Atlantic Health Care (the Company) has asked us to comment on their ability to provide the $4.4 million in equity and obtain the $14.0 million in necessary financing to construct and operate the proposed 80 bed state of the art skilled nursing facility in Baltimore City.

Mid-Atlantic Health Care et al owns and operates approximately 18 skilled nursing facilities in the Mid-Atlantic region. Based on our review of the financial statements and conditions of the Company, the Company has been profitable and is expected to continue to increase its profitability. The Company has a very healthy balance sheet and presently has the ability to provide the $4.4 million in equity and obtain the necessary financing for the above referenced proposed project.

Please contact the undersigned if you have any questions regarding this communication.

Very truly yours,

Leonard Sacks, CPA, CVA, CFF, CIRA, CDBV

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EXHIBIT O

Susquehanna

Bruce D. McLean
Commercial Banking
307 International Circle
Suite 600
Hunt Valley, MD 21030-1376
410-316-0273
Bruce.McLean@susquehanna.net

April 8, 2015

Scott M. Rifkin, M.D.
Mid-Atlantic Health Care, LLC
1922 Greenspring Drive
Timonium, MD 21093

Re: Proposed 80 Bed Nursing Home – Baltimore City, MD

Dear Dr. Rifkin:

We understand that you are seeking Certificate of Need approval from the Maryland Health Care Commission to construct a new 80 bed skilled nursing facility in Baltimore City, MD. The project will be undertaken by a new limited liability company with common ownership to be formed and under control of Mid-Atlantic Health Care, LLC. We welcome the opportunity to consider your request for us to provide the construction and acquisition financing for this $19,500,000 project.

Accordingly, Susquehanna Bank would be willing to consider providing the financing necessary to fund this project. If we were to ultimately agree to provide the necessary financing, our commitments typically have a life of 90 days.

Please understand that this correspondence is not to be construed as a commitment of any kind to provide the capital to fund this project. As you know, loan approvals require formal committee approval, which would be communicated to you in writing. Our due diligence process would be extensive, and would include Certificate of Need, building plans, specifications, pro-formas, budgets and additional financial information.

Please let us know if we can be of further assistance, and we look forward to working with you on this project.

Best regards.

Yours truly,

Bruce D. McLean

EXHIBIT P

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

STEPHEN N. DAVIS, MBBS, FRCP, FACP
Theodore E. Woodward Professor of Medicine
Professor of Physiology
Chairman, Department of Medicine
Department of Medicine
22 South Greene Street, Room N3W42
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sdavis@medicine.umaryland.edu
medschool.umaryland.edu/medicine

April 10, 2015

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: Baltimore Nursing and Rehabilitation, LLC Certificate of Need in Baltimore City

To Whom It May Concern:

I am Stephen N. Davis, MBBS, the Theodore E. Woodward Endowed Chair and the Professor and Chairman of the Department of Medicine at the University of Maryland School of Medicine. In my capacity, I also am Co-Director of the University of Maryland Clinical Translational Science Institute and the Program Director of the University of Maryland General Clinical Research Center.

I am writing to express my strong support for the proposed construction of a new comprehensive care facility to be located at 300 W. Fayette Street in downtown Baltimore. I have had several discussions with Dr. Scott Rifkin, CEO of Mid-Atlantic Health Care, LLC, about the project and am excited about continuing to explore the opportunity to partner with Mid-Atlantic Health Care, LLC to integrate this facility into our clinical pathways to create a state of the art post-acute care center focused on avoiding hospitalizations and lowering hospital re-admissions.

In my opinion, the possible collaboration and integration envisioned between the new facility and our clinical pathways would be unique in Baltimore City. Further, we believe this relationship will help further our responsibilities under the Maryland Medicare Waiver.

Respectfully Submitted,

Stephen N. Davis, MBBS, FRCP, FACP

cc: Scott Rifkin, MD; Mid-Atlantic Health Care, LLC

EXHIBIT Q

April 7, 2015

Mr. George Watson
Mid-Atlantic Healthcare
1922 Greenspring Ave, Suite 6
Timonium, MD 21093

Re: Fair Market Rental Rate for 300-306 W. Fayette Street

Dear George,

In reference to the property located at 300-306 W. Fayette Street, it is our professional opinion that the fair market rental rate is between $18.00 - $20.00 per square foot, on a full service, net of utilities basis. This lease structure would mean that landlord (owner) pays for the Base Year's operating expenses, insurance, and real estate taxes. Tenant would pay for its own utilities (separately metered).

Potential tenants for the property would include professional services firms, medical office users/healthcare, University of MD, non-profits, etc.

Please let us know if you require any additional information.

Very truly yours,

Douglas W. Brinkley
Senior Managing Director

Matthew L. Seward
Senior Vice President

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Baltimore, MD 21202
tel: +1 410 752 4285
fax: +1 410 576 9031
www.dtz.com

EXHIBIT R

AFFIRMATIONS

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's Certificate of Need Application and its exhibits and tables are true and correct to the best of my knowledge, information, and belief.

Signature

Name/Title

Chief Administrative Officer

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's Certificate of Need Application and its exhibits and tables are true and correct to the best of my knowledge, information, and belief.

Signature

George Watson

Name/Title